

**Thematic Evaluation**  
**UNFPA SUPPORT TO MATERNAL HEALTH**  
**2000-2011**

**VOLUME 2 Annexes**



**Evaluation Branch**  
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# UNFPA Support to Maternal Health (2000-2011)

## Thematic Evaluation

### VOLUME II Annexes

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## List of Acronyms

ABEF	Association de Bien-être Familiale
ABSF	Association Burkinabé des Sage Femmes
ACDI	Agence Canadienne de Développement International
ADB	Asian Development Bank
AFD	Agence Francais de Developpment
AHS	Academy of Health Sciences
AMDD	Adverting Maternal Death and Disability
ANC	Antenatal care
AOP	Annual operational plan
APRO	Asia and the Pacific regional office
ARP	African Regional Programme
ARRA	Administration of Refugees and Returnees Affaires
ARV	Anti-retrovirals
ASRH	Adolescent sexual and reproductive health
AusAid	Australian Agency for International Development
AUW	Afhad University for Women
AWARE	Action for West Africa Region (Reproductive Health)
AWP	Annual work plan
AYRHS	Adolescent and Youth Reproductive Health Strategy
BCC	Behavioral change communication
BDR	Birth and death registry
BEmONC	Basic emergency obstetric and newborn care
BP	Le Bureau-pays
BRIC	Brazil, Russia, India, China
CAP	Consolidated Appeal Process
CAPPD	Cambodia Association of Parliamentarians for Population and Development
CAR	Council for Administrative Reform
CARDI	Caribbean Agricultural Research and Development Institute
CARE	CARE International in Cambodia
CARMMA	Campagne pour l'Accélération de la Réduction de la Mortalité Maternelle en Afrique/ Campaign on Accelerated Reduction of Maternal, New Born and Child Mortality
CBD	Community-based distribution
CC	Commune Council
CCA	Common country assessment
CCCA	Comprehensive community conversation for action
CCP	Comprehensive condom programming
CDCF	Cambodian Development Coordination Forum
CDHS	Cambodia Demographic and Health Survey
CEDAW	Committee on the Elimination of Discrimination against Women
CEmONC	Comprehensive emergency obstetric and newborn care
CEPED	Centre Population et Développement
CERF	Central Emergency Response Fund
CHAG	Christian Health Association of Ghana
CHEMS	Cambodia Health Education and Media Services
CHEW	Community health extension worker
CHPS	Community-based health planning and services
CHR	Centre Hospitalier Régional
CHT	College of Health Science and Technologies
CHU	Centre hospitalier universitaire

CHW	Community health workers
CIDA	Canadian International Development Agency
CIEH	Centre for Information and Education on Health
CIP	Commune investment plan
CIPD	Conférence Internationale sur la Population et le Développement
CIPK	Council of Imams and Preachers of Kenya
CIS	Confédération internationale des sages-femmes
CMA	Country midwife advisor
CMC	Cambodia Midwifery Council
CO	Country office
COAR	Country office annual report
COMOG	Coalition of Muslim Organizations
CORHA	Consortium of Reproductive Health Associations
COST	Country office support team
CP	Country programme
CPA	Country programme assessment
CPAP	Country programme action plan
CPD	Country programme document
CPN	Consultation prénatale
CPR	Contraceptive prevalence rate
CS / C-Section	Caesarean section
CSLP	Cadre Stratégique de Lutte contre la Pauvreté
CSO	Civil society organizations
CSPS	Centre de Santé et de Promotion Sociale
CST	Country support team
CSWG	Contraceptive security working group
CYP	Couple years of protection
DANIDA	Danish International Development Agency
DBC	Distribution à base communautaire
DfID	Department for International Development (UK)
DGCoop	Direction Générale de la Coopération, Burkina Faso
DGISS	Direction Générale de l'Information Sanitaire et de la Statistique
DHD	District Health Department
DHMT	District Health Management Team
DHPES	Direction de l'hygiène publique et de l'éducation pour la santé
DHS	Demographic health survey
DMPA	Depot medroxy progesterone acetate
DOP	Department of organization and personnel
DOS	Division of Oversight Services
DOVVSU	Domestic violence and victim support unit
DP	Development partner
DRH	Department for Reproductive Health
DRH (french)	Direction des Ressources Humaines
DRS	Direction Régionale de la Santé
DS	District sanitaire
DSF	Direction de la Santé de la Famille
DSME	Direction de la Santé de la Mère et de l'Enfant
DVD	Digital video disc
EC	Emergency contraception
ECO	Ethiopian country office
EDS	Enquête démographique et de santé
EF	Equity Fund

EMA	Ethiopian Midwifery Association
EmONC	Emergency obstetric and newborn care
EmONC- IP	Emergency obstetric and newborn care improvement plan
ENSP	École nationale de santé publique
EU	European Union
FACE	Funding authorization certificate of expenditure
FBO	Faith-based organization
FCI	Family Care International
FGAE	Family Guidance Association Ethiopia
FGM	Female genital mutilation
FGM/C	Female genital mutilation/cutting
FIDA	Federation of Women Lawyers
FIFA	Fédération Internationale de Football Association
FMoH	Federal Ministry of Health
FNDP	Fifth National Development Plan
FO	Fistule obstétricale
FP	Family planning
FTIRM	Fast Track Initiative Road Map (for Reducing Maternal and Newborn Mortality)
GATPA	Gestion active de la troisième phase de l'accouchement
GAVI	Global Alliance for Vaccine and Immunization
GBV	Gender-based violence
GCA	Ghana country assessment
GDCC	Government Donor Co-ordination Committee
GDP	Gross domestic product
GF	Global Fund to Fight AIDS
GHS	Ghana Health Service
GIDD	Gender in development division
GIZ	Gesellschaft für Internationale Zusammenarbeit (German Technical Cooperation)
GNC	General Nursing Council
GNI	Gross national income
GoC	Government of Cambodia
GOE	Government of Ethiopia
GOG	Government of the Republic of Ghana
GOK	Government of Kenya
GP	Global programme
GPCC	General population census of Cambodia
GPRHCS	Programme Global pour la Sécurisation en Produits de Santé de la Reproduction/ Global Programme to Enhance Reproductive Health Commodity Security
GPRTU	Ghana Private Road Transport Union
GRMA	Ghana registered midwives' association
GRZ	Government of the Republic of Zambia
GSS	Ghana Statistical Service
GTP	Growth and transformation plan
H4+	UNAIDS, UNFPA, UNICEF, the World Bank, WHO
HACT	Harmonized approach to cash transfers
HAPCO	HIV/AIDS prevention and control office
HCMC	Health Center Management Committee
HEF	Health Equity Fund
HEW	Health extension worker
HIS	Health information system



HIV/AIDS	Human immunodeficiency virus/ acquired immunodeficiency syndrome
HMIS	Health management information system
HPA	Health poverty action
HPN	Health, population and nutrition
HQ	Headquarters
HR	Human resources
HRD	Human resource development
HRH	Human resources for health
HRHDD	Human resource for health development directorate
HSDP	Health sector development programme
HSS	Health systems strengthening
HSSP	Health Sector Support Programme
HSSP I	First Health Sector Support Programme
HSSP II	Second Health Sector Support Programme
HU	Health Unlimited
HWDP	Health workforce development plan
ICAP	International Center for Health Care and Treatment Programmes
ICASA	International Conference on AIDS and STIs in Africa
ICC	Interagency Coordinating Committee
ICM	International Confederation of Midwives
ICMA	International Consortium for Medical Abortion
ICPD	International Conference on Population and Development
IDWG	Institutional development working group
IEC	Information, education and communication
IEOS	Integrated emergency obstetric and surgery
IFC	Individuals, family, community
IFHP	Integrated Family Health Programme
IFIRP	Instituts de formation interrégionaux des paramédicaux
IGR	Intervention à gain rapide
IHP+	International Health Partnership
IMR	Infant mortality rate
INGO	International non-governmental organization
IP	Implementing partner
IPC	Inter-personal communication
IPPF	Fédération internationale pour la planification familiale
IRC	International Rescue Committee
IRSS	Institut de Recherche en Sciences de la Santé
IUCD	Intra uterine contraceptive devices
IUD	Intrauterine devices
JANS	Joint assessment of national strategies
JICA	Japan International Cooperation Agency
JOICEF	Japanese Organization for Cooperation in Family Planning
JPIG	Joint Partner Interface Group
JRM	Joint review meeting
KAP	Knowledge attitude and practice
KCO	Kenya country office
KDHS	Kenyan demographic health survey
KEMSA	Kenya medical supplies agency
KEWOPA	Kenya Women Parliamentary Association
KfW	Kreditanstalt fuer Wiederaufbau (German Development Bank)
KMTC	Kenya Medical Training College
KPHC	Kenya population and housing census

KRC	Kenya Red Cross
KYA	Khmer youth association
L&D	Labor & delivery
Lao PDR	Lao People's Democratic Republic
LMIS	Logistics management and information system
LRHS	Lao PDR reproductive health survey
LSIS	Lao PDR social indicator survey
LSS	Life saving skills
LWU	Lao PDR women union
LYU	Lao PDR youth union
m	Million
M&E	Monitoring and evaluation
MAF	Millennium Development Goals Acceleration Framework
MARP	Most at risk population
MAZ	Midwives Association of Zambia
MCAN	Media communication and advocacy network
MCH	Maternal and child health
md	Milliard
MDA	Maternal death audit
MDBS	Multi-donor budget support
MDGs	Millennium Development Goal
MDR	Maternal death review
MHTE	Maternal Health Thematic Evaluation/ <i>Évaluation Thématique Santé Maternelle</i>
MHTF	Maternal Health Thematic Fund/ <i>Fonds Thématique d'Affectation Spéciale pour la Santé Maternelle</i>
MIC	Ministry of Information and Culture
MICS	Multiple indicator cluster survey
MIS	Management information system
MISP	Minimum Initial Service Package
MMR	Maternal mortality ratio
MMR (french)	Maternité à moindre risque
MNCH	Maternal, newborn and child health
MNH	Maternal and newborn health
MOCC / MoCC	Ministry of Communications
MoE	Ministry of Education
MoEF	Ministry of Economy and Finance
MoEYS	Ministry of Education, Youth and Sports
MoF	Ministry of Finance
MOF&EP	Ministry of Finance & Economic Planning
MoFNP	Ministry of Finance and National Planning
MoG	Ministry of Gender
MOH	Ministry of Health
MOPAN	Multilateral Organization Performance Assessment Network
MoPH	Ministry of Public Health
MoPHS	Ministry of Public Health and Sanitation
MoWA	Ministry of Women Affairs
MOWAC	Ministry of Women and Children's Affairs
MOYAS	Ministry of Youth Affairs and Sports
MPA	Minimum package of activities
MPSC	Medical Product Supply Centre
MSYCD	Ministry of Sports, Youth and Child Development

MTP	Medium-term plan
MTR	Mid-term review
MUMCOP	Mumias muslim community programme, Kenya
MYFF	Multi-year funding framework
N	Total number of respondents
NA	National assessment
NAC	National AIDS Council
NACC	National AIDS Control Council
NADMO	National Disaster Management Organization
NCDM	National Committee on Disaster Management
NCPD	National Committee for Population and Development
NDPC	National Development Planning Commission
NGO	Non-government organization
NHIS	National health insurance scheme
NHPC	National health promotion centre
NIS	National Institute of Statistics
NMNCHC	National maternal newborn child health centre
NPC	National Population Council
NPO	National Programme Officer
NPP	National population policy
NRHP	National reproductive health programme
NSDP	National strategic development plan
OBC	Organization à base communautaire
OC	Outcome
OD	Operational district
OF	Obstetric fistula
OMD	Objectifs du millénaire pour le développement
OMS	Organisation mondiale de la santé
ONG	Organisation non gouvernementale
PAC	Programme coordination and assistance
PADS	Programme d'appui au développement sanitaire
PATH	Programme for appropriate technology in health
PATH	Programme de technologie appropriée en santé
PCM	Programme component manager
PD	Personnel department
PD	Partenaires développement
PDR	People's Democratic Republic
PEER	Participatory ethnographic evaluation and research
PEP	Post exposure prophylaxis
PF	Planification familiale
PFSA	Pharmaceutical Fund Supply Agency
PHD	Provincial Health Department
PMNCH	Partnership for maternal, newborn and child health
PMO	Provincial medical officer
PMTCT	Preventing mother-to-child transmission
PNC	Postnatal care
PNDS	Plan national de développement sanitaire
PNS	Politique nationale de santé
PNSR	Programme national de la santé de reproduction
PoA	Plan of action
PPAG	Planned Parenthood Association of Ghana
PPME	Planning Programme, Monitoring and Evaluation unit

PRS	Poverty reduction strategy
PSI	Population Services International
PSoN	Provincial schools of nursing
PSSPSR	Plan stratégique de sécurisation des produits de santé de la reproduction
PTA	Plan de travail annuel
PTF	Partenaires techniques et financiers
PTME	Prévention de la transmission mère-enfant
RAJECOPOD	Réseau des adolescents et jeunes congolais en population et développement
RAS	Resource allocation system
RBM	Results-based monitoring
RDC	République Démocratique du Congo
RGPH	Recensement général de la population et de l'habitat
RHB	Regional Health Bureau
RHCS	Reproductive health commodity security
RHIYA	Reproductive Health Initiative for Youth in Asia
RHSHF	Reproductive Health Stakeholders Forum
RHTF	Reproductive health thematic fund
RMNCH	Reproductive maternal newborn and child health
RO	Regional office
RSH	Reproductive and sexual health
RTC	Regional training center
SAF	Sampan'asa fampandrosoana (Département/ONG de développement de l'Église de Jésus Christ à Madagascar)
SAG	Sector advisory group
SALAMA	Centrale d'achats de médicaments essentiels et de matériels médicaux de Madagascar
SALFA	Sampan'asa loterana momba ny fahasalamana (Département/ONG de santé de l'Église luthérienne malagasy)
SBA	Skilled birth attendance
SCADD	Stratégie de croissance accélérée et de développement durable
SCEV	Service central education à la vie
SF	Sage femme
SF/ME	Sage femme maïeuticien d'état
SHHS	Sudan household health survey
SIDA	Swedish International Development Cooperation Agency
SIDA (french)	Syndrome de l'immunodéficience acquise
SIGL	Système d'information et de gestion de la logistique
SIGS	Système d'information pour la gestion sanitaire
SM	Santé maternelle
SMAG	Safe motherhood action group
SMN	Santé maternelle et néonatale
SNIS	Système national d'Information sanitaire
SNNPR	Southern Nations, Nationalities and Peoples Region
SONU	Soins obstétricaux et néonataux d'urgence
SONUB	Soins obstétricaux et néonataux d'urgence de base
SONUC	Soins obstétricaux et néonataux d'urgence de complémentaires
SPSR	Sécurité des produits de santé reproductive
SR	Santé reproductive
SRA	Santé de la reproduction des adolescents
SRAJ	Santé de la reproduction des adolescents et des jeunes
SRH	Sexual reproductive health
STI	Sexually transmitted infection

SWAA	Society for women and AIDS action
SWAp	Sector-wide approach
SWG	Sector working group
TA	Technical assistance
TBA	Traditional birth attendant
TC	Technical Committee
TD	Technical Division
TELMA	Télécommunication malagasy (Société)
TFR	Total fertility rate
TL	Team leader
TNA	Training needs assessment
TNDP	Transitional national development plan
ToR	Terms of reference
TOT	Training of trainers
TTF	Thematic Trust Fund
TV	Television
TVET	Technical and vocational education and training
TWG	Technical working group
UBW	Unified budget and workplan
UEMOA	l'Union Économique et Monétaire Ouest Africaine
UN	United Nations
UNAIDS	United Nations Programme on AIDS
UNCT	United Nations country team
UNDAF	United Nations Development Assistance Framework
UNDMT	United Nations Disaster Management Team
UNDP	United Nations Development Programme
UNESCO	United Nations Education, Social and Cultural Organization
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations International Children's Emergency Fund
UNU	United Nations University
UNV	United Nations Volunteers
UNZA	University of Zambia
URCB	Union des religieux et coutumiers du Burkina
US	United States
US\$	US-dollar
USAID	United States Agency for International Development
VCT	Voluntary counseling and testing
VFS	Violence fondée sur le sexe
VHC	Village Health Committee
VIH	Virus de l'immunodéficience humaine
VMW	Village midwives
VSO	Voluntary Services Overseas
WCHC	Women and Child Health Committee
WFP	World Food Programme
WHO	World Health Organization
YFS	Youth-friendly services
ZAMIG	Zambian midwifery interest group
ZANIS	Zambia news and information services
ZDHS	Zambian demographic and health survey
ZUNO	Zambian union of nurses organization

# 1. The global context of maternal health

## 1.1 The global maternal health situation

The global Maternal Mortality Ratio (MMR) has evolved positively, from 400 maternal deaths per 100,000 live births in 1990 to 210 maternal deaths per 100,000 live births in 2010. The MMR in developing regions was 15 times higher than in developed regions. Sub-Saharan Africa (56%) and Southern Asia (29%) accounted for 85% of the global burden in 2010.<sup>1</sup>

The two targets for assessing the fifth Millennium Development Goal (MDG five) ‘*Improve maternal health*’ are reducing the maternal mortality ratio (MMR) by three quarters between 1990 and 2015, and achieving universal access to reproductive health by 2015. However the overall aim of MDG five (a 75% reduction) is very unlikely to be achieved by 2015 as, globally, maternal mortality has fallen by 47% between 1990 and 2010 despite substantial reductions in maternal deaths in many regions of the world, apart from Southern Africa.

A total of 40 countries had high MMR (defined as MMR  $\geq$ 300 maternal deaths per 100,000 live births) in 2010. Among countries with MMR  $\geq$ 100 in 1990, 10 countries that have already achieved MDG five by 2010, nine countries are “on track”, 50 countries are “making progress”, 14 countries have made “insufficient progress”, and 11 are characterized as having made “no progress” and are likely to miss the MDG target unless accelerated interventions are put in place.<sup>2</sup>

A high number of maternal deaths could be prevented with improved access to family planning, adequate prenatal and postnatal care, along with skilled attendance at childbirth and the availability of emergency care for serious obstetric and neonatal complications. The interventions needed to avert maternal deaths require a functioning quality health system.

From 1990 to 2010, globally the number of women dying due to complications during pregnancy and childbirth declined by 47 percent, from 543,000 deaths in 1990 to 287,000 in 2010.<sup>3</sup> In 2008, 1,000 women died every day due to four major causes - severe bleeding after childbirth, infection, hypertensive disorders and unsafe abortion.

The adolescent birth rate decreased globally between 1990 and 2000, but since that time, progress has slowed and disparities between more educated or urban adolescents and rural, less educated and poorer adolescents have increased. The birth rate among girls with a low education level is over four times higher.<sup>4</sup> In some regions where overall fertility has declined, adolescent fertility remains high.

The proportion of women in developing countries who received skilled assistance during delivery increased from 55 percent in 1990 to 65 percent in 2009. Progress was made in all regions, but was especially dramatic in Eastern Asia, Northern Africa and South-Eastern Asia. The long-standing disparity between urban and rural areas is progressively reducing with more rural women receiving skilled assistance during delivery. The countries that have made the least progress are the ones where shortage and inadequate distribution of human resources has

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<sup>1</sup> WHO, Unicef, UNFPA and the WB estimates - Trends in maternal mortality: 1990 to 2010

<sup>2</sup> WHO, Unicef, UNFPA and the WB estimates - Trends in maternal mortality: 1990 to 2010

<sup>3</sup> WHO, Unicef, UNFPA and the WB estimates - Trends in maternal mortality: 1990 to 2010

<sup>4</sup> UNFPA (2010): *How universal is access to reproductive health – a review of evidence*, September 2010 ([http://www.unfpa.org/webdav/site/global/shared/documents/publications/2010/universal\\_rh.pdf](http://www.unfpa.org/webdav/site/global/shared/documents/publications/2010/universal_rh.pdf))

been the largest (i.e. Sub Saharan Africa); hence less than half the women giving birth in these regions are attended by skilled health personnel.<sup>5</sup>

## 1.2 The global maternal health response

The high death rate of women during pregnancy, childbirth or in the immediate postpartum period are due to complex factors related to health care delivery (access to family planning and skilled maternal health care, blood transfusions, anesthesia, sterile conditions and essential drugs) and social factors (poverty, women status, education and empowerment of women, culture and religion). According to UNFPA unavailable, inaccessible, unaffordable or poor quality care is the factor that is fundamentally responsible for so many maternal deaths. The challenge of reducing maternal death is hence multidimensional and needs complementarities between all actors, including non-health actors. Mobilizing communities and governments to understand a woman's right to these resources combined with efforts to eliminate financial, geographic and socio-cultural barriers aims at universal access to reproductive health, and thus will lead to a reduction in the number of maternal deaths.

Since the first international conference devoted to maternal mortality (Safe Motherhood Conference) sponsored by UNFPA, the World Bank and WHO in 1987, a plethora of international development agencies have responded to maternal health and reproductive health issues. Currently two frameworks serve to focus the efforts: The Programme of Action adopted at the International Conference on Population and Development (1995) and the Millennium Development Goals (2000).

Key initiatives supporting maternal health include the Secretary General Global Strategy for Women and Children Health, where a range of stakeholders made a commitment of totaling US\$ 40 billion for improved maternal and child health programmes and services. Strategic partnerships exist at global, regional and national level and UNFPA, the World Health Organization, UNICEF and the World Bank have joined forces to concentrate support in countries with the highest maternal mortality rates, starting with Afghanistan, Bangladesh, the Democratic Republic of the Congo, Ethiopia, India and Nigeria. The "Health Four," or "H4", and UNAIDS focus on backstopping countries' efforts to strengthen their health systems to reduce the maternal mortality ratio by 75 percent and achieve universal access to reproductive health by 2015. Furthermore, entities such as Women Deliver and PMNCH as well as a wide range of NGOs work globally and locally to generate political commitment and financial investment for fulfilling MDG five.

Funds, disbursed globally in support of maternal, newborn and child health activities have increased by 103 percent between 2003 and 2008, whilst the 68 Countdown priority countries received more than 70 percent of all disbursements. In 2009, 54 percent of donor assistance to maternal, newborn and child health was from bilateral agencies, 23 percent from multilateral agencies (World Bank, UNFPA, UNICEF and the European Commission), and 23 percent from the global health initiatives.<sup>6</sup>

Although multilateral institutions increased their overall aid volume by a quarter between 2003 and 2005, their aid stagnated in real terms and their share of overall disbursements fell

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<sup>5</sup> United Nations (2011): The Millennium Development Goals Report 2011  
[http://www.un.org/millenniumgoals/11\\_MDG%20Report\\_EN.pdf](http://www.un.org/millenniumgoals/11_MDG%20Report_EN.pdf)

<sup>6</sup> "Countdown to 2015: Tracking progress in maternal, newborn & child survival" at  
[http://www.who.int/child\\_adolescent\\_health/documents/9789280642841/en/index.html](http://www.who.int/child_adolescent_health/documents/9789280642841/en/index.html)

consistently.<sup>7</sup> A significant source of maternal, newborn and child health funding constitutes funding from foundations (e.g., the Bill & Melinda Gates Foundation), nongovernmental organizations (NGOs), and non-traditional donors (e.g., BRIC countries) and domestic maternal, newborn and child health funding from low- and middle-income countries.

## 2. Evaluation methodology

### 2.1 Evaluation process

The four phases of this assignment were:

- The extended desk phase, which was itself divided into two parts:
  - *Part one (“structuring stage”)* involved the detailed structuring and design of the evaluation, the development of clear evaluation questions and their operationalization using judgment criteria and indicators.
  - *Part two* of the extended desk phase, the “*data collection and analysis stage*”, involved the collection and desk analysis of existing, already documented information on UNFPA maternal health strategy design and its implementation. Based on this analysis, the evaluators developed preliminary hypotheses on UNFPA performance that informed the data collection and analysis during the subsequent field phase (i.e., the implementation of country case studies).
- The field phase, in which ten country case studies were carried out, to deepen the preliminary findings from the extended desk phase, and an online survey was conducted for additional insights from 55 country offices.
- The reporting phase, which brought together the findings from the different components of the two evaluations, and synthesized them in two different reports: one report for the thematic evaluation on maternal health; and the second report for the mid-term evaluation of the MHTF.
- The feedback and dissemination phase, including, if desired, a dissemination seminar, during which our team may present the conclusions and recommendations of the two evaluations. The dissemination phase is outside the scope of this assignment.

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<sup>7</sup> Countdown to 2015: assessment of official development assistance to maternal, newborn, and child health, 2003–08, *Lancet* 2010; 376: 1485–96



## 2.2 Sampling of case study countries

Table 1: Sampling of case study countries: Grouping of desk phase countries that have made large improvements in reducing maternal mortality; 2000 – 2010

CPIA / Administrative Quality	Large Improvements (1-20)							
	MHTF (2008/09)				Not MHTF / MHTF only since 2010			
High (3.5)	High GNI (higher than US\$1,000)		Low GNI (lower than US\$1,000)		High GNI (higher than US\$1,000)		Low GNI (lower than US\$1,000)	
	<i>High HIV Prevalence (6-12%)</i>	<i>Low HIV Prevalence (0-6%)</i>	<i>High HIV Prevalence (6-12%)</i>	<i>Low HIV Prevalence (0-6%)</i>	<i>High HIV Prevalence (6-12%)</i>	<i>Low HIV Prevalence (0-6%)</i>	<i>High HIV Prevalence (6-12%)</i>	<i>Low HIV Prevalence (0-6%)</i>
			Ghana (2009),	Malawi (2008)	Madagascar (2008) (rank 27), Ethiopia (2008),		MHTF 2010: Rwanda	
Medium (3.0)		Benin (2008), Cambodia (2008)				MHTF 2010: Bangladesh, Lao PDR, Nepal,		MHTF 2010: Niger, Sierra Leone
Low (2.5 and below)								MHTF 2010: DRC

**Table 2: Sampling of case study countries: Grouping of desk phase countries that have made relatively small improvements in reducing maternal mortality, 2000 – 2010**

CPIA / Administrative Quality	Little Improvements (41 – 55)							
	MHTF (2008/09)				Not MHTF / MHTF only since 2010			
High (3.5)	High GNI (higher than US\$1,000)		Low GNI (lower than US\$1,000)		High GNI (higher than US\$1,000)		Low GNI (lower than US\$1,000)	
	<i>High HIV Prevalence (6-12%)</i>	<i>Low HIV Prevalence (0-6%)</i>	<i>High HIV Prevalence (6-12%)</i>	<i>Low HIV Prevalence (0-6%)</i>	<i>High HIV Prevalence (6-12%)</i>	<i>Low HIV Prevalence (0-6%)</i>	<i>High HIV Prevalence (6-12%)</i>	<i>Low HIV Prevalence (0-6%)</i>
			Burkina Faso (2008)			No MHTF Kenya	Tanzania (rank 29; but high MMR in 2000)	
Medium (3.0)	Zambia (2008)					No MHTF Cameroon		
Low (2.5 and below)		Sudan (north) (2008), Cote D'Ivoire (2009)				MHTF 2010 Chad		MHTF 2010 Liberia





## 4. Data collection tools applied

**Table 3: Example of the structure of the information matrix for the country case studies**

Issues to assess	Data Sources (documents, stakeholders)											Key assumptions (no need to state the obvious)	Likelihood that assumption is fulfilled (High, Medium, Low)	
	UNFPA HQ	UNFPA Regional Offices	Country Offices	IPs	Government Coordinating Authority (Gov)	Programme Component Manager – SRH (Gov)	Gov (others)	HM+ UNHCR, UNICEF, World Bank, UNDAF)	Other UN Agencies (UNDAF)	Other Donors	Project Visits (all stakeholders)			
<i>JC 1.1. Correspondence between levels of UNFPA SRH / MH support and maternal health needs of vulnerable groups across partner countries</i>														
What qualitative criteria does UNFPA / do regional offices consider when deciding on the resource distribution for MNH between countries?		IP DC <sup>1</sup>	IN <sup>2</sup>										• Resource allocation process is documented in regional offices	High
To what extent have MNH commitments of partner donors influenced UNFPA's own level of commitment to MNH in high needs countries?		IP DC <sup>1</sup>	IN					IN					• Documentation of coordination process between UNFPA and other donors is available	Medium
To what extent did population size influence the distribution of resources among MNH high needs countries?	IP DC	IP DC												High
<i>JC 1.2. (Increased) availability of accurate and sufficiently disaggregated data for targeting most disadvantaged / vulnerable groups</i>														
To what extent do UNFPA/ IP monitoring tools include indicators to capture the specific situation of the most vulnerable?			IN DC	IN DC	IN DC	IN DC								High
To what extent do UNFPA COs utilize information from needs assessments other than the CCAs?			IN DC											High
Has UNFPA identified and targeted "vulnerable ...			...											High

**Table 4: Data collection result matrix per country**

Country case study Zambia (example)		
Issues to assess	Findings on issues, Conclusions for JCs	Issue treated in field mission (yes/no)

**Table 5: Format for interview reports**

INTERVIEW REPORT	Evaluation team member		Date
	Name of interviewee	Function	Place
Issues discussed			
Findings			
Other Observations by Evaluators			

**Table 6: Format for focus group reports**

FOCUS GROUP	Evaluation team member		Date
	Topic/ issues to be addressed		Place
<b>Participants (type, number, etc.)</b>			
<b>Issues discussed</b>			
<b>Findings</b>			
<b>Other Observations</b>			

## 5. Presentation of results of online survey

### 5.1 Introduction

The Evaluation Branch of UNFPA Division of Oversight Services (DOS) has commissioned two independent evaluations in the area of maternal health:

- The Maternal Health Thematic Evaluation (MHTE), to assess to what extent UNFPA overall assistance, i.e.; UNFPA support from all sources: core resources, co-financing and all thematic funds - has been relevant, effective, efficient and sustainable in contributing to the improvement of maternal health.
- The mid-term evaluation of the Maternal Health Thematic Fund (MHTF), to review the design, coordination and added-value of the MHTF as a targeted effort to improve maternal health.

In connection with these evaluations, the evaluation team has conducted an online survey with a sample of 55 UNFPA country offices. The sample had been derived from the overall sampling process as presented in the final report (Volume 1). The purpose of the survey was to complement the ten in-depth country case studies that have been carried out in UNFPA programme countries and the desk review of 22 UNFPA programme countries with representative information from a wider group of country offices on a selection of topics. All 22 countries reviewed during the desk phase and the ten case study countries were included in the survey.

The survey has focused in particular on the following issues:

- Maternal health related support country offices have received from regional offices
- Maternal health related support country offices have received from UNFPA headquarters
- The organizational capacity of country offices with regard to maternal health
- For those countries that have received funds from the Maternal Health Thematic Fund (MHTF), the survey also contains several questions that would provide information on the added value of the MHTF in the three areas mentioned above.

This section presents the results of the online survey without further interpretation. The analysis of the results and their interpretation has been integrated into the main text of the two final reports of the evaluations (volume 1).

Overall, the response rate of the survey reached 100 percent.



## 5.2 Overview of respondents

The sample of 55 countries has been selected during a multiple phase process presented in more detail in Volume 1 under the Methodology Section.

The selected countries are spread over four geographical regions covered by different regional offices (RO). The regional offices provide technical support to country offices (CO). Whenever the text and graphs refer to regional offices and cooperation with regional offices, reference is made to the four regions presented below. The table below presents an overview of the four geographical regions together with their respective coverage of the selected 55 countries<sup>8</sup>.

**Table 7: Regional offices and country offices**

Sub-Saharan Africa		Arab States	
1	Angola	21	Kenya
2	Benin	22	Lesotho
3	Botswana	23	Liberia
4	Burkina Faso	24	Madagascar
5	Burundi	25	Malawi
6	Cameroon	26	Mali
7	Central African Republic	27	Mauritania
8	Chad	28	Mozambique
9	Comoros	29	Niger
10	Congo (Brazzaville)	30	Nigeria
11	Cote d'Ivoire	31	Rwanda
12	Djibouti	32	Senegal
13	DRC	33	Sierra Leone
14	Equatorial Guinea	34	South Africa
16	Ethiopia	36	Tanzania
17	Gambia	37	Togo
18	Ghana	38	Uganda
19	Guinea	39	Zambia
20	Guinea-Bissau	40	Zimbabwe
			<b>Asia and Pacific</b>
			1 Afghanistan
			2 Bangladesh
			3 Bhutan
			4 Cambodia
			5 India
			6 Indonesia
			7 Lao PDR
			8 Nepal
			9 Pakistan
			10 Timor Leste
			<b>Latin America and Caribbean</b>
			1 Bolivia
			2 Haiti

The last section of this survey focused on support provided through the Maternal Health Thematic Fund (MHTF) and thus most answers to questions only include those countries which have benefitted from MHTF. The table below gives an overview of MHTF and non-MHTF recipient countries including an indication of the starting year for MHTF<sup>9</sup>.

<sup>8</sup> The list of countries per region is not exhaustive but limited to the countries participating in the survey.

<sup>9</sup> According to responses from the country offices.

**Table 8: Starting years of funding by MHTF**

<b>MHTF</b>						<b>NON-MHTF</b>		
1	Afghanistan	2010	21	Lao PDR	2010	1	Angola	
2	Bangladesh	2009	22	Liberia	2008	2	Bhutan	
3	Benin	2009	23	Madagascar	2008	3	Bolivia	
4	Burkina Faso	2009	24	Malawi	2009	4	Botswana	
5	Burundi	2009	25	Mali	2010	5	Comoros	
6	Cambodia	2009	26	Mauritania	2009	6	Equatorial Guinea	
7	Cameroon	2009	27	Mozambique	2010	7	Gambia	
8	Central African Republic	2008	28	Nepal	2009	8	India	
9	Chad	2010	29	Niger	2008	9	Indonesia	
10	Congo (Brazzaville)	2009	30	Nigeria	2008	10	Lesotho	
11	Cote d'Ivoire	2010	31	Pakistan	2010	11	South Africa	
12	Djibouti	2009	32	Rwanda	2008	12	Swaziland	
13	DRC	2010	33	Senegal	2010	13	Tanzania	
14	Eritrea	2008	34	Sierra Leone	2010	14	Togo	
15	Ethiopia	2009	35	Somalia	2008	15	Zimbabwe	
16	Ghana	2008	36	Sudan	2009			
17	Guinea	2008	37	Timor Leste	2009			
18	Guinea-Bissau	2008	38	Uganda	2008			
19	Haiti	2010	39	Yemen	2010			
20	Kenya	2008	40	Zambia	2009			

## 5.3 Support from UNFPA regional offices

**Question 5:** On a scale of 1 to 8, please rate the usefulness of the types of support services that you have received from the regional office; with 1 being “not at all useful”; and 8 being “very useful”. (Note: for types of support that you have not received, please select “Not applicable”)

**Table 9:** Usefulness of types of support services received from regional offices

Type of support	Absolute number of times selected by respondents (with 1 being “not at all useful”; and 8 being “very useful”)									Mean
	1	2	3	4	5	6	7	8	N/A	
Standardized workshops on topics proposed by the regional office	1	2	3	2	6	22	9	3	7	<b>5.65</b>
“On-demand”, customized workshops, addressing a topic of your choosing	2	1	1	4	3	3	3	3	35	<b>5.05</b>
In-country technical support (other than workshops) by regional office staff (direct technical support)	1	2	4	3	8	12	3	4	18	<b>5.24</b>
In-country technical support (other than workshops) by external consultant that had been recruited by regional office (facilitation of technical support)	2	1	1	3	7	8	7	2	24	<b>5.39</b>
Provision of guidance documents on issues related to maternal health or maternal health programming	2	1	5	4	3	15	11	7	7	<b>5.69</b>
Technical over phone/ Skype/ e-mail	2	1	3	6	9	9	11	4	10	<b>5.44</b>
Technical cooperation and exchange with another country office (only if facilitated by regional office)	2	3	2	1	3	7	4	4	28	<b>5.19</b>

**Notes:** N=55, n=55; except “Technical cooperation and exchange with another country office (only if facilitated by regional office)”: n=54

**Question 6:** Please consider types of support you ranked highest - What has made these types of support more useful than others?

**Presentation of results (grouped by evaluators without prioritization):**

**Table 10: Reasons for usefulness of support from regional offices**

Reasons for usefulness of support	Number of mentions
Effectiveness and high quality of in-country technical support	10
Relevance and specialization of workshops	10
Efficiency and credibility towards partners by guidance documents	5
Driving force of cooperation between country offices	6
Timely and open communication by technical support via phone/email	4
Others	14

**Notes:** N=55, n=49

**Question 7:** Please consider types of support you ranked lowest - What has made these types of support less useful than others?

**Presentation of results (grouped by evaluators without prioritization):**

**Table 11: Reasons for limited usefulness of support from regional offices**

Reasons for limited usefulness of support	Number of mentions
Technical support not targeted or not qualified	10
Technical constraints regarding internet connection	2
Training not targeted enough/ timing problems of workshops	6
Few documents made available	1
Little support received	20
All support was helpful	2

**Notes:** N=55, n=41

**Question 8:** On a scale of 1 to 8, please rate the usefulness of the support you have received from the regional office for each maternal health related thematic area; with (1) being “not at all useful”; and (8) being “very useful”. (Note: for thematic areas in which you have not received any support, please select “Not applicable”)

**Table 12:** Usefulness of support from regional offices for different maternal health related thematic areas

Thematic area of support	Absolute number of times selected by respondents (with 1 being “not at all useful”; and 8 being “very useful”)									Mean
	1	2	3	4	5	6	7	8	N/A	
Obstetric fistula, including prevention and treatment	0	3	3	2	3	5	10	6	23	<b>5.81</b>
Emergency obstetric and newborn care (EmONC)	1	0	2	2	2	8	11	3	26	<b>6.00</b>
Family planning & reproductive health commodity security	2	0	2	1	4	14	13	9	10	<b>6.20</b>
Midwifery	2	0	1	3	1	9	8	2	29	<b>5.69</b>
Human resources for health (other than midwifery)	2	0	3	5	2	8	3	0	32	<b>4.78</b>
Sexually transmitted infections and reproductive tract infections	1	2	0	6	3	7	5	0	31	<b>5.04</b>
Integration of maternal health with gender	1	3	2	4	5	6	2	4	28	<b>5.04</b>
Integration of maternal health with population and development	3	2	1	4	6	5	1	2	31	<b>4.54</b>

**Notes:** N=55, n=55

**Question 9:** On a scale of 1 to 8, please rate the usefulness of the support you have received from the regional office for each topic related to programme management, with (1) being “not at all useful”; and (8) being “very useful”. (Note: for thematic areas in which you have not received any support, please select “Not applicable”)

**Table 13:** Usefulness of support from regional offices for different topics related to programme management

Topics related to programme management	Absolute number of times selected by respondents (with 1 being “not at all useful”; and 8 being “very useful”)									Mean
	1	2	3	4	5	6	7	8	N/A	
Development of country programmes (CPDs / CPAPs)	9	2	2	3	3	7	10	13	9	<b>5.62</b>
Annual programme planning in maternal health	22	1	1	5	1	5	11	6	22	<b>5.34</b>
Budgeting and financial management	25	2	2	5	1	6	8	3	25	<b>4.93</b>
Knowledge management	25	2	4	2	8	4	7	3	25	<b>4.37</b>
Human resources (consultants)	23	4	3	3	6	3	7	5	23	<b>4.47</b>
Procurement	25	1	4	3	5	1	9	5	25	<b>4.93</b>
Monitoring	18	2	2	3	4	9	9	8	18	<b>5.03</b>
Evaluation	19	2	0	3	4	8	10	7	19	<b>5.26</b>

**Notes:** N=55, n=55, except: Development of country programmes (CPDs / CPAPs) (54), Annual programme planning in maternal health (54), Evaluation (54)

**Question 10:** On a scale of 1 to 8, please rate how satisfied you have been with support from the regional office overall; with (1) being “highly dissatisfied” and (8) being “highly satisfied”.  
(Note: if you have not received any support from regional level, select “N/A”)

**Table 14:** Overall satisfaction with support from regional offices

Support from regional office	Absolute number of times selected by respondents (with 1 being “highly dissatisfied”; and 8 being “highly satisfied”)									Mean
	1	2	3	4	5	6	7	8	N/A	
Overall satisfaction	3	2	3	9	17	12	6	1	2	<b>4.89</b>

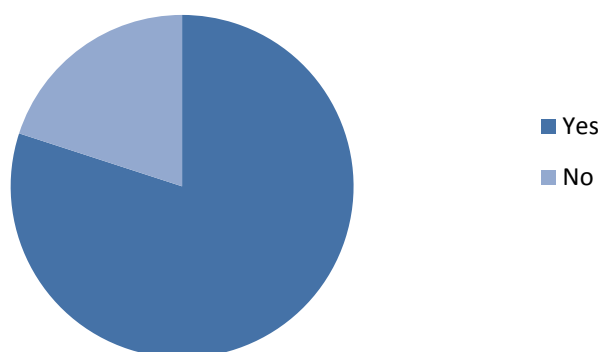
**Notes:** N=55, n=55

**Question 11:** Have you received support from the country office support team (COST) for your country, i.e., prior to the creation of the regional office structure?

**Table 15:** Support received from country office support team

	Support received from COST	
	Yes	No
In absolute figures	44	11

**Support from country office support team (in %)**

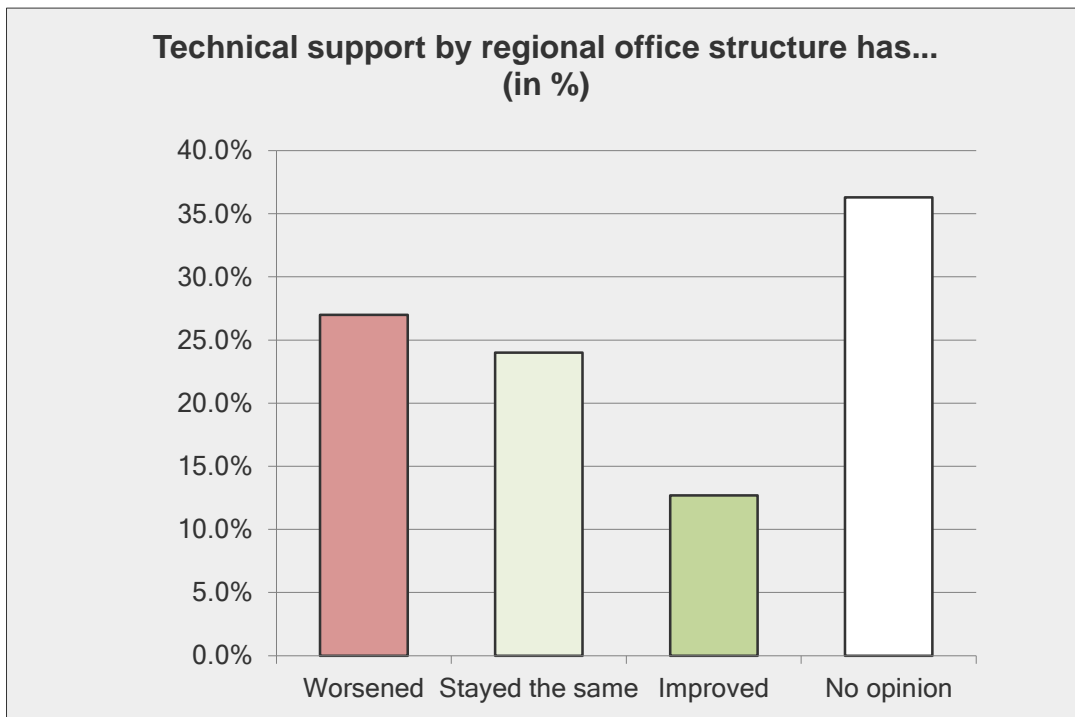


**Notes:** N=55, n=55

**Question 12:** [conditional on answer to question above]  
 In your opinion, with the transition from country office support teams to the regional office structure, has technical support available to your country office a) worsened, b) stayed the same or c) improved?

**Table 16:** Development of technical support with transition from country office support teams to regional office structure

	Support received from regional office structure has...			
	Worsened	Stayed the same	Improved	No opinion
In absolute figures	15	13	7	20
In percent	27%	24%	12.7%	36.3%



**Notes:** N=55, n=55



<b>Question 13:</b>	In your opinion, what are the three most important improvements the regional office should make, in order to make its support more useful to you than it has been in the past (several mentioned possible)?
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**Presentation of results (grouped by evaluators without prioritization):**

**Table 17:** Areas in which improvements from the regional office would be most useful for country offices

Areas in which improvements would be most useful	Number of mentions
Monitoring/ supervision/ field visits	18
Meetings/ communication regional office – country office	22
Sharing experiences/ best practice/ south-south cooperation	20
Technical support/ workshop/ feedback	23
Capacity building/ guidelines	7
Timely support	11
Joint planning/ support of planning process	10
Awareness of country office specific needs	4
Human Resources/ staff regional office	7
Human Resources/ staff country offices	9
Others	10

<b>Notes:</b>	N=55, n=55
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## 5.4 Support from UNFPA headquarters

<b>Question 14:</b>	On a scale of 1 to 8, please rate the usefulness of <u>the types of support services that you have received from UNFPA headquarters</u> ; with (1) being “not at all useful”; and (8) being “very useful”. (Note: for types of support that you have not received, please select “Not applicable”)
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**Table 18:** Usefulness of types of support services received from UNFPA headquarters

Types of support services from UNFPA headquarters	Absolute number of times selected by respondents (with 1 being “not at all useful”; and 8 being “very useful”)									Mean
	1	2	3	4	5	6	7	8	N/A	
Standardized workshops on topics proposed by headquarters	2	1	1	2	7	8	10	7	16	<b>5.89</b>
“On-demand”, customized workshops, addressing a topic of your choice	2	1	0	0	1	3	4	1	43	<b>5.25</b>
In-country technical support (other than workshops) by staff from headquarters (direct technical support)	0	1	2	3	3	7	7	5	27	<b>5.93</b>
In-country technical support (other than workshops) by external consultant that had been recruited by headquarters (facilitation of technical support)	1	1	2	1	2	7	6	4	31	<b>5.79</b>
Provision of guidance documents on issues related to maternal health or maternal health programming	2	1	1	2	6	10	20	10	3	<b>6.25</b>
Technical support over phone/ Skype/ e-mail	2	0	4	8	6	9	14	6	6	<b>5.63</b>
Technical cooperation and exchange with another country office (only if facilitated by regional office)	1	0	1	3	2	4	3	5	36	<b>5.84</b>

<b>Notes:</b>	N=55, n=55; except: “Standardized workshops on topics proposed by the regional office”: n=54
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**Question 15:** On a scale of 1 to 8, please rate the usefulness of the support you have received from UNFPA headquarters for each maternal health related thematic area; with (1) being “not at all useful”; and (8) being “very useful”. (Note: for thematic areas in which you have not received any support, please select “Not applicable”)

**Table 19: Usefulness of support received from UNFPA headquarters for different maternal health related thematic areas**

Thematic areas of support from UNFPA headquarters	Absolute number of times selected by respondents (with 1 being “not at all useful”; and 8 being “very useful”)									Mean
	1	2	3	4	5	6	7	8	N/A	
Obstetric fistula, including prevention and treatment	1	3	2	7	5	8	5	12	12	<b>5.70</b>
Emergency obstetric and newborn care (EmONC)	0	1	1	6	3	8	7	9	20	<b>6.09</b>
Family planning & reproductive health commodity security	0	1	0	1	5	13	12	12	11	<b>6.57</b>
Midwifery	1	2	1	4	5	9	6	6	20	<b>5.68</b>
Human resources for health (other than midwifery)	1	3	1	3	3	4	3	2	35	<b>4.90</b>
Sexually transmitted infections and reproductive tract infections	2	2	1	4	3	1	4	2	36	<b>4.74</b>
Integration of maternal health with gender	2	3	2	4	4	3	4	1	32	<b>4.52</b>
Integration of maternal health with population and development	2	1	1	3	5	3	2	2	35	<b>4.84</b>

**Notes:** N=55, n=55; except: “Midwifery” and “Integration of maternal health with population and development”: n=54.

**Question 16:** On a scale of 1 to 8, please rate the usefulness of the support you have received from UNFPA headquarters for each topic related to programme management; with (1) being “not at all useful”; and (8) being “very useful”. (Note: for thematic areas in which you have not received any support, please select “Not applicable”)

**Table 20:** Usefulness of support received from UNFPA headquarters for different topics related to programme management

Types of support services from UNFPA headquarters related to programme management	Absolute number of times selected by respondents (with 1 being “not at all useful”; and 8 being “very useful”)									Mean
	1	2	3	4	5	6	7	8	N/A	
Development of country programmes (CPDs / CPAPs)	0	0	1	2	8	7	10	5	22	<b>6.15</b>
Annual programme planning in maternal health	0	0	2	2	4	6	11	5	25	<b>6.23</b>
Budgeting and financial management	1	2	0	3	8	8	7	3	23	<b>5.56</b>
Knowledge management	1	1	4	6	7	7	8	4	17	<b>5.37</b>
Human resources (consultants)	1	4	0	4	4	7	3	2	30	<b>4.96</b>
Procurement	0	1	1	3	3	14	14	8	11	<b>6.32</b>
Monitoring	0	0	4	2	2	12	7	2	25	<b>5.76</b>
Evaluation	0	1	3	2	3	9	7	3	27	<b>5.75</b>

**Notes:** N=55, n=55; except “Monitoring”: n=54

<b>Question 17:</b>	From the list below, please rate each documents on the basis of their usefulness for your work of promoting maternal health in your country; on a scale of 1 to 8; with (1) being “not at all useful”; and (8) being “very useful” (Note: for documents that you are not familiar with, please select “Not applicable”)
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**Table 21: Usefulness of documents for promoting maternal health at country level**

Documents related to promoting maternal health	Absolute number of times selected by respondents (with 1 being “not at all useful”; and 8 being “very useful”)									Mean
	1	2	3	4	5	6	7	8	N/A	
<b>Maternal and newborn care</b>										
Managing complications in pregnancy and childbirth: A guide for midwives and doctors (WHO / UNFPA Strategic Partnership Programme)	1	0	0	2	1	11	20	13	7	<b>6.75</b>
Pregnancy, childbirth, postpartum and newborn care: A guide for essential practice (WHO / UNFPA Strategic Partnership Programme)	2	0	0	1	4	14	14	10	10	<b>6.40</b>
Adding it up - The costs and benefits of investing in family planning and maternal and newborn health (2009); UNFPA (financed by MHTF)	2	1	0	1	4	9	17	11	10	<b>6.42</b>
<b>EmONC</b>										
Monitoring emergency obstetric care – A handbook, 2009 (UNFPA, UNICEF, Columbia University/ AMDD Alliance; financed by MHTF)	0	0	0	1	4	10	18	19	3	<b>6.96</b>
<b>Family planning</b>										
Medical eligibility criteria for contraceptive use; third edition (WHO/ UNFPA Strategic Partnership Programme)	0	1	1	3	3	10	18	11	8	<b>6.51</b>
Selected practice recommendations for contraceptive use (WHO/ UNFPA Strategic Partnership Programme)	0	1	1	3	1	9	13	8	19	<b>6.42</b>
<b>Midwifery</b>										
Investing in midwives and others with midwifery skills - Saving the lives of mothers and newborns and improving their health; Author: UNFPA, 2008	0	0	0	5	5	11	13	11	10	<b>6.44</b>

Obstetric fistula										
Living testimony: Obstetric fistula and inequities in maternal health Author: UNFPA. Family Care International, 2007	1	2	3	4	3	8	13	6	15	<b>5.80</b>
Sexually transmitted infections and reproductive tract infections										
Sexually transmitted and other reproductive tract infections; Guidelines for the management of sexually transmitted infections	1	0	3	3	4	8	16	6	14	<b>6.10</b>
Others										
The Maternal Health Thematic Fund - Business Plan; 2008 - 2011	0	2	2	1	3	8	12	10	17	<b>6.34</b>
<b>Notes:</b>	N=55, n=55									

**Question 18:** Please consider the documents you have ranked highest - What has made these documents more useful to you than others (several mentions possible)?

**Presentation of results (grouped by evaluators without prioritization):**

**Table 22: Reasons for high usefulness of documents**

Reasons for high usefulness of documents	Number of mentions
Relevance/ applicability to country situation	6
Practical for planning and programming	13
Practical and useful in the implementation/ in the field	7
Useful tools for advisory to and cooperation with partners	6
Good evidence basis for awareness rising and advocacy	8
Useful instruments for training and capacity development	10
Good readability/ high quality	3

**Notes:** N=55, n=49

<b>Question 19:</b>	Please consider the documents you ranked lowest - What has made these documents <u>less useful to you than others?</u>
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**Presentation of results (grouped by evaluators without prioritization):**

**Table 23: Reasons for low usefulness of documents**

Reasons for low usefulness of documents	Number of mentions
Not being familiar with them	8
Topic of document was not relevant to the country context	6
None availability of document in local language to share with partners	2
Too theoretical, too generalized information	7
Too specialized	1
Outdated	1
All documents are useful	6

<b>Notes:</b>	N=55, n=33
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<b>Question 20:</b>	In your opinion, what are the three most important improvements <u>UNFPA headquarters</u> should make, in order to make its support more useful to you than it has been in the past?
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**Presentation of results (grouped by evaluators, no prioritization):**

**Table 24: Areas in which improvements from UNFPA headquarters would be most important**

Areas in which improvements from UNFPA headquarters would be most important	Number of mentions
More and closer monitoring or supervision/ more field visits	14
Closer communication between headquarters and country office	7
Enhance knowledge sharing/ distribution of best practices/ strengthen south-south cooperation	12
Communication in appropriate languages/ provide necessary translations	8
More training/ workshops	13
Provision of more technical support, improve technical support	10
Provision of more and better financial assistance	6
Timely support on requests, for deliveries and funds	7
Appropriate staff management and development in country offices	8
Strengthen involvement of country offices and respecting country needs	8
Clarify role of regional offices	4
Strengthen cooperation and division of labour with other UN agencies	2
Improve strategic planning and programming cycles	5
Others	5

<b>Notes:</b>	N=55, n=55
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**Question 21:** On a scale of 1 to 8, please rate how satisfied you have been with support from UNFPA headquarters overall; with 1 being “highly dissatisfied” and 8 being “highly satisfied”.  
(Note: if you have not received any support from UNFPA headquarters, please select “N/A”)

**Table 25: Overall satisfaction with support services received from UNFPA headquarters**

	Absolute number of times selected by respondents (with 1 being “highly dissatisfied”; and 8 being “highly satisfied”)									Mean
	1	2	3	4	5	6	7	8	N/A	
Overall satisfaction with support from UNFPA headquarters	1	1	5	3	9	15	14	3	4	<b>5.63</b>

**Notes:** N=55, n=55

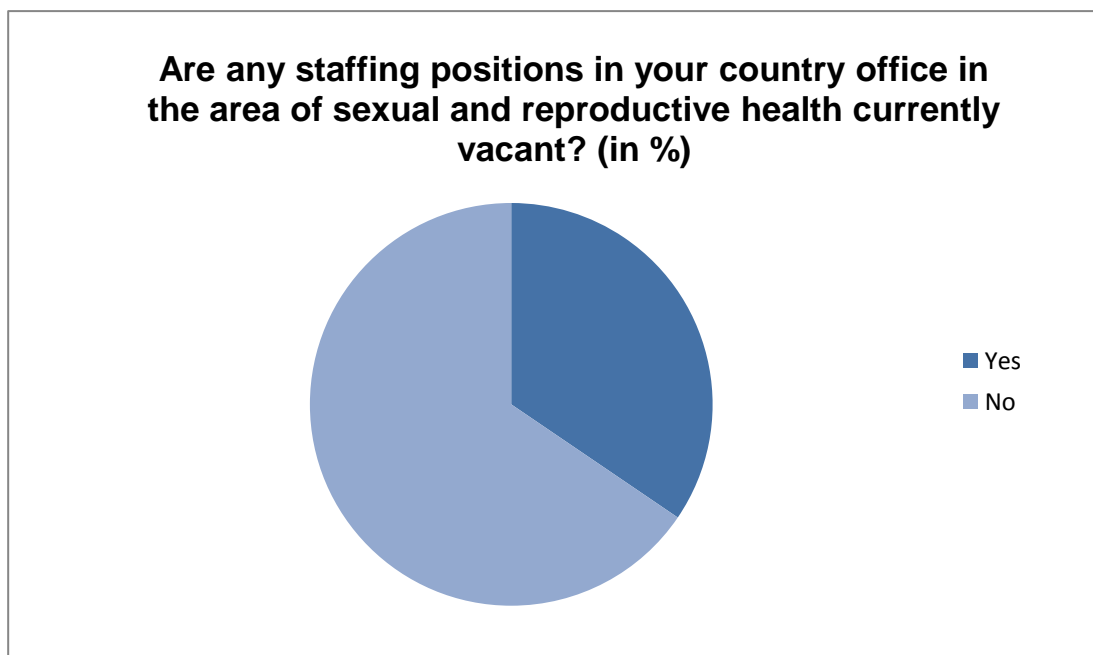


## 5.5 Country office capacity – maternal health

<b>Question 22:</b>	Are any staffing positions in your country office in the area of sexual and reproductive health currently vacant?
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**Table 26: Vacancy of staffing positions**

	Staff positions vacant	
	Yes	No
In absolute figures	19	36



<b>Notes:</b>	N=55, n=55
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<b>Question 23:</b>	[conditional on answer to question before] Please list the positions that have remained vacant and indicate the number of months they have remained vacant.
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**Average vacancy time: 15 months**

**List of positions that have remained vacant (grouped by evaluators, no prioritization):**

*National programme officer reproductive health*

*National programme officer reproductive health in charge of reproductive health commodity security and MHTF, vacant for 1 year*

*National programme officer maternal health/reproductive health commodity security, vacant for 2 months.*

*National programme officer reproductive health officer (6 months)*

*Reproductive health/ HIV programme officer, vacant 6 months*

*Adolescent sexual reproductive health officer programme officer, vacant 18 months*

<i>Reproductive health national officer 1, vacant 48 month</i>	
<i>Reproductive health national programme officer, vacant one year</i>	
<i>Adolescent sexual reproductive health officer (new) programme associate, 4 months</i>	
<i>Head, reproductive health unit, vacant 5 months</i>	
<i>Reproductive health policy national programme officer, vacant 4 years</i>	
<i>National programme professional personnel, Ministry of Health</i>	
<i>National programme officer VIH/SIDA 36 mois</i>	
<i>National programme officer gender-based violence, vacant 12 months</i>	
<i>National officer, level B health system strengthening officer, vacant 3 months</i>	
<i>Project officer fistula, vacant 4 months</i>	
<i>Conseiller technique principale reproductive health, vacant 48 months</i>	
<i>Monitoring and evaluation in reproductive health and maternal health component, vacant 2 months</i>	
<i>Reproductive health/ gender-based violence programme specialist 1, vacant 5 months</i>	
<i>Reproductive health/ gender-based violence programme specialist 1, vacant 18 months</i>	
<i>Technical advisor reproductive health commodity security, vacant 5 months</i>	
<i>Deputy representative (as programme director), vacant 14 months</i>	
<i>Assistant representative, vacant 3 years</i>	
<i>Engineering training consultant, vacant 6 months</i>	
<b>Notes:</b>	N=19, n=19

**Question 24:** On a scale of 1 to 8, please indicate to what extent you completely disagree (1) or completely agree (8) with the following statements regarding the number of staffing positions for maternal health in your country office.

**Table 27: Statements regarding number of staffing positions for maternal health**

Statements regarding the number of staffing positions for maternal health	Absolute number of times selected by respondents (with 1 being “completely disagree”; and 8 being “completely agree”)									Mean
	1	2	3	4	5	6	7	8	N/A	
The number of staffing positions in maternal health in the last three years has been fully adequate to do policy advocacy for maternal health with our partners (government & development partners)	5	6	4	5	10	10	10	3	2	<b>4.77</b>
The number of staffing positions in maternal health in the last three years has been fully adequate to make technical contributions in maternal health (e.g. leading of technical working groups, provision of technical guidance on maternal health)	4	5	7	4	7	13	10	3	2	<b>4.87</b>
The number of staffing positions in maternal health in the last three years has been fully adequate to establish UNFPA as the lead agency for policy advocacy to promote maternal health	5	5	3	8	6	12	10	3	3	<b>4.85</b>
The number of staffing positions in maternal health in the last three years has been fully adequate to fulfill all of our responsibilities related to the overall maternal health component of the country programme	4	9	9	5	5	10	10	1	2	<b>4.38</b>

**Notes:** N=55, n=55

**Question 25:** On a scale of 1 to 8, please indicate to what extent you completely disagree (1) or completely agree (8) with the following statements regarding the types of skills available / the skill mix in your country office for maternal health support.

**Table 28:** Statements regarding the types of skills/ skill mix available in country offices for maternal health support

Statements regarding the number of staffing positions for maternal health	Absolute number of times selected by respondents (with 1 being “completely disagree”; and 8 being “completely agree”)								Mean
	1	2	3	4	5	6	7	8	
The skill mix available in the country office in the last three years has been fully adequate to do effective policy advocacy for maternal health with our partners (Government & development partners)	2	2	5	8	8	14	14	2	<b>5.29</b>
The skill mix available in the country office in the last three years has been fully adequate to make meaningful technical contributions in maternal health (e.g. leading of technical working groups, provision of technical guidance)	1	1	6	7	6	18	11	5	<b>5.53</b>
The skill mix available in the country office in the last three years has been fully adequate to kick-start new initiatives in maternal health (e.g. the introduction of new concepts or approaches)	1	1	7	8	9	15	10	4	<b>5.33</b>
The skill mix available in the country office in the last three years has been fully adequate to kick-start new initiatives in maternal health (e.g. the introduction of maternal health).	1	2	5	8	8	12	15	4	<b>5.47</b>
The types of skills available in the country office in the last three years have been fully adequate to establish UNFPA as the lead agency for evidence-based technical contributions to promote maternal health.	1	2	5	10	10	10	14	3	<b>5.31</b>
The skill mix available in the country office in the last three years has been fully adequate to fulfill all of our responsibilities related to the overall maternal health component of the country programme.	1	3	6	11	8	6	18	2	<b>5.22</b>

**Notes:** N=55, n=55

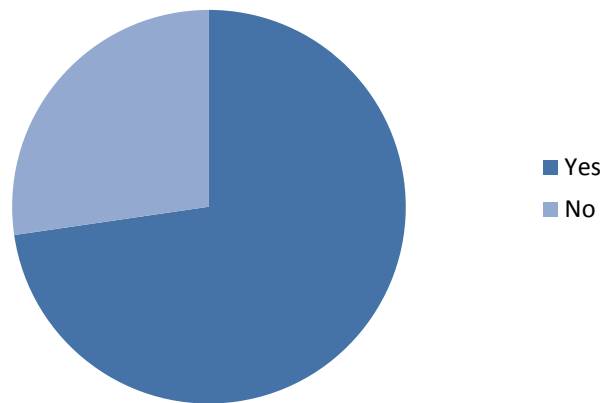
## 5.6 Maternal Health Thematic Fund (MHTF)

**Question 26:** Has your country office received funding from the Maternal Health Thematic Fund [if no, please continue with question 34]

**Table 29:** Funding received from MHTF

	Funding received from MHTF	
	Yes	No
In absolute figures	40	15

**Received funding from MHTF? (in %)**

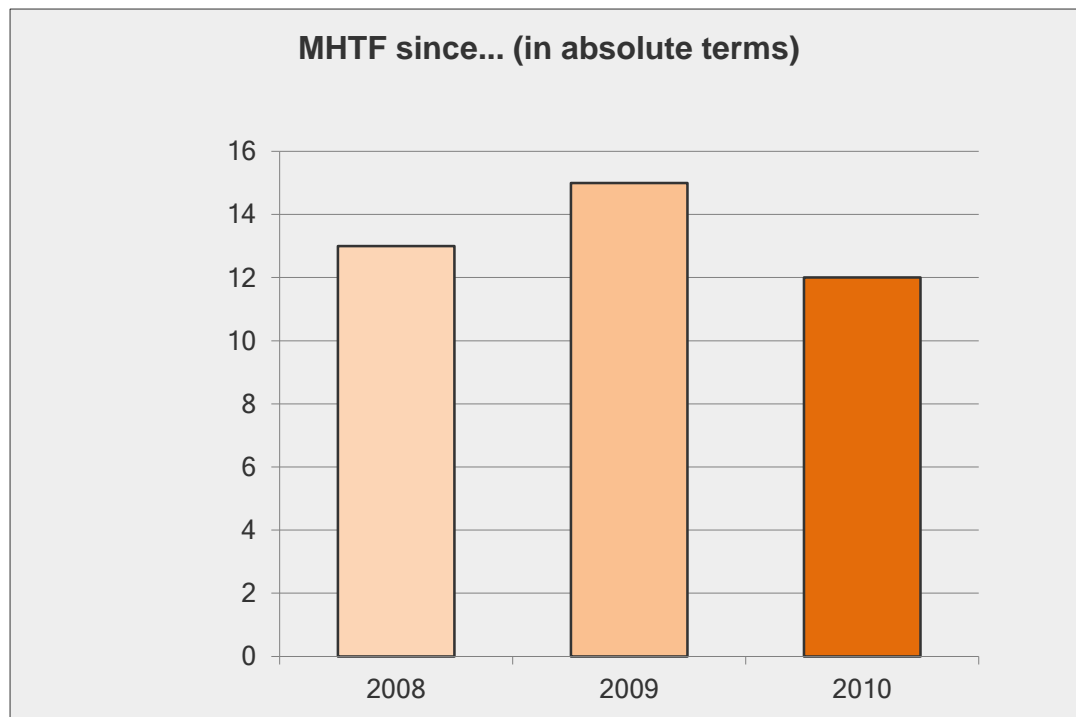


**Notes:** N=55, n=55

**Question 27:** Which was the first year your country office has received funding from the MHTF?

**Table 30:** Start year of funding by MHTF

	Support received from MHTF as of year...		
	2008	2009	2010
In absolute figures	13	15	12
In percent	32,5	37,5	30



**Notes:** N=40, n=40

**Question 28:** On a scale of 1 to 8, please indicate for each type of assistance to what extent the launch of the MHTF has improved the usefulness of assistance that you have received from the regional level of UNFPA; with (1) indicating “no improvement at all” and (8) indicating “a lot of improvement” (Note: for types of support that you have not received, please select “Not applicable”)

**Table 31: Improvement of usefulness of different types of assistance from regional offices since the launch of MHTF**

Type of assistance received from UNFPA regional level since the launch of MHTF	Absolute number of times selected by respondents (with 1 being “no improvement at all”; and 8 being “a lot of improvement”)									Mean
	1	2	3	4	5	6	7	8	N/A	
Standardized workshops on topics proposed by the regional office	1	2	2	5	4	8	6	2	10	<b>5.23</b>
“On-demand”, customized workshops, addressing a topic of your choosing	2	1	0	1	2	3	4	1	26	<b>5.14</b>
In-country technical support (other than workshops) by regional office staff (direct technical support)	3	1	3	4	4	6	6	1	12	<b>4.86</b>
In-country technical support (other than workshops) by external consultant that had been recruited by regional office (facilitation of technical support)	3	2	0	2	2	6	5	4	16	<b>5.33</b>
Provision of guidance documents on issues related to maternal health or maternal health programming	1	2	5	1	2	6	12	3	8	<b>5.56</b>
Technical support over phone/Skype/ e-mail	2	1	3	4	1	7	10	1	11	<b>5.31</b>
Technical cooperation and exchange with another country office (only if facilitated by regional office)	3	2	3	2	2	4	6	3	15	<b>4.96</b>

**Notes:** N=40, n=40

**Question 29:** On a scale of 1 to 8, , please indicate in the different technical areas to what extent the launch of the MHTF has improved the usefulness of the assistance that you have received from the regional level of UNFPA, with (1) indicating “no improvement at all” and (8) indicating “a lot of improvement” (Note: for thematic areas in which you have not received any support, please select “Not applicable”)

**Table 32: Improvement of usefulness of assistance in different technical areas from regional offices since the launch of MHTF**

Technical area support received from UNFPA regional level since the launch of MHTF	Absolute number of times selected by respondents (with 1 being “no improvement at all”; and 8 being “a lot of improvement”)									Mean
	1	2	3	4	5	6	7	8	N/A	
Obstetric fistula, including prevention and treatment	0	3	1	0	4	8	10	7	7	<b>6.15</b>
Emergency obstetric and newborn care (EmONC)	1	2	0	3	1	3	10	6	14	<b>6.08</b>
Family planning & reproductive health commodity security	2	1	1	1	4	7	10	7	7	<b>6.03</b>
Midwifery	0	2	0	6	2	6	6	4	14	<b>5.69</b>
Human resources for health (other than midwifery)	2	1	3	4	2	6	2	0	20	<b>4.45</b>
Sexually transmitted infections and reproductive tract infections	3	2	1	3	1	6	2	0	22	<b>4.28</b>
Integration of maternal health with gender	3	2	0	3	2	8	2	0	20	<b>4.55</b>
Integration of maternal health with population and development	3	1	1	3	2	2	2	1	25	<b>4.27</b>

**Notes:** N=40, n=40



**Question 30:** On a scale of 1 to 8, please indicate to what extent the launch of the MHTF has improved the usefulness of the assistance that you have received from the regional level of UNFPA in the different areas of programme planning and management; with (1) for “no improvement at all” and (8) for “a lot of improvement”.  
(Note: for thematic areas in which you have not received any support, please select “Not applicable”)

**Table 33: Improvement of usefulness of assistance from regional offices since the launch of MHTF in different areas of programme planning and management**

Support received from UNFPA regional level since the launch of MHTF related to programme planning and management	Absolute number of times selected by respondents (with 1 being “no improvement at all”; and 8 being “a lot of improvement”)									Mean
	1	2	3	4	5	6	7	8	N/A	
Development of country programmes (CPDs / CPAPs)	0	1	2	1	2	8	7	2	17	<b>5.87</b>
Annual programme planning in maternal health	0	0	0	2	2	10	8	3	15	<b>6.32</b>
Budgeting and financial management	1	0	2	1	3	8	10	0	15	<b>5.76</b>
Monitoring	1	0	3	2	2	14	3	0	15	<b>5.32</b>
Evaluation	0	1	0	3	4	12	4	1	15	<b>5.68</b>

**Notes:** N=40, n=40

**Question 31:** On a scale of 1 to 8, please rate how satisfied you have been with support from the regional office since the launch of the MHTF; with 1 being “highly dissatisfied”; and 8 being “highly satisfied”.  
(Note: if you have not received any support from regional level since the launch of MHTF, select “N/A”)

**Table 34: Overall satisfaction with support from regional offices since the launch of MHTF**

	Absolute number of times selected by respondents (with 1 being “highly dissatisfied”; and 8 being “highly satisfied”)									Mean
	1	2	3	4	5	6	7	8	N/A	
Overall satisfaction with support from UNFPA regional offices since the launch of MHTF	2	2	4	5	5	9	8	1	4	<b>5.03</b>

**Notes:** N=40, n=40

**Question 32:** On a scale of 1 to 8, please indicate to what extent the launch of the MHTF has improved types of skills available / the skill mix in your country office in different areas; with (1) for “no improvement at all” and (8) for “a lot of improvement”.

**Table 35: Improvement of types of skills/ skill mix available in country offices in different areas since the launch of MHTF**

Types of skills/ skill mix available in different areas since the launch of MHTF	Absolute number of times selected by respondents (with 1 being “no improvement at all”; and 8 being “a lot of improvement”)								Mean
	1	2	3	4	5	6	7	8	
Because of the launch of the MHTF, the skill mix available in my country office to do effective policy advocacy for maternal health with our partners (Government & development partners) has....	3	3	1	6	7	5	10	5	<b>5.28</b>
Because of the launch of the MHTF, the skill mix available in my country office to make meaningful technical contributions (e.g. leading of technical working groups, provision of technical guidance on maternal health) in maternal health has...	4	2	2	3	7	4	15	3	<b>5.35</b>
Because of the launch of the MHTF, the skill mix available in my country office to kick-start new initiatives in maternal health (e.g. the introduction of new concepts or approaches) has...	4	1	2	2	8	6	12	5	<b>5.50</b>
Because of the launch of the MHTF, the skill mix available in my country office to establish UNFPA as the lead agency for policy advocacy to promote maternal health has...	3	1	3	5	4	5	17	2	<b>5.48</b>
Because of the launch of the MHTF, the skill mix available in my country office to establish UNFPA as the lead agency for evidence-based technical contributions to promote maternal health has...	3	2	3	3	6	7	13	3	<b>5.38</b>
Because of the launch of the MHTF, the skill mix available in my country office to fulfill all of our responsibilities related to the overall maternal health component of the country programme has...	3	2	3	3	4	6	17	2	<b>5.48</b>
Because of the launch of the MHTF, the skill mix available in my country office to appropriately monitor and evaluate our maternal health interventions has...	3	2	3	6	9	5	11	1	<b>5.00</b>

**Notes:** N=40, n=40

**Question 33:** On a scale of 1 to 8, please indicate in which areas, even after the launch of the MHTF the greatest gaps remain between the current staff capacity of the country office team (positions & skill mix) and the staff capacity needed to fulfill its maternal health mandate; with (1) “no staffing gaps remain” and (8) “significant staffing gaps remain”.

**Table 36: Remaining gaps in staff capacities after the launch of MHTF**

Areas of staff capacity	Absolute number of times selected by respondents (with 1 being “no staffing gaps remaining”; and 8 being “significant staffing gaps remain”)								Mean
	1	2	3	4	5	6	7	8	
With regard to staff capacity for effective policy advocacy for maternal health with our partners (Government & development partners)...	4	7	5	6	4	5	9	0	<b>4.25</b>
With regard to staff capacity to make technical contributions in training of human resources for health...	5	7	5	4	6	5	6	2	<b>4.20</b>
With regard to staff capacity to make technical contributions in training of midwives...	3	7	6	7	4	4	5	4	<b>4.35</b>
With regard to staff capacity to make technical contributions in addressing regulatory and policy-related issues in human resources for health...	5	5	5	9	3	6	6	1	<b>4.18</b>
With regard to staff capacity to make meaningful technical contributions (e.g. leading of technical working groups, provision of technical guidance on maternal health)....	7	7	4	7	5	4	5	1	<b>3.83</b>
With regard to staff capacity to appropriately monitor and evaluate our maternal health interventions...	2	8	2	8	5	8	7	0	<b>4.45</b>
With regard to staff capacity to fulfill all of our responsibilities related to the overall maternal health component of the country programme...	5	6	2	8	7	5	4	3	<b>4.30</b>

**Notes:** N=40, n=40

<b>Question 34:</b>	If you would like to give us any other feedback regarding UNFPA's work in maternal health, please feel free to provide it here...
<b>Presentation of results:</b> Results are available to the evaluators only due to confidentiality and have been taken into account for the analysis presented in the final report (Volume 1).	

## 6. Overview: Evaluation questions

<b>Evaluation question 1:</b> <i>To what extent is UNFPA maternal health support adequately focused on addressing the reproductive and maternal health needs of the vulnerable groups among countries and within countries?</i>	
<b>Judgment criteria</b>	1.1. Correspondence between levels of UNFPA sexual and reproductive health/ maternal health support and maternal health needs of vulnerable groups across programme countries
	1.2. (Increased) availability of accurate and sufficiently disaggregated data for targeting most disadvantaged / vulnerable groups
	1.3. Needs orientation of planning and design of UNFPA supported interventions
<b>Evaluation question 2:</b> <i>To what extent has UNFPA successfully contributed to the harmonization of efforts to improve maternal health, in particular through its participation in strategic and multi-sectoral partnerships at global, regional and national level?</i>	
<b>Judgment criteria</b>	2.1. Harmonization in maternal health partnerships between UNFPA and United Nations (UN) organizations and World Bank (including H4+) at global, regional and country level
	2.2. Harmonization of maternal health support through partnerships at country and South-South/ regional
	2.3. UNFPA participation in partnerships for producing evidence for policy debates and definition and prioritization of coordinated operational maternal health research agenda
<b>Evaluation question 3:</b> <i>To what extent has UNFPA support contributed to a stronger involvement of communities that has helped to increase current levels of demand and utilization of services, in particular through its partnerships with civil society?</i>	
<b>Judgment criteria</b>	3.1. Government commitment to involve communities translated in sexual and reproductive health and maternal health strategies through UNFPA support
	3.2. Civil society organization (CSO) involvement in sensitization on maternal health issues and facilitating community-based initiatives to address these issues supported by UNFPA
<b>Evaluation question 4:</b> <i>To what extent has UNFPA contributed to the strengthening of human resources for health planning and human resource availability for maternal health?</i>	
<b>Judgment criteria</b>	4.1. Development strengthening of national human resources for health (HRH) policies, plans and frameworks (with UNFPA support)
	4.2. Strengthened competencies of health workers in HIV/AIDS, family planning, obstetric fistula, skilled birth attendance and EmONC to respond to sexual and reproductive health/ maternal health needs
<b>Evaluation question 5:</b> <i>To what extent has UNFPA anticipated and responded to reproductive health threats in the context of humanitarian emergencies?</i>	
<b>Judgment criteria</b>	5.1. Inclusion of sexual and reproductive health in emergency preparedness, response and recovery plans
	5.2. Accessibility of quality EmONC, family planning and reproductive health/ HIV services in emergency and conflict situations
	5.3. Accessibility to medical products in emergency and conflict situations
<b>Evaluation question 6:</b> <i>To what extent has the UNFPA contributed to the scaling up and increased utilization of and demand for</i>	

<i>family planning?</i>	
<b>Judgment criteria</b>	6.1. Increased capacity within health system for provision of quality family planning services in UNFPA programme countries
	6.2. Increased demand for and utilization of family planning services in UNFPA partner countries, particularly among vulnerable groups
	6.3. Improved access to contraceptives (commodity security)
<b>Evaluation question 7:</b> <i>To what extent has UNFPA contributed to the scaling up and utilization of skilled attendance during pregnancy and childbirth and EmONC services in programme countries?</i>	
<b>Judgment criteria</b>	7.1. Increased access to EmONC services
	7.2. Increased utilization of EmONC services
<b>Evaluation question 8:</b> <i>To what extent has UNFPA use of internal and external evidence in strategy development, programming and implementation contributed to the improvement of maternal health in its programme countries?</i>	
<b>Judgment criteria</b>	8.1. Integration of relevant evidence and UNFPA results data during global strategy development and implementation (Multi-Year Funding Framework 1 and 2, Strategic Plan; Sexual and Reproductive Health Framework)
	8.2. Consideration and integration of relevant maternal health / sexual and reproductive health evidence and results data during development of country strategies
	8.3. Results- and evidence based management of individual interventions throughout project life
<b>Evaluation question 9:</b> <i>To what extent has UNFPA helped to ensure that maternal health and sexual and reproductive health are appropriately integrated into national development instruments and sector policy frameworks in its programme countries?</i>	
<b>Judgment criteria</b>	9.1. UNFPA support improved comprehensiveness of analysis of causes for poor maternal health and of effectiveness of past maternal health policies/ strategies
	9.2. Maternal health and sexual reproductive health integration into policy frameworks and development instruments based on (UNFPA supported) transparent and participatory consultative process
	9.3. Monitoring and evaluation of implementation of sexual and reproductive/ maternal health components of national policy framework and development instruments
<b>Evaluation question 10:</b> <i>To what extent have UNFPA maternal health programming and implementation adequately used synergies between UNFPA sexual and reproductive health portfolio and its support in other programme areas?<sup>10</sup></i>	
<b>Judgment criteria</b>	10.1. Linkages established between programmes (reproductive health with gender and population & development) in intervention design
	10.2. Integration of monitoring and reporting of UNFPA operations
<b>Evaluation question 11:</b> <i>To what extent has UNFPA been able to complement maternal health programming and implementation at country level with related interventions, initiatives and resources from the regional and global level to maximize its contribution to maternal health?</i>	
<b>Judgment criteria</b>	11.1. Clarity of division of labor and delineation of responsibilities between UNFPA global, regional and country offices
	11.2. Alignment of UNFPA organizational capacities at country level and the (intended) division of labor and delineation of responsibilities
	11.3. Enhancement/ improvement of UNFPA country level programming and interventions through technical and programmatic support from global and regional level

<sup>10</sup> Gender (including female genital mutilation/ cutting, gender-based violence, HIV-PMTCT (prevention of mother-to-child HIV transmission), population and development.

**Evaluation question 12:**

*To what extent did UNFPA maternal health support contribute to the visibility of UNFPA in global, regional and national maternal health initiatives and help the organization to increase financial commitments to maternal health at national level?*

<b>Judgment criteria</b>	12.1. UNFPA presence in global and regional maternal health initiatives
	12.2. UNFPA leadership of maternal health advocacy campaigns at national level
	12.3. Increased financial commitments of partner governments to sexual reproductive health and maternal health

## 7. Typology

**Evaluation question 2: To what extent has UNFPA successfully contributed to the harmonization of efforts to improve maternal health, in particular through its participation in strategic and multi-sectoral partnerships at global, regional and national level?**

**Judgment criterion 2.1: Harmonization in maternal health partnerships between UNFPA and United Nations (UN) organizations and World Bank (including H4+) at global, regional and country level**

Activity type	Programming Periods		Description & Examples (Country; year)	Is (typically) associated with following outputs	Countries where this activity was implemented / planned (selection)
	2004 - 2007	2008 - 2010			
Participation in Global MH partnerships	X	X	<i>E.g., UNFPA participation in the “Partnership for Maternal, Newborn and Child Health”; “Safe Motherhood Initiative”</i>	N/A	N/A
Support of Government-owned sector strategies (e.g., health SWAps, Other national programmes) <b>(not only UN)</b>	X	X	<p><i>UNFPA support of health SWAps, which includes participation in various SWAp committees, technical and financial support of SWAps (often through basket funding); Technical support also delivered through “joint programmes” (see above).</i></p> <p><u>Examples:</u></p> <ul style="list-style-type: none"> <li>UNFPA began shifting from project approach to programme approach during Fifth Country Programme and has been a major player in the design and implementation of the Malawi Sector Wide Approach (SWAp) (Malawi CPAP 2008 -2011; lessons learned in 2002-2007)</li> <li>UNFPA participated in SWAp under 5<sup>th</sup> CP (2002 -2006), started to contribute to basket funding in 2004 (Tanzania CPAP 2007-2011, lessons learned 2002 -2006).</li> <li>UNFPA participation in multi-sectoral steering committee for the National Fistula Programme (Tanzania CPAP 2007 – 2011).</li> <li>UNFPA will continue to support the sector wide approach to the health sector and contribute to the district basket following the recommendations of the RH resource flow study of June 2005 (Zambia, CPAP 2007 – 2010).</li> <li>Government-donor coordination in RH/MH and to advance health SWAP approach within the Ministry of Health (Cambodia, AWP 2007)</li> </ul>	N/A	Malawi Tanzania Zambia Cambodia Ghana Nepal
Support of other Government-owned strategies		X	<ul style="list-style-type: none"> <li>Towards contributing on Universal access and utilization of quality maternal health services including the prevention of unsafe abortion and management of its</li> </ul>		Sudan



with smaller scopes (e.g., midwifery strategy)			complications, UNFPA will support (MHTF 2009-10): The development and endorsement of the Midwifery strategy (2009 -2011).		
Implementation of joint programmes in RH, i.e. with UNICEF, WHO, others		X	<p><i>Multi-component programmes, implemented together with key (UN) partners, e.g. WHO, UNICEF. Joint programme is often (but now always) used to offer support of health SWAp from the UN family (e.g. Tanzania). In Liberia, however, joint programme exists w/o health SWAp in existence.</i></p> <p><u>Examples:</u></p> <ul style="list-style-type: none"> <li>• At national level [UNFPA] will promote joint programmes with the United Nations Children's Fund (UNICEF), the United Nations World Food Programme (WFP), the Food and Agriculture Organization (FAO), United Nations Development Programme (UNOP) and the World Bank (Zambia CPAP 2007-2010)</li> <li>• Program on Reducing Maternal Mortality and morbidity which is in the process of implementation in partnership with the MOHSW and WHO (Liberia CPAP 2008 – 2012)</li> <li>• UNFPA/World Bank partnership on Sexual and Reproductive Health and rights aimed at reducing STIs/HIV/AIDS among war-affected youth; UN joint program on HIV/AIDS (Liberia CPAP 2008 – 2012)</li> <li>• Joint program will be carried out in the five target regions with other UN Agencies where a consolidated annual work plan, budget and M&amp;E will be followed. Joint programming with UNDP, ILO, UNAIDS, UNICEF, UNESCO and WHO will also be undertaken in various nation-wide programme activities (Ghana).</li> <li>• Exploratory discussions have taken place on joint programming on HIV/AIDS and safe motherhood with the United Nations Children's Fund (UNICEF) (Nepal, AWP 2008).</li> <li>• With UNICEF, WHO, OHCHR, UNAIDS, UNV and UNDP develop joint programs and joint programming in several areas including for maternal and neonatal care, decentralization and service delivery, SGBV</li> <li>• and HIV/AIDS; an MoU with UNIFEM on joint activities on a National Action Plan on UNSCR 1325 is being sought; and work with UNMIN and other bilateral agencies and NGOs; A joint United Nations presence (UNDP, UNICEF, UNFPA and WFP) in four districts to be developed and supported (Nepal, AWP 2008)</li> </ul>	N/A	Malawi Tanzania Zambia Liberia Ghana Nepal
Conducting joint needs assessments, e.g. for EmOnC or MH overall		X	<p><i>Joint assessment of the "state of MH" or other MH-related needs, either linked to the broader support of a health SWAp (e.g. Malawi); or merely linked to a joint programme (e.g. Liberia)</i></p> <p><u>Examples:</u></p> <ul style="list-style-type: none"> <li>• UNFPA collaboration with UNICEF and WHO to conduct nation-wide emergency obstetric care assessment (Malawi CPAP 2008 -2011; lessons learned in 2002-2007)</li> <li>• "Support an assessment of the state of maternal health in Liberia in partnership with WHO (Liberia CPAP, 2008-2012)</li> <li>• UNFPA will support the following: (a) conduct needs assessment of relevant MDAs and</li> </ul>	N/A	Malawi Liberia Ghana

			undertake training in gender budgeting; (b) conduct gender analysis of relevant sector programs and budgets (Ghana)		
Development and operationalisation of “road maps” for reduction of maternal and neonatal deaths		X			Malawi Tanzania Liberia Zambia Sierra Leone
Development of joint mechanisms for monitoring and evaluation (often linked to support of SWAp)  <i>Note: joint M&amp;E activities also developed under UNDAF (e.g. Nepal; also other countries)</i>	X	X	<i>Joint M&amp;E provisions, linked to SWAps; but also including monitoring of UNDAF results frameworks.</i>  <u>Examples:</u> <ul style="list-style-type: none"> <li>• Development of “MASEDA”, a demo-socioeconomic database to monitor progress towards achieving MDGs: an area of collaboration within the UNCT jointly with national implementing partners (Malawi CPAP 2008 -2011; lessons learned in 2002-2007).</li> <li>• UNFPA participation in the multisectoral maternal, newborn and child health partnership task force which follows up the implementation of maternal and child health activities in the health sector, including the implementation of the roadmap for the reduction of maternal and neonatal death (Tanzania CPAP 2007 – 2010)</li> <li>• UNFPA will continue to assist in national level meetings with all health sector stakeholders to monitor the SWAp to inform the decision on the level of resources to be commitment towards the health basket (Zambia, CPAP 2007 – 2010).</li> <li>• “UNFPA and the Government of Zambia through the Ministry of Finance and National Planning will conduct annual review meetings, which will help to determine the continuation of the partnership on the basis of satisfactory delivery of results (Zambia, CPAP 2007 – 2010).</li> <li>• UNDAF M&amp;E Results Framework (all countries)</li> <li>• Convene with support of the National Planning Commission and in consultation with the MoF an annual review meeting involving representatives of all functional ministries and other 21 partners to jointly review the overall program performance of the implementation of CPAP and agree on any necessary modifications (Nepal, 2007-10).</li> </ul>	N/A	Malawi Tanzania Zambia Cambodia Nepal
UNDAF coordination mechanisms (all countries)  <i>Including joint M&amp;E (see above)</i>			<ul style="list-style-type: none"> <li>• Within the UN System, UNCT has established theme groups and task forces to coordinate and manage implementation of UNDAF and country programs, especially for RH, gender, HIV and UNSCR 1325 for which UNFPA is currently the chair (Nepal).</li> <li>• Adopt the UNDAF Monitoring and Evaluation Plan (AWP 2008). According to this plan a Monitoring and Evaluation Task Force, consisting of representatives/program staff from UNDP, UNFPA, UNICEF, the Office of the UN Resident Coordinator, and World Food Programme (WFP), is responsible for implementation of the M&amp;E Plan. Monitoring activities will include quarterly reports and meetings, joint field visits by UNFPA staff and the implementing agencies and coordinating bodies, and joint monitoring with UNDAF partners</li> </ul>	N/A	All countries

Participation in Consolidated Appeals Process (CAP) and Cluster approach			<ul style="list-style-type: none"> <li>• UNFPA CO in Sudan actively participated in the implementation of 2009 CAP (2009 UN and Partners Work Plan in Sudan) and development of 2010 CAP. Moreover, during the expulsion of 13 NGOs in March 2009, UNFPA along with other UN agencies submitted proposal to CERF and received additional funds for the gap filling activities (Sudan).</li> <li>• In addition, a cluster approach was rolled out in Darfur States in 2009. UNFPA became a leading agency for RH (under Health Cluster) and GBV sub-clusters (under Protection cluster). UNFPA is member of UN Humanitarian Country Team at Khartoum and each Darfur States (Sudan)</li> </ul>		Sudan
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### Observations on the strategic context of the above activities (e.g., intended linkages to other activities and strategies)

- In some countries with health SWAp (e.g., Malawi, Tanzania), support of the health SWAp is linked to other “partnership” and “harmonization” components, such as the development of a “Road map for reduction of maternal and neonatal morbidity and mortality” (by UNFPA, WHO, UNICEF (both in Malawi and Tanzania) and the “operationalization of the Maputo Plan of Action” (also referred to both in Malawi and Tanzania) are all meant to be linked:
  - In Malawi, the “Maputo plan of action” provided (according to UNFPA information) the strategic framework for developing the road map; the road map is meant to be implemented as part of the health SWAp. One important question is: do all of these components really link up in reality?
  - In Tanzania,
    - partnership with WHO and UNICEF is meant to be fostered around the “roadmap for reducing maternal and neonatal deaths” (previously developed jointly by the three actors)
    - The “joint UNFPA-led programme in partnership with UNICEF, WHO and other agencies” is meant to ensure a “coordinated and harmonised and multisectoral UN approach in supporting government-led initiatives in reproductive health (e.g., including lobbying for integration of the [UN-promoted] RH road map in the MTEF. (link to EQ9; frameworks)
- In Tanzania, in addition, the Tanzanian Government has a “Joint Assistance Strategy for Tanzania” (JAST), which provides an additional set of “guiding principles” for donor coordination and harmonization. E.g., the JAST “requires the division of labour among development partners and the reduction of the number of partners in any sector”. “UN has agreed on division of labour; UNFPA is “lead agency in gender and RH” (Tanzania, CPAP 2007 – 2010).
- The UNDAF provide the “strategic framework” for joint UN planning, implementation and coordination. Present in all countries. UNDAF also includes “joint M&E”; sometimes invitation is made to other partners (Government, civil society, international community) to “participate in the UNDAF monitoring mechanism as appropriate” (Nepal, AWP 2008 – 2010).
  - “The UNDAF M&E process will remain closely aligned with national M&E processes” (Nepal).

## Judgment criterion 2.2: Harmonization of maternal health support through partnerships at country and South-South/ regional

Main activity types	Programming Periods		Description & Examples (Country; year)	Is (typically) associated with following outputs	Countries where this activity was implemented / planned (selection)
	2004 - 2007	2008 - 2010			
Development of regional plans of action (e.g. Maputo Plan)			<p><i>Support of regional conferences (participants: regional countries, donors, implementing partners) to develop “plans of action” or other frameworks. Maputo PoA became basis for drafting of national “RH road maps” in African countries (also supported by UNFPA; see below).</i></p> <p><u>Examples:</u></p> <ul style="list-style-type: none"> <li>• Development of the “Continental Policy Framework for the Promotion of Sexual and Reproductive health”; in collaboration with AU and IPPF (African Union, 2006)</li> <li>• Organisation of Conference “Universal Access to Comprehensive Sexual and Reproductive Health Services in Africa”; 18-20 September 2006, at the end of which the conference attendees adopted the “Maputo Plan of Action” (African Union, 2006).</li> </ul>	N/A	N/A
Operationalization of regional plans of actions (e.g. Developing MNH “road maps”, resulting from Maputo Plan), e.g., through technical support, organisation of consultation meetings.	X		<p><i>Often joint support (i.e., with UNICEF, WHO) of “RH road maps (often also tied to SWAp support)</i></p> <p><u>Examples:</u></p> <ul style="list-style-type: none"> <li>• “UNFPA collaborated with UNICEF and WHO and developed a road map for the reduction of maternal and neonatal morbidity and mortality” (Malawi CPAP 2008 - 2011; lessons learned in 2002-2007)</li> <li>• Development of roadmap for reduction of maternal and neonatal mortality in partnership with WHO and UNICEF; (Tanzania, CPAP 2007 -2010, lesson learned 2002 – 2006).</li> <li>• The reproductive health and STI/HIV prevention component will be based on the Road Map for reduction of maternal and neonatal morbidity and mortality <u>within the operationalization</u> of the Maputo Plan of Action (Malawi CPAP 2008 -2011).</li> <li>• Also other countries (<i>resulting from Maputo Plan of Action</i>)</li> <li>• The country program will help to develop a country-specific road map to attain the MDGs related to maternal and newborn health (Ghana).</li> <li>• The national road map for maternal mortality reduction (2009-2011) to be endorsed by the Federal Ministry of Health to tailor and coordinate the national response (Sudan).</li> </ul>	N/A	Malawi Tanzania Liberia Zambia Ghana Sudan

### Other kinds of activities:

An effective implementation of the new regional programme will only be achieved with the support of regional developments partners and UN Agencies, and concrete alignment and harmonization of different programmes. The regional programme aims therefore to create a more effective and dynamic regional working forum with sister agencies such as ECA, WHO/AFRO, UNAID, the UNICEF regional offices and African Development Bank. Through this forum UNFPA will support regional efforts to build, broker and strengthen strategic partnerships, harmonize strategies and support efforts to provide coordinated high-level technical support and long term capacity development to regional, sub-regional and national bodies and institutions such as Universities, the African Union, the Regional Economic Communities (RECs)), among others.

### Observations on the strategic context of the above activities (e.g., intended linkages to other activities and strategies)

- WHO/AFRO recommended in 2004 (Regional Committee RC04) that countries develop a national Road Map for accelerating the attainment of the Millennium Development Goals (MDGs) related to maternal and newborn health; this call was reiterated in the Maputo Plan of Action<sup>11</sup>, which “has resulted in an unprecedented effort to plan for MNH in Africa since 2006” (de Bernis & Wolman, 2009).
  - This explains why UNFPA is consistently engaged in promoting the development and implementation of MNH road maps.

### Judgment criterion 2.3: UNFPA participation in partnerships for producing evidence for policy debates and definition and prioritization of coordinated operational maternal health research agenda

Main activity types	Programming Periods		Description & Examples (Country; year)	Is (typically) associated with following outputs	Countries where this activity was implemented / planned (selection)
	2004 - 2007	2008 - 2010			
Participation in joint global initiatives (e.g., “Partnership for Maternal, Newborn and Child Health”; “Safe Motherhood Initiative”)			N/A	N/A	Note: Will only be considered in the evaluation, if it becomes apparent that outputs/ products from those partnerships have led to harmonization of efforts at country level.
Joint country level initiatives to generate data as input for evidence-			See below (so far only example) <u>Examples:</u>	N/A	Liberia, Ghana (partnership aspect not clear), Nepal

<sup>11</sup> I.e., the “Sexual Reproductive Health and Rights Plan of Action”

based planning			<ul style="list-style-type: none"> <li>UNFPA will continue to partner with UN agencies including UNDP, UNICEF, WHO, UNAIDS, UNHCR, UNIFEM and other development partners DFID, USAID, EU, and the World Bank in support of making data available for emergency response and program planning under the leadership of relevant government agencies including LISGIS and MPEA (Liberia CPAP 2008 – 2012)</li> <li>Evidence based research to inform advocacy efforts, and policy development and review will be supported within the 5th CP. The key interventions are (a) institutional capacity for conducting evidence-based research will be supported to ensure that a credible body of knowledge is created; and (b) support the conduct of operational and socio-cultural research to address issues on accessibility of STI services among young people (Ghana; partnership aspect not clear).</li> <li>Provide information for preparation of national plans and reports on MDGs monitoring, PRSP and other sectoral policies jointly between UNFPA, GoN, and other partners (Nepal, 2008-10)</li> </ul>		
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**Evaluation question 3: To what extent has UNFPA support contributed to a stronger involvement of communities that has helped to increase current levels of demand and utilization of services, in particular through its partnerships with civil society?**

**Judgment criterion 3.1: Government commitment to involve communities translated in sexual and reproductive health and maternal health strategies through UNFPA support**

Activity type	Programming Periods		Description & Examples (Country; year)	Is (typically) associated with following UNFPA CO outputs	Countries where this activity was implemented / planned
	2004 - 2007	2008 - 2010			
<p><b>Indicator 3.1.1</b> Government/UNFPA Support for community consultation</p> <p><b>1. INFORMATION AND COMMUNICATION</b></p> <ul style="list-style-type: none"> <li>Some topics are</li> <li>- Non-AYA focus</li> </ul>	X		<p><u>Examples of Information and Communication</u></p> <ul style="list-style-type: none"> <li>Performances on “how to save lives of women”, interactive theatre, drama and role play (2006, TFC).</li> <li>Study tours for SPs, PSPs and NTCDs from non-AYA UNFPA focal regions (2006)</li> <li>Community sensitisation durbars, material distribution for opinion leaders on ASRH in districts/villages (2007 TFC).</li> </ul>	<p>Improved demand to MH care, YFS in programme districts, comprehensive RH. Improved RH behaviour among men, women and young.</p> <p>Increase awareness of obstetric fistula, prevention</p>	Ghana

<p>districts</p> <ul style="list-style-type: none"> <li>- RH/Gender information gathering forms</li> <li>- Male Involvement</li> <li>- Material distribution</li> <li>- Healthy families</li> <li>- Obstetric fistula/care</li> <li>- RH/FP</li> <li>- MNH/ANC/EoC</li> <li>- BCC</li> <li>- HIV/AIDS</li> <li>- Harmful practices</li> </ul>	<p>X</p>	<p>X</p>	<ul style="list-style-type: none"> <li>• <i>Sensitize in forum of men/boys in religious and male-dominated institutions on issues about healthy families (2008)</i></li> <li>• <i>Community sensitization on Obstetric Fistula in 4 districts, FP in poor performing districts (2009)</i></li> </ul>	<p>and treatment. Improve coverage of supervised delivery/FP/PAC services.</p>	<p>Ghana</p>
<p>2. RESEARCH, ASSESSMENT and, REVIEWS for PLANNING</p>	<p>X</p>	<p>X</p>	<ul style="list-style-type: none"> <li>• <i>Organise community field trips to study on RH in rural areas. Provide credit facilities to vulnerable woman headed households (2006-7)</i></li> <li>• <i>Incentives to CBD in villages covered under HC (2007)</i></li> <li>• <i>BCC/Community awareness of FP/MN health services availability and education to selected persons on ANC, PNC / BS (2008).</i></li> <li>• <i>Meeting at community level about danger sign during pregnancies and deliveries (AWP 2010)</i></li> </ul>	<p>Promoted sensitisation for RH/RR to counter harmful practices.</p>	<p>Sudan</p>
<ul style="list-style-type: none"> <li>• <b>Some topics are:</b> <ul style="list-style-type: none"> <li>- Needs assessment</li> <li>- KAP survey</li> <li>- Baseline/End line survey</li> </ul> </li> </ul>	<p>X</p>	<p>X</p>	<p><b>Examples for Research, Assessment and Reviews</b></p> <ul style="list-style-type: none"> <li>• <i>Regular meetings of existing groups in the communities, including volunteer-based CBOs (2007-8).</i></li> <li>• <i>Awareness programme (IEC/BCC) for poor family members, women's community groups on fistula care and support (2010).</i></li> </ul> <p><b>Examples for Research, Assessment and Reviews</b></p> <ul style="list-style-type: none"> <li>• <i>Organise quarterly review meetings for PSPs and NTCDs Community based KAP surveys on YFS.</i></li> <li>• <i>Out of school Youth BCC base/end line assessment (2006, TFC), Rapid response planned for 2008.</i></li> <li>• <i>Conduct mystery client studies on YFS centres (2007)</i></li> <li>• <i>Development RH tools and techniques for YFS under AYA project (2006-7).</i></li> <li>• <i>Tracer seminar for CAFA to assess community activities (2007)</i></li> <li>• <i>Monthly/quarterly planning meetings, bi monthly supervision of CBD to do maternal death audit and CBD programme in villages. – OD to HC follow-up back to CBD (2008)</i></li> <li>• <i>Quarterly supervision on BS, BCC/IPC for 13 health and community centres (2009).</i></li> <li>• <i>Workshop to present summaries of results of CBD work each</i></li> </ul>	<p>Increased demand for high quality, comprehensive, client oriented and gender sensitive RH/STI/HIV information and services for the rural poor and vulnerable.</p> <p>Increase capacity of communities especially among excluded groups, to participate in local-level planning, monitoring, evaluation of quality RH services</p> <p>Fistula repaired clients reintegrated into the society/family.</p> <p>Improved access to MH/YFS in districts. (Comprehensive RH).</p> <p>Improved RH behaviour among beneficiaries. Strengthened capacity for planning, research and M&amp;E.</p> <p>Promotion of RH/RR to counter harmful practices</p>	<p>Cambodia</p> <p>Nepal</p> <p>Nepal</p> <p>Ghana</p> <p>Sudan</p>

<ul style="list-style-type: none"> <li>- Rapid response survey</li> <li>- Mystery clients survey</li> <li>- Tracer survey</li> <li>- Utilisation of tools and techniques survey</li> <li>- Census gathering</li> <li>- Vital data registration</li> <li>- Supervision</li> <li>- Extension of micro-credit</li> </ul>		<p style="text-align: center;">X</p> <p style="text-align: center;">X</p>	<p><i>semester (2010).</i></p> <ul style="list-style-type: none"> <li>• <i>Identify RH needs, and develop action plans that are responsive to the RH needs of the community, especially of excluded groups; hold regular meetings of existing groups in the communities, including volunteer-based CBOs to plan and follow-up (2008-9).</i></li> </ul>	<p>Strengthen national capacity to develop, implement and evaluate gender sensitive RH and HIV policies, strategies and protocols.</p> <p>Capacity of selected communities in programme-supported districts is increased, especially among excluded groups, to participate in local-level planning, monitoring and evaluation of quality reproductive health services</p>	<p>Cambodia</p> <p>Nepal</p>
<p><b>Indicator 3.1.2: Support for community mobilisation and mechanisms to involve community</b></p> <p><b>1. EDUCATION and TRAINING,</b></p> <ul style="list-style-type: none"> <li>• <b>Some topics are:</b> <ul style="list-style-type: none"> <li>- Peer services</li> <li>- Fundraising</li> <li>- Micro-credit schemes</li> <li>- Income generation</li> <li>- Re-integration</li> <li>- Institutional Capacity building of CBOs</li> <li>- Skills development in RH</li> <li>- Material development</li> <li>- South-South partnership</li> <li>- Study tours (internal and external)</li> <li>- Supportive</li> </ul> </li> </ul>	<p style="text-align: center;">X</p> <p style="text-align: center;">X</p> <p style="text-align: center;">X</p>	<p style="text-align: center;">X</p> <p style="text-align: center;">X</p>	<p><b><u>Examples of Education and Training</u></b></p> <ul style="list-style-type: none"> <li>• <i>Train peer educators in project/financial management and ICPD – signs of pregnancy danger and refer (2006).</i></li> <li>• <i>Conduct fundraising training workshop for CBO personnel on RR/RH/Gender (2006, TFC)</i></li> <li>• <i>Train FBOs, CBOs in project/ financial management, micro-credit schemes for health, SRH/STI/HIV (2007).</i></li> <li>• <i>Train social/health workers to Fistula patient re-integration into national programs / community (2008)</i></li> <li>• <i>Train health visitors in supportive supervision of village midwives, train in-service midwives SBA (2005).</i></li> <li>• <i>Train volunteers PE, communication skills, outreach, using of log books and local maps. (2006)</i></li> <li>• <i>Training workshops on improving status of women and their RH via income generating programmes (2007).</i></li> <li>• <i>Refresher on increasing RH/MNH basic services to old/new CBDs and supervisor training (2007-8).</i></li> <li>• <i>Training for IEC and material development -BCC/CBD (2009).</i></li> <li>• <i>Training to volunteers on BCC/IPC and VHSGs, home birth preparedness, CB birth/death registration (2010).</i></li> </ul>	<p>Strengthened capacity of IPs to manage, plan, formulate, implement and evaluate reproductive and adolescent health services.</p> <p>Improve skills on safe motherhood package, service standardisation, outreach RH/RR to counter harmful practices.</p> <p>Strengthen national capacity, NGO to develop, implement and evaluate gender sensitive RH and HIV services, policies, strategies and protocols.</p>	<p>Ghana</p> <p>Ghana</p> <p>Sudan</p> <p>Cambodia</p>



supervision	X	X	<ul style="list-style-type: none"> <li>Particular attention will be given to disadvantaged women working in garment factories and tea plantations to train them on RH, RR including HIV/AIDS prevention. This programme will be linked with the Micro credit programmes of NGOs and related programmes of other UN agencies (CPAP 2006-2010).</li> </ul>	Rights of women and girls promoted and gender equity enhanced.	B'desh
		X	<ul style="list-style-type: none"> <li>Strengthen clinical training sites in zonal hospitals close to CBD areas/ Regional Health Training Center for South-South collaboration (2008-9).</li> </ul>	Improved delivery of SRH/MH - care services,  Strengthened advocacy and awareness of RH/ARH/RR and gender	Nepal
<b>2. ADVOCACY and CAMPAIGNS</b>	X	X	<p><b>Examples for Advocacy and Campaigns</b></p> <ul style="list-style-type: none"> <li>Mixed key stakeholder meetings of leaders and elders, religious groups on out of school youth on Rights and BCC (2007, TFC)</li> <li>Community based campaigns and advocacy to be strengthened and necessary BCC materials to be produced to support the community mobilisation.</li> </ul>	Increased demand especially among poor and vulnerable groups for SRH services.	Ghana
<ul style="list-style-type: none"> <li>Some topics are <ul style="list-style-type: none"> <li>Advocacy/Campaigns , Initiatives</li> <li>Reproductive rights</li> <li>Additional technical resources</li> <li>Key stakeholders – Policy and Parents</li> <li>Out-of school</li> <li>Edu-entertainment</li> <li>ASRH</li> <li>Life skills</li> <li>Youth Platforms</li> <li>Social Inclusion</li> <li>Female condoms</li> <li>Increase financial support</li> </ul> </li> </ul>	X	X	<ul style="list-style-type: none"> <li>Edu-entertainment in youth clubs for youth and other risk groups on life skills education for responsible behaviour.</li> <li>Community mobilization will be done through several mass communication methods (e.g. community group meetings, folk song, film shows, orientation and training)</li> <li>Community advocacy activities will focus on SRH, gender and rights issues, adolescents' rights, HIV/AIDS.</li> <li>Development / establishment of the Platform for Youth for advocacy will be undertaken</li> <li>Community gatekeepers (parents, guardians, teachers, religious leaders etc.) support young people in making decisions about RH. Boy scouts, girl guides, youth clubs will be involved in mobilizing the young people.</li> <li>Advocacy with politicians, policy makers, civil society, community leaders—and emphasizing the involvement of men—to address key RH, ASRH, prolapsed, gender and social-inclusion issues (2008-9).</li> <li>Conduct advocacy workshops with policy makers and advocates for increased support for FP, ASRH and HIV/AIDS and female condoms (2010)</li> </ul>	Rights of women and girls promoted and gender equity enhanced.  Sexual reproductive health needs and education of young people addressed.	B'desh
		X		Improved delivery of health-care services, including MNH, FP, ASRH and prevention and management of STI/HIV.	Nepal

<p>3. <b>SERVICES</b></p> <p>• <b>Some topics are</b></p> <ul style="list-style-type: none"> <li>- Referral</li> <li>- Outreach</li> <li>- Onsite</li> <li>- Condom distribution</li> <li>- Refurbishment of centres</li> <li>- Standardisation</li> <li>- Quality of care</li> <li>- Equity Funds for Access</li> <li>- Performance based block grants</li> <li>- Legal Aid for VAW</li> <li>- Upgrading services</li> <li>- Scaling up services</li> <li>- Shelter homes for women and their family -GBV</li> <li>- Social inclusion and access</li> <li>- YSF/demand, access and utilisation</li> </ul>	<p>X</p> <p>X</p> <p>X</p> <p>X</p> <p>X</p> <p>X</p> <p>X</p>	<p>X</p> <p>X</p> <p>X</p> <p>X</p> <p>X</p> <p>X</p> <p>X</p>	<p><b><u>Examples of Service Support</u></b></p> <ul style="list-style-type: none"> <li>• <i>Meetings on community SDP-GHS facilities referral of patients to obstetric care in each district (2006-7)</i></li> <li>• <i>Promote and distribute condoms through multiple outlets including clinics, NTDs, peer educators (2008)</i></li> <li>• <i>Provide ASRH services by trained peer educators and NTDs; create/furnish adolescent friendly centre (2010).</i></li> <li>• <i>Development of standards, endorsement and piloting of youth friendly services and community centres. Support to CAFA (university) outreach activities (2006-7).</i></li> <li>• <i>CB referrals of pregnant women to HC Service system strengthening in Outreach to villages every two months.</i></li> <li>• <i>Distribution of pill and condom through VHSGs (2007-8)</i></li> <li>• <i>Financial access by CB skilled attendants to poor and vulnerable groups by the Equity Funds for RH in 10 ODs.</i></li> <li>• <i>Performance based block grant schemes for having performance based system to enhance availability of MNH quality of services and motivation of staff at all levels including commune/community groups (2009-10).</i></li> <li>• <i>CB interventions to be undertaken for strengthening BCC activities in two districts. Victims of violence to be given medical, legal and shelter by partnering with NGOs.</i></li> <li>• <i>Provision of treatment for STIs for young people especially those pregnant.</i></li> <li>• <i>Scaling up youth friendly services through NGO and government centres and in the former support to FSW networks to organise access (2008-10)</i></li> <li>• <i>Support to Dalit NGOs to access ASRH information and services (2009).</i></li> <li>• <i>Activities of ASRH/YFS with UN Trust Fund for Human Security (2010)</i></li> </ul>	<p>Improved access to maternal health care and youth friendly services in programme districts, comprehensive RH.</p> <p>Ensure provision of quality EOC care and blood transfusion.</p> <p>YF information/ services. Promoted sensitisation for RH/RR to counter harmful practices</p> <p>Increased access to high quality, comprehensive, client oriented and gender sensitive RH information and services (including HIV AIDS and STIs) for the rural poor and vulnerable</p> <p>Rights of women and girls promoted and gender equity enhanced. Prevention about RTI/STI/HIV/AIDS among young people and high-risk groups.</p> <p>Increased capacity of women and young people and vulnerable groups including humanitarian to demand for quality services.</p>	<p>Ghana</p> <p>Ghana</p> <p>Sudan</p> <p>Cambodia</p> <p>B'desh</p> <p>Nepal</p>
<p><b>Indicator 3.1.3</b></p> <p><b>Development of indicators</b></p>	<p>X</p>	<p>X</p>	<p><u>Government/UNFPA AWP /CPAP/COAR</u></p>		

<p><b>that promote community mobilisation through:</b></p> <p>Government/UNFPA UNFPA/CSO data collection and reporting as represented in</p> <ul style="list-style-type: none"> <li>- % increase</li> <li>- % improvement</li> <li>- Numbers</li> <li>- Proportion</li> <li>- Yes/no response to statements</li> <li>- Community health study findings</li> </ul>		<p><u>Percent increase in:</u></p> <ul style="list-style-type: none"> <li>• <i>Local plans in priority areas that integrate P&amp;D</i> (B'desh AWP 2010);</li> <li>• <i>Availability/ accessibility of reliable community level data disaggregated by sex and age in programme districts</i> (Ghana, AWP 2006)</li> <li>• <i>Facilities selected for UNFPA community RH and gender programming</i> (Ghana, AWP 2007);</li> <li>• <i>Civil society and commune partnership in programme districts and resource contribution</i> (Cambodia, AWP 2008)</li> <li>• <i>HIV positive pregnant women from rural areas who received antiretroviral as part of PMCT</i> (Nepal, AWP 2008)</li> </ul> <p><u>Percent improvement in:</u></p> <ul style="list-style-type: none"> <li>• <i>Community mobilisation through strengthened partnership coordination/ collaboration among agencies involved in the management of population and RH programmes in target districts</i> (B'desh CPAP 2006-10)</li> <li>• <i>Baseline/end line studies among CSO IPs; youth who know where to go for appropriate RH/HIV and STI services at community health centres and NGO/private clinics</i> (Ghana, B'desh CPAP 2006-10)</li> <li>• <i>MISP utilisation and provision of RH kits in target communities within programme districts</i> (B'desh COAR 2008)</li> <li>• <i>Condom use among MARPs, essential health package and cover of young people, including marginal and excluded groups</i> (Nepal, AWP, 2007-9).</li> </ul> <p><u>Reference output indicators for UNFPA CO and yes/no answers in COAR</u></p> <ul style="list-style-type: none"> <li>• <i>Strengthened capacity of civil society organizations to: (i) to incorporate population issues in public policies, plans and expenditure frameworks; (ii) and media to promote awareness and knowledge about RH, HIV (iii) to provide information, services and develop skills for RH and HIV/AIDS (iv) to use systems and mechanisms for protecting human rights of women and girls; and (v) to design and implement the GBV- response and prevention mechanisms</i> (All COAR 2008-9).</li> <li>• <i>Results of studies in emerging population and community issues reflected IP reports and incorporated in district/local plans</i></li> </ul> <p><u>UNFPA/CSO AWP</u></p> <p><u>Number of:</u></p> <ul style="list-style-type: none"> <li>• <i>Community stakeholder awareness, sensitisation meetings, durbars, public health education forums, volunteers trained and M&amp;E visits</i></li> </ul>	<p>Data on population dynamics, gender equality, young people SRH analysed and used at national and sub-national levels to develop and monitor policies and programme</p> <p>Access to and utilisation of quality RH/MNH information services</p> <p>RR and SRH demand promoted and integrated in public policies and humanitarian frameworks</p> <p>UNFPA intervention in the reference outputs and scope of involvement by CO</p> <p>Increased access to improved</p>	<p>AWP of countries</p> <p>CPAP of countries</p> <p>COAR of countries</p>
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	X	X	<p><i>planned and % implemented;</i></p> <ul style="list-style-type: none"> <li>• <i>Sub-IPs advocating for RH/MNH/ASRH;</i></li> <li>• <i>Transport unions involved in transporting women during labour and emergencies; (Ghana, 2007)</i></li> <li>• <i>Youth, Village and parent networks (Ghana, 2007)</i></li> <li>• <i>Male involvement about complication in pregnancy and delivery (Ghana, Cambodia 2007-8)</i></li> <li>• <i>Peer educators trained in ASRH/MH/HIV (Nepal, 2010)</i></li> </ul> <p><u>Proportion of:</u></p> <ul style="list-style-type: none"> <li>• <i>Facilities in YFS, CSO managed MNH facilities in programme district; birth attended by SBA; specialised outreach conducted by hospitals; peer services (Ghana 2005-7, Cambodia 2007 and Nepal 2007-8)</i></li> <li>• <i>Increase in access to and utilisation of YFS by the socially excluded (Nepal 2010-2011)</i></li> </ul>	<p>SRH information and services</p> <p>Increased demand by hard to reach population especially poor and vulnerable</p> <p>-</p> <p>Increased capacity of women, men and young people and other vulnerable groups to demand for quality RH services including MNH, FP, ASRH, HIV, STI and GVB</p>	<p>All AWP of CSOs/IP unless mentioned</p>
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**Observations on the strategic context of the above activities based on Government/UNFPA Intervention of the referenced outputs in 2007-8-9:**

- The Government of Ghana developed the CPAP (2006-10) with full participation of CBOs at both AWP planning and implementation stage. Strengthened capacity of these CBOs in order of priority were:
  - Incorporate population issues in their policy, plans and expenditure frameworks
  - HIV prevention among the young
  - Reproductive rights and services
  - Gender based violence
  - SRH promotional activities
- The Government of Bangladesh mentions CBOs as important recipients and district level interventions are highlighted in CPAP (2006-10). Strengthened capacity of CBOs in order of priority were:
  - Provide information and services and develop skills for HIV prevention
  - Design GBV response and prevention mechanism
  - Incorporating population issues into policy, local plans and expenditure frameworks,
  - Promotion of MNH/FP services
  - Reproductive rights as human rights
- The Government of Cambodia in its CPAP (2006-10) mentions commune councils, women's and children committees, community members and youth groups, health centre management committee and village health support groups as key elements of interventions for all 3 programme components. Strengthened capacities of local organisations in order of priority were:
  - Incorporate population issues in public policies, plans and expenditure frameworks
  - Implementation of GBV response and prevention mechanisms

- HIV prevention in concentrated MARP
- Promotion of SRH using BCC strategies
- Reproductive rights
- The Government of Sudan rarely mention communities in its CPAP (2006-2010). However it does mention CBOs in AWP and COARs. CBOs are mentioned for major interventions in the area of population, awareness raising, sensitising about FP services, HIV prevention and GBV. Human rights and reproductive rights are mentioned in case of humanitarian situations
- The Government of Nepal emphasises empowerment of CBOs. Promotion of family planning services, knowledge and awareness of SRH, prevention of HIV and human rights are given major priority. Population activities are of moderate scope and GBV given minor importance.

**Judgment criterion 3.2: Civil society organization (CSO) involvement in sensitization on maternal health issues and facilitating community-based initiatives to address these issues supported by UNFPA**

Activity type	Program ming Periods		Description & Examples (Country; year)	Is (typically) associated with following outputs	Countries where this activity was implemented / planned
	2004 - 2007	2008 - 2010			
<p><b>Indicator 3.2.1:</b>  <b>UNFPA mechanism to build CSO capacity for community sensitisation and involvement:</b></p> <p><b>Education seminars, forums, fellowships, scholarships and Training workshops in strategy development related to:</b></p> <ol style="list-style-type: none"> <li>1. Social mobilisation</li> <li>2. Political and public Advocacy</li> <li>3. Partnership support to local health facility/ committees</li> <li>4. Service skills</li> </ol>	X		<p><u><b>Examples of Social Mobilisation.</b></u></p> <ul style="list-style-type: none"> <li>• <i>Pre-implementation sensitisation of Regional/District Health Directorates on community based YFS services (2007, TFC)</i></li> <li>• <i>Print the endorsed NAS and disseminate copies to GOS, NGOs and others. Conduct Fistula treatment and awareness campaign in different locations (2006-8)</i></li> <li>• <i>National Centre for Health Promotion and NRHP to compliment new and existing work of NGO initiatives in sensitising key populations on RH/MNH (2007)</i></li> <li>• <i>Participation in the development and support of proactive links with community based health education structures such a health centres, management committee and village health support groups, school (formal and informal) peer education</i></li> </ul>	<p>Improved access to MH/YFS and care in districts, comprehensive RH. Improved RH behaviour among men, women and young</p> <p>National Information and Advocacy Strategy in line with ICPD principles to promote RH and Population issues</p> <p>Campaign for fistula treatment /prevention at community level</p> <p>Strengthen national capacity and that of NGOs to develop, implement and evaluate gender sensitive RH and HIV quality services policies, strategies and protocols. Increased awareness of women, men and youth about RH/ RR and services in priority areas.</p>	<p>Ghana</p> <p>Sudan</p> <p>Sudan</p> <p>Cambodia</p>

<p>development</p> <p>5. Monitoring &amp; Reporting</p> <p><u>Topics for social mobilisation:</u></p> <ul style="list-style-type: none"> <li>- New SRH services</li> <li>- Fistula campaign</li> <li>- Health promotion targeting</li> <li>- Community health education</li> <li>- BCC campaigns</li> <li>- Community mobilisation</li> <li>- Rights and VAW</li> <li>- IEC/BCC material development and dissemination</li> </ul> <p><u>Topics for Advocacy</u></p> <ul style="list-style-type: none"> <li>- Reproductive/MNH health/services</li> <li>- Reproductive rights and Gender</li> <li>- Transportation for women in labour</li> <li>- Fistula re-integration strategy</li> <li>- Promotion and support of midwives</li> <li>- Partnership for capacity building</li> <li>- Comprehensive community SRH advocacy</li> <li>- Partnership building in community mobilisation</li> </ul>	<p>X</p> <p>X</p> <p>X</p> <p>X</p> <p>X</p> <p>X</p> <p>X</p> <p>X</p> <p>X</p>	<p>X</p> <p>X</p> <p>X</p> <p>X</p> <p>X</p> <p>X</p> <p>X</p> <p>X</p>	<p>(2008-9)</p> <ul style="list-style-type: none"> <li>• <i>NGO/Youth organisation conduct activities on NCHP youth initiatives and large BCC campaigns(2010)</i></li> <li>• <i>Positive behavioural change and community mobilization will be fostered through Government, Private sector and Civil Society.(CPAP, 2006-2010)</i></li> <li>• <i>Develop multiple appropriate IEC/BCC materials/advocacy package (print, audio, video) for community in partnership with NHEICC (2008-10)</i></li> </ul> <p><b><u>Examples of Advocacy</u></b></p> <ul style="list-style-type: none"> <li>• <i>Conduct a workshop for trained health workers on community RH, RR and Gender (2006-7, TFC).</i></li> <li>• <i>Hold advocacy forum in districts for opinion leaders, District Assemblies, Chiefs, and the community as prelude to opening desk offices on GBV prevention and to support transport women in labour to hospital (2008).</i></li> <li>• <i>Advocacy meetings with social welfare officials to have fistula patients in leap program using advocates (2009)</i></li> <li>• <i>Conduct Advocacy workshop in support of prevention and management of OF in several locations (2008-9)</i></li> <li>• <i>Establishment/ demarcating functions of Midwifery Council. Supportive activities for the organisation of Midwifery Forum – Advocacy (2008)</i></li> <li>• <i>Support midwives to attend key regional/international conferences and events or visit Midwives Association (2009)</i></li> </ul>	<p>Increased demand especially among poor and vulnerable groups for SRH services.</p> <p>Increased awareness of obstetric fistula by stakeholders, including</p> <p>Strengthened advocacy and awareness of RH/ARH/RR and gender</p> <p>Increased support and commitment for elimination of obstetric fistula among policy makers and stakeholders at national and sub national levels</p> <p>Campaigning for fistula treatment and prevention at the community level conducted.</p> <p>Increased awareness of women, men and youth about RH, RR and availability of services in priority areas. Increased access to high quality, comprehensive, client oriented and gender sensitive RH information and services for the</p>	<p>B'desh</p> <p>Nepal</p> <p>Ghana</p> <p>Ghana</p> <p>Sudan</p> <p>Cambodia</p>
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- Emerging issues	X	X	<ul style="list-style-type: none"> <li>Maintain and strengthen midwifery as an attractive profession; strengthen Midwives Association (CMA) via training and coaching to improve organisational leadership, management and accountability; and intermittent technical support (2009-10).</li> </ul>	rural poor and vulnerable	B'desh
			<ul style="list-style-type: none"> <li>National comprehensive communication and advocacy strategy development for SRH (2009).</li> <li>Community Fistula Advocacy Programme (CFA) that includes rights, treatment patient follow-up, distribution of materials, rehabilitation, basic and refresher training, engaging new communities and M&amp;E of returnees (at district and union level). 2008-10</li> </ul>	Increased access to improve SRH information and services	Nepal
			<ul style="list-style-type: none"> <li>Establish partnerships with health facility management committees, NGOs/VIOs and CBOs in support of social mobilization and removing barriers for socially excluded groups to access key RH related services (2008-9)</li> </ul>	Increase capacity of excluded groups, to participate in local-level planning, monitoring and evaluation of quality services	Ghana
<u>Topics for partnership support</u>	X		<b><u>Examples of Partnership Support to Local Health Facility</u></b>	Improved access to maternal health care and youth friendly services in programme districts, comprehensive RH.	
- Equip/refurbish clinics/hospitals			<ul style="list-style-type: none"> <li>Procure contraceptive services for dual protection, clinical and outreach services (2006-7).</li> </ul>		
- Establish Specialist outreach			<ul style="list-style-type: none"> <li>(Provide YFS-TA on requests by various facilities in UNFPA districts (2006-7, TFC)</li> </ul>		
- Establish commodities procurement system			<ul style="list-style-type: none"> <li>Equip/refurbish hospitals for comprehensive EOC services/ maternity units in centres for basic EOC (2007)</li> </ul>		
- Establish VCT/PMCT/GBV services		X	<ul style="list-style-type: none"> <li>Organise specialist outreach on maternal health to selected hospitals (2007)</li> </ul>		
- Partnership in youth friendly services and referrals	X	X	<ul style="list-style-type: none"> <li>Support 2 institutions to provide VCT/PMCT services (2007, TFC).</li> </ul>	Care providers skills on comprehensive RH are improved.	Sudan
			<ul style="list-style-type: none"> <li>Introduce/ organise for 500 persons VCT services, select / support FBOs/CBOs to provide youth friendly services – 2 FBOs/8 franchise holders (2007, TFC).</li> </ul>	Improved referral link between community and facility services.	Cambodia
			<ul style="list-style-type: none"> <li>Provision of clinic supplies and equipments and hospital equipments for management of referred cases; printing of guidelines for clinical practice (2005-6)</li> </ul>		
			<ul style="list-style-type: none"> <li>Conduction of basic training for VMWs on MNH (2008)</li> </ul>	Increased awareness about RH, RR and availability of services in priority areas.	
				Increased access to high quality,	

<ul style="list-style-type: none"> <li>- Institutional collaboration</li> <li>- Franchising</li> <li>- Capacity building-technical support</li> <li>- Clinic protocols</li> <li>- Basic training</li> <li>- Social marketing</li> <li>- CSO Franchising</li> <li>- YFS including GBV</li> <li>- EOCC</li> <li>- Counselling</li> <li>- Clinic Protocols and operational guidelines</li> </ul>	X	X	<ul style="list-style-type: none"> <li>• Youth organisations and NGO RH/MNH services in comprehensive and friendly ASRH including HIV, GBV(2007)</li> <li>• TA to support the review of Community Based Distribution Programme of Family Planning (2007-8)</li> <li>• Provision of FP social marketing and franchising (2008-10)</li> <li>• Services in urban areas, especially for slum dwellers will be addressed through Urban Clinics (UC) operated by local government institutions and NGOs (2006-10)</li> <li>• Guidelines and protocols for YFS to be utilised through SDPs both from Government and NGOs. (2006-10)</li> <li>• FP/MNH/ARH/HIV through FPAN and its district clinics and development of MoU, protocols, guidelines for uterine prolapsed (2010-11).</li> </ul>	<p>comprehensive, client oriented and gender sensitive for rural poor/vulnerable</p> <p>Increased access to improved SRH information and services especially for young people</p> <p>Improved delivery of comprehensive health-care services</p> <p>Strengthened capacity of implementing agencies to manage, plan, formulate, implement and evaluate reproductive and adolescent health services.</p>	B'desh  Nepal
		X	<p><b><u>Examples of Service Skills Development</u></b></p> <ul style="list-style-type: none"> <li>• Training on planning, formulating, implementation, M&amp;E of RH/ARH for management, National Health Co-ordinators and Regional Anchor persons (2006-7).</li> <li>• Safe Motherhood clinical training for midwives (2005-6).</li> <li>• Training of local SPs to support VCT/PMCT service (2007, TFC).</li> <li>• Training for police officers on RH, gender, Rights, GBV, victim support and Project Planning (2007, TFC).</li> <li>• RH/ care providers in CSO centres trained on FP counselling</li> <li>• Training of care providers on management of chronic diseases associated with pregnancy, diabetes mellitus (2006-7)</li> <li>• Inclusion of selected NGOs in trainings for capacity building to analyse local situation and use of data planning at commune level (2007-8-9)</li> </ul>	<p>Care providers' skills on comprehensive RH are improved.</p> <p>Strengthened capacity of relevant government and NGOs to provide high quality reproductive health services, including HIV?STI in priority areas</p>	Ghana  Sudan  Cambodia
<p><u>Topics for service skills development</u></p> <ul style="list-style-type: none"> <li>- Safe Motherhood</li> <li>- VCT/PMCT</li> <li>- Comprehensive ARH</li> </ul>	X	X	<ul style="list-style-type: none"> <li>• Training of CB-SBAs to be expanded to all districts to provide care during home delivery/ referral system (2006).</li> <li>• Community based SBAs will continue to be trained through Bangladesh Nursing Council (BNC) and with support from DGHS/DGFP/ DG NIPORT (2007).</li> </ul>	<p>Increased access to improved sexual and reproductive health information and services. Sexual reproductive health needs and education of young people addressed.</p>	B'desh



<ul style="list-style-type: none"> <li>- Capacity development in gender/RR</li> <li>- Counselling</li> <li>- Pregnancy and Disease</li> <li>- Capacity building/data planning</li> <li>- RH services, fistula and gender empowerment</li> <li>- CB – SBA</li> <li>- Life skills, PE and livelihood</li> </ul>			<ul style="list-style-type: none"> <li>• <i>Life skills training to be linked to livelihood activities of NGOs, Ministry of Youth through youth clubs and with other livelihood initiative through WFP, FAO etc (2008-9).</i></li> <li>• <i>Provide support to peer education programme; and partner with NGOs/VIOs and other agencies involved in livelihood training (08-10)</i></li> </ul>	<p>Improved access to MH/YFS in districts. (Comprehensive RH).</p> <p>Strengthened capacity of implementing agencies to manage, plan, formulate, implement, monitor and evaluate reproductive and adolescent health services.</p>	<p>Nepal</p> <p>Ghana</p>
<p><u>Topics for Monitoring and Reviews</u></p>					
<ul style="list-style-type: none"> <li>- Monitoring, Evaluation, Supervision and Audit</li> <li>- Annual Programme Reviews</li> <li>- Field mission visits</li> <li>- Feasibility /Needs Assessments</li> <li>- Establish Baseline</li> <li>- Co-ordination/consultation</li> <li>- Action/operations research</li> <li>- Evidence reporting</li> <li>- Development of Protocols and guidelines</li> <li>- Quality of care</li> <li>- Programme reviews and implementation</li> <li>- Liaison</li> <li>- Field visits</li> <li>- Performance based system</li> <li>- Guidelines for scaling up</li> <li>- Data and knowledge</li> </ul>	<p>X</p> <p>X</p> <p>X</p>		<p><b><u>Examples of Monitoring and Reviews</u></b></p> <ul style="list-style-type: none"> <li>• <i>Conduct facility needs assessment for comprehensive EmOC and ASRH services in CHAG facilities in districts (2005-6).</i></li> <li>• <i>Conduct two quarterly national, support, supervisory, monitoring and evaluation visits to intervention facilities in the 5 target regions (2007, TFC)</i></li> <li>• <i>Joint APR meeting for multiple stakeholders)</i></li> <li>• <i>Essential baseline data on YFS information and services.</i></li> <li>• <i>Conduct Participatory Action research on link between violence and HIV and AIDS in districts</i></li> <li>• <i>Provision of logistics for the collection, management and dissemination of regional/national GBV data (2007, TFC)</i></li> <li>• <i>National support supervision, evaluation/outreach supervision of daily operations of NTCDs / recruitment.</i></li> </ul>	<p>Care providers' skill on comprehensive RH is improved.</p> <p>Strengthen national capacity to develop, implement and evaluate gender sensitive RH and HIV policies, strategies and protocols</p> <p>Increased access to high quality, comprehensive, client oriented and gender sensitive RH information and services (including HIV AIDS and STIs) for the rural poor and vulnerable</p>	<p>Sudan</p> <p>Cambodia</p>
	<p>X</p> <p>X</p>		<ul style="list-style-type: none"> <li>• <i>Assessments of availability and use of RH commodities in the 10 centres and one referral hospital (2006)</i></li> <li>• <i>Co-ordination meetings between NGOs and NRHP on potential to change partnerships as a result of new decentralisation and de-concentration laws and introduction of performance based incentive systems (2007)</i></li> <li>• <i>Consultation and participation in UNDAF Annual Review and Cambodian Development Council for co-ordination of RH</i></li> </ul>	<p>CPAP Programme Management</p>	<p>B'desh</p>

sharing	X	X	<p>country programme (2008-10)</p> <ul style="list-style-type: none"> <li>National NGO implementing partners ensure annual reports to government/UNFPA on the full utilisation of all received cash from UNFPA based on agreed (2009)</li> <li>Continue the development of guidelines for establishing and operating Maternity Waiting Homes (2010)</li> <li>Open field offices in selected districts for special pilot initiatives and regular field activities and to maintain liaison with GOB and NGO counterparts at local level.</li> <li>At the level of programme implementation, the government Ministries will act as programme Component Manager (PCM), based on the requirements of the UNFPA Policies and Procedures Manual. Programme Component Managers and Implementing Partners with each component managers are outlined below. The NGOs, private sector and civil society organisations will be subcontracted with the IPs as and when appropriate (CPAP 2006-10).</li> <li>The ERD, Ministry of Finance will be the central coordinating agency and jointly monitored by UNFPA, PCM, IPs like identified civil society and ERD through field visits, annual component and programme review meetings, studies, and qualitative and quantitative indicators, as per UNFPA guidelines (2006 -2010).</li> <li>Coordination Team in place, led by MOH, with UNFPA, WHO, UNICEF, The World Bank, Regional Development Bank, key bilateral, civil society and other partners for bi-annual M&amp;E of quality of thematic programmes (MHTF, 2010)</li> <li>Support to operationalise the National Adolescent Health and Development Strategy and guidelines in collaboration with RHIYA NGOs and VIOs for scaling-up of this approach</li> </ul>	<p>Enhanced political and social environment for MNH and SRH: national advocacy, engagement of civil society, national coordination and partnership building.</p> <p>Strengthened capacity of local agencies in six selected districts to plan, implement, monitor and evaluate quality reproductive health services</p>	<p>B'desh</p> <p>Nepal</p>
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Activity type	Program ming Periods		Description & Examples (Country; year)	Is (typically) associated with following outputs	Countries where this activity was implemented / planned	
	2004 - 2007	2008 - 2010				
<p><b>Indicator 3.2.2: UNFPA/CSO projects/activity budget line that aim to increase demand, access and utilisation as mentioned in AWP/CPAP for:</b></p> <ul style="list-style-type: none"> <li>- P&amp;D activities</li> <li>- SRH/MNH activities</li> <li>- Gender activities</li> </ul> <p>Government/UNFPA projects that have CSO/Community component in budget line not listed (Utilised in JC 3.1 activity audit and analysis)</p>	X		<ul style="list-style-type: none"> <li>• <i>Enhancing population policy, coordination and implementation (2005-6) GHA/01/P05, one project, one CSO</i></li> <li>• <i>Reproductive health information, service delivery and ASRH (2006) GHA5R215, GHA5R241, GHA5R235, 3 projects, 3 CSOs of which one is INGO (ASRH)</i></li> <li>• <i>Gender and male involvement, rights, advocacy, GBV/VAW (2006-7), GHA5G123, 3 project of which two are INGO (male involvement and GBV)</i></li> <li>• <i>RH - Integrated Community Based ASRH (2007)</i></li> <li>• <i>RH service delivery, (2007) GHA5R241</i></li> <li>• <i>Reproductive Health – Theatre for Change (2007-8)</i></li> </ul>	<p>Improve demand and access to MNH/YFS, improve male behaviour, supportive environment of population and RH, strengthen national and local capacity for gender policy programming and advocacy, repositioning FP, build capacity to manage, formulate an evaluate RH programmes</p>	Ghana	
		X	<ul style="list-style-type: none"> <li>• <i>Integrated RH, PD and Gender – Harmful practices (2004-6) SUD02P06</i></li> <li>• <i>Integrated RH Information and services (2007)</i></li> </ul>	<p>Increased gender mainstreaming, improved use of quality RH services and information</p>	Sudan	
		X	X	<ul style="list-style-type: none"> <li>• <i>Adolescent Reproductive Health (2004-2006), CMB02P07</i></li> <li>• <i>Gender/RH advocacy (2005-6), CMB3G104</i></li> <li>• <i>Support to Population census (2008), CMB3P32E</i></li> <li>• <i>BCC Campaigns, SRH (2008-10), CMB3R54K</i></li> <li>• <i>Intensified Response to HIV Prevention (2008-10), RAS6R43A</i></li> </ul>	<p>Strengthened capacity of NGOs to provide quality services, evaluate gender-sensitive RH and HIV policies, strategies and protocol</p>	Cambodia (needs further verification)
		X	X	<ul style="list-style-type: none"> <li>• <i>Youth Empowerment project (2006-), 00050386</i></li> <li>• <i>Advocacy/RH/ARH services and education for garment workers (2004-6), peer group (2004-7), rural co-operatives(2004-6), youth clubs (2004-6), mass communication (2004-6) and tea plantation female workers</i></li> </ul>	<p>Increased access to SRH, increased demand among poor and vulnerable, SRH education of young people, improved prevention of RTI, STI and HIV</p>	Bangladesh (needs further verification)
				<p>Improved inclusive health system focussing on essential health services/RH/MNH/FP/ASRH, increased coverage and service for poor and marginalised.</p>	Nepal	

		X	<p>(2004-9); BGD03P09/18/17/10/08/16</p> <ul style="list-style-type: none"> <li>• <i>Help End GBV</i> (2004-7), BGD03P14</li> <li>• <i>RH services to Urban Poor</i> (2004-6, 2008-9), BGD03P03</li> <li>• <i>Analogous Groups in 6 districts oriented in RH, Gender and Social Inclusion, Support to EOC Fund, New SRH developed in districts</i> (2008)</li> <li>• <i>Sex workers support, STI treatment, RH/FP/condoms and IEC distribution, peer education in VDCs, girls SRH orientation</i> (2008-2009)</li> <li>• <i>Reproductive Health, Obstetric Fistula</i> (2010), MHTF-NPL6R21M</li> <li>• <i>RH and ASRH information, capacity building and service delivery</i> (2011), NPL6R22A, NPL6R42B</li> </ul>		
<p><b>Indicator 3.2.3: UNFPA Mechanism for monitoring CSO/community involvement:</b></p> <p>Not separate but CSO/community involvement included for standard process of M&amp;E or reviews of special projects.</p>	X	X	<ul style="list-style-type: none"> <li>• <i>Update of CPAP planning and tracking tool and M&amp;E calendar</i> (all countries)</li> <li>• <i>Annual Work Plan Joint Review and Reporting protocol</i> (all countries)</li> <li>• <i>RH/PD/Gender component, annual CP review and UNDAF annual review (+ other project co-ordination meetings)</i> (all countries).</li> <li>• <i>Standard Progress Report</i> (required for all who have AWP)</li> <li>• <i>Technical backstopping – national and international</i> (all countries)</li> <li>• <i>Field monitoring visits</i> (all countries)</li> <li>• <i>Conduct of social audit in VDC and commune</i> (Nepal 2008 and Cambodia, 2009)</li> <li>• <i>Baseline and end line studies in collaboration with P&amp;D</i> (increasing significance in all countries)</li> <li>• <i>Mid-term evaluation</i> (required for all countries)</li> <li>• <i>Cash received by NGO IP utilised according to established national regulations, policies and procedures</i> (all countries).</li> <li>• <i>CSOs submit audit (required for all who have separate AWP), UNFPA audit where CSO/community activities mentioned if planned/expenditure</i></li> </ul>	<p>Extracted from CPAP Programme Management,</p> <p>Commitment of UNFPA and Government.</p> <p>Results Resource Framework</p> <p>CPAP Planning and tracking tool and M&amp;E Calendar</p>	<p>N/A</p> <p>Standard procedure for all (CPAP 2006-10)</p>

## Observations on the strategic context of the above activities based on UNFPA/CSO Interventions from CPAP 2006-10 and available AWP

- The CPAP 2006-10 (co-operative agreement between UNFPA and government only) generally promotes and supports civil society and their involvement with communities through strategic partnerships. Relationships with CSO cannot be described by government like those of inter-agency joint programming, rather a variety of CSOs/CBOs and FBOs are effectively engaged as and when needed in implementation at various levels of the decentralised system (Ghana, Cambodia, Bangladesh and Nepal to a lesser extent).
- Selected CSOs/CBOs and FBOs are permitted to implement programmes in specified local and national levels only after an assessment of their capacities. These assessments differ in intensity with Ghana being the highest and Sudan the lowest. CSOs in turn collaborate and interact with all types of national and local stakeholders as defined in the project document (separate AWP).
- CSOs/CBOs and FBOs are permitted to be involved in all 3 UNFPA programme components namely P&D, SRH and Gender. The extent of involvement by CSOs in any component can vary from year to year (Cambodia and Nepal) or some large ones could continue for several years (Bangladesh and Ghana). Usually there is a good tally between the type of CSO and component involvement as one of the selection criteria is long term evidence-results based expertise.
- Tri-partite partnership building (tiered approach) with government, CSO/CBO/FBO and external development partners contributes significantly to UNFPA and government project design, synergy and implementation in Ghana, Nepal and Bangladesh (e.g. SWAP, UNDAF, local consultative groups and PRSP) and in Cambodia the Midwives Association dominates the scene.
- CSOs tend to be utilised for emerging and sensitive issues and community based initiatives tend to be paramount in such a case. Scaling up of services by government in their own facilities and institutions tends to happen as sensitivity declines and pilot phase (or extended phased) is over. For this reason UNFPA-CSO partnership projects tend to be limited in size and duration.
- The AWP which should reflect the CPAP document for the stated period (often it doesn't for many reasons) is signed with each implementing partner and is also the main operational planning, reporting and budgeting tool for CSOs. In annual programme reviews, CSO are regular attendees if they hold a direct contract with UNFPA and have their own budget but not if they are part of a public agency budget line. This means that small CBOs can be excluded from attending annual reviews even in decentralised state (Bangladesh, Ghana and Cambodia, of recent, Nepal less so)
- It is envisaged that CSO/CBO and FBO partnerships will evolve and change overtime to reflect changing political and administrative realities in the country (Cambodia, Nepal and Sudan more so than Ghana and Bangladesh). Besides this, public sector is also introducing performance based incentive schemes (Cambodia) and social enterprising/marketing (Cambodia, Ghana and Bangladesh) in the interest of cost recovery and sustainability in the social sector which will have profound and hopefully effect on UNFPA CSO engagement and community involvement.

**Evaluation question 4: To what extent has UNFPA contributed to the strengthening of human resources for health planning and human resource availability for maternal health?**

**Judgment criterion 4.1: Development strengthening of national human resources for health (HRH) policies, plans and frameworks (with UNFPA support)**

Activity type	Programming Periods		Description-Country (Year)	Is (typically) associated with following outputs	Countries where this activity was implemented / planned
	2004 - 2007	2008 - 2010			
Developing and or harmonising training material/curricula through workshops, technical and /or financial assistance		X	<p><i>Réviser le document de formation en technologie contraceptive (manuel de référence et guide du formateur et carnet du participant) en tenant compte des besoins des personnes vivant avec le VIH et en renforçant la promotion des condoms Cote D'Ivoire RHCS 2010 Annual Work Plan and Monitoring Tool</i></p> <p><i>Appuyer l'elaboration du plan nationale de formation en SR</i> <i>Reviser, adopter, publier et diffuser les curricula...</i> <i>Un programme d'information pour les structures de référence (Cote D'Ivoire Appui a la réduction de la mortalité maternelle et néonatale, Plan de travail 2009)</i></p> <p><i>Harmoniser la formation et les prestations offertes par les partenaires communautaires en matière de SR (PF, MSR; IST/VIH) PLAN DE TRAVAIL ANNUEL 2010, Madagascar)</i></p>	<p>Disponibilité accrue des services de SR, y compris les services de SR des adolescents, dans la zone du programme</p> <p>RH rights and institutional capacity enforced</p> <p>Un paquet essentiel d'informations et de services de santé de la reproduction est disponible et accessible aux hommes, aux femmes et aux jeunes dans les zones d'intervention du programme</p>	Cote d'Ivoire Madagascar Cameroon
Providing technical, financial and/or logistical support to national and regional training institutions			<p><i>Appuyer le renforcement de la formation de la Technologie contraceptive dans les écoles de formation de base et PSP (Cote D'Ivoire RHCS 2010 Annual Work Plan and Monitoring Tool)</i></p> <p><i>Institutionalize RHCS in School of Public Health- Addis Ababa University (UNFPA GLOBAL AND REGIONAL PROGRAMME 2008-2011, ETHIOPIA 2010 Work Plan and Monitoring Tool)</i></p> <p><i>L'institutionnalisation de l'enseignement des modules de la SR et du genre dans la formation initiale des agents socio-sanitaires et dans les</i></p>	<p>Disponibilité accrue des services de SR, y compris les services de SR des adolescents, dans la zone du programme »</p> <p>Strengthened institutional capacity for managing reproductive health programmes, with attention to ensuring reproductive health commodity security</p> <p>RH rights and institutional capacity enforced</p> <p>Services de SR de qualité, intégrés et accessibles dans les zones d'intervention</p>	Cote d'Ivoire Ethiopia

			<i>programmes de formation professionnelle (CPAP Benin 2004 – 2008, 2009 - 2013)</i>	du programme/ : Les capacités institutionnelles et techniques, nationales et locales sont renforcées pour le suivi et la coordination du plan d'action de Maputo.	
<i>Technical and Financial support (such as Organising stakeholder meeting) to validate (or inform on) newly developed material and/or programmatic approaches</i>	X	X	<i>Editer et disséminer les documents de politiques, notes et procédures de SR et le document de stratégie de sécurisation des produits de la SR (Cote D'Ivoire RHCS 2010 Annual Work Plan and Monitoring Tool)</i>  <i>Organiser des séances de sensibilisation/plaidoyer sur les questions de droits à la SR/Pfà l'intention des Gouverneurs et du Conseil Economique et Social (Chad COUVERTURE ET TABLEAU DU PLAN DE TRAVAIL ANNUEL 2010)</i>  <i>Appuyer la mise à jour des Politique et Programme Nationaux de Santé de la Reproduction (PLAN DE TRAVAIL DU BUREAU 2006 UNFPA / Côte d'Ivoire)</i>  <i>Un symposium sur la SR organise (Cameroon, PTA 2010)</i>	Les documents cadres de santé de la reproduction sont édités et disséminés  « Disponibilité accrue des services de SR, y compris les services de SR des adolescents, dans la zone du programme »  Capacités nationales pour la prise en compte du PA/CIPD renforcée	Chad Cote d'Ivoire Cameroon

**Judgment criterion 4.2: Strengthened competencies of health workers in HIV/AIDS, family planning, obstetric fistula, skilled birth attendance and EmONC to respond to sexual and reproductive health/ maternal health needs**

Activity type	Programming Periods		Description – Country (YEAR)	Is (typically) associated with following outputs	Countries where this activity was implemented / planned
	2004 - 2007	2008 - 2010			
Developing and or harmonising training material/curricula through workshops, technical and /or financial assistance		X	<i>Develop and distribute 10,000 copies of FP Decision making kit to 4 regions and all health facilities in 25 Woredas of SNNPR (UNFPA GLOBAL AND REGIONAL PROGRAMME 2008-2011 ETHIOPIA 2010 Work Plan and Monitoring Tool)</i>	Increased gender- and culturally sensitive behaviour change communication interventions to address reproductive health and related socio-cultural issues	Ethiopia
Purchasing of expertise, equipment and consumables for the training component, including training		X	<i>Provide equipment and supplies for 8 midwifery training schools</i>  <i>Procure &amp; distribute contraceptives and life saving</i>	Implementation of the road map for maternal mortality reduction supported through increased availability of high-quality and gender-sensitive reproductive health services for women, men and young people, emphasizing safe motherhood,	Ethiopia

institution development			<p><i>maternal health drugs (including MgSO4 &amp; misopristol)</i></p> <p>(UNFPA GLOBAL AND REGIONAL PROGRAMME 2008-2011 ETHIOPIA 2010 Work Plan and Monitoring Tool)</p>	family planning, adolescent reproductive health services and attention to the most vulnerable.	
Organising training on technical issues in various formats (workshops, cascade, on-the job, shadowing, etc)	X	<p><i>Conduct ToT for 150 Health Workers Supervisors on Implanon and IUCD and support the cascade training of 1000 HEW's on Implanon insertion and counselling skills</i></p> <p><i>TOT on Interpersonal communication skill /counselling on RHCS/FP/HIV for 30 Federal and Regional Experts and rolling out for training of 80 service providers in 25 woredas of SNNP</i></p> <p>(UNFPA GLOBAL AND REGIONAL PROGRAMME 2008-2011 ETHIOPIA 2010 Work Plan and Monitoring Tool)</p> <p><i>Renforcement des compétences des prestataires de service et des pairs éducateurs en techniques de communication pour un changement de comportement (CPAP Benin 2004 – 2008)</i></p> <p><i>Le renforcement des compétences des prestataires en counseling (CPAP Benin 2004 – 2008)</i></p> <p><i>Organisation d'un atelier de formation des acteurs impliqués dans la collecte des données sur les indicateurs du programme de coopération UNFPANIGER (AWP Niger 2006 Agadez)</i></p> <p><i>Formation de 20 cadres du programme en CCC/SR, plaidoyer et counseling spécifique (AWP Niger 2007)</i></p> <p><i>Refresher FP/MCH/ANC30 days in service training at provincial hospital level for health care staff from health centers in Saravan, Sekong, and Attapeu (AWP Laos 2008)</i></p>	<p>Increased gender- and culturally sensitive behaviour change communication interventions to address reproductive health and related socio-cultural issues</p> <p>Strengthened institutional capacity for managing reproductive health programmes, with attention to ensuring reproductive health commodity security</p> <p>Les services de communication pour le changement de comportement dans le domaine de la santé de la reproduction et de l'insertion professionnelle des adolescents et jeunes disponibles et accessibles dans les zones d'intervention du programme</p> <p>Services de SR de qualité, intégrés et accessibles dans les zones d'intervention du programme</p> <p>Systèmes de gestion des ressources humaines, des informations sanitaires, de la coordination, de la supervision et suivi améliorés</p> <p>Accessibilité et Utilisation des Services de SR de qualité incluant les services de SSRJA dans les zones du programme accrues</p> <p>Improved quality of Maternal and Child Care services including long term FP services in health centres, district and provincial hospitals</p>	Ethiopia Chad Cameroon	



Providing technical, financial and/or logistical support to national and regional initiatives		X	<i>Appuyer la mise en œuvre du plan d'action de la CARMMA (Chad COUVERTURE ET TABLEAU DU PLAN DE TRAVAIL ANNUEL 2010)</i>	Increased availability of quality services	Chad
Organizing workshops and meetings for community based health information exchange		X	<i>Conduct advocacy w/shops and community conversation activities at 25 woredas of SNNP's on FP/RHCS especially long acting methods (UNFPA GLOBAL AND REGIONAL PROGRAMME 2008-2011 ETHIOPIA 2010 Work Plan and Monitoring Tool)</i>	Increased gender- and culturally sensitive behaviour change communication interventions to address reproductive health and related socio-cultural issues	Ethiopia
Technical and logistical support to supervision and training follow up			<i>Supervision formative dans le respect des protocoles de service. (CPAP Benin 2004 – 2008) Mission de Supervision/suivi des activités des ECD des districts par le niveau régional (DRSP/LCE, NPPP, VNUI) (AWP Niger 2006)</i>	Services de SR de qualité, intégrés et accessibles dans les zones d'intervention du programme Systèmes de gestion des ressources humaines, des informations sanitaires, de la coordination, de la supervision et suivi améliorés	

**Evaluation question 5: To what extent has UNFPA anticipated and responded to reproductive health threats in the context of humanitarian emergencies?**

**Judgment criterion 5.1: Inclusion of sexual and reproductive health in emergency preparedness, response and recovery plans**

Activity type	Programming Periods		Description and Examples	Is (typically) associated with following outputs	Countries where this activity was implemented / planned
	2004 - 2007	2008 - 2010			
Organising stakeholder meeting to validate (or inform on) newly developed material and/or programmatic approaches		X	<i>Organiser 6 jours de réflexion avec le comité de leaders des réfugiés sur les bienfaits de SR</i>	Disponibilité accrue des services de SR, y compris les services de SR des adolescents, dans la zone du programme	Chad
Supporting relevant data collection, analysis and dissemination of results for M&E or evidence creation through technical and logistical assistance	X	X	<i>Conduct rapid/regular assessment in humanitarian prone/affected areas and M&amp;E in project areas (planned but not done due to lack of staff) Monitor and report vulnerable women's condition especially for pregnant women in the flood prone areas Conduct a rapid assessment of available health sites, health workers and TBAs to be trained, and identify staff that has already been trained in AWD prevention and referral. Assess the capacity</i>	Les données sont collectées et analysées pour une réponse humanitaire plus cohérente  Acute Watery Diarrhea and RH response in food insecure areas	Cote d'Ivoire Ethiopia DRC

			<p><i>of health workers and TBAs to deliver RH services and refer cases. Assess equipment and drugs available (UNFPA CO Humanitarian report 2007)</i></p> <p><i>Evaluation rapide du niveau des prestations SR / SOU, PF, Genre...</i></p> <p><i>3 opérations de collecte des données (VBG à l'ouest, PDI, et CAP des ex-combattants) sont réalisées</i></p>	of West and East Harerghe Zones of Oromiya region	
Providing technical support to formulation of national strategies/policies	X		<p><i>Active participation in humanitarian coordination to gradually ensure that RH, HIV prevention, and gender issues including GBV are systematically and comprehensively integrated into joint contingency plans, humanitarian appeals and action plans</i></p> <p><i>Un plan de réponse est élaboré</i></p> <p><i>Include SRHR and HIV prevention needs in humanitarian situations into National RH and AYRH Strategies implementation plan (not implemented) (UNFPA CO Humanitarian report 2007)</i></p> <p><i>Support financial resource mobilization to address RH, HIV prevention, and gender issues (including GBV) in humanitarian situations especially through the CO resource mobilization strategy. (UNFPA CO Humanitarian report 2007)</i></p>	<p>Capacity of the CO to mobilize resources in support of crises response strengthened for addressing SRHR, HIV prevention and gender issues</p> <p>SRH and Rights aligned with the Maputo Continental Policy Framework for SRH&amp;R and HIV prevention included in the review, formulation and implementation of national development plans including in humanitarian response and recovery</p>	Ethiopia Cote d'Ivoire

**Judgment criterion 5.2: Accessibility of quality EmONC, family planning and reproductive health/ HIV services in emergency and conflict situations**

Activity type	Programming Periods		Description	Is (typically) associated with following outputs	Countries where this activity was implemented / planned
	2004 - 2007	2008 - 2010			
Organising training on technical issues in various formats (workshops, cascade, on-the job, shadowing, etc)	X	X	<p><i>Forme en 2 sessions de 6 jours chacune des prestataires de camps de réfugiées...sites déplacés et des communautés hôtes Chad AWP Réponse Hum 2010</i></p> <p><i>Au mois de janvier 2009, 25 prestataires ont été formés à Kinshasa sur la prise en charge de VVS.</i></p> <p><i>2 sessions de formation ont été organisées à l'intention de staff de l'UNFPA et des partenaires de mise en œuvre de la composante SR avec l'appui du Conseiller Régional en matière des urgences basé à</i></p>	<p>Disponibilité accrue des services de SR, y compris les services de SR des adolescents, dans la zone du programme</p> <p>Capacity of the CO to mobilize resources in support of crises response strengthened for addressing SRHR, HIV prevention</p>	Chad Ethiopia DRC Cameroon

			<p><i>Dakar.</i></p> <p><i>25 prestataires ont été formés à Kinshasa sur la prise en charge Clinique et psychosociale des victimes de violences sexuelles ; former le personnel sanitaire des structures de référence et des camps de réfugiés en PF, soins obstétricaux et néonataux d'urgence, prévention IST/VIH/SIDA et prise en charge des IST ; former, équiper et superviser les accoucheuses compétentes au sein des communautés hôtes et dans les camps de réfugiés. (Chad CPAP 2006-2010)</i></p> <p><i>Formation/mise à niveau sur site des prestataires en SOU (utilisation des ventouses, complications de avortements)</i></p> <p><i>Train health workers and TBAs on AWD identification, basic treatment and referral. Train 60 HEWs, CHAs and TBAs and 36 MoH staff to use delivery kits to reduce delivery complications, to identify and refer complicated cases and to promote awareness on antenatal and postnatal care and family planning.</i></p> <p><i>Train MoH health staff to use the clean delivery kits, diagnose, refer and treat STIs. Train 60 TBAs to use clean delivery kits, to refer women to health facilities for STI treatment, and on HIV/AIDS/STI prevention</i></p> <p><i>Build capacity of the staff to address humanitarian issues. Train Health Extension Workers (HEWs) and Traditional Birth Attendants (TBAs) and provide them with clean delivery kits. (UNFPA CO Humanitarian report 2007)</i></p> <p><i>200 Prestataires de service formés (Des formations en cascade ont été organisées en SONU (CIV OMP 2007 suivi des principaux indicateurs)</i></p>	<p>and gender issues</p> <p>Capacity of the CO to mobilize resources in support of crises response strengthened for addressing SRHR, HIV prevention and gender issues</p>	
Developing and or harmonising training material/curricula through workshops, technical and /or financial assistance	X	X	<p><i>Développer le module de formation pour les prestataires de soins (Chad AWP Réponse Hum 2010)</i></p>	Disponibilité accrue des services de SR, y compris les services de SR des adolescents, dans la zone du programme	Madagascar
Developing and /or harmonising as well as disseminating protocols and guidelines	X	X	<p><i>Diffuser les protocoles et standards de SONU en situation de crise (Chad AWP Réponse Hum 2010)</i></p> <p><i>45 000 documents ont été reproduits dont: 15 000 partogrammes, 15 000 fiches CPN, 15 000 fiches CPoN, 15 000 fiches PF</i></p>	L'accès des populations déplacées et des victimes des crises humanitaires aux services de santé de la reproduction, y compris à la prophylaxie post exposition est accru.	DRC Chad Ethiopia

			<p>et 15 000 cartes de RDV.</p> <p>11 plans de contingence ont été élaborés à raison d'un plan par province. (DRC Rapport d'Etape 2008)</p> <p>Present and disseminate UNFPA policy and guidelines in humanitarian settings among the staff (UNFPA CO Humanitarian report 2007)</p> <p>Diffuser les protocoles et standards de SONU en situation de crise (Chad AWP Réponse Hum 2010)</p>		
Providing individual medical care to victims in conflict zones through financing treatment and care		X	<p>7 504 victimes de violences sexuelles ont été prises en charge dans 8 provinces et 66 569 cas d'IST ont été soignés dans 4 provinces. (Rapport d'Etape 2009)</p>	<p>Disponibilité accrue des services de SR, y compris les services de SR des adolescents, dans la zone du programme</p> <p>Appuyer la réponse humanitaire</p>	DRC
Providing financial and/or logistical support to rehabilitate health facilities	X		<p>Réhabilitation légère des structures de santé</p> <p>Mise en place d'un système de communication et d'évacuation des urgences obstétricales (CADRE D'INTERVENTION HUMANITAIRE COTE D'IVOIRE- UNFPA 2003-2004)</p>	<p>Disponibilité accrue des Soins Obstétricaux d'Urgence de qualité dans huit (8) districts sanitaires des zones d'intervention du Programme à Korhogo/Ferkessédougou au Nord, Bouaké/Yamoussoukro au Centre, Daloa/Duékoué à l'Ouest, Bondoukou/Tanda à l'Est</p>	Cote d'Ivoire
Supporting relevant data collection, analysis and dissemination of results for M&E or evidence creation through technical and logistical assistance		X	<p>Conduct rapid/regular assessment in humanitarian prone/affected areas and M&amp;E in project areas (planned but not done due to lack of staff) Monitor and report vulnerable women's condition especially for pregnant women in the flood prone areas</p> <p>Conduct a rapid assessment of available health sites, health workers and TBAs to be trained, and identify staff that has already been trained in AWD prevention and referral. Assess the capacity of health workers and TBAs to deliver RH services and refer cases. Assess equipment and drugs available (UNFPA CO Humanitarian report 2007)</p> <p>Evaluation rapide du niveau des prestations SR / SOU, PF, Genre... 3 opérations de collecte des données (VBG à l'ouest, PDI, et CAP des ex-combattants) sont réalisées</p>	<p>Les données sont collectées et analysées pour une réponse humanitaire plus cohérente</p> <p>Acute Watery Diarrhea and RH response in food insecure areas of West and East Harerghe Zones of Oromiya region</p>	Chad Ethiopia DRC
Organising and /or providing assistance to participation in national and international fora /conferences/		X	<p>Organiser les journées commémoratives (Chad AWP Réponse Hum 2010)</p>	<p>L'accès des populations déplacées et des victimes des crises humanitaires aux services de santé de la reproduction, y</p>	Chad

meetings/commemorative days.				compris à la prophylaxie post exposition est accru.	
Organizing workshops and meetings for community based health information exchange			<p><i>Use Community Conversation as a tool of information and prevention on RH, HIV, GBV in humanitarian response</i> (UNFPA CO Humanitarian report 2007)</p> <p><i>Produire 18 émissions éducatives sur la SR en Arabe et Français</i> (Chad AWP Réponse Hum 2010)</p> <p>Inform the communities and especially WRA on safe motherhood, family planning and HIV/AIDS –</p> <p><i>Sensibilisation des communautés sur les risques de l'accouchement non assisté</i> (CADRE D'INTERVENTION HUMANITAIRE COTE D'IVOIRE- UNFPA 2003-2004)</p> <p><i>Conduct pilot projects of outreach RH &amp; HIV/AIDS services in humanitarian prone areas</i></p> <p><i>Strengthen RH, HIV/AIDS and GBV information and services delivered in displaced settings</i></p> <p><i>Provide community education to 40,000 mothers/WRA on AWD control and management – basic hygiene and sanitation, identification and referral of cases.</i></p> <p><i>Provide RH education on clean and safe deliveries, antenatal and postnatal care, family planning, and dangers of FGM to 40,000 women.</i></p> <p><i>Provide options and education to 40,000 WRA and caretakers (men and women) on STIs, HIV/AIDS, and availability of STI treatment at MoH facilities.</i> (UNFPA CO Humanitarian report 2007)</p>	<p>Reproductive Health support for vulnerable women in chronically flood affected areas of Amhara region</p> <p>Acute Watery Diarrhea and RH response in food insecure areas of West and East Harerghe Zones of Oromiya region</p>	<p>Cote d'Ivoire</p> <p>Ethopia</p> <p>Chad</p>

### Judgment criterion 5.3: Accessibility to medical products in emergency and conflict situations

Activity type	Programming Periods		Description	Is (typically) associated with following outputs	Countries where this activity was implemented / planned
	2004 - 2007	2008 - 2010			
Purchasing and distributing equipment and consumables for service providers	X	X	<p><i>Equiper en materiel medico-techniques</i> (Chad AWP Response Hum 2010, Chad CPAP 2006-2010)</p> <p><i>Build up stocks of emergency kits</i></p> <p><i>During emergencies, contribute to the MISIP by providing reproductive health services affected people</i> (UNFPA CO Humanitarian report 2007)</p> <p><i>Des kits d'urgences pour la reponse humanitaire sont prepositionnnes dans 2 regions au moins</i> (PTA 2009 CMR5R21A)</p> <p><i>(Assurer l'approvisionnement des structures de référence (centres de santé, hôpitaux de district et régionaux) et des camps de réfugiés en produits et consommables pour la prise en charge des complications obstétricales et néonatales</i></p> <p><i>Dans le cadre des urgences, 184 kits post-viol ont été pré-positionnés dans le Sud et Nord-Kivu pour une prise en charge de 10 120 victimes de violences sexuelles et les commodités SR ont été acheminées dans toutes les 22 zones de santé ciblées.</i> (DRC Rapport d'Etape 2009)</p> <p><i>Les commodités SR et les kits d'urgence ont été positionnés dans toutes les provinces en conflits.</i></p> <p><i>Fourniture d'équipements et matériels médicaux</i> (CADRE D'INTERVENTION HUMANITAIRE COTE D'IVOIRE- UNFPA 2003-2004)</p> <p><i>Distribute injectable contraceptives and condoms Provide 8,200 water guard bottles and 2,000 soaps to health facilities, HEWs, CHAs, and TBAs to be distributed to 2,000 of the most vulnerable pregnant and lactating women and mothers/WRA.</i></p> <p><i>Provide 4,000 clean delivery kits to 60 HEWs, CHAs and TBAs and 36 MoH workers working at health facilities to be distributed to pregnant women (over 6 months) and to be used by health workers and TBAs for assisting deliveries.</i></p> <p><i>Distribute 50,000 condoms to health sites and TBAs to be distributed/made available to community members coming to the site and/or attending RH education sessions.</i></p> <p><i>Provide 1 STI kit each to 2 hospital, 10 health facilities and 20 clinics.</i> UNFPA CO Humanitarian report 2007</p>	<p>Appuyer la réponse humanitaire</p> <p>Disponibilité accrue des services de SR, y compris les services de SR des adolescents, dans la zone du programme</p>	<p>Chad</p> <p>Cameroon</p> <p>Ethiopia</p> <p>Cote d'Ivoire</p> <p>DRC</p>

**Evaluation question 6: To what extent has the UNFPA contributed to the scaling up and increased utilization of and demand for family planning?**

**Judgment criterion 6.1: Increased capacity within health system for provision of quality family planning services in UNFPA programme countries**

Activity type	Programming Periods		Description & Examples (Country; year)	Is (typically) associated with following outputs	Countries where this activity was implemented / planned
	2004 - 2007	2008 - 2010			
Advocacy capacity building for FP repositioning/promotion	X	X	<ul style="list-style-type: none"> <li>• <i>Renforcement des capacités des cadres aux niveaux national et local en plaidoyer pour le repositionnement de la planification familiale et la réduction de la mortalité maternelle et néonatale: a) renforcer les capacités de la DSF, de la DPP, de la FSS, de la CAME, des DDS et des zones sanitaires, b) élaborer un Plan d'Action pour le repositionnement de la PF, c) élaborer et mettre en œuvre une stratégie de plaidoyer et son plan d'opérationnalisation pour le repositionnement de la PF (CPAP Benin 2009 2013)</i></li> <li>• <i>Organiser un concours au profit des formations sanitaires ayant les meilleurs indicateurs de PF (PTA Benin 2009)</i></li> <li>• <i>Appui aux activités de plaidoyer pour le repositionnement de la PF (PTA Niger 2010)</i></li> </ul>	<p>Les capacités institutionnelles et techniques, nationales et locales sont renforcées pour le suivi et la coordination du plan d'action de Maputo</p> <p>Les besoins non satisfaits en PF sont réduits de 25%</p> <p>La demande de services de santé de la reproduction, y compris la planification familiale, les soins de santé maternelle et les services de prévention des infections sexuellement transmissibles et du VIH/SIDA chez les populations vulnérables, accrue.</p>	Chad Cote d'Ivoire Ethiopia Madagascar
Technical support for the definition of RH quality standards	X	X	<ul style="list-style-type: none"> <li>• <i>Définir des normes en vue d'améliorer la qualité des services (CPAP BF 2006 2010)</i></li> <li>• <i>Review and update of medical eligibility criteria for different FP methods (AWP LAOS 2007)</i></li> </ul>	<p>Offre accrue d'un ensemble de services intégrés de qualité en matière de santé procréative, notamment la planification familiale, la santé des adolescents en matière de procréation, les soins obstétriques d'urgence et le traitement des fistules de l'appareil génital dans les zones d'intervention</p> <p>Increased availability and accessibility of client oriented reproductive health information and services</p>	Cameroon Chad Cote d'Ivoire
Technical support to RH services integration in health services			<ul style="list-style-type: none"> <li>• <i>Intégrer les services de consultation en SR dans 30% des formations sanitaires (PTA Benin 2009)</i></li> </ul>	Les besoins non satisfaits en PF sont réduits de 25%	Chad Cote d'Ivoire DRC

					Ethiopia
Technical and/or logistical support to revise PF training curricula		X	<ul style="list-style-type: none"> <li>• Réviser les modules de formation sur la PF et le SIGL en y intégrant les autres produits de SR (PTA BF 2010)</li> </ul>	Disponibilité accrue du paquet minimum des activités de santé de la reproduction de qualité y inclus la planification familiale, la santé sexuelle et reproductive des adolescents et des jeunes, les soins obstétricaux d'urgence et la réparation des fistules	Chad Cote d'Ivoire
Organise training for health care providers on FP (technical financial and logistical support)	X	X	<ul style="list-style-type: none"> <li>• Former au niveau national les prestataires des Régions en PF clinique (y compris le condom féminin, le DIU) (PTA BF 2010)</li> <li>• Renforcement des compétences des prestataires en counseling (CPAP BENIN 2004 2008)</li> <li>• Formation de 8 prestataires en pose et retrait norplant DIU (PTA Niger 2006)</li> </ul>	disponibilité accrue du paquet minimum des activités de santé de la reproduction de qualité y inclus la planification familiale, la santé sexuelle et reproductive des adolescents et des jeunes, les soins obstétricaux d'urgence et la réparation des fistules	Cameroon Chad Cote d'Ivoire DRC
Technical and logistical support to FP services to improve quality (on the job training – rehabilitation – equipment – contraceptives supply – incentives)	X	X	<ul style="list-style-type: none"> <li>• L'élargissement de la gamme de services par l'extension de la couverture en implants sub-dermaux, et la promotion du préservatif féminin (CPAP BENIN 2004 2008)</li> <li>• Mise à niveau des plateaux techniques (formation continue, réhabilitation de trois maternités de garnison et d'une maternité par zone sanitaire retenue, équipement et fourniture de matériel, médicaments essentiels et produits contraceptifs (CPAP BENIN 2004 2008)</li> <li>• Support to Scaling up of family Planning services by establishment of "Secondary post" of FP nearest of Health Facilities run by Catholic Church (PTA Rwanda 2010)</li> <li>• Mise en place de 4 sites de pose et retrait norplant et de 5 nouveaux sites de DIU (PTA Rwanda 2010)</li> <li>• Strengthen provision of free mini laparotomy services at provincial and district hospital in 3 southern provinces (assessment and procurement ML kits and medical supplies to provide free mini laparotomy services) (PTA Laos 2007)</li> <li>• Strengthen existing FP services delivery through the regular EPI outreach in initiative in 17 district in 3 southern provinces) (PTA Laos 2007)</li> </ul>	<p>Services de SR de qualité, intégrés et accessibles dans les zones d'intervention du programme</p> <p>National equity-driven scale-up of family planning and EmONC services, maternal and newborn health commodity security (in close coordination with UNFPA's Global Programme on RHCS and with joint financial support)</p> <p>Disponibilité des services de SR de qualité intégrant l'approche genre améliorée dans les zones d'intervention</p> <p>Increased availability and accessibility of client oriented reproductive health information and services</p>	Cameroon Chad
Strengthen management capacity for RH services	X		<ul style="list-style-type: none"> <li>• Formation des cadres en gestion de programmes à différents niveaux (national, départemental et zones sanitaires) (CPAP BENIN 2004 2008)</li> </ul>	Services de SR de qualité, intégrés et accessibles dans les zones d'intervention du programme	CHAD DRC



Technical support to insure that SR is introduced in pre service training	X		<ul style="list-style-type: none"> <li>• <i>Introduction des modules SR dans les institutions de formation initiale des agents socio-sanitaires</i> (CPAP BENIN 2004 2008)</li> </ul>	Services de SR de qualité, intégrés et accessibles dans les zones d'intervention du programme	Chad Cote d'Ivoire
Technical and logistical support for reinforce youth centres	X	X	<ul style="list-style-type: none"> <li>• <i>Consolider les centres de santé, notamment les centres destinés aux jeunes</i> (CPAP BF 2006 2010)</li> <li>• <i>Appuyer l'opérationnalisation des centres jeunes et les équiper en matériel à Zabré, Tenkodogo, Ouargaye et Koupela</i> (PTA BF 2010)</li> <li>• <i>Dynamiser l'animation des Centres de Jeunes et de Loisirs (CJL) afin d'y attirer un maximum d'ADO et jeunes pour recevoir les informations et services de SR et de lutter contre la pauvreté par l'acquisition de formation pouvant leur permettre de s'insérer dans le marché de l'emploi.</i> (Benin 2005)</li> </ul>	<i>Offre accrue d'un ensemble de services intégrés de qualité en matière de santé procréative, notamment la planification familiale, la santé des adolescents en matière de procréation, les soins obstétriques d'urgence et le traitement des fistules de l'appareil génital dans les zones d'intervention</i>	

**Judgment criterion 6.2: Increased demand for and utilization of family planning services in UNFPA partner countries, particularly among vulnerable groups**

Activity type	Programming Periods		Description & Examples (Country; year)	Is (typically) associated with following outputs	Countries where this activity was implemented / planned
	2004 - 2007	2008 - 2010			
Strengthening national capacity to design, implement mobilisation and communication campaigns/strategies for RH (including family planning)	X	X	<ul style="list-style-type: none"> <li>• <i>Renforcer l'aptitude à planifier, gérer et coordonner une campagne de mobilisation et une stratégie d'éducation</i> (CPAP BF 2006 2010)</li> <li>• <i>Planning for vasectomy promotion</i> (AWP LAOS (2007))</li> <li>• <i>Technical support to support demand creation and community empowerment for RH/MNCH-FP services through the development and distribution of appropriate IEC/BCC materials</i> (AWP Laos 2010)</li> </ul>	<p>Volume accru d'informations de qualité concernant la santé procréative, notamment la planification familiale et les soins obstétriques, prenant en compte les pratiques socioculturelles saines, les droits en matière de procréation et l'égalité des sexes, à l'intention des hommes, des femmes et des jeunes.</p> <p>Increased availability and accessibility of client oriented reproductive health information and services</p>	Chad
Support evidence based communication programming (studies,	X		<ul style="list-style-type: none"> <li>• <i>Recherche opérationnelle pour apprécier les besoins en services de SR et leur satisfaction</i> (CPAP BENIN 2004 2008)</li> </ul>	Services de SR de qualité, intégrés et accessibles dans les zones d'intervention du programme	Cote d'Ivoire DRC

operational research)			<ul style="list-style-type: none"> <li>• <i>Mettre en réseau les intervenants en PF pour la documentation et le partage des meilleures pratiques en PF</i> (PTA Benin 2009)</li> <li>• <i>Clients views on RH services (print &amp; disseminate key findings of PEER study to relevant policy makers)</i> (AWP Laos 2008)</li> <li>• <i>Review effectiveness and impact of out reach strategy (FP-CBD-FP/EPI-FP/DRF= to define catchment area and criteria)</i> (AWP Laos 2008)</li> <li>• <i>Support for feasibility study for contraceptive social marketing</i> (AWP Laos 2008)</li> </ul>	<p>Les besoins non satisfaits en PF sont réduits de 25%</p> <p>Output: Increased demand for SRH and reproductive rights in Saravan, Sekong and Attapeu</p> <p>Sub output 1: Increased understanding of critical issues regarding barriers to prevent access to reproductive health services among rural population from selected villages</p> <p>Increased availability and accessibility of client oriented reproductive health information and services</p> <p>Improved health systems including planning management human resources development logistics and information systems, focusing on maternal and neonatal health, adolescent sexual and reproductive health and prevention of sexually transmitted infection and HIV</p>	Ethiopia
Communication material reproduction (printing)	X		<ul style="list-style-type: none"> <li>• <i>Reproduire 2400 exemplaires d'une affiche sur la Planification familiale (40 x 60) et 150 exemplaires de la boîte à images sur la PF</i> (PTA BF 2010)</li> <li>• <i>Develop high quality IEC/BCC materials to disseminate RH, FP and maternal health information</i> (AWP Laos 2008)</li> <li>• <i>Production, reprint and implementation of MNCH/FP demand creation activities including production of quality IEC/BCC materials and media campaign</i> (AWP Laos 2010)</li> </ul>	<p>Disponibilité accrue du paquet minimum des activités de santé de la reproduction de qualité y inclus la planification familiale, la santé sexuelle et reproductive des adolescents et des jeunes, les soins obstétricaux d'urgence et la réparation des fistules</p> <p>Increased awareness and improved SRH knowledge to encourage health seeking behavior of populations of Southern provinces</p>	Chad Ethiopia
Technical and/or financial support for mass media communication on FP			<ul style="list-style-type: none"> <li>• <i>Appuyer la réalisation et la diffusion de 40 émissions radiophoniques et télévisuelle "Burkina Variétés" en langues locales sur la PF dans les villages du Burkina</i></li> </ul>	<p>Disponibilité accrue du paquet minimum des activités de santé de la reproduction de qualité y inclus la planification familiale, la santé sexuelle et reproductive des adolescents et des jeunes,</p>	Chad Ethiopia

			<p>(25 dans la ZI et 15 autres zones) (PTA BF 2010)</p> <ul style="list-style-type: none"> <li>• Aide à la création de 4 autres radios communautaires<sup>12</sup> pour améliorer la communication entre adolescents et jeunes sur les problèmes de population, notamment leur santé sexuelle et génésique et la prévention du VIH/SIDA (CPAP Benin 2004 2008)</li> <li>• Former le Communicateur de la DRSP en Communication audio visuelle de la SR en Tunisie (PTA Niger 2007)</li> </ul>	<p>les soins obstétricaux d'urgence et la réparation des fistules</p> <p>Environnement socioculturel favorable à l'utilisation des services de SR améliorée</p>	
Support to CSO for communication activities about FP (financial support, training, equipment...)		X	<ul style="list-style-type: none"> <li>• Appuyer la réalisation par les OSC de 150 projections de film suivie de discussions sur la PF dans toutes les régions du pays (PTA BF 2010)</li> <li>• Appuyer la réalisation de 400 représentations théâtrales sur la PF dans l'ensemble des districts sanitaires du pays par les troupes professionnelles (PTA BF 2010)</li> <li>• Former pendant 5 jours 175 membres des OBC sur la promotion de l'utilisation du condom féminin (PTA BF 2010)</li> </ul>	Disponibilité accrue du paquet minimum des activités de santé de la reproduction de qualité y inclus la planification familiale, la santé sexuelle et reproductive des adolescents et des jeunes, les soins obstétricaux d'urgence et la réparation des fistules	
Technical, financial and/or logistic support for community based distribution of contraceptives	X	X	<ul style="list-style-type: none"> <li>• Organiser la mise en œuvre des activités de distribution à base communautaire des produits contraceptifs et sensibilisation sur la SR dans tous les districts sanitaires (PTA BF 2010)</li> <li>• Assurer la formation des 824 ARC à la distribution à base communautaire des produits contraceptifs non prescriptibles (PTA BF 2010)</li> <li>• Développement des SBC par l'approvisionnement et la distribution à base communautaire des produits contraceptifs, y compris les préservatifs (CPAP Benin 2004 2008)</li> <li>• Mise en place de 10 sites de distribution à base communautaire de contraceptifs et préservatifs avec l'implication de tous les acteurs locaux (ECD, VNU, DRSP, NPPP, communautés, les autorités coutumières) en collaboration avec Initiative Jeune et des services de développement social (PTA Niger 2006)</li> <li>• Implantation et re-lancement des sites DBC (services</li> </ul>	<p>Disponibilité accrue du paquet minimum des activités de santé de la reproduction de qualité y inclus la planification familiale, la santé sexuelle et reproductive des adolescents et des jeunes, les soins obstétricaux d'urgence et la réparation des fistules</p> <p>Disponibilité des services de SR de qualité intégrant l'approche genre améliorée dans les zones d'intervention</p>	Chad

			<p>à base communautaires) Mirriah: 20 nouveaux sites Loga: 13 anciens sites relancés (PTA Niger 2006)</p> <ul style="list-style-type: none"> <li>• <i>Strengthening CBD worker network in 5 district in 3 southern provinces and expansion to 17 districts (regular monthly payment for CBD workers, supervision, CBD basic FP training, equipment) (AWP Laos 2007)</i></li> <li>• <i>Study tour to Chiang MAI CHW in ethnic minorities (AWP Laos 2007)</i></li> </ul>	Increased availability and accessibility of client oriented reproductive health information and services	
Organise training for health care providers on communication on FP (technical, logistical and/or financial support)	X		<ul style="list-style-type: none"> <li>• <i>Renforcement des compétences des prestataires de service et des pairs éducateurs en techniques de communication pour un changement de comportement (CPAP Benin 2004 2008)</i></li> <li>• <i>Former par zone sanitaire 40 acteurs impliqués dans les activités de SPSR et de promotion des préservatifs sur les techniques de conception, de diffusion des messages et techniques de réalisation du plaidoyer (PTA Benin 2010)</i></li> <li>• <i>Formation de formateurs en IEC/CCC/SR à Loga (PTA Niger 2006)</i></li> <li>• <i>Strengthen capacity of team to provide high quality health education including skilled FP and RH counseling (AWP Laos 2008)</i></li> </ul>	<p>Les services de communication pour le changement de comportement dans le domaine de la santé de la reproduction et de l'insertion professionnelle des adolescents et jeunes disponibles et accessibles dans les zones d'intervention du programme</p> <p>Disponibilité des services de SR de qualité intégrant l'approche genre améliorée dans les zones d'intervention</p> <p>Sub output 3: Increased awareness and improved SRH knowledge to encourage health seeking behavior of populations of Southern provinces</p>	Chad Ethiopia
Create partnership for community based communication on FP	X		<ul style="list-style-type: none"> <li>• <i>Le développement de la communication de proximité en SR par le partenariat avec des radios communautaires ou locales, par les ONG, les associations communautaires socio-professionnelles, les Associations de Parents d'Elèves (APE), les canaux traditionnels (patrimoine culturel) et l'extension de l'introduction des services de conseils et d'information au profit des adolescents et jeunes dans les maisons de jeunes et des orphelinats (CPAP Benin 2004 2008)</i></li> <li>• <i>Mobilisation sociale à travers les Comités de gestion des centres de santé publics et confessionnels (CPAP Benin 2004 2008)</i></li> <li>• <i>Campagne de sensibilisation sur la pF avec ONG ANBEF (PTA Niger 2010)</i></li> </ul>	<p>Les services de communication pour le changement de comportement dans le domaine de la santé de la reproduction et de l'insertion professionnelle des adolescents et jeunes disponibles et accessibles dans les zones d'intervention du programme</p> <p>Disponibilité des services de SR de qualité intégrant l'approche genre améliorée dans les zones d'intervention</p>	
Technical and financial support for sensitization activities			<ul style="list-style-type: none"> <li>• <i>Plaidoyer en direction des couches sociales résistantes à la SR afin de dégager des messages consensuels (CPAP Benin 2004 2008)</i></li> </ul>	La demande de services de santé de la reproduction, y compris la planification familiale, les soins de santé maternelle et les services de	

regarding RH			<ul style="list-style-type: none"> <li>Appui aux activités de sensibilisation pour accroître la demande des produits SR (PTA Niger 2010)</li> </ul>	prévention des infections sexuellement transmissibles et du VIH/SIDA chez les populations vulnérables, accrue	
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**Observations on the strategic context of the above activities (e.g., intended linkages to other activities and strategies)**

Most of the FP activities are funded by the GPRHCS or core funds.

**Judgment criterion 6.3: Improved access to contraceptives (commodity security)**

Activity type	Programming Periods		Description & Examples (Country; year)	Is (typically) associated with following outputs	Countries where this activity was implemented / planned
	2004 - 2007	2008 - 2010			
Technical and/or logistical support for strengthening RH commodity security programming implementation and monitoring at national level (Building national capacity - development of frameworks / programmes – collection of evidence - logistic systems - Training)	X	X	<ul style="list-style-type: none"> <li>Renforcer les capacités des pouvoirs publics dans les domaines de la sécurité des produits de santé procréative et à promouvoir la création de nouveaux mécanismes de financement (CPAP BF 2006 2010)</li> <li>Elaboration et la mise en œuvre en 2005 d'un plan stratégique de sécurisation des produits contraceptifs (2005-2015) (CPAP BF 2006 2010)</li> <li>Enquête afin d'apprécier l'impact du programme sur la sécurisation des contraceptifs et des produits vitaux de santé maternelle et reproductive (CPAP BF 2006 2010)</li> <li>Développement d'un plan de sécurisation des produits de SR (CPAP Benin 2004 2008)</li> <li>Réviser la SPSR 2009-2015 sur la base de l'étude de novembre 2008 (réforme CAME, système approvisionnement et distribution, etc.) (PTA Benin 2009)</li> <li>Former une équipe nationale de formateurs sur la SPSR (PTA Benin 2010)</li> <li>Recruter un Expert national et un chauffeur (+ véhicule) chargés d'appuyer la DSF pour la mise en œuvre du plan de SPSR (PTA Benin 2010)</li> <li>Revise the draft of RHCS strategic plan including its costing (PTA Rwanda 2010)</li> <li>Support the implementation of the 2010 RHCS plan (PTA Rwanda 2010)</li> <li>Develop a strategy to strengthen logistics and information</li> </ul>	<p>Offre accrue d'un ensemble de services intégrés de qualité en matière de santé procréative, notamment la planification familiale, la santé des adolescents en matière de procréation, les soins obstétricaux d'urgence et le traitement des fistules de l'appareil génital dans les zones d'intervention</p> <p>Les besoins non satisfaits en PF sont réduits de 25%</p> <p>National equity-driven scale-up of family planning and EmONC services, maternal and newborn health commodity security (in close coordination with UNFPA's Global Programme on RHCS and with joint financial support)</p> <p>Improved health systems including planning management human resources</p>	Chad Cote d'Ivoire DRC Ethiopia

			<p><i>systems in support of MNCH care (inc contraceptive (AWP Laos 2008)</i></p> <ul style="list-style-type: none"> <li>• <i>Support high level decision makers to attend sub regional meeting on RHCS advocacy and capacity building (AWP Laos 2009)</i></li> <li>• <i>Organiser chaque trimestre la rencontre du comité technique de suivi du plan de sécurisation des produits de Santé de la Reproduction (PTA BF 2010)</i></li> <li>• <i>Coordinate and support implementation of the Global Condom Initiative (Cote d'Ivoire AWP 2009)</i></li> </ul>	<p>development logistics and information systems, focusing on maternal and neonatal health, adolescent sexual and reproductive health and prevention of sexually transmitted infection and HIV.</p> <p>Improved understanding of reproductive health, population and gender laws, policies and issues among parliamentarians, central and local government officials, governors and village chiefs and their commitment to implement these laws and policies</p> <p>Disponibilité accrue du paquet minimum des activités de santé de la reproduction de qualité y inclus la planification familiale, la santé sexuelle et reproductive des adolescents et des jeunes, les soins obstétricaux d'urgence et la réparation des fistules</p>	
Advocacy aiming at increased political commitment for sustained funding of RH products		X	<ul style="list-style-type: none"> <li>• <i>Reproduire et disséminer le plan stratégique de sécurisation des produits SR (PTA BF 2010)</i></li> <li>• <i>Organiser deux rencontres de plaidoyer auprès des autorités et des partenaires en faveur de l'exonération des produits de SR à sécuriser (PTA BF 2010)</i></li> <li>• <i>Organiser une séance de plaidoyer en direction de l'Exécutif, de l'Assemblée nationale, des leaders religieux et traditionnels pour la SPSR et le repositionnement de la PF (PTA Benin 2010)</i></li> </ul>	<p>Disponibilité accrue du paquet minimum des activités de santé de la reproduction de qualité y inclus la planification familiale, la santé sexuelle et reproductive des adolescents et des jeunes, les soins obstétricaux d'urgence et la réparation des fistules</p> <p>Les besoins non satisfaits en PF sont réduits de 25%</p>	Chad Cote d'Ivoire
Supply of contraceptives and equipment		X	<ul style="list-style-type: none"> <li>• <i>Fournir des PRODUITS DE SR au niveau national (lofemenal, deprovera, DIU, norplant, condom féminin et autres) en appui à la mise en œuvre du plan de sécurisation des produits de SR (PTA BF 2010)</i></li> <li>• <i>Equiper les formations sanitaires en médicaments, produits contraceptifs et matériels médico-techniques selon les besoins (PTA Benin 2010)</i></li> </ul>	<p>Disponibilité accrue du paquet minimum des activités de santé de la reproduction de qualité y inclus la planification familiale, la santé sexuelle et reproductive des adolescents et des jeunes, les soins obstétricaux d'urgence et la réparation des fistules</p> <p>Les besoins non satisfaits en PF sont réduits de 25%</p> <p>Increased availability and accessibility of</p>	Chad DRC Ethiopia

			<ul style="list-style-type: none"> <li>• Procurement of contraceptives nationwide and forecast contraceptives requirements (AWP Laos 2007)</li> <li>• Support transportation cost for CC to all SDP in 3 provinces(AWP Laos 2007)</li> <li>• Procurement of consumables and equipment for FP services (IUD ML equipment)</li> </ul>	<p>client oriented reproductive health information and services</p> <p>Improved quality MCH care services including long term family planning in HC dist and prov hospital</p>	
Strengthen the national capacity for RH commodity management (training – tools)	X	X	<ul style="list-style-type: none"> <li>• Former douze (12) cadres en procurement (PTA BF 2010)</li> <li>• Assurer la formation et le suivi post formation au niveau DS sur le logiciel CHANNEL (PTA BF 2010)</li> <li>• Former une équipe nationale de formateurs pour la SPSR (PTA Benin 2009)</li> <li>• Informatiser la gestion des PSR (CHANNEL) dans 50% des zones sanitaires (PTA Benin 2009)</li> <li>• Strengthen contraceptive commodity management system (monitoring accuracy and frequency of reporting through LMIS- train MCHP and MCHD staff on LMIS modified version – regular update report CCM to UNFPA) (AWP Laos 2007)</li> </ul>	<p>Disponibilité accrue du paquet minimum des activités de santé de la reproduction de qualité y inclus la planification familiale, la santé sexuelle et reproductive des adolescents et des jeunes, les soins obstétricaux d'urgence et la réparation des fistules</p> <p>Les besoins non satisfaits en PF sont réduits de 25%</p> <p>Increased availability and accessibility of client oriented reproductive health information and services</p>	Chad Ethiopia

**Evaluation question 7: To what extent has UNFPA contributed to the scaling up and utilization of skilled attendance during pregnancy and childbirth and EmONC services in programme countries?**

**Judgment criterion 7.1: Increased access to EmONC services**

Activity type	Programming Periods		Description & Examples (Country; year)	Is (typically) associated with following outputs	Countries where this activity was implemented / planned
	2004 - 2007	2008 - 2010			
Developing and or harmonising training material/curricula through workshops, technical and			Capacity building, develop IEC/BCC materials, inclusion of RHCS into the RH courses and develop RHCS course materials (UNFPA GLOBAL AND REGIONAL PROGRAMME	Strengthened institutional capacity for managing reproductive health programmes, with attention to ensuring reproductive health commodity security	Ethiopia

/or financial assistance			2008-2011, ETHIOPIA 2010 Work Plan and Monitoring Tool)		
Purchasing of expertise , equipment and consumables for the training component, including training institution development			<p><i>Institutionalize RHCS in School of Public Health- Addis Ababa University</i></p> <p><i>Elaborer un projet conjoint en SONU Gouvernement/ partenaires (UNFPA, UNICEF, OMS etc.) COUVERTURE ET TABLEAU DU PLAN DE TRAVAIL ANNUEL 2010 Santé de la Reproduction TCHAD</i></p> <p><i>Provide equipment and supplies for 8 midwifery training schools , Midwifery books, Models, Manikins, Flip charts</i></p> <p><i>Procure &amp; distribute contraceptives and life saving maternal health drugs (including MgSO4 &amp; misopristol) (UNFPA GLOBAL AND REGIONAL PROGRAMME 2008-2011 ETHIOPIA 2010 Work Plan and Monitoring Tool)</i></p> <p><i>Appui à l'extension des sites de formation SONU au Niger (AWP Niger 2007 Zinder)</i></p>	<p>Strengthened institutional capacity for managing reproductive health programmes, with attention to ensuring reproductive health commodity security.</p> <p>Disponibilité des services de SR de qualité intégrant l'approche genre améliorée dans les zones d'intervention du programme</p>	Chad Ethiopia Cote d'Ivoire
Organising training on technical issues in various formats (workshops, cascade, on-the job, shadowing, etc)			<p><i>Training on integrated obstetric and emergency surgery Sexual and Reproductive Health Project (EC/ACP/UNFPA Programme 2004-2008 Project No. ETH 5R 201 FINAL COUNTRY PROJECT REPORT January 2004 - September 2008)</i></p> <p><i>Former 200 prestataires en CPN, PL, SONU, CIV PDT 2009</i></p> <p><i>Formation de 100 personnels de sante a l'utilisation des directives de maternité sans risques CI Project Japon 2008</i></p> <p><i>Dans les 22 zones de santé appuyées, les compétences de 220 prestataires ont été renforcées en matière de la maternité à moindre risque tandis que 124 prestataires ont été formés en SGONU RDC 2009 SR Rapport d Etape</i></p> <p><i>Au cours de l'année 2008, 210 prestataires ont bénéficié de la formation en MMR dans 11 zones de santé et 28 formateurs des prestataires ont été formés en MMR au niveau central et dans 11 provinces (DRC 2008 SR Rapport d Etape)</i></p> <p><i>200 personnels de santé forment en SONU dans le 10 de 25 DS d intervention (PTA SR 2010 CMR5R11A)</i></p> <p><i>Formation de 40 agents (Médecins, SFDE, infirmiers) en soins obstétricaux et néonataux d'urgence (SONU) à la</i></p>	<p>Increased access to quality reproductive health services by men, women and adolescents</p> <p>Increased gender- and culturally sensitive behaviour change communication interventions to address reproductive health and related socio-cultural issues</p> <p>Renforcer les capacités de 100 structures sanitaires et de 200 agents de sante en SONU</p> <p>La qualité des accouchements en présence de personnel qualifié, et les soins obstétriques et néonataux d'urgence sont améliorés dans les zones de santé ciblées</p> <p>Capacité national pour la réduction de la morb et mort maternelle est renforcer</p> <p>Disponibilité des services de SR de</p>	Madagascar Ethiopia Cote D'Ivoire Cameroon



	x		<p><i>maternité centrale de Zinder utilisant la nouvelle approche des SOU. A noter : 11 prestataires déjà formés en 2005 représentent 5% (AWP Niger 2006)</i></p> <p><i>Extension du contrat du Gynéco obstétricien pour le Centre Hospitalier Régional (CHR) d'Agadez pour la prise en charge des complications obstétricales (AWP Niger 2006)</i></p>	<p>qualité intégrant l'approche genre améliorée dans les zones d'intervention</p>	
Purchasing and distributing equipment and consumables for service providers			<p><i>Procure medical equipments essential for providing all signal function for 395 HC and 81 Hospitals as identified by the EmONC survey (Note: These facilities are facilities that have at least one midwife)</i></p> <p><i>Procure and equip adequately selected anaesthesia schools (Ethiopia H4 JP 2010)</i></p> <p><i>Acquérir du matériel médico technique pour la PF et les SONU (boîtes d'insertion et de retrait de l'implant, boîtes d'accouchement, boîtes de pose et retrait de DIU, boîtes de césarienne, mannequins) (COUVERTURE ET TABLEAU DU PLAN DE TRAVAIL ANNUEL 2010 Santé de la Reproduction TCHAD)</i></p> <p><i>Approvisionner les équipements et les matériels médicaux suivant le plan opérationnel (PTA 2010 Madagascar Joint-MHTF-GPRHCS-Reg Programme)</i></p> <p><i>Achat et Mise en place de 4 radios BLU (Tefaraw, Tchintouloust, Marandet, Assouass) pour renforcer le système d'évacuation en direction des CSI et des hôpitaux (AWP Niger 2006)</i></p> <p><i>Approvisionnement en médicaments SONU y compris contraceptifs des structures SOUB et SOUC (CSI, HD, maternité centrale) (AWP Niger 2007 Zinder)</i></p>	<p>Disponibilité accrue des services de SR, y compris les services de SR des adolescents, dans la zone du programme »</p> <p>Strengthened institutional capacity for managing reproductive health programmes, with attention to ensuring reproductive health commodity security</p> <p>Disponibilité des services de SR de qualité intégrant l'approche genre améliorée dans les zones d'intervention</p> <p>Disponibilité des services de SR de qualité intégrant l'approche genre améliorée dans les zones d'intervention du programme</p>	<p>Cameroon Ethiopia Chad Madagascar</p>
Providing financial and/or logistical support to rehabilitate and equip medical institutions			<p>Réhabiliter 40 maternités et 10 blocs opératoires</p> <p>Equiper 40 maternités et 10 blocs opératoires</p> <p>Fournir a 100 structures des kits, produits et consommables CIV PDT 2009</p> <p>Réhabilitation de 5 hôpitaux régionaux</p> <p>Equipment de 53 maternité</p> <p>Fourniture de produits, médicaments... (CI Project Japon 2008)</p> <p>29 maternités ont été réhabilitées et équipées pour offrir les</p>	<p>Renforcer les capacités de 100 structures sanitaires et de 200 agents de sante en SONU</p> <p>Renforcement des services de sante maternels et néonataux pour la prise en charge des soins obstétricaux d'urgence</p> <p>La qualité des accouchements en présence de personnel qualifié, et les soins obstétriques et néonataux d'urgence sont</p>	<p>Cote d'Ivoire DRC</p>

			<p>services de qualité dont 8 au Nord-Kivu, 6 à l'Equateur, 3 au Bas-Congo, 3 au Kasai-Oriental, 2 au Maniema, 1 au Sud-Kivu (DRC 2009 SR Rapport d Etape)</p> <p>Appui à la prise en charge de la césarienne : a) appuyer la mise en réseau informatique des hôpitaux offrant la césarienne, b) apporter un appui à la fourniture des kits de césarienne aux hôpitaux couverts par le programme (CPAP Benin 2009-2013)</p> <p>Mise à niveau de 3 SOUC (Bilma, Arlit, CHR) et 30 SOUB par la fourniture et le transport des équipements complémentaires pour la prise en charge des complications obstétricales d'urgence par les agents formés en SOU (AWP Niger 2006)</p>	<p>améliorés dans les zones de santé ciblées</p> <p>Les zones de concentration du programme planifient et fournissent les services intégrés de SR/PF/IST/VIH/Sida de qualité.</p> <p>Disponibilité des services de SR de qualité intégrant l'approche genre améliorée dans les zones d'intervention</p>	
<p><i>Technical and Financial support (such as Organising stakeholder meeting) to validate (or inform on) newly developed material and/or programmatic approaches</i></p>			<p><i>Support documentation and organize national and regional dissemination forums on MNH (Ethiopia H4 JP 2010)</i></p> <p><i>Organiser des journées bilan des activités de SR et journées de sages femmes</i></p> <p><i>Organiser un prix d'excellence pour la motivation du personnel....</i></p> <p><i>Produire et distribuer des outils de référence et contre référence</i></p> <p><i>3 cases de sante...rapprocher les populations des zones d'access difficile CIV PDT 2009,</i></p> <p><i>Organiser un atelier d'élaboration du plan d'action SFE (COUVERTURE ET TABLEAU DU PLAN DE TRAVAIL ANNUEL 2010 Santé de la Reproduction TCHAD)</i></p> <p><i>Renforcer le processus d'Assurance Qualité (dont la réalisation des audits de décès maternels, la disponibilité des produits sanguins sécurisés) (CPAP Benin 2009-2013)</i></p>	<p>Improve quality of MNH services (JP Ethiopia)</p> <p>Renforcer les capacités de 100 structures sanitaires et de 200 agents de sante en SONU</p> <p>Disponibilité accrue des services de SR, y compris les services de SR des adolescents, dans la zone du programme »</p>	<p>Cote d'Ivoire Chad Ethiopia</p>
<p>Supporting relevant data collection, analysis and dissemination of results for M&amp;E or evidence creation through technical and logistical assistance</p>			<p><i>Documenting best practices and success stories in RHCS, FP safe motherhood initiatives and midwifery (UNFPA GLOBAL AND REGIONAL PROGRAMME 2008-2011 ETHIOPIA 2010 Work Plan and Monitoring Tool)</i></p> <p><i>Organiser au moins quatre (04) missions de supervision par an du niveau central vers la périphérie (COUVERTURE ET TABLEAU DU PLAN DE TRAVAIL ANNUEL 2010 Santé de</i></p>	<p>Increased access to behaviour change communication for men, women and adolescents</p> <p>Disponibilité accrue des services de SR, y compris les services de SR des adolescents, dans la zone du programme »</p>	<p>Ethiopia Chad DRC Madagascar</p>

			<p><i>la Reproduction TCHAD)</i></p> <p><i>Les briefings sur les décès maternels et néonataux ont été réalisés à Mbandaka et Matadi. Ces briefings ont été enrichis des exercices de terrain dans les structures des soins par les prestataires et l'on a noté l'implication active des cadres du niveau intermédiaire et périphérique. (DRC 2009 SR Rapport d Etape)</i></p> <p><i>11 visites de suivi de niveau intermédiaire ont été réalisées par le PNSR dans toutes les provinces (DRC 2008 SR Rapport d Etape)</i></p> <p><i>Mettre en place d'un comité de l'audit de décès maternel et définir leur responsabilité: élaborer les outils pour l'audit de décès maternels (fiches, les canevas de rapports annuels, circuit,...) (PTA 2010 Madagascar Joint-MHTF-GPRHCS-Reg Programme)</i></p>	<p>La qualité des accouchements en présence de personnel qualifié, et les soins obstétriques et néonataux d'urgence sont améliorés dans les zones de santé ciblées</p> <p>Un paquet essentiel d'informations et de services de santé de la reproduction est disponible et accessible aux hommes, aux femmes et aux jeunes dans les zones d'intervention du programme</p>	
Organising and /or providing assistance to participation in national and international fora/conferences/meetings/commemorative days.			<p><i>Appuyer la participation aux foras internationaux sur la SR et autres missions (COUVERTURE ET TABLEAU DU PLAN DE TRAVAIL ANNUEL 2010 Santé de la Reproduction TCHAD)</i></p> <p><i>Au cours de mois de novembre 2009, le Bureau UNFPA a co-organisé la 1<sup>ère</sup> journée provinciale de lutte contre la mortalité maternelle à Goma. (RDC 2008 SR Rapport d Etape)</i></p> <p><i>Le PNSR a organisé du 09 au 11 novembre 2009 au centre Nganda un atelier de révision de la Feuille de Route avec l'appui technique et financier de l'UNFPA, l'OMS et l'UNICEF. Le document de la Feuille de Route a été réélu, actualisé et révisé. Les objectifs et certaines stratégies ont été reformulés. (RDC 2009 SR Rapport d Etape)</i></p>	<p>« Disponibilité accrue des services de SR, y compris les services de SR des adolescents, dans la zone du programme »</p> <p>La qualité des accouchements en présence de personnel qualifié, et les soins obstétriques et néonataux d'urgence sont améliorés dans les zones de santé ciblées</p>	Madagascar Chad
Developing and /or harmonising protocols and guidelines			<p><i>Dans le cadre de la vulgarisation de la Feuille de Route SR, 300 exemplaires ont été reproduits et diffusés dans les ZS ciblées. (RDC 2008 SR Rapport d Etape)</i></p> <p><i>Diffusion des protocoles et directives sur les soins obs d'urgence CI Project Japon 2008</i></p> <p><i>Printing and distribution of treatment protocol and guideline</i></p> <p><i>Sexual and Reproductive Health Project EC/ACP/UNFPA Programme 2004-2008 Project No. ETH 5R 201 FINAL COUNTRY PROJECT REPORT January 2004 - September 2008</i></p>	<p>La qualité des accouchements en présence de personnel qualifié, et les soins obstétriques et néonataux d'urgence sont améliorés dans les zones de santé ciblées</p> <p>Renforcement des services de sante maternels et néonataux pour la prise en charge des soins obstétricaux d'urgence</p>	Ethiopia DRC Cote D'ivoire

Providing technical support to formulation of national strategies/policies			<p><i>Consultation on phasing out and integration of emergency obstetric and emergency surgery</i></p> <p>Sexual and Reproductive Health Project EC/ACP/UNFPA Programme 2004-2008 Project No. ETH 5R 201 FINAL COUNTRY PROJECT REPORT January 2004 - September 2008</p> <p><i>Elaborer des outils de plaidoyer (argumentaires) sur la SPSR et la Réduction de la Mortalité et Morbidité Maternelle, néonatale et infantile (COUVERTURE ET TABLEAU DU PLAN DE TRAVAIL ANNUEL 2010 Santé de la Reproduction TCHAD)</i></p> <p><i>Développement des SONU/SAA ainsi que la prise en charge des complications secondaires (fistules obstétricales) (CPAP Benin 2004-2008)</i></p> <p><i>Renforcer la mise en œuvre des SONU communautaires et cliniques (SOUB, SOUC, PHPP-GATPA, SONU-SAA, système de référence et contre référence) dans les zones d'intervention (CPAP Benin 2009-2013)</i></p>	<p>Increased access to behaviour change communication for men, women and adolescents.</p> <p>Disponibilité accrue des services de SR, y compris les services de SR des adolescents, dans la zone du programme »</p> <p>Services de SR de qualité, intégrés et accessibles dans les zones d'intervention du programme</p> <p>Les zones de concentration du programme planifient et fournissent les services intégrés de SR/PF/IST/VIH/Sida de qualité.</p>	Chad Ethiopia
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#### Judgment criterion 7.2: Increased utilization of EmONC services

Activity type	Programming Periods		Description	Is (typically) associated with following outputs	Countries where this activity was implemented / planned
	2004 - 2007	2008 - 2010			
Supporting relevant data collection, analysis and dissemination of results for M&E or evidence creation through technical and logistical assistance			<p>Documentation of lessons learned and best practices</p> <p>Sexual and Reproductive Health Project EC/ACP/UNFPA Programme 2004-2008 Project No. ETH 5R 201 FINAL COUNTRY PROJECT REPORT January 2004 - September 2008</p> <p><i>Conduct training assessment of service providers in order to provide 'Friendly services' (AWP Laos 2008)</i></p>	<p>Increased access to behaviour change communication for men, women and adolescents</p> <p>Improved quality of counselling services and communication to quality sexual reproductive health services in Attapeu</p>	Ethiopia
			<i>Financer la prise en charge des urgences obstétricales et néonatales dans les formations sanitaires sites STP dans la</i>	Capacity des structures de sante et des communautés renforcer pour la résolution	Cameroon

Providing technical, financial and/or logistical support to national and regional health care institutions			<p><i>région d'Atsimo Andrefana jusqu'à la sortie des résultats de l'évaluation du système mis en place (PTA 2010 Madagascar Joint-MHTF-GPRHCS-Reg Programme)</i></p> <p><i>Former/recycler le personnel de sante en SONU, recherche opérationnelle, supervision facilitant intégrée, suivi-évaluation (PTA CMR5R11A 2009)</i></p>	<p>des problèmes de SR et la mobilisation... Capacité national pour la réduction de la morb et mort maternelle est renforcer</p>	Madagascar
Providing technical support to formulation of national strategies/policies			<p><i>Développer des mécanismes de partage de coup des urgences obstétricales (PTA CMR5R11A 2009)</i></p> <p><i>Evaluer la politique de gratuité des services de santé maternelle (accouchement, césarienne) et de planification familiale en vue d'apprécier le coût/efficacité (PTA 2010 Madagascar Joint-MHTF-GPRHCS-Reg Programme)</i></p> <p><i>Meeting with provincial health department, provincial and district hospitals decision makers to discuss and determine on cost of services) (AWP Laos 2008)</i></p>	<p>Un paquet essentiel d'informations et de services de santé de la reproduction est disponible et accessible aux hommes, aux femmes et aux jeunes dans les zones d'intervention du programme</p> <p>Improved quality of counselling services and communication to quality sexual reproductive health services in Attapeu</p>	Cameroon Madagascar
Organizing workshops and meetings for community based health information exchange			<p><i>Former 200 agents communautaires sur les thématiques SR et répondant aux besoins de la communauté au niveau des régions de concentration de UNFPA (PTA 2010 Madagascar Joint-MHTF-GPRHCS-Reg Programme)</i></p> <p><i>Dans la zone de santé de N'sele, 250 chefs de familles et Autorités administrative ont été sensibilisés au cours d'une grande campagne organisée à cet effet. (DRC 2008 SR Rapport d Etape)</i></p>	<p>Un paquet essentiel d'informations et de services de santé de la reproduction est disponible et accessible aux hommes, aux femmes et aux jeunes dans les zones d'intervention du programme</p> <p>La qualité des accouchements en présence de personnel qualifié, et les soins obstétriques et néonataux d'urgence sont améliorés dans les zones de santé ciblées</p>	Madagascar DRC

**Evaluation question 8: To what extent has UNFPA use of internal and external evidence in strategy development, programming and implementation contributed to the improvement of maternal health in its programme countries?**

Not applicable

**Evaluation question 9: To what extent has UNFPA helped to ensure that maternal health and sexual and reproductive health are appropriately integrated into national development instruments and sector policy frameworks in its programme countries?**

**Judgment criterion 9.1: UNFPA support improved comprehensiveness of analysis of causes for poor maternal health and of effectiveness of past maternal health policies/ strategies**

Activity type	Programming Periods		Description & Examples (Country; year)	Is (typically) associated with following outputs	Countries where this activity was implemented / planned
	2004 - 2007	2008 - 2010			
Technical and logistical support for data collection (e.g. census)	X	X	<p><i>Provision of technical support and equipment for the completion of specific surveys (e.g. census) and studies by Governmental partners.</i></p> <p><u>Example</u></p> <ul style="list-style-type: none"> <li>• <i>“Preparatory activities of the 2009 Kenya Population and Housing Census (Kenya, 2008) (financed: “support for cartographic mapping in three districts”, “development of census instruments”, “development of census advocacy strategy”, “resource mobilization”, “procurement of laptops”, “hiring logistics coordinator” (NOTE: AWP financed under “population &amp; development)</i></li> <li>• <i>Support of “socio-demographic surveys” (Kenya, 2008); financed: training, editing, printing, etc.</i></li> <li>• <i>Support preparation of 2012 population and housing census (establish collaborators forum, meetings, field work, census planning, development of management and implementation strategy) (Tanzania, 2007) (under P&amp;D)</i></li> <li>• <i>Support the printing and publication of the census products; printing of technical documents (Malawi, CPAP 2008 – 2011)</i></li> <li>• <i>Put in place gender and poverty disaggregated database at national and sub-national levels was an important intervention, which is contributing to planning and program intervention at different levels (Bangladesh, AWP 2007-8)</i></li> <li>• <i>Capacity for collection, analysis and interpretation of population and poverty data will be strengthened and further in-depth analysis of recent surveys, undertaken to provide more detailed information on emerging population issues (Cambodia).</i></li> <li>• <i>Conduct training needs assessment and train staff of statistical offices and Implementing Partners at central and district levels; (b) provide</i></li> </ul>	<p>Increased availability of Gender-Sensitive Data for Planning, Implementation, Monitoring and Evaluation of Population and RH programme at all levels (Kenya)</p> <p>Increased capacity and strengthened government and civil society partnerships to improve and engender outcome-based planning, budgeting and monitoring processes</p> <p>Increased national capacity to generate, analyze and disseminate gender disaggregated data for policy formulation (Malawi).</p>	<p>Kenya Tanzania Malawi Bangladesh Cambodia Ghana Nepal</p>

			equipment for census data production and dissemination to line ministries at national level and DDCs of project districts; and (c) develop and implement a plan for the 2011 population census (just completed in June 2011). (Nepal)		
TA for studies on “barriers” to access to RH services to support implementation of health / SRH policies	X	X	<p>Various studies (including needs assessments or situational analyses) to support the evidence-based formulation and implementation of health &amp; SRH policies</p> <p><u>Example:</u></p> <ul style="list-style-type: none"> <li>Conduct an assessment on factors that influence access to RH services (financial, physical, gender &amp; socio-cultural barriers), with special focus on cost sharing, including exemptions and waiver practices (Tanzania, MoH-Zanzibar, 2007) <ul style="list-style-type: none"> <li>Including dissemination (Tanzania, 2008)</li> </ul> </li> <li>Conduct a situational analysis of existing data tools; review and revise tools for collection, dissemination of disaggregated at service points (Tanzania, 2008, joint programme)<sup>13</sup></li> <li>“Undertake ethnographic research in selected districts / communities to identify socio-cultural factors influencing MNCH related service demand, utilization and care practices (Tanzania, 2008, joint programme)</li> <li>“Support the appraisal and analysis of existing information on the underlying drivers of the epidemic (UNFPA will lead the Joint Team on AIDS)” (Zambia, CPAP 2007-2010)</li> <li>Provide technical support in specific census thematic analysis (maternal mortality, poverty mapping, population projections, etc.) (Malawi, CPAP 2008 – 2011) <b>(in P&amp;D)</b></li> <li>Conduct and disseminate the findings of a study on the extent and consequences of unsafe abortions (Malawi, CPAP 2008 – 2011)</li> <li>Provide for data collection and analysis for focused studies related to harmful practices such as early marriage, dowry, gender-based violence etc. that affect RR and access to RH and documentation of these issues (Bangladesh, 2007-8).</li> </ul>	<p>Increased national capacity to generate, analyze and disseminate gender disaggregated data for policy formulation (Malawi)</p> <p>Improved information management for maternal and newborn child health (Tanzania)</p>	<p>Tanzania Zambia Malawi Bangladesh</p>
Trainings of policy / decision makers on policy & poverty analysis	X		<p>Trainings of policy / decision makers on policy &amp; poverty analysis to ensure that policy strategies / frameworks take into account RH (and gender, P&amp;D); sometimes incl. follow-up</p> <p><u>Examples:</u></p>	<p>Increased national capacity to generate, analyze and disseminate gender disaggregated data for policy formulation (Malawi)</p> <p>Improved information management</p>	<p>Tanzania Malawi Bangladesh Ghana</p>

<sup>13</sup> The special aspect about this activity is that it is part of a “joint programme” with WHO, UNICEF, UNFPA “on reduction of Maternal and Newborn Mortality”

		<ul style="list-style-type: none"> <li>• Organise sessions with policy / decision makers and analysts to review policy and poverty analysis, institutional and technical challenges and response to capacity gaps and integration of population issues; gender; “impact on well-being of the poor, women, young people and vulnerable groups” (Tanzania, 2007) <b>(P&amp;D)</b></li> <li>• Training of “selected participants” on preparation of policy briefs on RH (and P&amp;D, gender) (Tanzania, 2007); Post-training follow-up programme to support ex-trainees on carrying out actions... (Tanzania, 2007)</li> <li>• Develop and disseminate advocacy packages on unsafe abortion for policy makers, religious leaders, community leaders, training institutions and service providers (based on previous study, see above) (Malawi, CPAP 2008 – 2011).</li> <li>• Support to Bangladesh Bureau of Statistics (BBS) for production of reliable and quality data, policy simulation, digitized enumeration mapping, institutional capacity building will be continued (Bangladesh),</li> <li>• Undertake training of 25 District Planning Officers, District Budget Analysts and Regional Population Officers on integration modules; Train relevant staff in population studies at RIPS (Ghana, AWP 2007).</li> </ul>	for maternal and newborn child health (Tanzania)	
Evidence-based advocacy for RH / MNH issues in policy-fora (often linked to health SWAp)		<ul style="list-style-type: none"> <li>• Membership of different fora<sup>14</sup> gives UNFPA entry points to provide government with evidence-based arguments for greater investment in reproductive health.</li> <li>• Workshop for focal points for HIV/AIDS from 16 ministries - identified and oriented on SRH services and HIV prevention activities. Ministries to develop draft action plan of HIV prevention activities to incorporate into sectoral plans (Bangladesh, AWP 2007).</li> <li>• Organize the sensitization and advocacy meetings with key government officials from Northern Region to support communities with equipment to transport women in labor to hospitals; Advocacy meetings with social welfare officials in the Northern Regions to include fistula patients in the leap program using fistula advocates (Ghana, MHTF 2010)</li> <li>• Organization of International Seminar on decentralization and RH services by MoLD and MoHP (Nepal, AWP 2007-2008); Orientation of</li> </ul>	N/A	Tanzania (Malawi <sup>15</sup> ) Zambia Bangladesh Ghana Nepal

<sup>14</sup> a) MOHSW technical committee to support inclusion of RH in key health sector planning and monitoring, including annual health sector and technical reviews, the medium term expenditure framework, appraisal of health sector performance indicators, annual milestones and evaluations, development and review of health policy options; b) the banded financing committee to review health sector spending and approve financial requisitions for the central and district level; and oversee audits while at the same time building government capacity for financial management, c) the SWAp committee, where wider stakeholder participation including civil society organisations, provides the opportunity to reach consensus on health sector priorities (Tanzania CPAP 2007 – 2011).

<sup>15</sup> Based on the fact that UNFPA also support the health SWAp in Malawi.



			<i>decentralized management package of Health Facility Management Committee and key policy stakeholders at district level (AWP 2007-2008); Exposure visits for high level policy makers of MOLD and MOHP on decentralization of Health and RH services (Nepal AWP 2007-2008)</i>		
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#### **Other kinds of activities (outside of scope of current JCs):**

- Unspecified support of “policy reviews” to ensure that RH / MH issues are integrated; for example:
  - Tanzania: UNFPA offers support in “reviewing the Zanzibar Population Policy”. To “take on board challenges of the Outcome Document and the Maputo Plan of Action for the Operationalization of the Continental Policy Framework for Sexual and Reproductive Rights” – however, not clear, what the actual contribution of UNFPA was supposed to be.
  - Liberia: “Promote the review and update of policies to ensure RH care for vulnerable groups” - AWP suggests that this is based on TA; but process is not described (Liberia 2008; LBR4R23A, Reproductive Health Component, Output 1).
- Tanzania: support of Health SWAp, “with a focus on strengthening national capacity to provide integrated quality and gender responsive reproductive health services”...
  - UNFPA was contributing US\$ 600,000 per year (2007 – 2010) to the “health sector basket”, flanked by TA for “policy implementation” (AWP MoH (URT 6201), 2007 – 2010).
  - UNFPA is contributing to health sector basket, “through TA and policy dialogue” (e.g. regional and national TA for implementation of health sector strategic plan”; and also “provision of technical support through national programme staff” (2007, AWP, MoH). Not clear what contribution the TAs were meant to make!
  - **Other countries with UNFPA SWAP support, e.g. Malawi (and others)**
- Tanzania: TA for operationalization of Partnership for Maternal Newborn and Child Health Roadmap (MoH AWP URT 6201, 2008)
  - **Other countries with “RH / MH road map”, e.g., Malawi**
- Tanzania: “Gender Budgeting Initiative”: “through gender-responsive budgets, governments uphold socio-economic development commitment and promote good governance through increasing accountability, participation and transparency”. “Project will contribute in supporting the Government to strengthen engendering budget, planning, growth and poverty monitoring systems that foster participation and gender equality”.
  - E.g., through evidence-based advocacy; gender analysis reviews, working sessions with budget committees, review of budget guidelines, etc., influencing the budgeting process in health (among others), through working sessions with budget officers, “backstopping activities” during budget development, development of tools for GBI

#### **Observations on the strategic context of the above activities (e.g., intended linkages to other activities and strategies)**

- Tanzania: Support of health SWAp (see above).
- In Malawi, UNFPA supports SWAp (see above); and also “contributed to the development of the [...] Reproductive Health Policy [...] (see CPAP Malawi, 2008 – 2011 (lessons learned from period 2002 – 2007).

**Judgment criterion 9.2: Maternal health and sexual reproductive health integration into policy frameworks and development instruments based on (UNFPA supported) transparent and participatory consultative process**

Main activity types	Programming Periods		Description & Examples (Country; year)	Is (typically) associated with following outputs	Countries where this activity was implemented / planned
	2004 - 2007	2008 - 2010			
<p>Organisation of participatory “policy” events (e.g. on HIV policy, etc.), including logistical support</p> <ul style="list-style-type: none"> <li>Also for dissemination (e.g. Tanzania)</li> </ul> <p>NOTE: Also in other areas, e.g., gender, population and development!</p>	X		<p><i>Participatory policy events with various stakeholders, for drafting or dissemination of policies; inclusion of SRH components in relevant policies and frameworks</i></p> <p><u>Examples:</u></p> <ul style="list-style-type: none"> <li><i>Hold sensitisation meetings for policy makers and other stakeholders on the need to develop and implement the National HIV &amp; AIDS prevention strategy; Hold a consultative meeting to generate consensus on the HIV prevention strategy; Hold a workshop to develop the National HIV and AIDS prevention strategy (Zambia, CPAP 2007 – 2010)</i></li> <li><i>(ii) sequential workshops to develop national guidelines and protocols for condom programming (iii) technical and financial support for dissemination and implementation of condom programming guidelines and protocols (iv) workshops to review, update &amp; standardize life skills training manuals for high risk groups (truckers, sex workers, youth, street children) (v) conduct dissemination of training manuals to all stakeholders (Zambia CPAP 2007 – 2010)</i></li> <li><i>Conduct 3 day workshop to develop costed annual implementation plan for road map (i.e., Zanzibar action plan for Road Map for Accelerated Reduction of Maternal and Newborn Deaths) (Tanzania, MoH, 2007)</i></li> <li><i>Conduct 1-day meeting to share action plan with key stakeholders for their input (Tanzania, MoH, 2007)</i></li> <li><i>Meeting to disseminate roadmap to key stakeholders and national and zonal level, translation, printing (Tanzania, 2008)</i></li> <li><i>“Develop collective Advocacy Strategy for GBV and HIV / Aids”, e.g., through: prepare evidence / information packages, working sessions with government officials, media, press releases”, Public engagement.</i></li> <li><i>Operationalisation of Plan of Action for Health of the National Youth Policy in all 8 provinces (4 districts each province) (financed were</i></li> </ul>	<p>A national HIV prevention strategy is developed by 2008</p> <p>Mechanisms to prevent the transmission of HIV focusing on high-risk behaviour are in place by 2010.</p> <p>Increased availability of integrated and quality RH services in selected project sites with particular focus in 4 districts (Kenya)</p>	<p>Zambia Tanzania Kenya Bangladesh Ghana</p>

			<p><i>“accommodation for launch for 2 days for 40 persons”; “Transport for 40 persons”; “T-shirts with health messages” (Kenya, 2008)</i></p> <ul style="list-style-type: none"> <li>• <i>“The advocacy programme attempted to bring about positive behavioural change by addressing issues of reproductive health and rights, gender and HIV/AIDS awareness through partnership with various sectoral ministries, along with parliamentarians, opinion and religious leaders and private sector” (Bangladesh COAR 2005-6).</i></li> <li>• <i>Organize 8 specialist outreach programs and ensure community decision makers are informed; Hold maternal health seminar with prominent stakeholders (Ghana, AWP 2006-07).</i></li> </ul>	
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**Observations on the strategic context of the above activities (e.g., intended linkages to other activities and strategies)**

In Zambia, the “participatory policy events” are part of a larger package to support the development of a “national HIV prevention strategy”. However, even this larger package is focused largely on improved appraisal and analysis of information (e.g., on the “underlying drivers of the epidemic”)

**Other observations**

In some country programmes, UNFPA supports “policy strengthening” through its population programme (e.g. in Zambia and Kenya). This is an area where possible synergies could be exploited.

- E.g. in Kenya, UNFPA supported “increased participation and influence of women parliamentarians in the institutional mechanisms of parliament and the community” through activities such as “policy fora on the family protection bill, marriage bill 2009, [...] FGM policy for parliamentary committees, parliamentarians and relevant stakeholders; and other advocacy events (e.g. to “support the capacities of women parliamentarians on gender related legislation to strengthen their collaboration between parliamentary committees, academia and key stakeholders in articulating the “women agenda” in parliament. This also relevant for the RH agenda. (2009 support to *Kenya Women Parliamentary Association*)
- In Zambia, the population and development component supported “[s]trengthened institutional capacity to implement, coordinate, monitor and evaluate the national population policy and the national gender policy”; or “[i]mproved capacity of institutions at all levels to collect analyze and utilize data for planning and policymaking”. For example: “The programme will support the analysis of the 2006 demographic and health survey, the 2010 population and housing census, and the 2010 demographic and health survey and utilization for public policy formulation (Zambia, CPAP 2007 – 2010). However, it is noteworthy that this does not include the Zambian health policy / or any RH relevant issues.

**Judgment criterion 9.3: Monitoring and evaluation of implementation of sexual and reproductive/ maternal health components of national policy framework and development instruments**

Main activity types	Programming Periods		Description & Examples (Country; year)	Is (typically) associated with following outputs	Countries where this activity was implemented / planned
	2004 - 2007	2008 - 2010			
Technical support to improve M&E of implementing partners (including Gov.); including monitoring of poverty reduction strategies (P&D)	X	X	<p><i>Technical support to develop specific tools (e.g., checklists, guidelines) or procedures (e.g. for coordination) and skill development; and also for the implementation of specific studies (e.g. baseline studies)</i></p> <ul style="list-style-type: none"> <li><i>In collaboration with implementing partners, develop field monitoring visit checklist; strengthen IPs M&amp;E capacity through dialogue and providing guidelines, establishing action plans to follow-up on recommendations (NOTE: P&amp;D intervention) (Tanzania, 2007)</i></li> <li><i>Work with CST, national and regional experts, to enhance capacity of implementing partners in results-based management, strategic planning, etc. (NOTE: P&amp;D intervention) (Tanzania, 2007)</i></li> <li><i>Coordination and M&amp;E of Youth Activities (Kenya, 2008) (financed: 3 half day meetings of 12 person to establish coordination mechanism)</i></li> <li><i>Provide TA for CamInfo development and introduce and launch as a national data monitoring tool (Cambodia, AWP 2005).</i></li> <li><i>Key next steps include TA for strengthening evidence based planning and monitoring at the national and local levels, including development and monitoring of the National Strategic Development Plan 2006-2010 (Cambodia)</i></li> <li><i>Provide TA on the conduct a baseline study of all midwifery institutions nationwide and Ghana Registered Midwives Association and Government Registered Midwives Group (Ghana, MHTF 2009)</i></li> </ul>	<p>Increased capacity and strengthened government and civil society partnerships to improve and engender outcome-based planning, budgeting and monitoring processes (Tanzania).</p> <p>Increased availability of integrated and quality RH services in selected project sites with particular focus in 4 districts (Kenya)</p>	Tanzania Kenya Cambodia Ghana
Development of joint mechanisms for monitoring and evaluation (often linked to support of SWAp)  <i>Note: even though monitoring activities may be joint, UNFPA at times still required</i>	X	X	<p><i>Joint M&amp;E provisions, linked to SWAps; but also including monitoring of UNDAF results frameworks.</i></p> <p><u>Examples:</u></p> <ul style="list-style-type: none"> <li><i>Development of “MASEDA”, a demo-socioeconomic database to monitor progress towards achieving MDGs: an area of collaboration within the UNCT jointly with national implementing partners (Malawi CPAP 2008 - 2011; lessons learned in 2002-2007).</i></li> <li><i>UNFPA participation in the multisectoral maternal, newborn and child health partnership task force which follows up the implementation of maternal and child health activities in the health sector, including the implementation of</i></li> </ul>	N/A	Malawi, Tanzania, Zambia, (Bangladesh), Cambodia

<p>for joint monitoring to follow UNFPA guidelines.</p>			<p><i>the roadmap for the reduction of maternal and neonatal death (Tanzania CPAP 2007 – 2010)</i></p> <ul style="list-style-type: none"> <li>• <i>UNFPA will continue to assist in national level meetings with all health sector stakeholders to monitor the SWAp to inform the decision on the level of resources to be commitment towards the health basket (Zambia, CPAP 2007 – 2010).</i></li> <li>• <i>“UNFPA and the Government of Zambia through the Ministry of Finance and National Planning will conduct annual review meetings, which will help to determine the continuation of the partnership on the basis of satisfactory delivery of results (Zambia, CPAP 2007 – 2010).</i></li> <li>• <i>UNDAF M&amp;E Results Framework (all countries)</i></li> <li>• <i>As part of the MoU Implementing partners agree to the following joint mechanism (AWP 2009-10): - Periodic on-site reviews and spot checks of their financial records by UNFPA or its representatives; - Programmatic monitoring of activities <u>following UNFPA’s standards and guidance for site visits and field monitoring (Cambodia).</u></i></li> </ul>		
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**Other observations**

- No clear sign of “strategic planning”, i.e. a strategy that is intended to bind the individual activities together (e.g. Kenya, youth project, 2008)

**Evaluation question 10: To what extent have UNFPA maternal health programming and implementation adequately used synergies between UNFPA sexual and reproductive health portfolio and its support in other programme areas?<sup>16</sup>**

**Judgment criterion 10.1: Linkages established between programmes (reproductive health with gender and population & development) in intervention design**

Activity type	Programming Periods		Description & Examples (Country; year)	Is (typically) associated with following outputs	Countries where this activity was implemented / planned
	2004 - 2007	2008 - 2010			
<p><b>Indicator 10.1.1</b></p> <p><b>Needs assessment/situational analysis and surveys analyse gender –based constraints that:</b></p> <ul style="list-style-type: none"> <li>Affect RH programme objectives</li> <li>Impede RH programme Objectives</li> <li>Facilitate RH programme objectives</li> </ul> <p>Topics include:</p> <ul style="list-style-type: none"> <li>RH care in case of GVB (2000)</li> <li>Effect of 3 delays (2000)</li> <li>Reproductive rights (2000)</li> <li>Status of women and</li> </ul>			<p><b><u>Example of UNFPA Supported Needs Assessment and Analysis in Gender Based Constraints that Affect, Impede and Facilitate RH Programme Objectives:</u></b></p> <ul style="list-style-type: none"> <li><i>A Practical Approach to Gender- Based Violence: A Programme Guide for Health Care Providers and Managers, which offers step-by-step assessment and guidance on how to address violence against women and girls in RH/MH care settings (Global 2000).</i></li> <li><i>Needs assessment missions in “Making Safe Motherhood a Reality” looks at constraints (delays due to obstacles and barriers) faced by women in MNH services from first day of pregnancy to delivery and beyond (9 African and Central American countries, (Cote d’Ivoire, 2000).</i></li> <li><i>Situational analysis from 51 countries on the national legal trends in the institutionalization of women’s reproductive rights and documentation report implications for RH information and services (Centre for Reproductive Law and Policy 2000).</i></li> <li><i>The State of World Population 2000 report focused attention on the damage done by gender constraints, inequality and the need to improve the status of women and the effect of RH/MH programmes.</i></li> <li><i>Assessment focusing on emerging issues in reproductive health including sexuality, gender-based violence and ethics/religious issues (Ford Foundation, 2000).</i></li> <li><i>An in-depth needs assessment of 138 women’s health care facilities in Nicaragua was completed and an assessment of women’s access to obstetric services in five countries in West Africa (Ghana) was carried out (Columbia University (2001).</i></li> <li><i>Rapid response needs assessment to take early and effective action to meet the emergency reproductive health needs of men and women refugees, the internally displaced and others affected by crisis (Inter-agency group 2001).</i></li> </ul>	<p>RH Output 2.1: Increased capacity to integrate the full continuum of MH care in national health systems.</p> <p>Gender output 2.1: Improved advocacy for women and adolescent girls reproductive rights, male participation and elimination of harmful practices</p>	UNFPA Annual Reports

<sup>16</sup> Gender (including female genital mutilation/ cutting, gender-based violence, HIV-PMTCT (prevention of mother-to-child HIV transmission), population and development.

<p>demand for RH services (2000)</p> <ul style="list-style-type: none"> <li>- Emerging issues in RH – sexuality, GBV and ethics (2000).</li> <li>- Access to OF services (2001)</li> <li>- Emergency RH needs, 3 delay (2001)</li> <li>- MMR and women’s access to services (2004)</li> <li>- Humanitarian situation and GBV/MISP (2004)</li> <li>- FGM/C (2005)</li> <li>- Gender, RH and poverty alleviation (2005)</li> <li>- Gender and OF (2006)</li> <li>- MH road map in Africa (2008)</li> <li>- OF survey on comprehensive care (2009)</li> <li>- Midwifery needs (2008-9)</li> <li>- Family planning and commodity security (2008-9)</li> <li>- Midwifery capacity building (2008-9)</li> <li>- EmONC(2008-10)</li> </ul>		<ul style="list-style-type: none"> <li>• <i>KAP survey and needs assessment on GVB and humanitarian situation in Sudan, Cote d’Ivoire, DRC and Malawi (2004).</i></li> <li>• <i>Needs assessment of FGM/C and mapping of in Somalia, Benin, Malawi, Cote d’Ivoire, Ethiopia and Tanzania and Sudan (2005)</i></li> <li>• <i>A national EmONC assessment in Malawi showed that only 2 out of 94 health facilities targeted for delivering basic EmONC services were actually able to deliver this service (2005).</i></li> <li>• <i>UNFPA has assisted 30 countries to complete needs assessments and surveyed women to restore hope and dignity to women and girls. More than 20 countries have moved from need assessment and planning to implementation to prevent OF (2006).</i></li> <li>• <i>Where needs were not immediately known during UNFPA conducted emergency reproductive health assessments. UNFPA provided pregnant women with basic supplies (2008).</i></li> <li>• <i>A participative needs assessment of the progress made by African countries in developing their Maternal and Newborn Health Road Maps and operational plans (including gender) was conducted by the UNFPA Technical Division and Regional Office for Africa, collaboratively with national MNH teams (Ministry of Health, UN and additional partners). The findings are currently in the final stages of analysis (2008)</i></li> <li>• <i>For obstetric fistula, the needs assessments started in late 2002. To date, more than 40 OF assessments have been conducted on comprehensive care - Nepal, Bangladesh, Niger and Rwanda (2009-10).</i></li> <li>• <i>No gender based RH assessment or constraint analysis in MHTF. The focus is on health based needs assessments that have implications for averting maternal death by improving women’s access to quality services. This access focuses overtly on EmONC health facilities and midwifery capacity building than taking the client perspectives (AR 2008-9)</i></li> <li>• <i>National needs assessments of the accessibility and quality of EmONC (Ethiopia, Haiti and Cambodia, 2008)</i></li> <li>• <i>Placing an international midwife advisor in the country office, undertaking a capacity assessment of training institutions and strengthening the midwifery association, presentation of needs assessment district by district (Ethiopia, 2008)</i></li> <li>• <i>EmONC needs assessment and the resulting data is being used to scale up and monitor the availability of EmONC services (Ethiopia, Haiti and Cambodia, 2009)</i></li> <li>• <i>12 of the 15 MHTF countries have conducted midwifery needs assessments, the results of which were used to make adequate plans in the areas of education, regulations and associations (2009).</i></li> <li>• <i>Maternal Health Thematic Fund support for EmONC needs assessments matched by significant contributions from UNICEF and partner governments to conduct the surveys in 8 of the 15 MHTF countries (2009).</i></li> </ul>	<p><u>MHTF Business Plan</u>  Output: Up-to-date needs assessments for the SRH package with a particular focus on family planning, human resources for MNH, and Emergency Obstetric and Newborn Care (EmONC)</p>	<p>HTF Annual Reports</p>
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		<ul style="list-style-type: none"> <li>• <i>District-based maternity care service delivery plans based on EmONC needs assessments community health care services and referrals to EmONC (2010)</i></li> </ul>		
<p><b>Indicator 10.1.2</b></p> <p><b>RH/MH programme design draw on data collection and information from P&amp;D utilising training, studies, research, reviews and evaluations that:</b></p> <ul style="list-style-type: none"> <li>• Identify needs of emerging populations</li> <li>• Constraints of emerging populations</li> </ul> <p>Emerging issues, emerging populations and emerging constraints include:</p> <ul style="list-style-type: none"> <li>- Gender and rights (2000)</li> <li>- Programme design (2000)</li> <li>- Environment (2001)</li> <li>- RH, PD and Gender in PRSP (2001)</li> <li>- Resources (national and international)</li> <li>- Internal migration (2002)</li> <li>- Ageing (2002)</li> <li>- Poor and</li> </ul>		<ul style="list-style-type: none"> <li>• <i>UNFPA developed state-of-the-art training to improve implementation of population programmes and in support of RH programme design (Lao PDR 2000).</i></li> <li>• <i>A study of 44 countries was conducted to determine the extent to which reproductive health, gender and population and emerging issue of environment were included in their poverty reduction strategy papers (2001).</i></li> <li>• <i>An evaluation of UNFPA efforts to develop national capacity in reproductive health analyzed 10 years of interventions, best practices, lessons learned and emerging issues of migration, ageing, poor and vulnerable groups in six countries: Brazil, Côte d'Ivoire, Egypt, Nepal, Nigeria and Viet Nam (2002).</i></li> <li>• <i>UNFPA released the results of a Global Survey that summarizes responses from 169 countries on the steps taken to implement the ICPD Programme of Action. The results identified RH needs of emerging population – people living with HIV, most at risk population (sex workers, IDU) – 2004</i></li> <li>• <i>UNFPA and the International Migration Policy Programme assessed the challenges and opportunities presented by population movements in the joint publication, Meeting the Challenges of Migration: Progress since the ICPD. The report, launched in October, focused on migration trends, policy development, refugee protection, human trafficking, data, development and human rights and its implication on SRH service planning and design (2004).</i></li> <li>• <i>The future dividends of investing in reproductive health were outlined in the 2005 UNFPA report, Reducing poverty and Achieving the Millennium Development Goals: Arguments for Investing in Reproductive Health &amp; Rights. Disaggregated socio-economic data alluding to the state of health of women and girls emphasized the importance gender sensitive approaches and reproductive rights to health programme planning (2005).</i></li> <li>• <i>The commitment to rights-based programming was presented in the publication Rights into Action: UNFPA Implements Human Rights-Based Approach. The Fund also published the results of a survey that asked 165 countries about the impact of culture, Culture in the Context of UNFPA Programming: ICPD+10 Survey Results on Culture It found that in many cases, culture of population was viewed as both a contributing factor and a constraint to SRH information and services (2005).</i></li> <li>• <i>UNFPA has been helping governments create policies that respond to the impact of population ageing and meet the needs of older persons, especially the poor and women (2005).</i></li> <li>• <i>UNFPA engaged in inter-agency collaboration to ensure that key measurements for issues such as maternal mortality and international migration are included in population and housing censuses and surveys (2006)</i></li> <li>• <i>The results of the UNFPA supported census in Haiti were helpful in determining where more resources will be needed—namely, in education and reproductive health services in poor rural and urban areas (2006).</i></li> </ul>	<p><u>P&amp;D Output 1.2:</u> Strengthened capacity to advocate for and incorporate inter-linkages of population dynamics and gender equality, SRH, young people's needs and HIV AIDS in national and sectoral development plans, poverty reduction strategies and humanitarian assistance frameworks</p> <p><u>P&amp;D Output 4.1:</u> Emerging population issues increasingly incorporated in policy formulation and in national development frameworks</p>	<p>UNFPA Annual Reports, Country AWP</p>



<ul style="list-style-type: none"> <li>vulnerable groups (2002)</li> <li>- Women's health (2002)</li> <li>- PLHA (2004)</li> <li>- MARP - Sex Workers, IDUs (2004)</li> <li>- Refugee protection (2004)</li> <li>- Human trafficking (2004)</li> <li>- Human rights (2004)</li> <li>- Reproductive rights (2005)</li> <li>- Culture, RH/MH practices and Gender (2005)</li> <li>- Maternal mortality data collection (2006)</li> <li>- International migration (2006)</li> <li>- Poor rural and urban RH services (2006)</li> <li>- Elderly care-givers (effect of HIV/AIDS) - 2006</li> <li>- Census data for planning and services (2006)</li> <li>- Data for CCA and CPAP (2008)</li> <li>- Ageing (2008)</li> <li>- Urbanisation</li> </ul>		<ul style="list-style-type: none"> <li>• <i>The United Nations Secretary-General released a report in November highlighting major developments since the Madrid International Plan of Action on Ageing was adopted by the United Nations Member States at the 2002 Second World Assembly on Ageing (2006)</i></li> <li>• <i>UNFPA project assists approximately elder caregivers of people with AIDS and their children in several countries ravaged by HIV AIDS. As part of this project, UNFPA demonstrated to local administrators and national authorities the value of assisting older people affected by HIV/AIDS and advocated policies and action plans to ease their economic, social and physical difficulties (2006).</i></li> <li>• <i>UNFPA played leadership and coordinating roles by offering technical support that ensured Poverty, Population and Development census of Sudan met international standards and yielded complete and credible information to help design UNFPA country programme (2008).</i></li> <li>• <i>UNFPA prepared the Report of the Secretary-General on the Monitoring of Population Programmes focusing on Population Distribution, Urbanization, Internal Migration and Development. The report examined the unprecedented transformation of world population from rural to urban brought about by migration from rural areas and by the natural increase of the urban population, as well as the re-classification of settlements that were previously considered rural. The report described UNFPA's assistance to countries in RH, development and gender planning (2008)</i></li> <li>• <i>UNFPA convened two special sessions at the World Ageing and Generations Congress in St. Gallen, Switzerland: one on women, health and emerging care-giving needs in developing countries, the other on building capacity to implement the Madrid International Plan of Action on Ageing (2008).</i></li> <li>• <i>In Ethiopia, UNFPA supported the development of a National Population Plan of Action and a Manual for Integration of Population Variables, which together will guide future policymaking in a variety of sectors including social protection and RH (2009).</i></li> </ul> <p>MHTF does not speak of emerging issues, emerging populations or emerging constraints but it does have new areas of intervention and collaboration with government in MH.</p> <ul style="list-style-type: none"> <li>• <i>In collaboration with UNFPA's Global Programme on Reproductive Health Commodity Security (GPRHCS), the Campaign to End Fistula, and the new Midwives Programme, the MHTF provides support to priority countries, those showing the least progress on Millennium Development Goal 5, in capacity development, technical support and the provision of lifesaving equipment, supplies and drugs. Funding from the MHTF is intended to be very "strategic", to quickly identify and solve bottlenecks which are preventing progress in maternal health, and to be "catalytic" in stimulating donor collaboration at the national level (2008-9).</i></li> </ul>	<p><u>MHTF Business Plan Outputs</u></p> <p>Proportion of countries with national development plans that allocate domestic resources for an essential SRH package. Outputs related to new Midwifery Programme</p>	<p>MHTF Annual Reports, 5 AWP's (Ghana, Sudan, Cambodia, Bangladesh and Nepal)</p>
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<p>and rural –urban migration (2008)</p> <ul style="list-style-type: none"> <li>- Passing of new laws on RH (2009)</li> <li>- Labour and Social Protection (2009)</li> <li>- Midwifery (2008-9)</li> </ul>					
<p><b>Indicator 10.1.3</b></p> <p><b>Activities in Project strategies within 3 programmes target (in country):</b></p> <ul style="list-style-type: none"> <li>• Gender based RH constraints</li> </ul> <p>Forum, seminar, workshop, radio programme, dialogue and consultation, assembly</p> <ul style="list-style-type: none"> <li>- RH need and social/gender barriers to access</li> <li>- Feminisation of HIV AIDS</li> <li>- Utilisation of services</li> <li>- Inter-linkages</li> <li>- Women's income/ status</li> <li>- Women and girl's fights</li> <li>- Gender equity</li> <li>- GBV</li> </ul>			<p><b><u>Examples of country activities that target gender based RH constraints</u></b></p> <ul style="list-style-type: none"> <li>• <i>Advocacy forum in districts for opinion leaders, District Assemblies, Chiefs and community on RH need, social obstacles and gender barriers to access as prelude to opening desk offices (Ghana 2006)</i></li> <li>• <i>Seminar on RH, population and gender inter-linkages for media personnel (Ghana, 2006, TFC 2007)</i></li> <li>• <i>Advocacy seminar for traditional rulers/ opinion leaders on RH and gender inter-linkages (Ghana, 2007)</i></li> <li>• <i>Radio discussions on gender, STI/HIV/AIDS – feminisation and call to utilise services (Ghana, 2006-7)</i></li> <li>• <i>Conduct workshops for health workers and CBO personnel on inter-linkages of reproductive health/rights /gender issues (Ghana, 2007)</i></li> <li>• <i>Organize one ToT training course and forum on Gender, Youth &amp; RR and networking (Sudan, 2007)</i></li> <li>• <i>Sensitize and develop capacity of media and civil society organizations to report on and advocate for women's and girl's rights, gender equality and a reduction in gender based violence (Cambodia, 2008-10).</i></li> <li>• <i>Advocacy cross-cutting activities, inter-linkages with SRH/RR, adolescents' rights, HIV/AIDS and gender (Bangladesh, CPAP 2006-2010)</i></li> <li>• <i>Support for non-formal education on inter-linkages population/ RH and gender at the community level for knowledge, access/ demand for RH/HIV/AIDS services (Nepal, 2008)</i></li> </ul>	<p>Strengthened linkages among population, reproductive health, gender and development in policies and programmes. . Availability of timely and reliable age, gender and spatially disaggregated population and RH data at the national level and in UNFPA supported districts (Ghana, CPAP)</p> <p>Promotion of young people's participation and empowerment in development (Sudan, CPAP)</p> <p>Increased awareness of women, men and youth about RH, RR and available services in priority areas (Cambodia, CPAP).</p> <p>Increased demand especially among the poor and vulnerable for RH services (Bangladesh, CPAP)</p>	<p>AWP (CO and IPs), CPAP 2006-10) where mentioned.</p>

<ul style="list-style-type: none"> <li>• RH constraints of Emerging populations/issues <ul style="list-style-type: none"> <li>- Census enumeration</li> <li>- Birth and death vital registration</li> <li>- Male involvement and activism</li> <li>- BCC and urban youth,</li> <li>- Advocacy</li> <li>- ASRH advocacy</li> <li>- Youth services</li> <li>- Decentralisation effects</li> <li>- Girl-child</li> <li>- MARP (sex workers, IDUs, MSM)</li> <li>- Teachers, parents, local leaders and community members</li> <li>- Mother's groups</li> </ul> </li> </ul>			<p><b><u>Examples of country activities that target RH Constraints of Emerging Populations/Issues</u></b></p> <ul style="list-style-type: none"> <li>• <i>Stakeholder meetings and community durbars, public population education forum and human resource training of community volunteers for birth and death registration and community registers, enumeration, data capture of new issues and new groups and collection of disaggregated by sex and age (Ghana, 2006)</i></li> <li>• <i>Sensitize men/boys in religious groups and institutions on issues about healthy families (Ghana, 2007, TFC)</i></li> <li>• <i>Advocacy forum for FBOs, Youth groups, the Private Sector on YFS (Ghana, 2007)</i></li> <li>• <i>Support Media Activities – Radio/TV spots with information/messages on male participation for the achievement of Gender equality, RR and MDGs (2007).</i></li> <li>• <i>Selection criteria for Male Gender Activist by communities, build capacity on community, population and gender (Ghana, 2007)</i></li> <li>• <i>Positive Discrimination targeting women for livestock, micro finance and RH input support (Ghana, 2007)</i></li> <li>• <i>Establish National and State Advocacy Task Force HIV/AIDS and National Census (Sudan, 2006)</i></li> <li>• <i>Organize regional study tour for staff (Egypt/Tunisia, workshop on Gender sensitization for male involvement (Sudan, 2006).</i></li> <li>• <i>Evidence-based national dialogue and consultation on investing in youth, focus on girls and RH, to be submitted and endorsed (Sudan 2007)</i></li> <li>• <i>Publish IEC and training manual on ASRH (Cambodia 2007)</i></li> <li>• <i>Decentralised NRHP and harmonise the following (Cambodia 2008-10)</i></li> <li>• <i>Commune Councils on:</i></li> <li>• <i>Sensitization on key population, gender and RH issues</i></li> <li>• <i>Women's and children's committees on:</i></li> <li>• <i>Development/ support of links with community based health, gender and education structures such as the HCMC, VHSG, CBD, midwives, schools, and in and out of school peer education and youth initiatives</i></li> </ul>	<p>Improved capacity to deliver quality health care services, including MNH, FP, ASRH and the prevention and management of STI and uterine prolapsed (Nepal CPAP)</p> <p>Strengthened advocacy and awareness of reproductive health, adolescent sexual and reproductive health, reproductive rights and gender at the national level and in UNFPA-supported districts (Ghana, CPAP)</p> <p>Promotion of young people's participation and empowerment in development (Sudan CPAP)</p> <p>Increased access to high quality, comprehensive, client oriented and gender sensitive RH information and services for rural and vulnerable groups (Cambodia CPAP)</p> <p>Population, RH and emerging gender concerns integrated into national and sectoral plan (Bangladesh, CPAP)</p> <p>Increased coverage for ASRH programmes and for HIV prevention in selected districts (Nepal</p>	<p>AWP (CO and IPs), CPAP 2006-10) where mentioned.</p>
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<ul style="list-style-type: none"> <li>• GBV, FGM/C/HIV/STI addressed: <ul style="list-style-type: none"> <li>- Sexual abuse</li> <li>- GBV</li> <li>- Victim support</li> <li>- HIV/STI services</li> <li>- Youth friendly services</li> <li>- OF prevention, treatment and re-integration</li> </ul> </li> </ul>		<ul style="list-style-type: none"> <li>• <i>Community Members and Youth PE:</i></li> <li>• <i>Sensitization on key population, gender and RH issues and empowerment to claim their rights support</i></li> <li>• <i>CBD, midwives, in and out of school peer education and youth programmes) empower vulnerable women/ youth</i></li> <li>• <i>Support for Health Centre Management Committees and Village Health Support Groups.</i></li> <li>• <i>Implement the EU/UNFPA Reproductive Health Initiative for Youth in Asia (RHIYA 2003-6, Bangladesh).</i></li> <li>• <i>Research studies on emerging population issues such as plateauing of fertility, contraceptives and adolescent RH (Bangladesh, CPAP 2006-2009).</i></li> <li>• <i>Train public health SDP/NGOs in SRH treatment in youth friendly/ gender sensitive manner (Bangladesh, 2009).</i></li> <li>• <i>Sensitization group meetings for young girls on SRH with a focus on vulnerable due to low socio-economic status, gender inequality and lack of negotiation skills (Bangladesh, CPAP 2006-9).</i></li> <li>• <i>Dissemination of common understanding; plans and implementation of integration approaches to facilitate government process in taking corrective measures against discriminatory practices to MARP in RH/MH services (Bangladesh, CPAP 2006-10).</i></li> <li>• <i>Organize periodic meetings for community gatekeepers (teacher, parents, local leaders, CBOs and members) to orient them on ASRH and RR/Gender (Nepal 2009)</i></li> <li>• <i>FM Radio/ BCC programme on RH and gender (2009)</i></li> <li>• <i>Integration of analogous groups into mother's groups and handover of community mobilization process to this group and FCHVs (Nepal 2009-10).</i></li> </ul> <p><b><u>Examples of country activities that target GBV, FGM/C and HIV</u></b></p> <ul style="list-style-type: none"> <li>• <i>Service providers trained in counselling to support sexually abused/GBV persons and 24 hr service (Ghana, 2006-7)</i></li> <li>• <i>Training programme for police officers on inter-linkages of gender, rights, GBV, victim support and project planning (Ghana, 2007, TFC)</i></li> <li>• <i>Organize one ToT training workshop on FGM campaigning skills and support field trips (Sudan 2007)</i></li> <li>• <i>Co-ordination with NRHP, MoH of GBV, population needs, HIV, counselling and referral services into the basic RH service packages and the female condom. (Cambodia 2008)</i></li> <li>• <i>Introduce and expand youth friendly clinical services and appropriate health services and referral for survivors of gender based violence (Cambodia, 2010)</i></li> <li>• <i>Capacity building of female care givers from MCHWs and doctors in OF prevention, diagnosis, management and rehabilitation and camps in hospitals</i></li> </ul>	<p>CPAP).</p> <p>Strengthened capacity of national and local institutions including the government, Parliament, NGOs and CSOs to effectively implement the National Gender Policy and UNFPA comprehensive programme integration (Ghana). Improved capacities for</p>	<p>AWP (CO and IPs), CPAP 2006-10) where mentioned.</p>
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		<p>with FCHV (Nepal, 2010)</p> <ul style="list-style-type: none"> <li>• Awareness on OF through community mobilization, care giver and family member sensitization (Nepal, 2010).</li> </ul> <p>MHTF does not mention gender constraints (except transportation in Sudan) or emerging issues/populations but only mentions issues related to constraints and capacity building of midwifery that limits access. (AR 2008-9).</p>	<p>gender mainstreaming in RH and other programmatic areas (Sudan CPAP)</p> <p>Promoted sensitisation for RH, RR and counter to harmful practices (Cambodia CPAP).</p> <p>Increased awareness and empowerment of women and youth in the priority areas to claim their rights (Bangladesh CPAP)</p> <p>Rights of women and girls promoted and gender equity enhanced (Nepal CPAP)</p>	
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#### Observations on the global and regional/country strategic context of the above activities

- The Strategic Plan P&D outcome 1 explicitly states the relationship between population dynamics and its inter-linkages with gender equality and SRH and HIV AIDS to be incorporated in public policies, poverty reduction plans and expenditure frameworks. Countries have translated the UNFPA outcome into their P&D outputs in similar ways but to illustrate differences too the country outputs are noted:
  - Strengthened institutional and technical capacity to integrate population and gender concerns into development planning and budgeting at the national level and UNFPA supported districts (Ghana);
  - Promotion of young people's participation and empower in development (Sudan);
  - Improved national/ decentralised capacity to integrate/implement population, poverty, health and development issues within plans (Cambodia)
  - Population and gender concerns integrated into national and sectoral plans (Bangladesh);
  - Population, gender, RH and social inclusion are integrated into plans, implementation, budget and M&E at national/ district level (Nepal)
- The Strategic Plan SRH outcomes (4 altogether) are less explicit about population dynamics and gender but the related outputs mention inter-programme improvement/ increase in demand, access and utilisation. The inter-linkages are also mentioned for purpose of funding and indicators that are underpinned by population based evidence such as sex and age, community grouping and location. Countries have translated UNFPA SRH outcomes into following country outputs:
  - Improve access to MH care/ YFS, behaviour among men, women and youth; strengthen capacity in comprehensive ASRH (Ghana)
  - Essential EmONC/integrated RH package available at SDPs and increased awareness of RH information among youth (Sudan)
  - Strengthened national capacity to develop, implement and evaluated gender-sensitive RH/HIV policies, strategies and protocols (Cambodia)
  - Population and gender concerns integrated into national and sectoral plans (Bangladesh)
  - Capacity of selected communities/youth especially among excluded groups to participate in planning and monitoring of SRH services (Nepal)
- The Strategic Plan Gender outcomes focus more on creating an enabling and protective/preventive environment (especially for women and young girls to advances equity and equality. Countries have translated UNFPA gender outcomes into following country outputs:
  - Strengthen capacity of national/local public institutions and civil society to effectively implement the National Gender Policy (Ghana)
  - Strengthen technical and institutional capacity for gender analysis/mainstreaming/GBV response and budgeting at national/local levels (Sudan)

- Strengthen capacity of priority ministries, communes and media to promote empowerment of women and youth, claim rights/equity (Cambodia)
- Rights of women and girls promoted and gender equity enhanced (Bangladesh)

### Judgment criterion 10.2: Integration of monitoring and reporting of UNFPA operations

Activity type	Progra mming Periods		Description & Examples (Country; year)	Is (typically) associated with following outputs	Countries where this activity was implemented / planned
	2004 - 2007	2008 - 2010			
<p><b>Indicator 10.2.1</b></p> <p><b>Partner country P&amp;D Programme supports M&amp;E of:</b></p> <ul style="list-style-type: none"> <li>• MNH/SRH interventions in partner countries</li> </ul> <p>Workshops, co-ordination/ review/planning meetings, field visits, missions and seminars</p> <p>Topics include</p> <p>Ghana:</p> <ul style="list-style-type: none"> <li>- Analysis of programme (s) relevant data (2005)</li> <li>- M&amp;E at various levels (2005)</li> <li>- Data check and endorsement (2005)</li> <li>- Development and</li> </ul>			<ul style="list-style-type: none"> <li>• <i>Annual production, 3 programme area review analysis and dissemination of the State of Ghana Population Report</i> (Ghana, 2005-)</li> <li>• <i>Monitoring/ technical backstopping visits and strengthen capacity of NPC Secretariat to undertake coordination activities</i> (Ghana 2005-)</li> <li>• <i>Assess/ evaluation of 3 programme integration training; distribute printed copies of integration modules to Districts and appropriate agencies</i> (Ghana 2005-)</li> <li>• <i>Monitoring and evaluation undertaken of programme co-ordination between the 3 goal areas</i> (2005 -).</li> <li>• <i>Review meetings on the integration modules with KNUST, DOP, to include emerging issues and population</i> (Ghana 2006).</li> <li>• <i>Review and training of 25 District Planning Officers, District Budget Analysts and Regional Population Officers on integration modules M&amp;E</i> (Ghana 2006).</li> <li>• <i>Organise annual programme review meeting for to assess progress of work on co-ordination and integration of the project and plan for following year</i> (Ghana 2006).</li> <li>• <i>Pilot of Community population registers in communities and baseline Survey on population disaggregated data, RH services statistics and gender based equity</i> (Ghana 2007)</li> <li>• <i>P&amp;D develop/ review/ adapt culturally sensitive materials in for use in refugee and host communities and for posting in health facilities and population areas</i> (Sudan 2005)</li> <li>• <i>Operationalise set of indicators at national and state levels to monitor population, RH and gender programmes and the Millennium</i></li> </ul>	<p>Strengthen institutional and technical capacity to integrate population, RH and gender concerns into development planning and budgeting at the national level and in UNFPA supported districts (Ghana CPAP)</p> <p>Strengthened national and local capacity in collecting, analysing, interpreting, disseminating and utilising disaggregated population data for RH and gender (Sudan CPAP)</p> <p>Improved analysis and utilisation of data disaggregated by age, sex, economic status and location for SRH programming (Cambodia CPAP)</p> <p>Population, RH and emerging gender concerns integrated into national and sectoral plan (Bangladesh, CPAP)</p> <p>Strengthen national and sub-national</p>	AWP of CO and IPs and CPAP 2006-2010 (where mentioned)

<p>implementation of integration modules (2006)</p> <ul style="list-style-type: none"> <li>- Community baseline survey set up (2007)</li> </ul> <p>Sudan:</p> <ul style="list-style-type: none"> <li>- Evidence based material development (2005))</li> <li>- Operationalisation of integrated M&amp;E modules (2006)</li> <li>- Cross programme data sharing (2006)</li> </ul> <p>Cambodia:</p> <ul style="list-style-type: none"> <li>- Capacity building in integrated M&amp;E (2008-)</li> <li>- Participatory planning</li> <li>- National and Local planning of services</li> <li>- Performance and Equity funding</li> <li>- RH Surveys and emerging population</li> <li>- RH modules in census</li> </ul> <p>Bangladesh:</p> <ul style="list-style-type: none"> <li>- RH strategy development</li> <li>- Disaggregated database</li> <li>- Capacity in research</li> <li>- Analysis and utilisation</li> </ul>		<p><i>Development Goals (Sudan 2006)</i></p> <ul style="list-style-type: none"> <li>● <i>Workshops to increase in the use of population data in RH programme design and service delivery (Sudan 2006)</i></li> <li>● <i>Review and monitor national and sectoral annual plans to integrate population, reproductive health and gender (Sudan 2007)</i></li> <li>● <i>Share access to information and services data across local areas by population groups, with government and NGOs and get feedback (Sudan 2007)</i></li> </ul> <p>Decentralised NRHP with support of population experts will co-ordinate integrated M&amp;E with (Cambodia 2008-):</p> <ul style="list-style-type: none"> <li>● <i>Commune on capacity building to analyze the local situation and use data for RH and gender planning</i></li> <li>● <i>Women's and children's committees on:</i></li> <li>● <i>capacity building of members to advocate for women's and youth needs and rights, and to articulate these needs as part of the local planning process</i></li> <li>● <i>Undertake the prioritization of population research topics and research on emerging reproductive health issues to inform policy, strategy and service delivery</i></li> <li>● <i>Build capacity for collection, analysis and interpretation of population, health and poverty data and provide in-depth analysis of recent socio-health surveys, undertaken to research more detailed information on performance, equity funding and emerging population issues.</i></li> <li>● <i>Build capacity of National Institute of Statistics/Ministry of Planning, selected Provincial and District Departments of Planning, and commune councils to collect, analyze and use population, RH, gender and poverty data.</i></li> <li>● <i>Support Census 2008, CDHS 2005 and 2010 Support prioritization of research topics and research on emerging population issues (migration, youth, elderly, urbanization)</i></li> </ul> <ul style="list-style-type: none"> <li>● <i>Review and develop RH strategies based on village level digitised enumeration population maps for districts (Bangladesh CPAP).</i></li> <li>● <i>Build gender, RH, M&amp;E and poverty disaggregated database at national and sub-national levels to contribute to planning reviews and programme intervention at different levels.</i></li> <li>● <i>Improve analysis and utilisation of data including disaggregation by gender, age, economic status, and preparation of action plans based on the national policies to ensure a favourable policy environment for RH,</i></li> </ul>	<p>capacity to collect and analyse socio-economic data disaggregated by age, sex, ethnicity, caste, economic status and location for evidence based RH/MH planning and monitoring (Nepal CPAP)</p>	
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<p>of data</p> <ul style="list-style-type: none"> <li>- RH Model site locations</li> <li>- UNDAF M&amp;E indicators</li> <li>- Support scheme data collection against harmful practices</li> <li>- Demand based RH financing for women</li> </ul> <p>Nepal:</p> <ul style="list-style-type: none"> <li>- CPAP planning and tracking updates (2006-)</li> <li>- M&amp;E of VCT/PMCT sites (2007)</li> <li>- RH and Gender Baseline and tracking (2007)</li> <li>- M&amp;E training for IPs (2008)</li> <li>- HSSIS indicators (2008-9)</li> <li>- Evidence based NGO programming (2008)</li> <li>- M&amp;E at district level (2009)</li> <li>- RH field studies on discontinuation (2009)</li> <li>- Update comprehensive data base system (2009)</li> <li>- Census and RH/Gender modelling (2009)</li> <li>- CPAP evaluation roll out (2010-11)</li> </ul>		<p><i>RR.</i></p> <ul style="list-style-type: none"> <li>● <i>Co-ordination review meetings on the outcomes and outputs to contribute to all six UNDAF outcomes as reflected in the CPD RRF. These are aggregated in 3 mutually reinforcing programme components: Reproductive Health (RH), Gender, and Population and Development (P&amp;D).</i></li> <li>● <i>Support schemes to be provided for data collection and analysis for focused studies related to harmful practices such as early marriage, dowry, gender-based violence etc. and documentation of these issues.</i></li> <li>● <i>Operations research to be conducted on demand based RH financing, gender and population policy research/studies supported by DPs (Bangladesh CPAP).</i></li> </ul> <ul style="list-style-type: none"> <li>● <i>Update CPAP planning/ tracking tool and M&amp;E calendar (2006-)</i></li> <li>● <i>Monitor and evaluate VCT/PMCT sites as model sites for services and fully integrated into SRH and Gender programme (Nepal 2007).</i></li> <li>● <i>Survey to establish baselines for all RH and Gender components and tracking (2007)</i></li> <li>● <i>M&amp;E training for Implementing Partners plan (2008)</i></li> <li>● <i>Support to and roll out of Health System Strengthening Information System (HSSIS) 2008-9</i></li> <li>● <i>Integration of NGO bottom up planning process and implementation of RH and Gender action plan and M&amp;E tool (2008)</i></li> <li>● <i>Field study on discontinuation of injectable contraceptives</i></li> <li>● <i>Conduct RH Pilot survey in respect of the 2011 Census</i></li> <li>● <i>Establish a M&amp;E system through a comprehensive database system in the UNFPA focus districts for all components (2008-9)</i></li> <li>● <i>Use and update M&amp;E system through a comprehensive database system in the UNFPA focus districts for all components (2010)</i></li> <li>● <i>UNFPA CPAP evaluation for all components outcomes and outputs and thematic interventions (Nepal 2010-11)</i></li> </ul>		
<p><b>Indicator 10.2.2</b></p>		<p><b><u>Examples of M&amp;E of Gender related MH constraints</u></b></p>	<p>Strengthened capacity of national and local institutions including the government, Parliament, NGOs and</p>	<p>AWP of CO and IPs and CPAP 2006-</p>



<p><b>Partner country RH programme M&amp;E tracks progress in:</b></p> <ul style="list-style-type: none"> <li>Gender related MH constraints</li> </ul> <p>Workshops, co-ordination/ planning meetings, annual programme reviews, field visits/studies, logistics and management, data collection and analysis, missions, seminars, media and press launch, publications, tools and study guide, Topics include Ghana</p> <ul style="list-style-type: none"> <li>GBV/VAW (2006)</li> <li>Mobility/transportation (2007)</li> <li>Access, demand and utilisation M&amp;E indicators (2007)</li> <li>Family resources (2007)</li> <li>Male involvement (2007-8)</li> <li>Male activism (2007-8)</li> </ul> <p>Sudan:</p> <ul style="list-style-type: none"> <li>Gender equity (2006)</li> <li>Gender mainstreaming (2006)</li> <li>Participatory M&amp;E (2006)</li> <li>Capacity – GBV (2007)</li> </ul>		<ul style="list-style-type: none"> <li>Provision of logistics for collection, management and disseminating of GBV data (for regional and District offices) (Ghana 2006)</li> <li>Media Activities, RH/Gender Baseline Study (including family resources and transportation), M&amp;E indicator (access, demand and utilisation) development (Ghana 2007),</li> <li>Male Gender Activist participatory Monitoring of achievements, challenges/constraints and impact at Community Level (Ghana 2007)</li> <li>Review and Publish study report on 'Men's Attitudes and Behaviours to Sexual and Reproductive Health Issues, Shared Parenthood, Violence Against Women and HIV/AIDS (Ghana 2007-8)</li> <li>Develop and print Study Guides for three categories of men's groups and conduct two- days' ToT</li> <li>Male Gender Activist participatory identification process (Ghana 2007)</li> <li>Conduct research study on gender equity, mainstreaming and RH services (Sudan 2006)</li> <li>Organize review seminar on MDG 3 &amp; 5 national progress and publish a report on Sudan, UNFPA programme and MDGs (Sudan, 2006)</li> <li>Annual Review meeting on achievement of programme and CPAP outcomes (Sudan 2006-)</li> <li>Submit national strategy on gender-based violence for approval and integrated programme operationalization (Sudan 2007)</li> <li>Submit for review sectoral plans to government on addressing gender-based violence and SRH/ MH/HIV services (Sudan)</li> <li>Gender-based violence information and monitoring system in place, tracking and data sharing (Sudan 2007)</li> <li>Build capacity of Ministry of Women's Affairs to support and monitor Gender Mainstreaming and links to RH/ RH across line ministries and provinces (Cambodia 2007).</li> <li>Build capacity of Ministry of Women's Affairs, and selected Provincial and District Department's of Women's Affairs to advocate for women's and girl's rights, to promote gender equality and reduce gender based violence and access to services (Cambodia, 2008).</li> <li>Sensitize and build capacity of Ministry of Women's Affairs for Women and HIV/AIDS initiatives (Cambodia 2009).</li> <li>Sensitize and strengthen capacity of the Ministry of Planning and Ministry of Health to prioritize and mainstream gender issues and RH (Cambodia, 2009)</li> </ul>	<p>CSOs to effectively implement the National Gender Policy (Ghana CPAP).</p> <p>Promoted application of integrating approaches for quality RH programmes with women empowerment under the human rights principles (Sudan CPAP)</p> <p>Responses to gender-based violence, including female genital mutilation and domestic and sexual violence, and to early marriage are strengthened through improved policies, security and protection systems, and community mobilization, including in emergency and post-emergency situations (Sudan CPAP)</p> <p>Strengthened capacity of priority ministries, selected commune councils and the media to promote empowerment of women and youth (Cambodia, CPAP)</p> <p>Rights of women and girls promoted and gender equity enhanced (Bangladesh CPAP)</p> <p>Policies of relevant sectoral ministries are revised to reduce institutional and social barriers to exercising rights and accessing services for all excluded groups (Nepal, CPAP)</p> <p>Women and excluded groups participate in designing and implementing peace-building initiatives</p>	<p>2010 (where mentioned)</p>
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<p>- Advocacy (2006)</p> <p>Cambodia:</p> <ul style="list-style-type: none"> <li>- Gender mainstreaming (2007)</li> <li>- GBV monitoring system (2008)</li> <li>- Empowerment (2009)</li> <li>- Local planning (2010)</li> </ul> <p>Bangladesh:</p> <ul style="list-style-type: none"> <li>- Women's support schemes</li> <li>- Operations research</li> </ul> <p>Nepal</p> <ul style="list-style-type: none"> <li>- Baseline (2008-9)</li> <li>- Evidence based action plans and reviews (2010)</li> </ul> <ul style="list-style-type: none"> <li>• Emerging issues/ populations</li> </ul> <p>Seminar, Workshops, KAP assessments, Consultancy, Endorsements, Dissemination, Co-ordination meetings, Review of Annual Operation Plan, Department annual report reviews, Protocol development, Reviews of sectoral plans, CPAP monitoring, UNDAF</p>	<ul style="list-style-type: none"> <li>• <i>Build capacity of selected Provincial and District Department's of Women's Affairs to integrate gender issues and RR/RH into local planning and to train/support Commune Women's and Children's Committees (Cambodia 2010)</i></li> <li>• <i>Support schemes to be provided for data collection and analysis for focused studies related to harmful practices such as early marriage, dowry, gender-based violence etc. and documentation of these issues.</i></li> <li>• <i>Operations research to be conducted on demand based RH financing, gender and population policy research/studies supported by DPs to contribute to this component.</i></li> </ul> <ul style="list-style-type: none"> <li>• <i>Baseline studies to provide crucial information to tailor to tailor interventions to the specific socio-cultural circumstances of the population in the six districts and end line research in collaboration with P&amp;D (2008-9).</i></li> <li>• <i>Development of evidence based annual RH and gender action plans in partnership with local NGOs and endorsement at district level (2010)</i></li> </ul> <p><b><u>Examples of M&amp;E of Emerging Issues/Populations</u></b></p> <ul style="list-style-type: none"> <li>• <i>Multiple stakeholder s on state of population of Ghana with a focus on the most deprived districts (poor and vulnerable) and RH services and gender equity (2006-7).</i></li> <li>• <i>Workshops with new communities groups to draw action plans, indicating how parents can support out of school youth (both gender) on their SRR (AWP 2007 TFC)</i></li> <li>• <i>Conduct assessment of KAP of young people (rural and urban) on ASRH in to establish baseline data on target population in focal regions/districts (2007)</i></li> <li>• <i>Hire International consultant (CST) to review/finalize the draft National Advocacy Strategy in line with ICPD, RH and population development in Sudan context; hold workshop to discuss and review the integrated programme data, receive endorsement and disseminate to government and NGOs INGOs (Sudan, 2006-7)</i></li> <li>• <i>Provide regular in-depth information on emerging population and updated data for CPAP monitoring and build on and contribute to national monitoring and evaluation systems (2006 -).</i></li> <li>• <i>Co-ordination meeting for development, implementation and monitoring</i></li> </ul>	<p>and in operationalising UN Security Council resolution 1325 on women peace and security (Nepal AWP 2008)</p> <p>Improved access to maternal health care and youth-friendly services in programme districts. (Comprehensive RH)- Ghana CPAP</p> <p>Improved access to maternal health care and youth-friendly services in program districts (Sudan CPAP)</p> <p>Strengthened advocacy and awareness of RH/ASRH, RR and gender at national level and in UNFPA-supported districts (Cambodia, CPAP)</p> <p>Strengthen capacity to develop, implement and evaluate gender sensitive RH and HIV policies, strategies and protocols (Cambodia, CPAP)</p> <p>Sexual and RH needs and education of</p>
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<p>reviews, Thematic review, Mid-term reviews, Communication, Analysis, Micro planning, Rapid response surveys</p> <p>Topics include:</p> <p>Ghana:</p> <ul style="list-style-type: none"> <li>- Poor and vulnerable groups (2006)</li> <li>- Gender equity (2006-7)</li> <li>- Community groups (2006-7)</li> <li>- Parents (2007)</li> <li>- Rural and urban youth (2007)</li> <li>- Out-of school youth (2007)</li> <li>- ASRH (2006-7)</li> </ul> <p>Sudan</p> <ul style="list-style-type: none"> <li>- Advocacy (2006-7)</li> </ul> <p>Cambodia:</p> <ul style="list-style-type: none"> <li>- CPAP monitoring update (2006-)</li> <li>- HIV (MARP), including migrants (2008)</li> <li>- Access and utilisation monitoring and Evaluation (2008)</li> <li>- RH plan on emerging priorities (2009)</li> <li>- Quality and service protocols (2009)</li> </ul>		<p><i>of the access and utilisation of reproductive health, HIV/AIDS (MARP support) and gender elements of Health Sector Strategic Plan (Cambodia 2008)</i></p> <ul style="list-style-type: none"> <li>• <i>Workshop on the development, implementation and monitoring of the RH issues, HIV/AIDS groups and gender elements of the Annual Operational Plans from relevant MoH departments and the National AIDS Authority (Cambodia, 2008).</i></li> <li>• <i>Indicative departments RH plan (to be revised on an annual basis based on emerging priorities and needs): NRHP, HRD, Personnel Department, NCHP, DPHI send collective reports (Cambodia 2009).</i></li> <li>• <i>Workshop to revise RH/Gender protocols, service, drug, equipment and training packages based on results of new NRHS (Cambodia 2009).</i></li> <li>• <i>Hold an annual NSDP review, the health sector annual and mid-term reviews, the education sector review, the gender assessment and the HIV/AIDS review (2009-10).</i></li> </ul> <ul style="list-style-type: none"> <li>• <i>The UNDAF AR Process- Assessment of continued relevance of UNFPA programme and contribution to national RH, gender and population goals (Bangladesh CPAP)</i></li> <li>• <i>UNFPA will organise thematic reviews during the 6th CP implementation i.e. Gender, Safe Motherhood, Youth and Contraceptive Security.</i></li> <li>• <i>Organise Mid-Term Review (MTR) of country programme and ensure that recommendations is very useful in identifying priority RH, gender and population issues for the 7th country programme (Bangladesh CPAP).</i></li> </ul> <ul style="list-style-type: none"> <li>• <i>Development of annual RH and gender action plans and reviews in partnership with NGOs (Nepal 2008)</i></li> <li>• <i>Field monitoring visit for NCASC and FHD (Nepal 2008)</i></li> <li>• <i>Contribute to preparation of UNFPA standard progress report integrating 3 programme areas and UNDAF AR</i></li> <li>• <i>Monitoring and communication activities and mid-term evaluation of 3 components (Nepal, 2009).</i></li> <li>• <i>Conduct technical analysis of public sector PHN and MCHW and private sector ANMs (focus gender parity)</i></li> <li>• <i>Micro-planning and re-activation of dysfunctional outreach care services in hill districts (Nepal 2009-10).</i></li> <li>• <i>Organizing of rapid response teams for needs assessment and review of joint programming (Nepal 2008-10)</i></li> </ul>	<p>young people (Bangladesh CPAP)</p> <p>Improved capacity to deliver quality health care services, including MNH, FP, ASRH and the prevention and management of STI and uterine prolapsed (Nepal CPAP).</p> <p>Strengthened capacity of local agencies in selected districts to plan, implement, monitor and evaluate high quality RH services (Nepal CPAP).</p>	
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<ul style="list-style-type: none"> <li>- Health sector and mid-term reviews (2009-10)</li> </ul> <p>Bangladesh</p> <ul style="list-style-type: none"> <li>- UNDAF assessments</li> <li>- Thematic reviews on Gender, Safe Motherhood, Youth and Contraceptive Security.</li> <li>- Midterm reviews</li> </ul> <p>Nepal:</p> <ul style="list-style-type: none"> <li>- Gender action plans and review</li> <li>- Field monitoring</li> <li>- UNDAF reporting</li> <li>- Gender parity in RH/MH employment</li> <li>- Micro-planning of dysfunctional outreach</li> <li>- Rapid response needs assessment</li> </ul>				
<p><b>Indicator 10.2.3</b></p> <p><b>AWP HAVE NO MENTION OF CROSS-PROGRAMME EXCHANGE OF REPORTS</b></p> <p><b>Global/Regional published reports/document/manual on Cross programme co-operation by:</b></p>		<p><b><u>Examples of published reports, documents and manual on SRH cross-programme co-operation with references to gender and population</u></b></p> <ul style="list-style-type: none"> <li>• <i>Reference Manual on Medical Eligibility Criteria for Different Types of Contraceptives</i> (UNFPA and WHO, 2000)</li> <li>• <i>HIV/AIDS Manual for the Nation's Schools</i> (Cambodia MoH, UNFPA and UNESCO, 2000).</li> <li>• <i>Joint Report on success stories for the Reduction of maternal mortality, HIV/AIDS, gender and poverty-related diseases</i> (UNFPA, WHO, UNAIDS, UNICEF, UNESCO and the World Bank, 2001).</li> <li>• <i>Technical reports and evidence based documents on gender and HIV and implications for RH services, health system for UNGASS/HIV Summit</i> (2001)</li> <li>• <i>Report on Maternal Mortality Update and a companion booklet, Into</i></li> </ul>	<p><u>RH output 1.2:</u> Models for scale up of the essential SRH package available and disseminated</p> <p><u>RH output 1.3:</u> Increased availability of programming tools and guidelines to facilitate integration of RHCS in national and sectoral policies and programming processes, including emergency preparedness, response and recovery</p> <p><u>RH output 1.4:</u> Strategy on comprehensive approaches to generate demand for SRH available and introduced.</p>	<p>UNFPA Annual Reports</p>

<ul style="list-style-type: none"> <li>- SRH</li> <li>- P&amp;D</li> <li>- Gender</li> </ul> <p>SRH topics:</p> <ul style="list-style-type: none"> <li>- Contraceptive choice</li> <li>- Commodity and Contraceptive security (2000)</li> <li>- STI/HIV AIDS (2000)</li> <li>- Maternal mortality</li> <li>- Maternal health</li> <li>- ASRH and youth services</li> <li>- Condom programming</li> <li>- Fistula</li> <li>- Family planning</li> <li>- RRSRH Framework</li> </ul>		<p><i>Good Hands: Progress Reports from the Field</i> (2004).</p> <ul style="list-style-type: none"> <li>● <i>Document on Women and HIV/AIDS: Confronting the Crisis</i> (2004).</li> <li>● <i>Inter-agency report, At the Crossroads: Accelerating Youth Access to HIV/AIDS Interventions.</i> (2004).</li> <li>● <i>Two documents – Selected Practice Recommendations for Contraceptive Use and Medical Eligibility Criteria for Contraceptive</i> (UNFPA and WHO, 2004)</li> <li>● <i>The Global Task Team report on Improving AIDS Coordination</i> (UNAIDS and UNFPA, 2005)</li> <li>● <i>The report, Our Voice, Our Future: Young People Report on Progress Made on the UNGASS Declaration of Commitment on HIV/AIDS</i> (2005).</li> <li>● <i>Two manuals on Condom Programming for HIV Prevention were published jointly by UNFPA, WHO and PATH</i> (2005).</li> <li>● <i>Series of national eight-page “report cards” focusing on HIV prevention for girls and young women</i> (UNFPA and IPPF, 2006)</li> <li>● <i>Global Coalition Report on Keeping the Promise: An Agenda for Action on Women and AIDS</i> (2006).</li> <li>● <i>Program for Appropriate Technology document on Meeting the Need: Strengthening Family Planning Programs</i> (2006).</li> <li>● <i>UNFPA and WHO collaborated with Averting Maternal Death and Disability and the International Federation of Gynecology and Obstetrics to produce a Manual on obstetric fistula, the first of its kind</i> (2006).</li> <li>● <i>Report on Donor Support for Contraceptives and Condoms for STI/HIV Prevention</i> (2007)</li> <li>● <i>The Countdown to 2015 for Maternal, Newborn and Child Survival conference Report on Tracking Progress in Maternal, Newborn and Child Survival in 68 developing countries</i> (2008).</li> <li>● <i>Endorsement of Reproductive Rights and Sexual and Reproductive Health Framework</i> (2008)</li> <li>● <i>Secretary-General first-ever report on fistula in response to a General Assembly resolution</i> (2008)</li> <li>● <i>Adding It up: the Costs and Benefits of Investing in Family Planning and Maternal and Newborn Health, a report by UNFPA and the Guttmacher Institute</i> (2009).</li> <li>● <i>UNAIDS, UNFPA, UNICEF and the WHO report on Children and AIDS: The Fourth Stocktaking Report</i> (2009)</li> </ul> <p>MHTF has no special published reports, documents and manual on MH cross-programme UNFPA co-operation. However there are 4 thematic fund</p>	<p><u>RH output 3.1:</u> Improved knowledge of the situation regarding provision and uptake of family planning</p> <p><u>RH output 3.2:</u> Challenges to provision of quality family planning services analysed</p> <p><u>RH output 4.1:</u> Improved knowledge base for strengthening linkage between SRH and HIV/AIDS at the policy, system and services level especially for women and girls, vulnerable groups and people living with HIV</p> <p><u>RH output 5.1:</u> Knowledge base and capacity building strategies strengthen to ensure access of marginalised young people to essential package of SRH services</p> <p><u>RH output 5.2:</u> Knowledge based increased and capacity building strategies strengthened to include gender sensitive life-skills based SRH education in policies and curricula of secondary schools and out of school programmes.</p>	
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<p>P&amp;D Topics include:</p> <ul style="list-style-type: none"> <li>- State of the World's Population with focus on special topics of programme co-operation</li> <li>- Women, men, youth and adolescents</li> <li>- Government commitments</li> <li>- Environment</li> <li>- Sustainable development</li> <li>- Poverty</li> <li>- MYFF</li> <li>- Programme &amp; M&amp;E indicators</li> <li>- Emerging populations</li> <li>- Migration (internal and international)</li> <li>- Refugee,</li> <li>- Human trafficking</li> <li>- Data collection</li> </ul>		<p>reports that cross reference each other:</p> <ul style="list-style-type: none"> <li>• Maternal Health Thematic Fund Annual Report 2008-9</li> <li>• The Global Programme on Reproductive Health Commodity Security Annual Report 2008-9</li> <li>• Midwives Programme Progress Report 2008-9</li> <li>• The Campaign to End Fistula Annual Report 2008 -9</li> </ul> <ul style="list-style-type: none"> <li>• A tool for EmONC needs assessment “Monitoring Emergency Obstetric Care: A Handbook” and the accompanying modules has been utilized by MHTF (UNFPA, UNICEF, WHO and Columbia University, 2008)</li> </ul> <p><b><u>Examples of published reports, documents and manual on P&amp;D cross-programme co-operation with SRH and Gender</u></b></p> <ul style="list-style-type: none"> <li>• <i>The Status of the World Population 2000 report focused attention on the damage done by gender inequality and the need to improve status of women and their health.</i></li> <li>• <i>Report featuring country case studies to track the commitment of governments to UNFPA's 3 inter-linked programmes (2001)</i></li> <li>• <i>Report, Footprints and Milestones: Population and Environmental Change (2001).</i></li> <li>• <i>Technical report, Population, Environment and Poverty Linkages: Operational Challenges, provides an overview of the complex linkages with health and gender and documents UNFPA support (2001).</i></li> <li>• <i>Report on “Personalising Population” to direct media attention to 3 programme areas (2001).</i></li> <li>• <i>The first-ever report on the MYFF was prepared based on information collected from 123 countries on 3 programme area and co-operation (2001).</i></li> <li>• <i>Report on common set of gender-sensitive population-based RH indicators used in MDG reports and in the UN -CCAs and, through these instruments, in poverty reduction strategy papers (PRSPs). 2002</i></li> <li>• <i>State of World Population report for 2002 addressed the theme “people, poverty and possibilities” (2002).</i></li> <li>• <i>Joint publication, Meeting the Challenges of Migration: Progress since the ICPD (UNFPA and International Migration Programme 2004).</i></li> <li>• <i>The African Union endorsed a new statistical publication, State of African Population Report, when it was launched by UNFPA during the Summit of African Heads of State and Governments in Maputo, Mozambique (2004).</i></li> <li>• <i>The State of the World's Population report focused on, The Cairo Consensus at Ten: Population, Reproductive Health and the Global</i></li> </ul>	<p><u>P&amp;D output 1.1:</u> SRH, gender equality, young people's issues and HIV AIDS from a population dynamic perspective increasingly included within UN inter-agency mechanisms, inter-governmental processes and other international fora.</p> <p><u>P&amp;D output 2.1:</u> Strengthened national capacity to participate in policy dialogues for including young people's issues in PRS and other development frameworks</p> <p><u>P&amp;D output 3.2:</u> Increased utilisation of data from household and thematic surveys to monitor the MDG target on universal access to RH and other international development goals.</p> <p><u>P&amp;D output 4.1:</u> Emerging population issues increasingly incorporated in policy formulation and in national development frameworks</p>	
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<ul style="list-style-type: none"> <li>- and analysis</li> <li>- Donor commitment to resources to ICPD PoA</li> <li>- Evidence based- Advocacy</li> <li>- Employment in health sector</li> <li>- Migrant worker</li> <li>- Strategic Plan and Planning and Reporting documents</li> <li>- Youth mobility</li> <li>- Religion</li> </ul>		<p><i>Effort to End Poverty with a focus on women</i> (2004).</p> <ul style="list-style-type: none"> <li>• <i>Report on Reducing Poverty and Achieving the Millennium Development Goals: Arguments for Investing in Reproductive Health &amp; Rights</i> (2005).</li> <li>• <i>The report on Advocacy and Resource Mobilization for the 2010 Round of Censuses</i> (2005).</li> <li>• <i>Report on International Migration and the Millennium Development Goals, which cited acute shortages of health workers in Africa</i> (2005).</li> <li>• <i>The State of World Population report shone a worldwide spotlight on the plight of migrant women in A Passage to Hope: Women and International Migration</i> (2006)</li> <li>• <i>UNFPA produced the first-ever youth companion to its flagship report, The State of World Population. Moving Young through first-hand accounts</i> (2006).</li> <li>• <i>2<sup>nd</sup> MYFF report based on all UNFPA countries</i> (2008)</li> <li>• <i>UNFPA Strategic Plan and Annual Reporting</i> (2008)</li> <li>• <i>Culture was the focus of The State of the World Population report</i> (2008).</li> <li>• <i>Under UNFPA's leadership, all 14 member agencies of the group collaborated on a joint publication, International Migration and Human Rights</i> (2008).</li> <li>• <i>On the eve of the Copenhagen Conference, UNFPA released The State of World Population 2009 on climate change and an accompanying special supplement on youth.</i></li> <li>• <i>In Ethiopia, UNFPA supported the development of a National Population Plan of Action and a Manual for Integration of population, health and gender variables, which together will guide future policymaking in a variety of sectors</i> (2009).</li> <li>• <i>Reference manual and training guide on population and reproductive health within the context of Islam</i> (2009).</li> </ul> <p><b><u>Examples of published reports, documents and manual, film and TV news on gender cross-programme co-operation with SRH and Population and Development</u></b></p>		
<p>Gender topics include:</p> <ul style="list-style-type: none"> <li>- Gender and policy</li> <li>- Gender and Reproductive rights</li> <li>- GBV/VAW</li> <li>- CEDAW monitoring</li> <li>- Culture</li> <li>- Human Rights</li> <li>- Women NGOs and</li> </ul>		<ul style="list-style-type: none"> <li>• <i>International report documenting evidence and trends in the institutionalization of women's reproductive rights in 51 countries</i> (2000).</li> <li>• <i>A Practical Approach to Gender-Based Violence: A Programme Guide for Health Care Providers and Managers, in (SRH) health care settings</i> (2000)</li> <li>• <i>CEDAW monitoring report on countries commitment to SRH and rights</i> (2002).</li> <li>• <i>UNFPA co-sponsored a report on the Impact of Armed Conflict on Women and Women's Role in Peace-building.</i> 2002).</li> </ul>	<p><u>Gender output 1.1:</u> Women and adolescent girls reproductive rights increasingly incorporated in policies and funding frameworks, humanitarian and transition programmes as related to Beijing, CEDAW and CRC.</p>	

<p>peer networks</p> <ul style="list-style-type: none"> <li>- Leadership skills</li> <li>- Integrating gender</li> <li>- Capacity building</li> <li>- Mental health</li> <li>- FGM/C prevention</li> <li>- Violations of women and girls in humanitarian situations</li> <li>- GBV victim support</li> <li>- Male involvement to end violence</li> </ul>		<ul style="list-style-type: none"> <li>• <i>Publication Culture Matters: Working with Communities and Faith-based Organizations are drawn from a longer UNFPA report called Working from Within: A culturally Sensitive Approach in UNFPA Programming. The companion booklet, 24 Tips for Culturally Sensitive Programming, presents recommendations based on UNFPA gender, population and SRH research (2004).</i></li> <li>• <i>UNFPA prepared a training manual on culture, gender, reproductive rights and human rights (2004).</i></li> <li>• <i>“In all countries of the world, violence against women persists as a pervasive scourge, endangering women’s lives and violating their rights. Such violence also impoverishes families and communities, drains government resources and restricts economic development.”—2006 report of the United Nations Secretary-General</i></li> <li>• <i>Young women developed a training manual with UNFPA and the World YWCA to bring leadership skills and life skills in RH and gender issues to their peers worldwide (2006).</i></li> <li>• <i>Training manual and resource pack on gender budgeting in SRH to build the capacity of national partners and civil society organizations. Both products were tested and distributed to UNFPA Country Offices and partners (UNFPA and UNDP 2006).</i></li> <li>• <i>Report on, Mental Health Aspects of Women’s Reproductive Health: A Global Review of the Literature. The report, explores options for an integrated approach to mental and reproductive health (UNFPA and WHO 2008).</i></li> <li>• <i>Published the Technical Report of Global Consultation on Female Genital Mutilation/ Cutting, which summarizes the deliberations of the global consultation (2008).</i></li> <li>• <i>Inter-agency initiative developed and piloted the first-ever system to safely collect, store, share and analyze data on reported gender-based violence (UNFPA, ICR and UNHCR, 2008).</i></li> <li>• <i>UNFPA developed the Training Manual on Culturally Sensitive Approaches to Development Programming to support capacity-building training on cultural sensitivity for United Nations country teams (2008)</i></li> <li>• <i>Published a new volume of case studies documenting successful approaches in eight countries: Programming to Address Gender-based Violence (2009).</i></li> <li>• <i>Published Partnering with Men to End Gender-based Violence: Practices That Work (2009).</i></li> </ul>	<p><u>Gender output 2.2:</u> Increased understanding of-cultural norms, beliefs and behaviours for SRH programming</p> <p><u>Gender output 2.3:</u> Increased programming on male participation, especially in the areas of gender equality, gender based violence, HIV prevention and SRH, including in humanitarian and post emergency settings</p> <p><u>Gender output 4.2:</u> Increased global awareness on impact and scope of GBC, including in humanitarian and transition situations.</p>	
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**Observations on the global and regional strategic/country context of the above activities**

The UNFPA Strategic Plan responds to General Assembly resolution 59/250 on the triennial UNFPA comprehensive policy review of inter-agency co-operation, inter-programme linkages and operational activities. The Strategic Plan guides all programme development from needs assessment to monitoring of performance and progress. The CPAP proposed programme and management operates under a One National Strategy, One National Plan, One Monitoring and Evaluation System and One Overall Coordination Structure under the leadership of the country and one Validation system.



The AWP is the operational tool for programme implementation. UNFPA relies on Management Results Framework (joint) to strengthen the IPs ability to manage the financial and human resources and effectively utilise CPAP M&E tracking tool together with planning, monitoring, reporting and knowledge sharing system to widen people's participation. The CPAP M&E tracking Tool and the CPD-RRF are the centre pieces of UNFPA's Results Based Management and accountability at country level. In monitoring and reporting all 3 programme components follows the UNFPA Policies and Procedure Manual and rules of the host country as noted in the CPAPs.

UNFPA has a score card system for monitoring (especially base lines) and management of outputs at each level. UNFPA conducts oversight exercises based on risk models to ensure programme relevance, adequacy and quality M&E. UNFPA carries out continual monitoring of expenditures ad obligation in the Atlas system and hold managers accountable to meeting planned expenditures and agreed programme results. UNFPA reports trends in the strategic plan outcomes using sets of common output indicators for each of the 3 programme areas and does comparisons across countries on an annual basis.

In spite of 30-40 years of UNFPA involvement countries continue to have weak M&E data systems for planning and reporting. This not just due to insufficient investment in census and household surveys but more due to lack of continuous programme records and administrative systems in country as well as changes in UNFPA due to UN reforms and UNDAF. With the introduction of the Strategic Plan and the Atlas System the financial aspect has stabilised to a great extent.

***Evaluation question 11: To what extent has UNFPA been able to complement maternal health programming and implementation at country level with related interventions, initiatives and resources from the regional and global level to maximize its contribution to maternal health?***

Not applicable

**Evaluation question 12: To what extent did UNFPA maternal health support contribute to the visibility of UNFPA in global, regional and national maternal health initiatives and help the organization to increase financial commitments to maternal health at national level?**

**Judgment criterion 12.1: UNFPA presence in global and regional maternal health initiatives**

Activity type	Programming Periods		Description & Examples (Country; year)	Is (typically) associated with following outputs	Countries where this activity was implemented / planned
	2004 - 2007	2008 - 2010			
<p><b>Indicator 12.1.1:</b>  <b>INITIATION, SUPPORT and IMPLEMENTATION of SRH/MH Advocacy/Campaign by UNFPA (or in co-operation with external agencies):</b></p> <p><b>1. Public Advocacy:</b></p> <ul style="list-style-type: none"> <li>• <b>Cause advocacy.</b> Topics included by year: <ul style="list-style-type: none"> <li>- Regional harmful practices (2000)</li> <li>- HIV prevention for MH (2002)</li> <li>- Campaign to End Obstetric Fistula (2002)</li> <li>- Culture and SRH/MH (2002)</li> <li>- Female condom (2004)</li> <li>- Fistula campaign expanded (2006)</li> <li>- Midwives/SBA (2008)</li> <li>- Condoms/dual protection (2008)</li> <li>- Fistula campaign further expanded (2008)</li> <li>- Safe Motherhood expanded alliance (2008)</li> </ul> </li> </ul>	X	X	<p><b><u>Examples of Cause Advocacy</u></b></p> <ul style="list-style-type: none"> <li>• Support/ implement counselling/advocacy campaigns for the eradication of harmful traditional practices, such as FGM in Bangladesh, Indonesia and Kenya (2000)</li> <li>• UNFPA initiative to prevent HIV infection among young people, pregnant women and mobile populations in the Arab region, Central America and the Caribbean (2002).</li> <li>• Launched an advocacy campaign to end obstetric fistula, an injury caused by prolonged labour, in 11 African countries (2002).</li> <li>• UNFPA initiated and implemented Socio-Cultural Research to inform advocacy campaigns with culturally appropriate messages (2002).</li> <li>• UNFPA launched the Female Condom Initiative to advocate, promote and facilitate female condom programming in more than 20 countries (2004).</li> <li>• Galvanizing support for maternal health is the advocacy goal of the UNFPA-led Campaign to End Fistula, worked in 40 countries in sub-Saharan Africa, South Asia and the Arab States (2006).</li> <li>• UNFPA and the International Confederation of Midwives launched an advocacy initiative, capacity building and service programme to increase the number of births attended by midwives in 11 developing countries (2008).</li> <li>• The UNFPA-led Global Condom Initiative, an advocacy and information effort to prevent HIV and unintended pregnancies, continued its work in 55 countries. With UNFPA's assistance 20 countries drafted National Condom Strategies (2008).</li> <li>• Campaign to End Fistula reached an important milestone</li> </ul>	<p>Not stated in UNFPA Annual Report. Arrived at from Global Programme Results Framework.</p> <p><u>PD Output1.2:</u> Strengthened capacity to advocate for and incorporate linkages of population dynamics and gender equality, SRH, young people's needs in national and sectoral development plans, PRS and humanitarian assistance framework.</p> <p><u>RH Output 1.1:</u> Expanded support from global actors for the preservation and advancement of SRH/RR agenda.</p> <p><u>RH Output 1.4:</u> (Demand) Strategy on comprehensive approaches to generate demand for SRH available and disseminated.</p> <p><u>Gender Output 2.1:</u> Improved advocacy for women and adolescent girls, reproductive rights, male participation and</p>	<p>Source: UNFPA Annual Reports (2000-2009), MHTF Annual Report (2008-2009)</p> <p>Global/Regional</p>

<ul style="list-style-type: none"> <li>- MDGs and MMR/MH (2008)</li> <li>- Census and housing survey (2008)</li> <li>- Midwives Programme (2009)</li> <li>- Indigenous practices in SRH/MNH (2009)</li> <li>- SRH and human rights (2009)</li> <li>- Ageing, SRH and rights (2009)</li> </ul> <ul style="list-style-type: none"> <li>• <b>Peer advocacy.</b> Topics included by year:</li> </ul>	X	X	<p><i>when it announced that it had quadrupled in size. The Campaign now reaches more than 45 countries in Africa, Asia and the Arab States, compared to 12 countries when the Campaign was launched in 2003 (2008).</i></p> <ul style="list-style-type: none"> <li>• <i>UNFPA and The White Ribbon Alliance for Safe Motherhood extended their global advocacy collaboration to include working in partnership at the national level in 13 countries including: Bangladesh, Burkina Faso, India, Indonesia, Malawi, Nepal, Pakistan, Rwanda, South Africa, Tanzania, Uganda, Yemen and Zambia (MHTF 2008).</i></li> <li>• <i>Ensuring that the High-Level Meeting at the United Nations on the MDGs addressed maternal health and highlighted MDG5. UNFPA and more than 100 governments, NGOs and international organizations anticipated in a special, exclusive side event on mothers and children. The High-Level meeting on the MDGs led to \$2 billion in pledges of support for MDGs 4 and 5 (MHTF 2008).</i></li> <li>• <i>UNFPA's Census Initiative supported the development of technical and advocacy capacities of national statistical offices to carry out national population and housing censuses and paved the way for the round of censuses in 2010 and beyond (2009).</i></li> <li>• <i>The Midwives Programme (information, advocacy and technical), jointly executed by UNFPA and the International Confederation of Midwives, was integrated into the MHTF in April 2009.</i></li> <li>• <i>UNFPA participated in the first "dialogue and advocacy" of the United Nations Permanent Forum on Indigenous Issues and integrating socio-cultural norms into SRH/MNH (2009)</i></li> <li>• <i>UNFPA supported national human rights institutions in Cameroon, El Salvador, India, Indonesia, the Maldives, Mali, Nicaragua and Sri Lanka to integrate reproductive rights into larger human rights initiatives (2009).</i></li> <li>• <i>UNFPA support to HelpAge International enabled the organization to expand its Age Demands Action campaign to ensure that the voices of older persons are heard by policymakers (2009).</i></li> </ul> <p><b><u>Examples of Peer Advocacy</u></b></p> <ul style="list-style-type: none"> <li>• <i>RH Initiative for Youth (and Advocacy) in Asia (42-60 countries), the Africa-Caribbean-Pacific SRH Programme</i></li> </ul>	<p>elimination of harmful practices</p> <p><u>Gender output 2.2:</u> Increased understanding of socio-cultural norms, beliefs and behaviours for SRH programming</p>	
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<ul style="list-style-type: none"> <li>- Youth and SRH (1997, 2004-6)</li> <li>- UNFPA/NGO partnership in SRH/MH (2000)</li> <li>- Peer Education (2002)</li> <li>- Youth Resources (2002)</li> <li>- Global youth organisations and SRH/MH/HIV (2004)</li> <li>- Private sector media and SRH</li> <li>- ICPD +10 NGO Alliance (2004)</li> <li>- Youth Networks (2008)</li> <li>- Youth advocacy and outreach (2008)</li> </ul> <ul style="list-style-type: none"> <li>• <b>Crisis or case advocacy.</b> Topics included by year: <ul style="list-style-type: none"> <li>- Disaster management (2006)</li> <li>- Emergencies and support (2008)</li> <li>- Humanitarian relief (2008)</li> <li>-</li> </ul> </li> </ul>	X	X	<p><i>and the RH Initiative for Youth (and Advocacy) in the South Caucasus (1997-2004-6).</i></p> <ul style="list-style-type: none"> <li>• <i>UNFPA funded the International Women’s Health Coalition to provide support to NGO advocacy in the Beijing+5 meeting to protect sexual and reproductive rights on the international agenda (2000).</i></li> <li>• <i>Youth Peer Education Electronic Resource advocacy networking component of a regional initiative connected to trainers who, in turn, reached some peer educators with information on ASRH and behaviour, CEEC and CAR (2002).</i></li> <li>• <i>UNFPA supported technically the Global Youth Partners Initiative on SRH and HIV (2004).</i></li> <li>• <i>“Countdown 2015”, an initiative of Family Care International, IPPF, Population Action International and many other partners. The round table issued a Declaration of Support and recommendations for accelerating and furthering implementation of the ICPD plan. The initiative also produced a Global/Country Report Card that assessed country performance on ICPD commitments (2004).</i></li> <li>• <i>UNFPA continued to partner with youth networks and other organizations, such as Youth Coalition, Boy Scouts, Girl Scouts, YMCA and others, and to undertake global advocacy efforts with partners such as MTV and the Dance for Life Foundation (2008).</i></li> <li>• <i>A key vehicle for UNFPA’s advocacy and outreach to youth is Y-PEER, the Youth Peer Education Network, a groundbreaking and comprehensive youth-to-youth initiative in SRH/MH pioneered by UNFPA (2009). Y-SAFE is an advocacy extension in CEEC and CAR</i></li> </ul> <p><b><u>Examples of Crisis or Case Advocacy</u></b></p> <ul style="list-style-type: none"> <li>• <i>SPRINT Initiative in South East Asia and MISP integration and disaster preparedness (2006)</i></li> <li>• <i>UNFPA supported advocacy events to increase local and regional capacity to respond to emergencies and improve “South-South” collaboration (2008).</i></li> <li>• <i>UNFPA and the International Federation of Red Cross and Red Crescent Societies agreed to extend their worldwide partnership to provide advocacy, deliver services and develop capacity in disaster areas (2008)</i></li> </ul>		
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<p><b>2. Private Advocacy</b></p> <ul style="list-style-type: none"> <li>• <b>Citizens' advocacy.</b> Topics included by year: <ul style="list-style-type: none"> <li>- Integrated services, YFS (2000)</li> <li>- Face-to-Face debate on the issues (2000-1)</li> <li>- Goodwill for SRH/MH (2001)</li> <li>- Fundraising (2002)</li> </ul> </li> </ul>	X	X	<p><b><u>Example of Citizen's Advocacy</u></b></p> <ul style="list-style-type: none"> <li>• <i>UNFPA raised funds and provided technical support for African Youth Alliance (partnership) from Gates Foundation to advocate the integration of HIV with RH/MNH and gender and upgrade youth friendly services in Ghana and Tanzania (2000).</i></li> <li>• <i>Support to UNFPA Goodwill Ambassadors who use their celebrity to draw attention to the reproductive health care needs of people in developing countries. Visiting and publicizing UNFPA-supported programmes, they attract much needed media and public attention (2001).</i></li> <li>• <i>Face to Face Campaign where powerful and interested world citizens come forward to advocate and debate the issues in the media (2000-2001).</i></li> <li>• <i>34 Million Friends advocacy campaign to raise funds and show support for UNFPA when the USA administration cut \$34 million in funding to UNFPA in July 2002 (2002).</i></li> <li>• <i>19 UNFPA Goodwill Ambassadors attended a June meeting of celebrity advocates of UN causes. Discussions on advocacy and on forgotten emergencies (2002).</i></li> </ul>		
<ul style="list-style-type: none"> <li>• <b>Self advocacy</b> Topics included by year: <ul style="list-style-type: none"> <li>- Awards (2000-)</li> <li>- Capacity building (internal) -2002</li> <li>- Advocacy skills and policy dialogue (external) 2004</li> <li>- Gender equity and empowerment (2006)</li> </ul> </li> </ul>	X	X	<p><b><u>Examples of Self Advocacy</u></b></p> <ul style="list-style-type: none"> <li>• <i>Annual UNFPA Population award given to leading advocates in the area of SRH/MH (2000-)</i></li> <li>• <i>Staff members from UNFPA participated in workshops on advocacy and media skills to enhance their ability to build constituencies and support for the organization (2002).</i></li> <li>• <i>UNFPA continued to strengthen and improve its programmes, advocacy and policy dialogue (2004):</i> <ul style="list-style-type: none"> <li>- <i>A high-level consultation in New York reinforced the links between HIV prevention and SRH/Gender.</i></li> <li>- <i>A new youth advisory programme at UNFPA headquarters opened an avenue for the participation of young people.</i></li> <li>- <i>Workshops and publications advanced the Fund's commitment to culturally sensitive programming to advance human rights.</i></li> <li>- <i>Civil society leadership was strengthened at a global round table in London.</i></li> <li>- <i>Parliamentarians renewed their commitment to the Cairo agenda and population and reproductive health</i></li> </ul> </li> </ul>		

			<p>at a meeting in Strasbourg</p> <ul style="list-style-type: none"> <li>UNFPA participated in the Inter-Agency Network on Women and Gender Equality. The network, consisting of United Nations agencies, funds and programmes, focuses on gender issues, advocates and promotes gender equality throughout the United Nations system</li> </ul>		
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Activity type	Programming Periods		Description & Examples (Country; year)	Is (typically) associated with following outputs	Countries where this activity was implemented / planned
	2004 - 2007	2008 - 2010			
<p><b>Indicator 12.1.2:</b> <b>FOUNDED, LED, ACTIVE MEMBER of regional UN inter-agency groups on SRH/MH advocacy/campaigns</b></p> <p><b>1. Political Advocacy</b></p> <ul style="list-style-type: none"> <li><b>Policy advocacy.</b> Topic included by year <ul style="list-style-type: none"> <li>Political commitment and resource mobilisation (2000)</li> <li>National and legal framework (2000)</li> <li>Inter-agency groups and aid instruments (2001)</li> <li>Government/NGO partnership in SRH/MH (2002)</li> <li>Commodity security (2002)</li> <li>Emerging population dynamics (2006)</li> <li>Regional co-operation and HIV prevention (2006)</li> <li>Capacity building in advocacy (2006-7)</li> </ul> </li> </ul>	X	X	<p><b><u>Example of Inter-agency Policy Advocacy</u></b></p> <ul style="list-style-type: none"> <li>UNFPA led and together with UNAIDS, developed and implemented an inter-agency initiative to strengthen political commitment and financial support from African leaders to combat HIV/AIDS in Burkina Faso, Ethiopia, Ghana and Tanzania (2000).</li> <li>Joint cooperation with the Centre for Reproductive Law and Policy to strengthen national legal and policy advocacy to improve access to reproductive health care in 51 countries (2000).</li> <li>UNFPA participated in inter-agency initiatives such as sector-wide approaches (SWAs), Poverty Reduction Strategy Papers (PRSPs), Common Country Assessments (CCAs) 2001</li> <li>Advocacy Campaign for Stronger Voices for Reproductive Health, fostering partnerships between governments and civil society to improve the quality of SRH services (2002)</li> <li>Strategic Pathway to Reproductive Health Commodity Security (SPARCHS) to support developing a strategic commitment and funded technical and advocacy action plan for ensuring an adequate supply and range of choice of quality contraceptives and other reproductive health commodities (2002).</li> <li>UNFPA provides policy, advocacy and technical support to governments globally to ensure that population ageing is recognized as an important development factor, and</li> </ul>	<p><u>PD Output 1.1:</u> SRH, gender equality, young people's issues and HIV AIDS from a population dynamics perspective increasingly included within inter-agency mechanism, intergovernmental processes and other international fora.</p> <p><u>PD Output 3.3:</u> Results of studies on emerging population issues increasingly incorporated into national development plans and PRS</p> <p><u>RH Output 2.1:</u> Increased (access and utilisation) capacity to advocate and integrate the full continuum of MH care in national health systems.</p> <p><u>Gender Output 3.1:</u> Reproductive rights of women and adolescent girls' rights increasingly included into human rights protection and participatory mechanisms</p>	<p>Source: UNFPA Annual Reports (2000-2009) and MHTF Business Plan (2008)</p> <p>Regional</p>

<ul style="list-style-type: none"> <li>- Accelerated MH service access and utilisation (2007)</li> <li>- Disaggregated Data availability, emerging populations and data utilisation (2008-9)</li> <li>- Accelerated Reduction of MMR (2009)</li> <li>- Ageing population (2009)</li> </ul> <p><b>2. Public</b></p>		<p><i>that older persons are included in policy discussions and activities funded (2006).</i></p> <ul style="list-style-type: none"> <li>• <i>UNFPA supported the African Union in developing and adopting the plan, recommending two immediate actions: Linking HIV prevention and family planning, and integrating HIV/AIDS into maternal and newborn health programmes (2006).</i></li> <li>• <i>UNFPA led in inter-agency collaboration to ensure that key measurements for issues such as maternal mortality and international migration are included in population and housing censuses and surveys (2006).</i></li> <li>• <i>UNFPA led two regional advocacy and resource mobilization workshops for the 2010 round of population and housing censuses (2006-7).</i></li> <li>• <i>The Maputo Plan of Action commits African governments to work towards the goal of universal access to sexual and reproductive health services by 2015 and the integration of HIV programming into such services (2007).</i></li> <li>• <i>UNFPA's strengthened its focus on improving data, research and institutional capacity for formulating, monitoring and evaluating migration policies and programmes; promoting policy dialogue on migration issues and advocacy for SRH/MNH services (MHTF 2008-9)</i></li> <li>• <i>The African Union Commission, with support from UNFPA, launched the Campaign for Accelerated Reduction of Maternal Mortality in Africa— CARMMA (MHTF 2009).</i></li> <li>• <i>UNFPA and the UN Department of Economic and Social Affairs (DESA) organized a conference that brought together representatives from 10 Eastern and Central European countries to discuss how they are addressing the challenges of their ageing populations (2009).</i></li> <li>• <i>UNFPA, the Doha International Institute, Northwestern University and the United Nations Programme on Ageing co-hosted an international seminar on ageing—the first to focus on developing countries—that drew attention to the need for SRH policies and sustainable social safety nets for older persons (2009).</i></li> <li>• <i>UNFPA chaired the Global Migration Group from January to June 2008. Under UNFPA's leadership, all 14 member agencies of the group collaborated on a joint publication, International Migration and Human Rights.</i></li> </ul>	<p><u>Gender Output 4.1:</u> Improved advocacy for promoting law enforcement, protection and prevention policies on GBV, including humanitarian and transition programmes.</p>	
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<p><b>Advocacy/Campaigns</b></p> <ul style="list-style-type: none"> <li>• <b>Public Will Campaign.</b> Topics include <ul style="list-style-type: none"> <li>- Prevention of harmful practices (2004)</li> <li>- Promote MH/reduce MMR (2006)</li> <li>- Sensitise and protect women's health (2008)</li> </ul> </li> </ul>	X	X	<p><b><u>Example of Inter-agency Public Will campaign</u></b></p> <ul style="list-style-type: none"> <li>• UNFPA's global Campaign to End Fistula focuses on prevention and treatment in 30 countries in sub-Saharan Africa, South Asia and the Arab States (2004).</li> <li>• Galvanizing support for maternal health is the advocacy goal of the UNFPA-led Campaign to End Fistula, worked in 40 countries in sub-Saharan Africa, South Asia and the Arab States (2006).</li> <li>• UNFPA-UNICEF Joint Programme and Trust Fund, networks of parliamentarians, religious leaders, NGOs, civil society and the media were created to advocate for the abandonment of FGM/C and strengthen support for Campaign to end Fistula (MHTF 2008)</li> </ul>		
<ul style="list-style-type: none"> <li>• <b>Cause Campaigns</b> Topics include <ul style="list-style-type: none"> <li>- <b>Safe motherhood (19987, 2000- )</b></li> <li>- Youth and condom programming (2002)</li> <li>- Emergency SRH/MH care (2008)</li> <li>- Youth involvement, comprehensive SRH (2008)</li> <li>- Prevention of GBV (2009)</li> <li>- Partnership with CBO/FBO (2009)</li> </ul> </li> </ul>	X	X	<p><b><u>Examples of Inter-agency Cause Advocacy Campaigns</u></b></p> <ul style="list-style-type: none"> <li>• For 13 years the Safe Motherhood Initiative (1987) has been working to improve the health of mothers in developing countries. It is an example of effective collaboration between UNFPA, the World Health Organization, UNICEF, the World Bank, the Population Council, the Regional Prevention of Maternal Mortality Programme in Africa, the Safe Motherhood Network in Nepal, Family Care International, the International Planned Parenthood Federation, the International Federation of Gynaecology and Obstetrics, and the International Confederation of Midwives (2000).</li> <li>• UNFPA remains an active member of the Inter-Agency Group on Safe Motherhood and has begun MHTF (2008)</li> <li>• UNFPA was designated by UNAIDS as the UN system's HIV/AIDS resource on young people and on condom programming, and continued to co-chair, with UNIFEM, the inter-agency task team on gender, MH and HIV/AIDS (2002).</li> <li>• UNFPA expanded its ability to deliver urgent and effective health care to women and families in the countries of the Pacific Islands through the Joint Country Presence Initiative, established jointly with UNICEF and the United Nations Development Programme (2008).</li> <li>• Under UNFPA's leadership, the Inter-Agency Task Team on SRH/MH, HIV and Young People expanded its global advocacy role in HIV prevention and its membership beyond the United Nations to include selected youth</li> </ul>		



<ul style="list-style-type: none"> <li>• <b>Individual behaviour change campaigns</b> Topics include <ul style="list-style-type: none"> <li>- Poster development (2000)</li> <li>- Prevention of stigma and discrimination (2002-3)</li> </ul> </li> </ul> <p><b>3. Group advocacy</b></p> <p><b>Partnerships</b></p> <ul style="list-style-type: none"> <li>- UNDAF (2001-)</li> <li>- Agreements within bilateral and multilateral aid instruments (2004)</li> <li>- Joint statements (2008)</li> </ul>		<p>networks or associations, bilateral and multilateral agencies (2008)</p> <ul style="list-style-type: none"> <li>• A new regional campaign spearheaded by Kudai and UNFPA is called, "Violence Kills Love. Stop It!" The SRH campaign aims to educate young people about gender-based violence and change the cultural norms that tolerate it (2009).</li> <li>• UNFPA convened and supported the establishment of the Inter-agency Task Force on Faith-based Organizations, representing 10 United Nations entities on population, development and SRH/MH (2009).</li> </ul> <p><b><u>Individual Behaviour Change Campaign</u></b></p> <ul style="list-style-type: none"> <li>• International Annual Poster competition on SRH/MH. 52 countries participated and the winner's poster utilised for global/regional campaign (2000).</li> <li>• "Live and let live" was the slogan of the World AIDS inter-agency campaign 2002-2003, in which region s focused on eliminating stigma /discrimination in SRH/MH issues.</li> </ul> <p><b><u>Examples of Partnership Agreements/Statements</u></b></p> <ul style="list-style-type: none"> <li>• United Nations Development Assistance Framework (UNDAF) and advocates for SRH/PD and Gender (2001-)</li> <li>• UNFPA lead focal agency in additional areas of MNH work: Obstetric fistula (2004)</li> <li>• WHO-UNFPA-UNICEF-World Bank (H4, PMNCH)) Joint Country Support for Accelerated Implementation of Maternal New Born Continuum of Care (2008)</li> </ul>		
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Activity type	Programming Periods		Description & Examples (Country; year)	Is (typically) associated with following outputs	Countries where this activity was implemented / planned
	2004 - 2007	2008 - 2010			
<b>Indicator 12.1.3</b> <b>Third party/inter-agency referencing of UNFPA TA</b>	X	X	<b><u>Examples of Print Products/Technical Resources</u></b>	PD Output 3.2: Increased utilisation of data from	Source: UNFPA Annual Reports (2000-2009)

<p><b>products/technical resources in SRH/MH:</b></p> <p><b>1. Technical print production</b></p> <ul style="list-style-type: none"> <li>- Manual on prevention of GBV (2000-1)</li> <li>- Guidelines/Standards for MISP (2000)</li> <li>- Indicator for SRH, Gender and M&amp;E (2002)</li> <li>- Training modules (2002)</li> <li>- Manual on integrating HIV prevention (2004)</li> <li>- Accelerating youth involvement (2004)</li> <li>- SRH Report Cards (2006)</li> <li>- Data collection on women, SRH/HIV (2006)</li> <li>- Data collection of refugees and GBV (2008)</li> <li>- Census data collection and models for analysis (2008)</li> <li>- Tracking progress in MNH (2008)</li> <li>- Tools and Mapping for MNH (2009)</li> <li>- IDP profiling guidelines (2009)</li> <li>- Tools for South-South partnership (2009)</li> <li>- E-learning course on gender (2009)</li> </ul>		<ul style="list-style-type: none"> <li>• <i>In collaboration with the United Nations Development Fund for Women (UNIFEM) and WHO, UNFPA prepared a new manual, A Practical Approach to Gender-Based Violence: A Programme Guide for Health Care Providers and Managers, and field tested in 2001.</i></li> <li>• <i>UNFPA is a founding member of the Inter-Agency Working Group on Reproductive Health for Refugees, which developed guidelines standards for a minimal initial service package (MISP) for meeting basic needs in emergency situations (2000).</i></li> <li>• <i>UNFPA and the World Bank expanded collaboration in reproductive health, gender and culture. Joint activities include sharing experiences and publications, monitoring indicators and developing training modules for RH/gender mainstreaming (2002).</i></li> <li>• <i>UNFPA has been actively involved in the development of policies, guidelines and procedures with the UN Inter-Agency Initiative on Disarmament, Demobilization and Reintegration, particularly in HIV prevention (2004).</i></li> <li>• <i>At the Bangkok conference, UNFPA launched an inter-agency report, At the Crossroads: Accelerating Youth Access to HIV/AIDS Interventions (2004)</i></li> <li>• <i>In collaboration with International Planned Parenthood, the Global Coalition on Women and AIDS, and Young Positives, UNFPA issued a series of national eight-page “report cards” focusing on RH/MH/HIV prevention for girls and young women. The reports are designed as an advocacy tool for policymakers and service providers (2006).</i></li> <li>• <i>As part of a wider initiative to prevent HIV infection, particularly among adolescent girls, the United Nations Global Coalition on Women and AIDS, with support from UNFPA, developed a guide to global policy action (2006)</i></li> <li>• <i>As part of an inter-agency initiative with the International Rescue Committee and the Office of the United Nations High Commissioner for Refugees, UNFPA developed and piloted the first-ever system to safely collect, store, share and analyse data on reported gender-based violence and SRH of women (2008).</i></li> <li>• <i>Within the United Nations “early recovery cluster,” UNFPA provided technical support for the design of census projects in Angola, the Democratic Republic of the Congo and Togo, and to support the implementation of census projects in Burundi, Chad, Djibouti, Liberia and Madagascar (2008).</i></li> <li>• <i>Tracking Progress in Maternal, Newborn &amp; Child</i></li> </ul>	<p>household /thematic surveys to monitor MDG target on universal access to RH and other international development goals.</p> <p><u>RH Output 1.2:</u> Models for scale up of the essential SRH package available and disseminated</p> <p><u>RH Output 1.4:</u> Strategy on Comprehensive approaches to generate demand for SRH available and disseminated.</p> <p><u>Gender output 4.2 and 4.3:</u> Increased global awareness and response on impact and scope of GBV as part of SRH services, including in humanitarian and transition situations</p>	<p>Global/Regional</p>
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<p><b>2. All Media (print and visual)</b></p> <ul style="list-style-type: none"> <li>- Documentary on women's rights and health</li> <li>- Fistula advertising posters</li> <li>- Documentaries on SRH and Human Rights</li> <li>- Investigative documentaries on</li> </ul>	X	X	<p><i>Survival</i>, a report released at the 2008 Countdown to 2015 conference, revealed that few of the 68 developing countries that account for 97 per cent of maternal and child deaths worldwide are making fast enough progress to prevent maternal, infant and child deaths (MHTF 2008).</p> <ul style="list-style-type: none"> <li>• Development of technical guidance tools and mapping exercises on OF, including: the roll-out of a handbook for emergency obstetric and neonatal care; the launch of the Averting Maternal Death and Disability Program by Columbia University's Mailman School of Public Health, UNFPA, UNICEF and WHO; the development of a standard module on obstetric fistula, now part of the EmONC assessment tool; and completion and pilot testing of the internationally standardized competency-based training manual for fistula treatment and care (MHTF 2009)</li> <li>• Within the "protection cluster," UNFPA collaborated with the Office of the United Nations High Commissioner for Refugees and other partners to finalize Internally Displaced Persons Profiling Guidelines and applied them in Chad and the Democratic Republic of the Congo. The guidelines were designed to help obtain a better picture of who and where displaced people are and how to compile accurate estimates to guide protection programming and advocacy (2009).</li> <li>• In 2009 alone UNFPA orchestrated over 400 South-South cooperation initiatives, providing opportunities for developing countries to share its knowledge, tools, techniques and develop new capacities.</li> <li>• UNFPA partnered with UNICEF, the United Nations Development Fund for Women (UNIFEM) and the United Nations Development Programme to develop the "Inter-Agency E-Learning Course on Gender," the first of its kind to serve all four agencies (2009).</li> </ul> <p><b><u>Example of Media Products/Technical Resources</u></b></p> <ul style="list-style-type: none"> <li>• <i>Face to Face Campaign Spokesperson for Finland</i>, produced a television documentary on RH and women's rights with the technical support of UNFPA (2000)</li> <li>• <i>The Renew initiative on Fistula and MH</i> included press and London transit advertisements and a public service announcement developed free of charge by the London affiliate of Young &amp; Rubicam advertising agency (2006).</li> </ul>		
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<p>GBV and prevention</p>			<ul style="list-style-type: none"> <li>• <i>At a high-level panel on the 60th anniversary of the Universal Declaration of Human Rights, UNFPA launched UNFPA at Work: Six Human Rights Case Studies, which highlighted national initiatives to promote and protect human rights, particularly in the areas of gender, women's empowerment and culture. (2007)</i></li> <li>• <i>UNFPA supported Women on the Frontline, a series of seven investigative documentaries on gender-based violence. The half-hour documentaries aired worldwide on BBC World for seven weeks, in multiple languages, reaching an estimated 220 million households (2008).</i></li> <li>• <i>There were also high profile media pieces that focused on maternal health issues. UNFPA worked closely with The Washington Post on a maternal health story out of Sierra Leone, which ran a front page story in the Sunday edition. With support from UNFPA, United Nations Television produced stories focusing on maternal health in Nepal and Haiti, which were distributed globally via UN in Action to over 50 broadcasters and transmitted on CNN International.</i></li> </ul>		
<p><b>3. Awards (joint or alone)</b></p> <ul style="list-style-type: none"> <li>- Membership in inter-agency standing committee</li> <li>- Census work</li> <li>- Fistula prevention and care</li> <li>- Film</li> <li>- UNDAF (MOP)</li> </ul>	<p>X</p>	<p>X</p>	<p><b>Example of Awards</b></p> <ul style="list-style-type: none"> <li>• <i>UNFPA was accorded full membership in the United Nations Inter-Agency Standing Committee for Humanitarian Affairs in April 2000.</i></li> <li>• <i>In Mongolia, the national award for Best Statistician was presented to UNFPA's representative in the country, for work in strengthening and reforming the country's National Statistical Office (2001).</i></li> <li>• <i>The UNFPA Campaign to End Fistula was recognized for its work globally with an award from UNDP (2008).</i></li> <li>• <i>UNFPA and partnered with Engel Entertainment to produce an award-winning film on fistula survivors (2008).</i></li> <li>• <i>For its contribution to harmonization within the United Nations system, UNFPA received recognition through the 2008 Multilateral Organizations Performance Assessment Network Survey (2009)</i></li> </ul>		

**Observations on the global and regional strategic context of the above activities**

As stated in UNFPA's SRH Framework, one of the main strategies for improving maternal health will be advocacy and policy dialogue.

In order to conduct its initiatives much of which are closely related to advocacy and communication campaigns around the issues, UNFPA has founded, led, co-chaired, co-operated with and become a member of a variety of inter-agency groups on Safe Motherhood, PMNCH, harmful practices GRHCS, population data and census, gender, humanitarian assistance to name a few. Through these operational inter-agency groups UNFPA links upward globally and downward to countries and as such is involved in a variety of global co-operation mechanisms for aid and development. These are the realization of the CEDAW (1979); the World Conference on Human Rights (1993); the PoA ICPD (1994 + 5 +10); the FIC on Women (1995); the Millennium Declaration (2000) and MDGs; UN Security Council resolution 1325 (2000); the UN GASS on HIV/AIDS (2001); the World Summit on Sustainable Development (2002); General Assembly resolution 59/250 on the triennial comprehensive policy review (TCPR) of operational activities of the United Nations, and the Paris Declaration on Aid Effectiveness and the World Summit Outcome (2005) on Universal Access to RH (2007).

Besides these UNFPA is part of regional UN inter-agency groups and has co-operative status with initiatives of the African Union and Maputo Plan of Action, Asian Population and Development Association, Asian/African Forum of (women) Parliamentarians, Regional Co-operation Framework for Arab States, South Asian Association for Regional Co-operation, Economic Co-operation Organisation, Regional Initiatives for South-South Co-operation. At country – level UNFPA is a leading member of UNDAF and UN inter-agency programme theme groups and participates in country aid instruments such as SWAPs, PRSP and CCA.

Besides these it has international, regional and national co-operation in support of its programmes with civil society, foundations and private sector.

### Judgment criterion 12.2: UNFPA leadership of maternal health advocacy campaigns at national level

Activity type	Programming Periods		Description & Examples (Country; year)	Is (typically) associated with following outputs	Countries where this activity was implemented / planned
	2004 - 2007	2008 - 2010			
<p><b>Indicator 12.2.1</b> <b>UNFPA leadership in</b></p> <p>1. <b>Memorandum of Understanding (co-operation) with international agencies that is translated into agreements with national governments and has an advocacy component (and not mentioned in JC1)</b> Topics included in multiple countries:</p> <ul style="list-style-type: none"> <li>- Population policy, census, national data collection, analysis and management (2000)</li> <li>- Safe motherhood and Obstetric care (2000)</li> <li>- NGO partnership and capacity development (2001)</li> <li>- RH commodities and condom programming (2002)</li> <li>- RH for Refugee Women (2002)</li> <li>- End Fistula (2003)</li> <li>- HIV prevention/theme group (2004)</li> <li>- ICPD +10 (2010)</li> <li>- SRH for Refugees and IDP</li> </ul>	X	X	<p><b>Examples:</b></p> <ul style="list-style-type: none"> <li>• <i>Role in supporting all countries to formulate effective population policies, undertake national censuses and develop/ maintain health information systems (2000)</i></li> <li>• <i>Lead in (with Columbia University) in obstetric care, "Making 'Safe Motherhood' a Reality" project to make existing hospitals and health centres capable of providing such care. India, Morocco, Mozambique and Nicaragua. Needs assessment missions were also carried out in nine African and Central American countries (2000).</i></li> <li>• <i>Partner (with IPPF) on SRH capacity development of NGOs working with young people in 11 Eastern Europe and Central Asian countries (2001).</i></li> <li>• <i>Partner (with Rotary International) signed a Memorandum of Co-operation to work together on population, RH/MH issues in Africa (2001)</i></li> <li>• <i>United Nations Department of Peacekeeping Operations and UNFPA as the expert developed guidelines on condom programming for peacekeeping missions in all countries of presence and signed a MoU on the provision of reproductive health supplies, including condoms, essential drugs and HIV testing kits (2002)</i></li> <li>• <i>UNFPA signed a MoU with the International Federation of Red Cross and Red Crescent Societies to boost the cooperation in providing reproductive health services, particularly to refugee women in humanitarian situations (2002)</i></li> <li>• <i>UNFPA's leadership global Campaign to End Fistula focuses on advocacy, prevention and treatment in 30 countries in sub-Saharan Africa, South Asia and the Arab States (2003).</i></li> <li>• <i>As a co-sponsor of the global United Nations Joint Programme on HIV/AIDS (UNAIDS), UNFPA</i></li> </ul>	<p><u>PD Output 2.1:</u> Strengthened national capacity to participate in policy dialogue for census including young people's issues in PRS and in other development frameworks</p> <p><u>RH Output 2.2:</u> Global strategy for accelerated PMCT scale up implemented, particularly focusing on a basic package of HIV services in maternal health care settings and RH for women living with HIV</p> <p><u>Gender Output 1.1:</u> Women and adolescent girl's reproductive rights increasingly incorporated in policies and funding frameworks, humanitarian and transition programmes as related to Beijing, CEDAW and CRC</p>	<p>Source: UNFPA Annual Report (2000-2009)</p> <p>Global/countries Regional/countries</p>

<p>(2004)</p> <ul style="list-style-type: none"> <li>- SRH policies, women ministers and Parliamentarians (2005)</li> <li>- SRH and African Union (2005)</li> <li>- UN reforms (2005)</li> <li>- Female condoms (2005)</li> <li>- Universal access to RH (2005)</li> <li>- Peer education (2006)</li> <li>- SRH and youth involvement (2008)</li> <li>- Thematic Funds (2008-)</li> </ul>			<p><i>contributed leadership at many levels, including participation in each country's United Nations Theme Group on HIV/AIDS (2004).</i></p> <ul style="list-style-type: none"> <li>• <i>UNFPA led UNF supported joint NGO activities for the ICPD 10th anniversary. UNFPA, UNF and the Summit Foundation also spearheaded the World Leaders' Statement supporting the ICPD (2004).</i></li> <li>• <i>UNFPA and Mano River Union secretariat signed an agreement to advocate for the prevention of HIV/ AIDS among refugees, the internally displaced and people living with HIV/AIDS in Côte d'Ivoire, Guinea, Liberia and Sierra Leone (2004).</i></li> <li>• <i>UNFPA led negotiations on future cooperation with the new Committee on Population and Development of African Speakers of Parliaments, and continued to enhance the advocacy skills and capacity of the Regional Network of African Women Ministers and Parliamentarians in advocacy, resource mobilization and leadership (2005).</i></li> <li>• <i>Strategic partnerships were formalized to support the New Partnership for Africa's Development (NEPAD) Plan of Action and ensure a focus on reproductive health and population issues. A MoU entered into effect between UNFPA and the African Union (2005).</i></li> <li>• <i>As a member of the United Nations Development Group, UNFPA played a leadership role in speeding up United Nations reform and making sure it has a meaningful impact on all United Nations country teams as they serve their national counterparts (2005).</i></li> <li>• <i>Supported by UNFPA, PATH, the Bill &amp; Melinda Gates Foundation, the William and Flora Hewlett Foundation, and the Department for International Development in the United Kingdom convened the Global Consultation on the Female Condom where world experts came to an unprecedented agreement to work together to intensify female condom country programming (2005).</i></li> <li>• <i>UNFPA supported the advocacy on the milestone agreement at the World Summit where leaders committed themselves to: "Achieving universal access to reproductive health by 2015, as set by the ICPD PoA Universal access has become the advocacy slogan for all CO programming (2005-).</i></li> <li>• <i>UNFPA provided expertise to develop a training manual for the World YWCA to bring advocacy and leadership skills to their peers worldwide (2006).</i></li> <li>• <i>Under UNFPA's leadership, the Inter-Agency Task</i></li> </ul>		
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			<p><i>Team on HIV and Young People expanded its global advocacy role in HIV prevention and its membership beyond the United Nations to include selected national youth networks or associations, bilateral and multilateral donors, civil society and foundations (2008)</i></p> <ul style="list-style-type: none"> <li>• <i>UNFPA Thematic Funds initiated and MHTF Programming, each with its own AWP, activities and funds (MHTF 2008, 2009)</i></li> </ul>		
<p><b>Indicator 12.2.2</b> <b>UNFPA leadership in</b></p> <p><b>2. AWPs, Planning and Resource allocation for 3 programme components.</b></p> <ul style="list-style-type: none"> <li>- Major – lead (with government)</li> <li>- Moderate – joint inter-agency programming</li> <li>- Minor – uptake as and when necessary</li> </ul>	X	X	<p><b><u>Example in order of country programme priority:</u></b></p> <p><b>CO AWP Assessment of UNFPA Intervention in CPAP reference outputs. Strengthen capacity in:</b></p> <ul style="list-style-type: none"> <li>• <i>Population issues (major); Youth rights/needs (moderate); Manage/ use census (major); FP awareness (moderate); Quality MH service (moderate); Ensure RHCS (major) ; FP services (moderate); HIV services moderate), Protection of rights (moderate) ; GBV response (moderate);</i></li> <li>• <i>Population issues (major); Youth rights/needs (moderate); Manage/ use census (major); FP awareness (major); Quality MH service (major); Ensure RHCS (moderate); FP services (moderate); HIV services major), Protection of rights (moderate) ; GBV response (moderate)</i></li> <li>• <i>Population issues (major); Youth rights/needs (major); Manage/ use census (major); FP awareness (moderate); Quality MH service (major); Ensure RHCS (moderate); FP services (major); HIV services (moderate); Protection of rights (moderate); GBV response (major).</i></li> <li>• <i>Population issues (moderate) Youth rights/needs (major); Manage/ use census (moderate); FP awareness (moderate); Quality MH service (major) Ensure RHCS (moderate); FP services (major); HIV services (major) ; Protection of rights (moderate) GBV response (major).</i></li> <li>• <i>Population issues (moderate); Youth rights/needs</i></li> </ul>	<p><b>PD Output 1.1:</b> SRH, gender equality, young people's issues and HIV/AIDS incorporated in public policies, poverty reduction plans and expenditure frameworks</p> <p><b>RH Output 3.1:</b> Improved knowledge of the situation regarding provision and uptake of MH/family planning across priority countries</p> <p><b>RH Output 3.2:</b> Challenges to provision of quality MH/FP services analysed.</p>	<p>Ghana CPAP (2006-2010); COAR 2008</p> <p>Sudan CPAP (2006-2010); COAR 2008</p> <p>Cambodia CPAP (2006-10); COAR 2008</p> <p>Bangladesh CPAP (2006-10); COAR 2008</p> <p>Nepal CPAP (2006-10); COAR 2008</p>



			<i>(minor); Manage/ use census (major); FP awareness (major); Quality MH service (moderate); Ensure RHCS (moderate); FP services (major); HIV services (major); Protection of rights (major); GBV response (minor).</i>	
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**Observations on the national strategic context of the above activities**

The CPAP defines the programme, strategy and management of UNFPA’s presence in the country. The AWP is the operational document and COAR incorporates an evidence based M&E tool. The successful implementation by UNFPA of the country programme within which advocacy and communication campaigns have to take place rely on a coordinated partnership among all stakeholders especially the government. Ministries (usually Ministry of Finance is responsible for the coordination of external financial resources and the lead coordinating agency while the Ministries of Health, Women and Children’s Affairs and the National Population Council Secretariat (NPCS) are Programme component managers for RH, Gender and P&D respectively and are the focus of advocacy. This advocacy effort is geared to contribute to the realization of the priorities and outcomes identified in the CCA/UNDAF, MDGs and the Growth and Poverty Reduction Strategy as well as raise and share resources.

Other ministries and departments, provinces and district administration are also part of the advocacy loop as they play strategic roles to ensure effective implementation of programmes and activities outlined in the CPAP. There is joint programming and collaboration with UNIDO and UNESCO, and development partners such as UNDP, UNICEF, WFP, ILO, UN Habitat, World Bank, UNAIDS, EC, JICA, USAID, DFID, and UNHCR. UNFPA participates in inter-agency initiatives such as sector-wide approaches (SWAs), Poverty Reduction Strategy Papers (PRSPs), Common Country Assessments (CCAs). Civil Society Organisations including NGOs/CBOs, FBOs and traditional leaders are effectively engaged in implementation at various levels of the national political and administrative system.

UNFPA engages the services of various media groups to advance advocacy and participate in public communication campaigns. For UNFPA research institutions are key in the organization of evidence-based information and data in all programme areas. Parliament, DAs, FBOs, Traditional leaders, and the Private Sector are the focus of advocacy too in order to ensure a holistic approach towards the attainment of desired outcomes in a participatory, multi-sectoral and multi-disciplinary manner.

Country programmes are autonomous and reflect country priorities using ICPD PoA and UNFPA Strategic Plan and SRH Framework as guidance in formulating the CPAP and CPD RRF. Within this well specified country context, UNFPA has to discreetly manoeuvre a leadership role to determine the agenda and jointly advocate for key issues. WHO has identified six building blocks of the health system one of which is national leadership and governance (stewardship). How well UNFPA facilitates; co-ordinates and collaborates in public and policy dialogue can differ for a variety of reasons that are internal to the organisation and external to it, across countries and programmes.

### Judgment criterion 12.3: Increased financial commitments of partner governments to sexual reproductive health and maternal health

Activity type	Programming Periods		Description & Examples (Country; year)	Is (typically) associated with following outputs	Countries where this activity was implemented / planned
	2004 - 2007	2008 - 2010			
<p><b>Indicator 12.3.1: UNFPA tools, information, evidence utilized for fund-raising jointly with governments:</b></p> <ul style="list-style-type: none"> <li>• Interactive co-operations: conferences, consultations, donor meetings and technical seminars</li> <li>• Documentation: Population based data, guidelines, standards, methodology and indicators</li> <li>• Inter-agency groups and development aid instruments</li> <li>• Advocacy and communication campaigns</li> </ul> <p>- Dual Advocacy strategy (2000)</p> <p>- 1st MYFF (2000)</p> <p>- Results oriented M&amp;E tools (2000)</p> <p>- Updated resource allocation system (2000)</p> <p>- Global Donor meeting on poor countries (2001)</p> <p>- Prevention advocacy (2001)</p> <p>- Partnership-Leveraging strategy (2001)</p>	X	X	<p><b>2000</b></p> <ul style="list-style-type: none"> <li>• <i>Development of UNFPA Advocacy Strategy for mobilisation of resources and SRH and Rights promotion</i></li> <li>• <i>Country situational analysis for development of 1<sup>st</sup> MYFF and re-introduction of results-resource framework.</i></li> <li>• <i>First set of results-oriented tools for programme M&amp;E distributed to country offices</i></li> <li>• <i>Approved an updated system for resource allocation based on a country's level of need and achievement.</i></li> </ul> <p><b>2001</b></p> <ul style="list-style-type: none"> <li>• <i>Donor meeting to mobilize resources for poor countries to conduct censuses and strategies for reducing costs.</i></li> <li>• <i>Advocacy for prevention gains focus, revised guidelines for country policy change, building alliances, mobilizing resources and bringing about safer behaviour.</i></li> <li>• <i>Re-examination of partnership strategy to leverage limited resources to establish services inclusive of vulnerable populations.</i></li> <li>• <i>Initiates a transition exercise within the Fund to strengthen UNFPA's lead role in the achievement of the ICPD and MDGs.</i></li> <li>• <i>Finalize a new human development resource strategy focusing on training and learning, upgrade field connectivity to enhance knowledge sharing, and continue to streamline administrative and financial systems for simpler monitoring.</i></li> <li>• <i>A new organizational identity for UNFPA launched. Underpinning these changes clearer strategic</i></li> </ul>	<p><u>PD Output 3.3:</u> Integrated socio-economic demographic databases increasingly used in national development plans</p> <p><u>RH Output 1.2:</u> Models for scale up of the essential SRH package available and disseminated</p> <p><u>RH Output 1.3:</u> Increased availability of programming tools and guidelines to facilitate integration of RHCS in national and sectoral policies and programming process, including emergency preparedness</p> <p><u>RH Output 1.4:</u> (Demand) Strategy on comprehensive approaches to generate demand for SRH available and disseminated.</p>	<p>5 CPAP 2006-2010; UNFPA Annual Report 2000-2009 and COAR 2008-9</p> <p>5 CPAP 2006-2010; UNFPA Annual Report 2000-2009 and COAR 2008-9</p>

<ul style="list-style-type: none"> <li>- Transition phase and country assessments (2001)</li> <li>- Human development resource strategy (2001)</li> <li>- Field knowledge sharing (2001)</li> <li>- HQ/CO connectivity (2001)</li> <li>- Streamlining financial and administrative system (2001)</li> <li>- Brand enhancement (2001)</li> <li>- Results based management (2001)</li>   <li>- Regional resource mobilisation (2002)</li> <li>- Data analysis for management of resources (2002)</li> <li>- UNAIDs co-sponsor (2002)</li> <li>- Condom programming (2002)</li> <li>- Partnership agreements (2002)</li>   <li>- MYFF evaluations (2004)</li> <li>- Regional resource mobilisation (2004)</li> </ul>	X	X	<p><i>directions in UNFPA's mandated areas of work, and stronger institutional capacity and mechanisms to anticipate and adjust to new issues and challenges, and to more effectively plan and manage our resources.</i></p> <ul style="list-style-type: none"> <li>• <i>Initiates an overall shift towards results-based management, including the full use of MYFF.</i></li> </ul> <p><b>2002</b></p> <ul style="list-style-type: none"> <li>• <i>Safe-Motherhood/ EoC results used to mobilize resources to make services more widely available (Sub-Saharan Africa)</i></li> <li>• <i>Introduction of Youth Peer Education Electronic Resources (CEEC, CAR)</i></li> <li>• <i>Data analysis for management of resources and organization of intensive, rapid and comprehensive national survey of health facilities and resources, covering every district in several countries (Africa and South Asia)</i></li> <li>• <i>UNFPA was designated by UNAIDS as the UN system's HIV/AIDS resource on young people and on condom programming.</i></li> <li>• <i>Continued to co-chair, with UNIFEM, the inter-agency task team on gender and HIV/AIDS and new funds from UNAIDS to integrate reproductive health and YSF (Arab States).</i></li> <li>• <i>Strengthened relationships with partners increased its ability to shape global/regional agendas, ability to allocate resources and set accountable benchmarks.</i></li> </ul>		<p>5 CPAP 2006-2010; UNFPA Annual Report 2000-2009 and COAR 2008-9</p>
<ul style="list-style-type: none"> <li>- Participation in –country aid instruments, SWAPs, PRSP and CCA (2005)</li> <li>- Country resource mobilisation (2005)</li> <li>- PMNCH, inter-agency joint programming and resource mobilisation (2005)</li> <li>- Board member of new partnership initiatives (2005).</li> <li>- Data and census updates (2005)</li> </ul>	X	X	<p><b>2004</b></p> <ul style="list-style-type: none"> <li>• <i>Evaluation of 1<sup>st</sup> MYFF and 2<sup>nd</sup> MYFF introduced</i></li> <li>• <i>Creation of a unit in the Arab League to integrate the resources of the Pan Arab Project for Family Health (PAPFAM), funded by AGFUND. It hosts a dynamic database; serves as a clearing house for social indicators, and provide South-South technical support.</i></li> </ul> <p><b>2005</b></p> <ul style="list-style-type: none"> <li>• <i>Declaration of commitment to stronger leadership and the scaling up of comprehensive response through rejuvenated participation in SWAPs and PRS and improved mobilisation of in-country resources.</i></li> </ul>		<p>5 CPAP 2006-2010; UNFPA Annual Report 2000-2009</p>



<p>forecasting resource need (2009)</p> <ul style="list-style-type: none"> <li>- New directions (need based) in regional and country funding (2009)</li> <li>- Other resources (private) sustained (2009)</li> </ul>	<p>X</p>	<p>X</p>	<p><i>world commit more resources to prevent and eliminate violence against women.</i></p> <ul style="list-style-type: none"> <li>• <i>UNFPA organizes a donor meeting and two regional advocacy and resource mobilization workshops.</i></li> <li>• <i>New opportunities with the Learning and Career Management Branch of the Division of Human Resources, including a training on culturally sensitive programming for field-based staff in all regions</i></li> </ul> <p><b>2008</b></p> <ul style="list-style-type: none"> <li>• <i>UNFPA develops a SRH framework to provide overall guidance and cohesive UNFPA action to implement the SRH and rights elements of the UNFPA Strategic Plan developed the same year. The framework builds on the goals ICPD 1994, the Millennium Summit and the MDGs 2000, the 2005 World Summit and the addition in 2007 of the goal of universal access to reproductive health to MDG 5, which aims to improve maternal health.</i></li> <li>• <i>UNFPA developed two instruments to planning and mobilization of resources for 2010 censuses: a census-costing instrument and a census database</i></li> <li>• <i>UNFPA is a leader in implementing United Nations reform and maintains strategic partnership programme with WHO, UNICEF and UNIFEM, to promote coherent country-level operations and evidence based results.</i></li> <li>• <i>Strong stewardship of resources and in several countries established new international operations manager positions dedicated to such tasks.</i></li> <li>• <i>UNFPA also stresses activities that promote coordination among different divisions and offices, at all levels of its work, whether global, regional or national</i></li> <li>• <i>To better serve countries in need, UNFPA has increased its responsiveness to its country offices and sought to build local capacity through the transference of skills and knowledge.</i></li> <li>• <i>Work closely with other United Nations entities, especially UNICEF, UNAIDS and the United Nations Development Programme, to make United Nations reform a reality.</i></li> <li>• <i>UNFPA support has resulted in the development of national plans and policies to empower women, expand access to reproductive health and account for population dynamics and emerging issues such as</i></li> </ul>		
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		<p>ageing, migrants, refugees, IDP and MARP.</p> <ul style="list-style-type: none"> <li>Increased emphasis on consistent oversight of resources under UNFPA management and consistent application of an internal control framework and all elements of an internal oversight policy.</li> </ul> <p><b>2009</b></p> <ul style="list-style-type: none"> <li>UNFPA calculated the latest cost estimates for implementing the PoA ICPD (1994) to enable governments and international organizations to assess the amount of funding needed to sustain or expand population related programming in the future. The estimates appeared in two publications: <i>Financial Resource Flows for Population Activities</i> and <i>Financing the ICPD Programme of Action: Fifteen Years Later</i>.</li> <li>UNFPA provided support to 155 developing countries, areas and territories based on a resource allocation system: 45 in sub-Saharan Africa, 14 in the Arab States, 20 in Eastern Europe and Central Asia, 40 in Latin America and the Caribbean, and 36 in Asia and the Pacific.</li> <li>Sub-Saharan Africa received the largest percentage of UNFPA regular resources at \$136.2 million, followed by Asia and the Pacific at \$87.8 million, Latin America and the Caribbean at \$34.1 million, the Arab States at \$31 million and Eastern Europe and Central Asia at \$14.9 million.</li> <li>Private sector participation and foundation funding sustained in spite of recession</li> </ul>		<p>5 CPAP 2006-2010; UNFPA Annual Report 2000-2009 and COAR 2008-9 MHTF Annual Report 2008-9</p>
<p><b>Indicator 12.3.2:</b> <b>Total Income (as a result of UNFPA resource mobilisation as noted) and MHTF/Campaign to End Fistula annual resources</b></p>		<p><u>Example of trends in UNFPA income</u></p> <p><b>2000</b></p> <ul style="list-style-type: none"> <li>Total income was \$366.1 million, compared to \$287.7 million in 1999 an increase of 5%</li> </ul> <p><b>2001</b></p> <ul style="list-style-type: none"> <li>Total income was \$396.4 million, compared to \$367.4 million (adjusted) in 2000 an increase of 1.8%</li> </ul> <p><b>2002</b></p> <ul style="list-style-type: none"> <li>Total income was \$373.1 million, compared to \$396.4 in 2001, a decrease of 3.2%.</li> </ul> <p><b>2004</b></p>	<p>No Outputs noted in Annual Report</p>	<p>UNFPA Annual Report</p>

<p><b>Global and Regional Advocacy Expenditure and Programme %</b></p>		<ul style="list-style-type: none"> <li>• Total income \$506.1 million, compared to \$397.9million in 2003, an increase of 27.4%</li> </ul> <p><b>2005</b></p> <ul style="list-style-type: none"> <li>• Total income \$565 million, compared to \$506.1 million in 2004, an increase of 11.6%</li> </ul> <p><b>2006</b></p> <ul style="list-style-type: none"> <li>• Total income was \$605.5 million, compared to \$565 million in 2005, an increase of 7.2%</li> </ul> <p><b>2008</b></p> <ul style="list-style-type: none"> <li>• Total income was \$845.3 million, compared to \$752.2 million for 2007, which is an increase of 12.4%.</li> <li>• MHTF total income was \$25 million</li> </ul> <p><b>2009</b></p> <ul style="list-style-type: none"> <li>• Total income was \$783.1 million, down from \$845.3 million in 2008, a decrease of 7.3%</li> <li>• MHTF total income was \$14.6 million and the Campaign to End Fistula was \$6.98 million</li> </ul> <p><b><u>Example of Advocacy Expenditure</u></b></p> <ul style="list-style-type: none"> <li>• <b>1999-2000:</b> <ul style="list-style-type: none"> <li>- Africa - \$2.9 million in 1999; \$2.7 million in 2000 which is 4.9% and 5.7%</li> <li>- LAC - \$1.3million in 1999; \$1.0 in 2000 which is 6.8% and 6.3%</li> <li>- Asia &amp; Pacific - \$ 3.7million in 1999; \$3.3million in 2000 which is 6.3% and 7.6%</li> <li>- Arab States - \$0.6 0million in 1999; \$8 2million in 2000 which is .3% and 4.7%</li> <li>- Interregional and global - \$2.6million in 1999, \$3.9 in 2000 which is 10.9% and 34.2%</li> </ul> </li> </ul> <p><b>2001-2002</b></p> <ul style="list-style-type: none"> <li>- Africa - \$ 2.2million in 2001; \$5.4million in 2002 which is 3.9% and 7.32%</li> <li>- LAC - \$ 0.8million in 2001; \$1.6million in 2002 which is 4.7% and 7.5%</li> <li>- Asia &amp; Pacific - \$ 4.1million in 2001; \$5.5million in 2002 which is 7.3% and 8.7%</li> <li>- Arab States –\$0.9million in 2001; \$1.1million in 2002 which is 4.0% and 4.8</li> <li>- Interregional and global advocacy expenditures - \$8.0million in 2001; \$9.7million in 2002 which is 41.5% and 46.3%</li> </ul>		<p>UNFPA Annual Report</p>
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<p><b>Budget allocations in country by programme components</b></p> <ul style="list-style-type: none"> <li><b>Ghana</b> (Governance highly effective-MMR improvements) large</li> <li><b>Sudan</b> (Governance less effective-MMR improvements) least</li> <li><b>Cambodia</b> (Governance medium effective – MMR large improvements)</li> </ul>		<ul style="list-style-type: none"> <li><b>2003</b> <ul style="list-style-type: none"> <li>- Africa - \$3.7m in 2003 which is 5.8%</li> <li>- Arab States - \$1.3 in 2003 which is 5.9%</li> <li>- Asia and Pacific - \$5.6m which is 10.6%</li> <li>- LAC - \$1.2m which is 8.7%</li> <li>- Interregional expenditure \$9.6m which is - 41.3%</li> </ul> </li> </ul> <p><b>No separate advocacy budget after 2004. A budget line called Empowerment has been included.</b></p> <p><b>Ghana programme total: \$27 million</b></p> <ul style="list-style-type: none"> <li><b>RH:</b> \$11.8 million, (\$6.8 million in regular resources and \$5 million in other resources) – <b>43.7%</b></li> <li><b>PD:</b> \$7.9 million (\$3.9 million from regular resources and \$4 million from other resources) – <b>29.3%</b></li> <li><b>Gender:</b> \$5 million (\$2 million from regular resources and \$3 million from other resources) – <b>18.5%</b></li> <li><b>Programme co-ordination and assistance:</b> \$2.3 million from regular resources – <b>8.5%</b></li> </ul> <p><b>Sudan programme total: \$33 million</b></p> <ul style="list-style-type: none"> <li><b>RH:</b> \$22 million (\$12 million from regular resources and \$10 million from other resources) – <b>66.7%</b></li> <li><b>PD:</b> \$5 million (\$4 million from regular resources and \$1 million from other resources) – <b>15.2%</b></li> <li><b>Gender:</b> \$5.2 million (\$3.2 million from regular resources and \$2 million other resources) – <b>15.7%</b></li> <li><b>Programme co-ordination and assistance:</b> \$0.8 million from regular resources – <b>2.4%</b></li> </ul> <p><b>Cambodia programme total: \$27 million</b></p> <ul style="list-style-type: none"> <li><b>PD:</b> \$6 million (\$4 million in regular resources and \$2 million other resources) - <b>22.2%</b></li> <li><b>Gender:</b> \$2million (all regular resources) – <b>7.4%</b></li> <li><b>RH:</b> \$18 million (\$11 million in Regular resources and \$7 million other resources) - <b>66.7%</b></li> <li><b>Programme co-ordination and assistance:</b> \$1</li> </ul>	<p><u>RH Output 1:</u> Improved access to MH care and YFS</p> <p><u>PD Output 2:</u> Strengthened institutional and technical capacity to integrate planning/ budgeting</p> <p><u>Gender Output 1:</u> Strengthened capacity to effectively implement the national gender policy</p> <p><u>RH Output 1:</u> An essential and integrated RH health package and RH commodities are available</p> <p><u>PD Output 2:</u> Enhanced capacity to integrate population dynamics, into planning and monitoring</p> <p><u>Gender Output 1:</u> Strengthened technical and institutional capacity for gender analysis and budgeting.</p> <p><u>PD Output 1:</u>Improved national and decentralized capacity to integrate, budget and implement</p> <p><u>Gender Output 1:</u> Strengthened capacity of priority institutions to promote the empowerment of women and youth</p> <p><u>RH Output 3:</u></p>	<p>UNFPA Annual Report</p> <p>Ghana CPD-RRF (2006-10)</p> <p>Sudan CPD-RRF (2009-12)</p> <p>Cambodia CPD-RRF (2006-10)</p>
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<ul style="list-style-type: none"> <li>• <b>Bangladesh</b> (Governance medium effective – MMR large improvements)</li> <li>• <b>Nepal</b> (Governance medium effective – MMR large improvements)</li> </ul>		<p><i>million from regular resources – 3.7%</i></p> <p><b>Bangladesh programme total: \$40.5 million</b></p> <ul style="list-style-type: none"> <li>• <b>RH:</b> \$28.05 million (\$20.05 million from regular resources and \$8 million from other resources) - <b>69.3%</b></li> <li>• <b>Gender:</b> \$7 million (\$5 million from regular resources and \$2 million from other resources) – <b>17.3%</b></li> <li>• <b>PD:</b> \$4.45 million (\$3.95 million from regular resources and \$0.5 from other resources – <b>10.9%</b></li> <li>• <b>Programme co-ordination and assistance:</b> \$1 million from regular resources – <b>2.4%</b></li> </ul> <p><b>Nepal programme total:\$28 million</b></p> <ul style="list-style-type: none"> <li>• <b>RH:</b> \$17 million (\$11 million from regular resources and \$6 million from other resources) – <b>60.7%</b></li> <li>• <b>PD:</b> \$5 million (\$3 million from regular resources and \$2 million from other resources) – <b>17.8%</b></li> <li>• <b>Gender:</b> \$5 million (\$2 million from regular resources and \$3 million from other resources) – <b>17.8%</b></li> <li>• <b>Programme co-ordination and assistance:</b> \$1 million from regular resources – <b>3.6%</b></li> </ul>	<p>Increased access to high-quality, comprehensive, client-oriented and gender-sensitive SRH information and services</p> <p><u>RH Output 1:</u> Increased access to improved sexual and reproductive health information and services</p> <p><u>Gender Output:</u> Rights of women and girls promoted and gender equity enhanced</p> <p><u>PD Output 2:</u> Improved analysis and utilization of data disaggregated by age, sex, economic status and location</p> <p><u>RH Output 1:</u> Improved, inclusive health systems focusing on essential health-care services, including MNH/FP /HIV</p> <p><u>PD Output 2:</u> Population, gender, RH integrated into development plans, implementation, budgets</p> <p><u>Gender Output 1:</u> Policies of relevant sectoral ministries are revised to reduce institutional and social barriers to exercising rights and accessing services, for all excluded groups</p>	<p>Bangladesh CPD-RRF (2006-10)</p> <p>Nepal CPD-RRF (2006-10)</p>
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#### Observations on the strategic context of the above activities

UNFPA country offices are part of a unified secretariat and as such are beneficiaries of global and regional initiatives which are then shared with countries as technical support, programme management, monitoring and evaluation and government commitments. There are strict protocols for communication between UNFPA global, regional and country offices and initiatives (including advocacy) must stay within the stipulated co-operation remit even as UNFPA seeks to accelerate the process of change (top-down and bottom up) and keep its visibility given the context of UNDAF.

UNFPA has adopted a common operational framework in country for programme management, raising funds and transferring cash. The utilisation of the new harmonized approach is a further step in implementing the Rome Declaration on Harmonization and Paris Declaration on Aid Effectiveness. UNFPA provides joint leadership with government for policy directions and integration of ICPD PoA. Global and regional initiatives coming into the country have to be part and parcel of standing agreements on inter-agency joint programming and government co-operation unless stated otherwise. Planning, programming and implementation are undertaken by UNFPA at the national, regional and district levels after assessments of the capacities of institutions at those levels. Selected NGOs, CSOs, CBOs and FBOs implement programmes at local and national levels after an assessment of their capacities. Multi-sectoral management and monitoring mechanisms at the national and district levels are established.

UNFPA Country Office and its representative, programme experts and administration utilise the tools, information, evidence provided by the global and regional offices to influence the process on the ground to jointly prioritise programmes, further mobilise resources and allocate budgets for SRH/MNH in a simultaneous cycle of constancy and change as envisaged by the CPAP and CPD RRF.

## 8. Evaluation matrices

### 8.1 Analytical matrices for MHTE

#### **8.1.1 Evaluation question 1: To what extent is UNFPA maternal health support adequately focused on addressing the reproductive and maternal health needs of the vulnerable groups among countries and within countries?**

##### **Judgment criterion 1.1: Correspondence between levels of UNFPA sexual and reproductive health/maternal health support and maternal health needs of vulnerable groups across programme countries**

There is no or little correspondence between the allocation of UNFPA maternal health support among countries and the prevalence and severity of maternal health needs in the countries. An internal UNFPA report (UNFPA, 2011) found no correlation between the reproductive health status in UNFPA programme countries and the levels of UNFPA investment in reproductive health.<sup>17</sup> This is possible because the specific criteria;<sup>18</sup> and the different steps in UNFPA resource allocation (among country groups) and resource distribution system (within each of the three country groups) renders the influence of the quantitative allocation criteria that represent measure of maternal health needs relatively indirect. The resource allocation system merely considers, to what extent a country has reached a series of eight relatively high thresholds, when assigning it to one of the needs-based country groups.<sup>19</sup> The allocation system does therefore not systematically consider how far the different countries in each group are away from reaching the agreed thresholds. This could in principle result in a situation where the aggregated needs in the high needs group (Group A) are so high that the additional resources that UNFPA allocates to this group are not sufficient to give these countries the intended higher share of support in comparison to the medium need countries in Group B. Also, the Resource Distribution System that is responsible for distributing resources within each of the groups gives considerable leeway to headquarters and the regional offices to base the distribution of resources on considerations other than maternal health related criteria. These include overall socio-economic quantitative criteria (gross national income per capita, for example); but also additional qualitative criteria (judgment criterion 1.1).<sup>20</sup>

The Maternal Health Thematic Fund has helped UNFPA to increase the correspondence between UNFPA maternal health support and the prevalence of the greatest needs, by means of the country selection mechanism of the fund (see separate report on the mid-term evaluation of the MHTF).

##### **Judgment criterion 1.2: (Increased) availability of accurate and sufficiently disaggregated data for targeting most disadvantaged/ vulnerable groups**

Although the intention to focus maternal health support on the “most vulnerable” is stated in UNFPA global, regional and country-level programming documents, country offices typically have not developed an operational definition of the term “most vulnerable”, and its meaning specifically with regard to maternal health or maternal mortality.<sup>21</sup> Many country offices asserted that instead of

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<sup>17</sup> Based on the correlation of the “lifetime risk of maternal death (LRMD) with the proportion of indicative assistance in reproductive health”; the same lack of correlation is also true for other sexual and reproductive health indicators, such as contraceptive prevalence, unmet needs or teenage pregnancy rates and budgets or expenditures” (UNFPA, 2011)

<sup>18</sup> I.e., the set of eight maternal health and sexual and reproductive health indicators and the associated targets

<sup>19</sup> I.e. the “high needs group” (Group A); the “medium needs group” (Group B), or the “low needs group” (Group C).

<sup>20</sup> Such as “Degree of political support to the ICPD agenda”, “Absorptive capacity” or the “Humanitarian response, transition and recovery situation in each country”

<sup>21</sup> All country offices that were visited during the field phase of the evaluation cited very broad definitions of the term “most vulnerable”, if the term was defined at all. In some cases, the term was meant to include all “women, girls, youth, extremely poor, disabled and elderly etc. or according to geographical location, such as remote, hard to reach, or urban slums population” (e.g., in Kenya, Madagascar).

focusing on particular demographic groups, they would target populations geographically, i.e. by providing support at sub-national levels in particular to states or provinces with particularly high maternal mortality rates, low rates of deliveries in health centers or other indicators that captured the maternal health performance.<sup>22</sup> Many definitions of “most vulnerable” mentioned specific groups like migrants, out of school youth/ pregnant teenagers, etc. as specific target groups. Another criterion used to describe UNFPA’s target group, i.e., the group of the “most vulnerable” in a majority of countries were “remote populations”, i.e. “populations that were hard to reach by the health system”.<sup>23</sup>

This finding of the case studies, i.e., that country offices generally have worked without a clear and operational definition of the “most vulnerable” to target UNFPA support, is in line with the findings of the assessment of selected common country assessments (carried out during the desk phase of this evaluation) that formally are the basis for developing the United Nations Development Assistance Framework (UNDAF).<sup>24</sup> The extent to which past common country assessments had identified specific maternal health needs of particular demographic groups was limited. A number of assessments limited themselves to very basic data and often left out specific information on maternal health/ reproductive health. Almost all common country assessments were lacking sufficiently disaggregated data for targeting most disadvantaged and vulnerable groups. Many common country assessments were based on old or estimated data and therefore could not capture the country’s health-related situation at that moment.<sup>25</sup> Only about half of the examined common country assessments contained a specific chapter on maternal health/ reproductive health in which maternal health related statistics as well as qualitative data were provided.<sup>26</sup> Only eight out of 22 common country assessments contained an analysis of root causes for poor maternal health.<sup>27</sup>

The lack of operational definitions of maternal health-related vulnerability and the absence of appropriate analyses of maternal health situations and root causes in the common country assessments notwithstanding, UNFPA support<sup>28</sup> has consistently helped to increase the availability of data for the planning and programming of maternal health support. Financial, logistical and technical support of macro-level data collection activities, like the census or the Demographic and Health Surveys were the most common and most regular type of activity in this regard (see table 25).

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<sup>22</sup> UNFPA worked on the basis of this type of “geographic targeting” in countries like Sudan or Zambia, where UNFPA had agreed with the Governments on particular “focus states” for UNFPA support.

<sup>23</sup> Such a notion was part of the definition of the “most vulnerable populations” in Ethiopia, Kenya, PDR Lao and Madagascar.

<sup>24</sup> UN agencies, including UNFPA, are preparing their country programmes for each country in a joint process, working out the United Nations Development Assistance Framework (UNDAF). The UNDAF is developed on the basis of a common needs assessment of all UN agencies, the so-called common country assessment (CCA). UNFPA is responsible for the sufficient consideration of maternal health issues in the common country assessment as well as later in the UNDAF (for details, please see the desk report of this evaluation).

<sup>25</sup> Usually the assessments rely on the national Demographic and Health Surveys (DHS); other sources are the Ministry of Health and international organizations (WHO, UNICEF). Many common country assessments fall back on the main indicators of MDG 5. As a consequence the indicators maternal mortality ratio, skilled birth attendance and contraceptive prevalence can be found in almost all common country assessments where they usually are the crucial quantitative basis for further analysis of maternal health/ reproductive health. In some cases further official MDG 5 indicators, like antenatal care and adolescent birth rate are used. Only few common country assessments bring in additional indicators such as caesarean rate, female genital mutilation or obstetric care. The strong focus on MDGs can also be seen in the structure of some common country assessments, which follows the classification of the eight MDGs.

<sup>26</sup> Some common country assessments at least identify maternal health/ reproductive health as an important issue and give explicitly information on it in a summarized way. Six out of the 22 assessed common country assessments, however, did not provide any specific information on the issue of maternal health/ reproductive health but limited themselves to the presentation of general health issues.

<sup>27</sup> Some countries carried out an analysis but only mention immediate causes such as the concrete reasons for maternal deaths, e.g. hemorrhage, obstructed labor, abortion, etc. and ignore the structural root causes or just cover the health sector in general disregarding maternal health/reproductive health issues.

<sup>28</sup> Financed generally under the population & development sub-programme at country level.

In addition, however, at least some country offices also carried out additional socio-economic and socio-behavioral studies<sup>29</sup> that focused on specific aspects of maternal health and maternal health services, such as skilled birth attendance, emergency obstetric and newborn care (EmONC) (often with MHTF support), family planning, etc. These kinds of assessments followed less of a regular, periodical schedule than the censuses and Demographic and Health Surveys, and were more often the result of a longer, issue-focused dialogue between UNFPA country offices and their partner governments.<sup>30</sup>

- In PDR Lao, for example, where the UNFPA country office has successfully established a long-term working relationship with the national Government throughout its efforts to promote the development of the national maternal, newborn and child health package,<sup>31</sup> the dialogue between UNFPA and the national government led the Ministry of Health to decide for the implementation of an skilled birth attendance assessment, which subsequently was supported by UNFPA. This decision had evolved out of a longer dialogue between the country office and the national government.<sup>32</sup> Together with a peer study, the skilled birth attendance assessment itself played an important role in defining the content of the national skilled birth attendance plan, i.e., the national maternal, newborn and child health strategy;
- In Burkina Faso, the UNFPA country office has been engaged in a relatively steady exchange with the national government on several issues, including the development of the countries Reproductive Health Act and its subsequent implementation that also led to the installation of the EmONC subsidy.<sup>33</sup> This prolonged dialogue also prompted a number of situational analyses regarding provision of services for reproductive health (EmONC, etc.) and socio-behavioral studies in reproductive health

In addition, the MHTF funded a series of EmONC assessments in programme countries, to kick-start the development of national EmONC scale-up plans (see report of the MHTF mid-term evaluation for details).

The country case studies suggest that the “standard” data generation activities, such as censuses or the Demographic Health Surveys (DHS) are commonly used for policy making on maternal health and other issues. This notwithstanding some of the country offices have used additional strategies to disseminate data from large scale assessment; and to discuss implications for policies and programming with their partners. In Cambodia, for example, the UNFPA country office has been using annual conferences of provincial governors and district health authorities,<sup>34</sup> among other things, to publicize and discuss newly generated data. As mentioned in the answer to the evaluation question 9, it has been also UNFPA long-term and well-established partnership with the National Committee on Population and Development (NCPD) that is making this type of evidenced-based advocacy possible.

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<sup>29</sup> Often called “situation analyses” or “assessments” (such as “skilled birth attendants assessment”; “EmONC assessment”, etc.).

<sup>30</sup> On the description of the different types of dialogues between UNFPA country offices and their partner governments, please also see evaluation question 9 on the development of maternal health policy frameworks.

<sup>31</sup> See evaluation question 9 on UNFPA support to the development of maternal health policy frameworks.

<sup>32</sup> See evaluation questions 9 for details.

<sup>33</sup> See evaluation question 9.

<sup>34</sup> I.e., the “Population and Development Annual Meetings” (five meetings in each region) by NCPD that attract participation of Governors, provincial, district and commune councillors (see evaluation question 9 on policy frameworks).

**Table 37: Contributions of reproductive health country sub-programmes to increased availability of accurate and sufficiently disaggregated data for targeting most vulnerable groups**

Countries	Specific definition of “most vulnerable” in country	Increased availability of disaggregated data for targeting “most vulnerable” through UNFPA support	Availability of monitoring and evaluation data on most vulnerable groups	Demand for and use of data (in particular by government)
Burkina Faso	(-) No specific definition (all rural population considered vulnerable)	(+) Support of macro surveys (DHS) and situational analyses regarding <u>maternal health</u> : Support of Demographic and Health Surveys (DHS) in 2003 and 2011; UNFPA supported situational analyses regarding provision of services for reproductive health (EmONC, etc.) and socio-behavioral studies in reproductive health.	(-) Monitoring indicators stem from National Health Information System (NHIS) and are collected at health district level. However, HMIS does not disaggregate results among most vulnerable groups	(+) <u>Demographic and Health Survey results and situational analyses used in national planning</u> ; i.e., situational analyses will inform national planning process coordinated by Ministry of Health through Department of Maternal and Child (DSME).
Cambodia	(-) “Vulnerability” not defined for maternal health; only for HIV/ AIDS	(+) UNFPA support of census, training of staff, other specific assessments/ <u>situational analyses</u> : UNFPA supported census provided trends of maternal mortality ratio based on administrative, geographic, income and remote area differentials; Funded training of 144 staff members of the National Institute of Statistics (NIS) to do secondary analysis of data disaggregated by urban/ rural, gender and wealth quintile (poor and poorest) of both census and DHS; Inter-agency assessment on vulnerability and sexual and reproductive health (2011) with implications for expanding maternal health services to MARP.	[No information]	(+) <u>Various uses/ dissemination channels for disaggregated data on maternal health</u> , e.g., to develop costing tools to expand service to rural, remote and poor areas, health equity funds for poor (HEF) and voucher schemes (with UNFPA support; part of National Reproductive Health Programme); High-level annual conference of provincial governors and district health authorities in five regions conducted by the National Committee on Population and Development (NCPD) to disseminate and utilize reproductive health/ maternal health data. <sup>35</sup>
Ethiopia	(+/-) Vulnerable in maternal health: “female domestic workers, migrants (national and international) <b>hard to reach by the health</b>	(+) Support of the DHS and census helped to identify specific vulnerable groups and include data on HIV/AIDS/ sexually transmittable infections and maternal mortality.	[No information]	(+/-) UNFPA reproductive health programme aligned with Government priorities; data used for Government priority setting

<sup>35</sup> UNFPA supported dissemination of Cambodian DHS data at “operational district” level in past two cycles (2005 and 2010)

Countries	Specific definition of “most vulnerable” in country	Increased availability of disaggregated data for targeting “most vulnerable” through UNFPA support	Availability of monitoring and evaluation data on most vulnerable groups	Demand for and use of data (in particular by government)
	<b>services</b> , out of school youth” (according to National Reproductive Health Strategy); previous definitions covered “all women and children” (too broad)			
Ghana	(-) Population groups not defined as “vulnerable” by Ministry of Health or UNFPA but rather as target groups based on their health and social needs (e.g., women suffering from fistula”)	[No information]	[No information]	[No information]
Kenya	(-) Broad / unspecific definition of vulnerable groups: e.g., “women, girls, youth, extremely poor, disabled and elderly etc. or <b>according to geographical location, such as remote, hard to reach, or urban slums population</b> ”. Assumption that “more vulnerable groups will be in hard to reach, rural areas	(+) Intensive and long-standing support of macro-surveys (DHS): UNFPA-supported surveys have collected information on maternal mortality, antenatal visits, delivery in health facilities, etc.; disaggregation based on “urban/ rural”, and other socio-economic and demographic data down to province levels	[No information]	[No information]
Lao PDR	(+/-) Common country assessment definition: “women, children, young people and <b>rural populations, particularly those in remote communities</b> and from	(+) <u>Support of various macro-surveys and other analyses on maternal health</u> : Lao PDR Reproductive Health Survey (LRHS) 2005 (disaggregated data by level of education, urban / rural, access to transport / roads, regions, provinces); Skilled birth	(-) UNFPA monitoring system not designed to track whether needs of vulnerable groups have been addressed	(+) Various assessments undertaken with UNFPA support allowed generating evidence for more targeted programming towards remote areas and small ethnic groups; assessments were tied to long-term initiatives (SBA, etc.) and

Countries	Specific definition of “most vulnerable” in country	Increased availability of disaggregated data for targeting “most vulnerable” through UNFPA support	Availability of monitoring and evaluation data on most vulnerable groups	Demand for and use of data (in particular by government)
	smaller ethnic groups”	attendance (SBA) assessment (2008) <sup>36</sup> , PEER Study (2008) <sup>37</sup> ; EmONC assessment (MHTF, 2011) <sup>38</sup>		demand by Government
Madagascar	(-) Broad definition, not operational: “pregnant women, pregnant teenagers, adolescent girls, youth, mothers, newborn, and women with fistula etc. or according to <b>geographical location, such as ‘remote’ or ‘hard to reach population’</b> ”.	(+) Support of various macro-surveys and other assessments for maternal health: Demographic and Household Survey (DHS), etc.	[No information]	(+/-) Data often dispersed; not stored in central location, which makes accessing difficult
Sudan	(-) No definition/ operationalization of term in Sudan; instead geographic targeting: Within five focal states (outside of Darfur), UNFPA has provided maternal health support without attention to particular demographic groups	(+) UNFPA has financed/ carried out large number of additional needs assessment and ex-ante studies; covering maternal and reproductive health overall, as well as specific areas, such as EmONC, family planning and reproductive health commodity security (RHCS)	(-) No results monitoring of UNFPA projects (see evaluation question 8)	(+) Assessments used to inform UNFPA programming; and to show gaps in service provision to influence/ lobby for changes in governmental priorities, at national level, but also in particular at the level of UNFPA focal states
Zambia	(-) Concept of “most vulnerable” not operationalized / applied by UNFPA; instead geographic targeting (focusing on lower performing provinces <sup>39</sup> )	(+/-) Logistical and financial support of macro-level surveys (census, DHS) & some other specific assessments (e.g. fistula assessment,	[No information]	(-) Country office has not followed up on promoting the use of the findings from survey; or other socio-economic studies in maternal health relevant factors

<sup>36</sup> The skilled birth attendance assessment allowed drawing a clear picture of existing services, e.g., coverage, human resources, facilities and training. The assessment also provided information on the services that needed to be reinforced, particularly in rural areas.

<sup>37</sup> The PEER study focused upon ethnic and rural women’s perceptions and needs related to reproductive health.

<sup>38</sup> The EmONC assessment looked at coverage, access, utilization and referral systems for EmONC services.

<sup>39</sup> Based on percentage of births attended by skilled personnel.



### **Judgment criterion 1.3: Needs orientation of planning and design of UNFPA supported interventions**

The role and significance of country programme action plans (CPAPs) in needs-oriented planning and design of UNFPA supported interventions varies<sup>40</sup> between countries; and the quality of the CPAPs differs significantly regarding this issues. Whereas some CPAPs identify and name the most vulnerable groups, explain the rationales for identifying these groups as most vulnerable and align their reproductive health strategies with the specific groups, other CPAPs do not provide any disaggregation of the vulnerable groups at all and either refer to vulnerable groups as a whole or to a very superficial breakdown by sex and age (women, men, young people). Positive examples are the CPAPs of Ivory Coast, Ethiopia and Nepal, which initially identify the most vulnerable groups and then align the reproductive health strategies with their needs and constraints. Moreover, Nepal is the only case that provides a specification of vulnerable groups by their social status regarding the caste system in the country. Many CPAPs, however, rather focus on HIV than on maternal health issues and thus specify groups primarily by their vulnerability to HIV.

However, beyond the CPAP, country offices generally carry out, finance and technically support a host of other studies and macro-surveys that in principle can be used to inform their own programming; and to inform policy advocacy with their partner governments:

- All country programmes visited during the field phase of this evaluation had provided some form of support to national censuses and national Demographic and Health Surveys (DHS). In its most limited form, this support took the form of financial contributions, logistical support (i.e., with printing, or the organization of dissemination workshops) and limited dialogue on the inclusion of certain indicators.<sup>41</sup> Other country offices (e.g., Sudan, Madagascar) took a leading role in the implementation of these types of surveys, and were responsible for most of the aspects of the large scale assessments.<sup>42</sup>
- In addition, most country offices also implemented or carried out additional socio-economic, socio-cultural or socio-behavioral studies (see judgment criterion 1.2 for details).

While the practice of supporting macro-level surveys and other situational analyses, etc. was standard practice in country programmes,<sup>43</sup> country offices more strongly differed in how they were able to use the findings from studies to support evidence-based and needs-based programming of their partner governments and to develop targeted at the needs-based projects themselves.

- The country offices that performed best in relation to needs-based targeting were able to use data and findings from macro-level surveys or from other socio-economic or socio-cultural studies to advocate with their partner governments at national level for policy changes or programmes that were specifically directed at the needs, barriers to access or other challenges of certain demographic groups, i.e., women below poverty level, communities in remote areas, etc. This can be labeled as a form of socio-economic targeting, i.e. the focusing of UNFPA efforts on improving the situation of one particular socio-economically defined population group. One example is the use of the skilled birth attendance assessment and a complementary PEER study of the country office in Lao PDR to advocate for the provision of delivery incentives for midwives in remote areas and the initiative to make available free assisted delivery to women in lowest health quintile.<sup>44</sup>

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<sup>40</sup> Along with the annual work plans (AWP), UNFPA country programme action plans (CPAPs) are the basis for the implementation of the Fund country programmes. Thus, CPAPs should identify maternal health needs and constraints of (most) vulnerable and disadvantaged groups and develop specific and customized strategies.

<sup>41</sup> This kind of limited involvement occurred for example in Zambia.

<sup>42</sup> E.g., in Sudan.

<sup>43</sup> See above; all country offices supported data collection activities in some form or another.

<sup>44</sup> See evaluation question 7 (EmONC) and evaluation question 9 (policy frameworks) for details

Another example is UNFPA promotion of the idea of an emergency obstetric and newborn care (EmONC) subsidy in Burkina Faso.<sup>45</sup> In these cases, UNFPA advocacy with the government was also aided by the well-established long-term relationships that the UNFPA country offices had developed with key government agencies.<sup>46</sup>

- The weakest examples of use of evidence for needs-based targeting are characterized by the hesitance of country offices to use findings from macro-surveys or other studies to advocate for addressing the needs of a particular socio-economic group; and to limit the use of data to merely geographic targeting, i.e. of selected provinces, districts or states with the highest incidence of maternal deaths, or other low-performing maternal health indicators. The clearest example of this kind of limited, merely geographic targeting is the UNFPA country programme in Zambia, where UNFPA merely has used demographic and health data from macro-surveys to select three focal provinces for its maternal health programme.<sup>47</sup> However, in particular in the recent past, i.e. the last 2-3 years, the country office has not used findings from surveys or studies to lead advocacy for policy changes that would benefit those groups in the country that have had the greatest difficulties in accessing maternal health services.<sup>48</sup> Another example is the targeting approach in Kenya, where UNFPA, in coordination with the Government, used maternal health data to select its focal districts and target sites; but has not used data to advocate for targeting of specific, disadvantage demographic groups that have had the greatest difficulties in accessing maternal health services.<sup>49</sup>

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<sup>45</sup> See evaluation question 7 (EmONC). Other possible examples are the UNFPA advocacy for funding and extension of the existing midwifery programme in Cambodia.

<sup>46</sup> As discussed in evaluation question 9 on UNFPA contributions to integrating maternal health in national policy frameworks and evaluation question 7 on EmONC.

<sup>47</sup> I.e., for direct cooperation with the local authorities to support maternal health and reproductive health service provision.

<sup>48</sup> In Zambia, these would be, for example, women in rural, remote communities that have difficulties to access health facilities due to large distances, lack of transportation, lack of accommodation at health facilities, etc.

<sup>49</sup> Interestingly, the UNFPA reproductive health programmes in Kenya and Zambia are also similar in another aspect: Staff in both country offices had assigned a lot of importance to following the priorities of the respective governments and to determine details about UNFPA reproductive health programme in response to specific requests from their partner governments. As a result, both programmes had become relatively fragmented over time and had not been able to define a coherent strategic framework that would bind their individual projects together, and ensure their consistency and accumulated effectiveness over time. The difficulties that these programmes have had to use research data to advocate for amendments of national strategies on behalf of specific groups can also be explained on the basis of this factor.

**Table 38: Contributions of reproductive health country sub-programmes to needs orientation of planning and design of UNFPA supported interventions**

Countries	National policies reference maternal health specific data (collected with UNFPA support)	Interventions (other than policies) include specific & customized strategies to address needs of specific vulnerable groups/ most vulnerable	Targeting mechanisms	Overall assessment of needs oriented planning and programming as facilitated by country office
Burkina Faso	(+) Adoption of EmONC subsidy policy (2006); and its implementation (2006 / 07) Supporting data set: [No information]	(+) Use of studies to design interventions; and technical support to build capacity of local authorities for needs-based planning fistula treatment among marginalized women; based on initial fistula assessment (2004); subsequent module development and management of cases Capacity support / technical support of regional health and district health plans (part of basket funding mechanism) <sup>50</sup> .	<u>Geographic targeting</u> , i.e. by States (Sahel, East and Central East) <u>Socio-economic targeting</u> (e.g., for EmONC subsidy; fistula treatment)	(+) Contribution to data availability; data used in policies (e.g., EmONC subsidy policy); influences socio-economic targeting (EmONC subsidy) and geographic targeting
Cambodia	(+) Fast Track Road Map for Reducing Maternal and Newborn Mortality (2010-2015) targets all peri-urban and rural <i>operational districts</i> showing poor performance (data source for planning not provided)	(+) Repeated use of midwifery review (2007) to advocate for funding and extension of midwifery programming	<u>Geographic targeting</u> , i.e., by promoting the expansion of the National Safe Motherhood Action Plan (2001 – 2005); and Community-Based Distribution Programme to small towns and rural/ remote areas	(+) UNFPA country office has been highly strategic in how it conducts and utilizes needs assessments/ reviews to get attention for planning and designing its pro-poor interventions.

<sup>50</sup> As part of decentralization, each health district in principle has ability to track performance of health facilities and plan its actions based on health outcomes per district, and presence of disadvantaged populations. However this type of planning required skills that none of the health districts had at the time of the evaluation, at least in part because UNFPA was not possible, due to lack of staff, to provide sufficient support to all health districts to facilitate needs-based targeting of the most disadvantaged groups within each district.

Countries	National policies reference maternal health specific data (collected with UNFPA support)	Interventions (other than policies) include specific & customized strategies to address needs of specific vulnerable groups/ most vulnerable	Targeting mechanisms	Overall assessment of needs oriented planning and programming as facilitated by country office
Ethiopia	(+) Various need assessments initiated and done by UNFPA over the years (in cooperation with Ministry of Health & partners) that form basis of Government health sector development plans, for example. <sup>51</sup>	(+) Various studies done that form basis of UNDAF and AWP Ongoing at time of evaluation was the Ministry of Health led joint (UNFPA and many other partners) facility assessment to evaluate preparedness for the new cadre of integrated emergency and obstetric surgeons (IEOS) (new health care; see evaluation question 7 on EmONC).	[No information]	(+) UNFPA contributed to increased availability of data; Country office also used data as basis for detailed UNDAF / common country assessment and CPAP formulation (also see findings from desk report); also evidence of demand-driven assessments that are linked to long-term strategy (i.e., assessment of preparedness of health facilities for new health care)
Kenya	(+) UNFPA and whole donor community has to follow national strategies; thus, needs assessments or surveys on national and regional level are collaboratively designed, planned and conducted with national and development partners. In this way, UNFPA has been supporting various needs assessments/ surveys on different topics related to maternal health <sup>52</sup> as basis for national programming	(-) Fragmented UNFPA projects (although following Government priorities) targeted identified groups; but were too fragmented to make a contribution: Country office implemented reproductive health programme as discrete projects spread in nine districts with an array of areas <sup>53</sup> but with no provisions for projects to link up.	<u>Initially</u> : fragmented projects in nine districts; Selection of four sub-national implementation sites, to become “Centers of Excellence”	(-) Sufficient data for needs-oriented planning available (compiled also with UNFPA support), governmental strategy is based on these assessments, i.e. is needs oriented. However, UNFPA country office has found it challenging to define an appropriate niche for in particular its sub-national support in the past; i.e. to use its support to respond to the needs of the identified target populations;

<sup>51</sup> Examples of studies include “Report on the National Situational Analysis of Pre-Service Midwifery Training in Ethiopia, 2008”, National Baseline Assessment for Emergency Obstetric & Newborn Care Ethiopia 2008, maternal health Care Seeking Behaviour in Ethiopia: Findings from EDHS 2005 National Survey on availability of Modern Contraceptives and Essential Life Saving Maternal/ Reproductive Health Medicines in Service Delivery Points in Ethiopia 2010, Ethiopia Young Adult Survey A Study In Seven Regions, 2010 Baseline EMONC survey in 2008; also UNFPA support of DHS 2005, 2011 and Census 2007”.

<sup>52</sup> E.g., the baseline assessment of obstetric fistula (2004), situation analysis ‘Contributing towards efforts to abandon female genital mutilation (2007) in Kenya’; ‘Can Community Midwives make a difference?’ (2008).

<sup>53</sup> Such as adolescent pregnancy, female genital mutilation, unsafe abortion, legal and reproductive rights, drug abuse, poverty, food security for widows and orphans, integrated reproductive health services, sexual transmittable infections, etc.

Countries	National policies reference maternal health specific data (collected with UNFPA support)	Interventions (other than policies) include specific & customized strategies to address needs of specific vulnerable groups/ most vulnerable	Targeting mechanisms	Overall assessment of needs oriented planning and programming as facilitated by country office
				relevance of “center of excellence” approach not yet determined.
Lao PDR	(+) Country office used findings from skilled birth attendance assessment; PEER Study to advocate for measures directed at vulnerable groups (delivery incentives for midwives in remote areas; free assisted delivery for women in lowest health quintile)	(+) See “policies” on left (delivery incentives; free assisted delivery) In addition, geographical focus on 10 poor districts in three Southern provinces	<u>Combination of geographic and socio-economic targeting</u> : UNFPA has selected poorest districts in three provinces for sub-national interventions; Used findings from skilled birth attendance assessment; PEER Study to advocate for measures directed at vulnerable groups (delivery incentives for midwives in remote areas; free assisted delivery for women in lowest health quintile)	(+) Demand driven studies & surveys are used for geographic targeting and national-level advocacy for support for specific demographic groups/ vulnerable groups.
Madagascar	(+/-) Country office has supported number of surveys; without direct link to policy revisions. This also has to do with current political situation, i.e., since 2009.	[No information]	[No information]	[Insufficient information to assess]
Zambia	(-) Mostly logistical and financial support to macro-level surveys and assessments, <sup>54</sup> only some socio-cultural research into barriers; Overall little follow up to ensure policy changes	(-) Priorities for programming set by Government; no clearly identifiable attempt by country office for evidence-based dialogue with Government; or evidence-based programming; no coherent strategy to address specific needs of “most vulnerable”  Support of Safe Motherhood Action	<u>Geographic targeting (sub-national level); no specific focus (in recent years) at national level</u> ; Selection of focal provinces in coordination with Ministry of Health in 2008; prior to that, no geographic targeting/ sub-national support	(-) UNFPA has provided financial and logistical support to the Zambian Government to generate data that could be used to improve the needs oriented planning of maternal health services. However, the country office has generally not followed up on the actual use of the data, but has left the definition of

<sup>54</sup> E.g. needs assessment on fistula (basis of fistula programme; financial contribution to ‘Comprehensive Training Needs Assessment on Education and Practice of Nursing and Midwifery’ (2009, not MHTF).

Countries	National policies reference maternal health specific data (collected with UNFPA support)	Interventions (other than policies) include specific & customized strategies to address needs of specific vulnerable groups/ most vulnerable	Targeting mechanisms	Overall assessment of needs oriented planning and programming as facilitated by country office
		Groups (initiated by UNFPA)	Some “socio-economic targeting” prior to 2008; i.e. with national advocacy for Safe Motherhood Action Groups (demand creation for reproductive health services in rural / remote areas); but not sufficient follow-up.	priorities solely in the hands of the Government. No coherent needs-oriented UNFPA programming in recent years; support fragmented in small-scale funding opportunities.

### **8.1.2 Evaluation question 2: To what extent has UNFPA successfully contributed to the improved harmonization of efforts to improve maternal health, in particular through its participation in strategic and multi-sectoral partnerships at global, regional and national level?**

#### **Judgment criterion 2.1: Harmonization in maternal health partnerships between UNFPA and United Nations organizations and the World Bank (including H4+) at global; regional and country level**

The extent of harmonization of maternal health support depends largely on the quality of the overall coordination mechanisms that UNFPA and its partners have employed. Apart from UNFPA participation in the UNDAF process, the most relevant mechanisms that UNFPA is party to are sector-wide approaches in health and United Nations (UN) joint programmes that, in partnership with agencies such as the World Health Organization (WHO) or UNICEF, are also used to channel the UN contribution to health sector-wide approaches (SWAp).<sup>55</sup>

The country case studies show that UNFPA successful contributions to harmonization mechanisms associated with health SWAp depended in large part on the ability of country offices to make quality technical contributions to the respective technical working groups and other coordination bodies.<sup>56</sup> In other words, country offices that were successful in advancing harmonization in maternal health did so because they were able to use SWAp coordination mechanisms and other policy platforms<sup>57</sup> to help launch the review of drafting of policies, or other high level strategies that, apart from being picked up by national governments, also attracted the support of other development partners.<sup>58</sup> Some of the best examples that illustrate how UNFPA has been able to advance aid harmonization in this way are its support of the maternal, newborn and child health package in Lao PDR;<sup>59</sup> or its involvement in the Health Sector Support Programme (HSSP) I and II in Cambodia that the UNFPA country office used to advocate along with its partners for the set-up of the Health Equity Fund (HEF) or, more recently, for the development of an emergency obstetric and newborn care (EmONC) scale-up plan (financed with MHTF support) that has attracted widespread support from development partners.<sup>60</sup>

Both of these cases display a number of similarities that are logically linked to the eventual effects on aid harmonization:

- In both cases, the UNFPA country offices have participated in the respective coordination forums actively, consistently and regularly: Both country offices used the membership in these bodies to promote specific initiatives over a longer period of time, which allowed the UNFPA teams to earn credibility and trust among development partners.<sup>61</sup>

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<sup>55</sup> See also findings from desk report of this evaluation.

<sup>56</sup> This corrects a finding from the desk phase that suggested that UNFPA actual contribution to aid harmonization through its participation of these aid modalities was less dependent on UNFPA technical expertise in maternal health, but much more tied to the practical experience of UNFPA staff when working with these aid modalities, including its practical experience in squaring UNFPs internal administrative and fiduciary rules with the funding regulations of pooled funds, sector-budget support arrangements, etc.

<sup>57</sup> I.e., technical working groups, high level policy fora, etc.

<sup>58</sup> UNFPA success in advancing harmonization has therefore been closely linked to the success of its country offices to advance the integration of maternal health into policy frameworks in its programme countries (see evaluation question 9).

<sup>59</sup> See evaluation question 9, judgment criterion 9.2 for more information on the strategy of the UNFPA country office in Lao PDR to contribute to the development of the maternal, newborn and child health package.

<sup>60</sup> See evaluation question 7 in this report or the respective evaluation question in the final report of the MHTF mid-term evaluation for more information on the contributions of the EmONC assessment in Cambodia to the EmONC scale-up plan. See Annex B for a comparative analysis of the contributions of individual country offices to maternal health aid harmonization.

<sup>61</sup> Trust and acknowledged expertise of UNFPA among development partners in Cambodia is also illustrated by the fact that at time of evaluation, UNFPA served as the Chair of HSSP II and had taken the lead on maternal health

- In both cases, UNFPA used findings from research and data that helped to generate to flag gaps or other deficits in the national maternal health situations: In Lao PDR, the UNFPA country office financed the skilled birth attendance assessment of 2008, which is seen as a first step towards the development of a maternal health strategy.<sup>62</sup> In Cambodia, the country office made repeated use of the midwifery review of 2007 it had carried out, i.e., to advocate for increased funding and the extension of midwifery programming in the country, e.g., to lobby for the financial incentives for deliveries for skilled birth attendants. The MHTF-funded EmONC assessment played an important role for flagging deficits in the national EmONC situation in Cambodia.<sup>63</sup>
- Also in both cases, country offices had maintained lasting relationships with important governmental stakeholders and utilized these relationships to ensure that partner governments sustained and even increased their support of the initiatives they promoted among donors.<sup>64</sup> This increased the standing of UNFPA in donor coordination forums; and helped the country teams to convince donors to sign up to support the related initiatives.

In contrast, many of these characteristics were missing from UNFPA policy campaigns in countries, where UNFPA has not been able to mobilize much support among development partners to support joint initiatives. In Kenya, for example, although UNFPA was a member of some donor coordination groups, the country office overall was perceived to be absent from a number of key forums by development partners; and also was not known for having initiated the creation of mechanisms for harmonization.<sup>65</sup> In Zambia, UNFPA was formally member of most relevant coordination forums, but had a poor attendance record<sup>66</sup> and also was perceived to be little pro-active in launching policy campaigns that development partners could support.<sup>67</sup>

Technical, evidence-based advocacy helped UNFPA country teams like Cambodia, but also Burkina Faso,<sup>68</sup> to create opportunities to further the harmonization of maternal health support around specific policy initiatives (see above). At the same time, UNFPA internal financial and administrative procedures presented have made it challenging for these country teams to remain a closely integrated members of the aid harmonization mechanism that had made these joint policy initiatives possible in the first place. In Burkina Faso, UNFPA specific fiduciary and administrative procedures have regularly led to delays of its contributions to the basket fund that had been set up to finance the implementation of the national “Programme d’Appui pour le

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issues. Also, feedback from development partners in Cambodia showed that UNFPA was using the technical working groups as a channel for advocating for its EmONC initiative: “We came to know about [the EmONC assessment] because of UNFPA involvement in Technical Working Group on Health” (interview with development partner).

<sup>62</sup> See evaluation question 9 on maternal health integration into policy frameworks; also, see Annex B

<sup>63</sup> E.g., in Cambodia, where the EmONC improvement plan has been taken up as a priority in HSSP II, development partners stated that “UNFPA has helped fund the EmONC assessment and the quality is good so we are using them” (interviews with development partners). See evaluation question 7 for details.

<sup>64</sup> E.g., to promote the maternal, newborn and child health package in Lao PDR, UNFPA had organised a series of advocacy events of different type; first to bring government officials on board and to convene a national workshop to decide on the need to conduct a national skilled birth attendance assessment; then to analyse the results of the assessment and to discuss the subsequent steps (see evaluation question 9 on policy frameworks).

<sup>65</sup> Interviews with development partners.

<sup>66</sup> See evaluation question 11 on the issue of country office capacity and its implications for being able to attend coordination meetings, etc.

<sup>67</sup> See evaluation question 9 on framework. One example from Zambia that can illustrate how differently the UNFPA team was set up to promote donor harmonization is the attempt of the country office to launch a reproductive health commodity security committee to oversee the management of reproductive health commodities on the behalf of the development partners and the Government. Other than similar activities in Cambodia, Burkina Faso or Lao PDR, the committee in Zambia was not as clearly linked to a long-term UNFPA initiative in the area of reproductive health commodity security (RHCS); was not accompanied by similar intensive advocacy attempts of UNFPA. In addition, the UNFPA country team had not established itself to the same extent as a long-term partner in donor coordination forums, on the basis of long track record of repeated technical contributions and campaigns. Consequently, the RHCS committee stopped functioning after only four meetings, when important governmental and development partners did not maintain their interest (see evaluation question 6 on family planning).

<sup>68</sup> E.g., linked to the establishment of the EmONC law and EmONC subsidy in the country.



Développement Sanitaire” (PADS). In Cambodia, the UNFPA country office was considering abandoning the joint financing mechanism in place for the HSSPII at the time of the evaluation that it had just joined in 2010, because of internal procedural difficulties.<sup>69</sup> This intention had drawn significant criticism from development partners.<sup>70</sup>

By the time of the evaluation, the H4+ had not yet made a significant contribution to donor harmonization in maternal health support. This is particularly true if one considers primarily the harmonization efforts that originated from country level. Although H4+ had been launched in most if not all of the case study countries, the predominant assessment of UNFPA teams and the other partners was that the initiative had not changed the way UN agencies cooperated in any fundamental way. By and large, partners continued to work the way they had worked before the launch of H4+, and largely used the previously existing mechanisms to convene meetings.<sup>71</sup> An exception is the pilot initiative that had been launched by the H4+ partners at global level and that had led to the submission of a number of joint H4+ maternal health programmes, among other things in Zambia and Burkina Faso.<sup>72</sup>

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<sup>69</sup> This experience confirms findings from the previous desk phase of the evaluation that pooled funding mechanisms have remained relatively underused; and that in particular UNFPA internal fiduciary rules are often one of the reasons why country offices continue to rely on parallel funding (see desk phase report for details).

<sup>70</sup> See also country note on Cambodia.

<sup>71</sup> Such as the UNDAF subgroup for health in Zambia, or other previously existing coordination mechanisms.

<sup>72</sup> See country notes for information from country case studies and interviews with H4+ partners.

**Table 39: Comparison of findings from selected field phase countries – UNFPA contribution to aid harmonization in maternal health**

Countries	Primary mechanisms for aid harmonization (apart from UNDAF) in maternal health	UNFPA role in coordination / harmonization bodies (incl. funding)	Specific initiatives (selection) that have contributed to harmonization (cross-referenced from other evaluation questions)	Role of H4+
Burkina Faso	Basket fund, associated with “Programme d’Appui pour le Développement Sanitaire” (PADS), participation of France, Germany, Sweden, the Netherlands, World Bank, UNFPA); also tool to implement the Plan National de Développement Sanitaire (PNDS)	UNFPA is active participant However, UNFPA’s <u>specific procedures</u> regularly lead to delays, e.g., of its financial contributions to the basket fund	UNFPA lobbied for <u>EmONC law</u> that established the <u>EmONC grant</u> that now ensures that patients and their families pay only 20% of EmONC costs (law evolved out of maternal and newborn health road map) ➢ National policy now supported by members of basket fund (PADS) and other donors (see on left)	Recent development of joint H4+ project on maternal health, to be funded by CIDA; project developed through an initiative of MHTF team and UNFPA headquarters.
Cambodia	Health Support Sector Project I (2001-2005) and Health Systems Strengthening Programme (HSS) II (2006-2010) under aegis of the Ministry of Economy and Finance (MoEF) and World Bank.	Generally, active participation in HSSP I and II; at time of evaluation, UNFPA served as the Chair of HSSP II; has taken lead for maternal health; advocated for funding increases for maternal health  <u>Financing:</u> UNFPA began to contribute funding in 2006, by using its own discrete funding mechanism. In 2010, shifted to pooled fund; was already reconsidering decision at time of evaluation, because of internal procedural difficulties (Note: drew criticism from partners).	<ul style="list-style-type: none"> <li>• <u>UNFPA advocacy for health equity funds for poor (HEF)</u> and voucher schemes (with UNFPA support; part of National Reproductive Health Programme) (see evaluation question 1) ➢ Developing of costing tools to expand service to rural, remote and poor areas (see evaluation question 1)</li> <li>• <u>EmONC assessment / improvement plan (MHTF):</u> Within HSSP II, EmONC Improvement Plan is taking as priority: “UNFPA has helped fund the EmONC assessment and the quality is good so we are using them. We came to know about it because of UNFPA involvement in Technical Working Group on Health” and “with Ministry of Health and HSSP II support now sustainability of the Plan is assured”<sup>73</sup></li> </ul>	H4+ is functional, but UNFPA, UNICEF and WHO often meet in the country under a variety of coordinating mechanisms. Development partners did not see an urgent need to have H4 at country level; H4+ has not yet contributed to more harmonized maternal health support among partners; is only utilized for special events such as UN Secretary General’s Joint Plan of Action on Reducing Maternal Mortality (2010) and the utilization of First Lady by the Parliamentarian Forum as a national champion for maternal health (2010-11).
Ethiopia	SWAP to support implementation of Ethiopian “Health Sector Development Programme”;	UNFPA is member in various important committees – Health, Population and Nutrition (HPN) Donor Group, International Health Partnership (IHP), Reproductive Health taskforce, Safe Motherhood Technical Working Group (TWG), family planning TWG and other sub groups.	<ul style="list-style-type: none"> <li>• UNFPA reproductive health programme aligned with Government priorities; data used for Government priority setting (see evaluation question 1); Suggesting less opportunities for UNFPA country office to launch initiatives independent of Government-owned ones that could have harmonizing effect ➢ Still, some positive effects on</li> </ul>	H4+ group constituted in Ethiopia; H4 partner have agreed on division of labour, albeit under UNDAF; without specific reference to H4+ concept.

<sup>73</sup> Feedback from external development partners

Countries	Primary mechanisms for aid harmonization (apart from UNDAF) in maternal health	UNFPA role in coordination / harmonization bodies (incl. funding)	Specific initiatives (selection) that have contributed to harmonization (cross-referenced from other evaluation questions)	Role of H4+
		<p>Country office has gained status of regular member in Joint Core Coordinating Committee Meeting</p> <p>However, staffing bottlenecks prevent country office from fully participating in all TWGs (see evaluation question 10)</p> <p><u>Financing:</u> UNFPA used US\$1 million (MHTF funds) to contribute to pooled fund associated with SWAp, which secured its position in SWAp coordination and policy dialogue structure<sup>74</sup></p>	<p><u>harmonization:</u> e.g.; “Joint In-Country UN (WHO, UNFPA and UNICEF) Concept Paper on Reduction of Maternal and Newborn Mortality focused on need for concerted effort to increase access to skilled birth attendance, EmONC and family planning” (see evaluation question 7)</p>	
Ghana	<p>Health SWAp existing; however, with only World Bank and UNFPA as active partners (at time of evaluation), as attention has shifted to multi-donor budget support; no SWAp meeting convened since 2008</p>	<p>Active participation of UNFPA country office in various coordination/ harmonization bodies: quarterly business meetings with UN agencies and bi-annual national Health Summit; Also an active member of Health Sector Working Group (co-chaired by Ministry of Health and WHO). UNFPA co-chairs the Sector Working Group on Data Collection and monitoring and evaluation with National Development Planning Commission (NDPC), which it helped set up</p>	[No information]	<p>There are meetings held under the H4+ (includes UNAIDS) but not referenced as such for the agencies still meet under all the numerous coordination mechanisms currently existing among development partners. UNFPA continues to work most closely with WHO and UNICEF but does not pool funds with either of them.</p>
Kenya	<p>Donor contribution has been strongly regulated by Government; All higher coordination mechanisms chaired by representatives of line ministries. SWAp is existent in theory, while no basket funding on a large scale exists.</p>	<p>UNFPA member of some coordination group; however absent from some key ones; has not taken initiative to launch mechanisms for coordination, harmonization, joint programmes: UNFPA country office absent from many key coordination bodies and mechanisms, i.e. H4+ group;<sup>75</sup> also not invited to join new working group on “reproductive</p>	[No information]	<p>H4+ present; led by UNICEF; with varying UNFPA participation</p>

<sup>74</sup> See separate report of the MHTF mid-term evaluation.

<sup>75</sup> Group is led by UNICEF; UNFPA was reported to be absent to some important meetings by development partners; disputed by Kenya UNFPA country office.

Countries	Primary mechanisms for aid harmonization (apart from UNDAF) in maternal health	UNFPA role in coordination / harmonization bodies (incl. funding)	Specific initiatives (selection) that have contributed to harmonization (cross-referenced from other evaluation questions)	Role of H4+
		health programme business plan design".		
Lao PDR	Joint funding of maternal, newborn and child health (MNCH) package (introduced with UNFPA support) <sup>76</sup>	<p>Strong UNFPA support to development of maternal, newborn and child health package (see evaluation question 9 on policy frameworks), which serves as vehicle for aid harmonization and alignment.</p> <p>Active country office participation in associated technical working groups (created in 2008); mechanism itself is still experiencing some difficulties (lack of horizontal coordination).</p> <p><u>Recent joint programme</u> (UNFPA, UNICEF, WHO and WFP), funded by the Grand Duchy of Luxembourg, designed to support Ministry of Health implementation of the National Integrated Package of MNCH Services. UNFPA responsible for midwifery education and training.</p>	<ul style="list-style-type: none"> <li>• Various assessments undertaken with UNFPA support allowed generating evidence for more targeted programming towards remote areas and small ethnic groups; assessments were tied to long-term initiatives (skilled birth attendance, etc.) and demanded by Government (see evaluation question 1)</li> </ul>	H4+ not very significant mechanism in Lao; cooperation of nominal H4 partners predates introduction of H4 concept.
Sudan	Few opportunities have existed for donor harmonization independent of Government. Existing coordination meetings dominated by Sudanese Government. No pooled/ basket funding; no reproductive health policy to be supported by development partners	Some loose cooperation with partners like JICA, WHO; e.g., with WHO on human resources for health/ midwifery; however, <u>without support from well-established coordination bodies</u> .	<p>Assessments used to inform UNFPA programming; and to show gaps in service provision to influence/ lobby for changes in Governmental priorities, at national level / at the level of UNFPA focal states (see evaluation question 1).</p> <p>BUT: no well-established coordination bodies (see on left) that would allow donor harmonization (outside of Government sanctioned forums) (see on left)</p>	Practical significance of the H4 group in Sudan has been low. The group had only been organized a few months prior to evaluation, by WHO. However, at the time of the evaluation, the initiative had not yet translated into any concrete joint interventions or other joint initiatives.
Zambia	SWAp structures are the main and most inclusive multi-lateral forum in Zambia for coordination and harmonization between Zambia Government, development partners,	UNFPA is formally a member of all of SWAp groups. However, its attendance has been relatively irregular and in most groups, UNFPA did not stand out as a vocal,	<u>Country office has not followed up</u> on promoting the use of the findings from survey; or other socio-economic studies in maternal health relevant factors (see evaluation question 1)	H4+ concept in Zambia provided some motivation to intensify an already ongoing cooperation between UN agencies in maternal health, for most part due to submission of two

<sup>76</sup> See Evaluation question 9 on policy frameworks in this report.

Countries	Primary mechanisms for aid harmonization (apart from UNDAF) in maternal health	UNFPA role in coordination / harmonization bodies (incl. funding)	Specific initiatives (selection) that have contributed to harmonization (cross-referenced from other evaluation questions)	Role of H4+
	and civil society. They include, amongst other things, a "Sector Advisory Group", a "Cooperating Partners (CP) Group" and a large number of thematic technical working groups and sub-groups.	pro-active contributor. At least in part, this has been due to severe staffing bottlenecks at the country office. In the case of the family planning technical working group that has been led by UNFPA, its attendance and input was more regular and appreciated by the members.	Demise of RHCS committee in Zambia: Lack of support among development partners and Government (see evaluation question 6)	joint programmes of H4+ partners (initiated by H4+ at global level). The H4+ group was formally constituted in 2009 and consists largely of UN agencies that had already been cooperating under the UNDAF subgroup for health. Group continues to meet as the UNDAF subgroup, and does not convene meetings under the H4+ label.

## **Judgment criterion 2.2: Harmonization of maternal health support through partnerships at country and South-South/ regional**

UNFPA had intended to contribute to a more harmonized and intensified support to maternal health in African programme countries by engaging in the promotion of the Maputo Plan of Action, and its translation into national-level maternal and newborn health road maps.<sup>77</sup> However, the extent to which the national maternal health road maps were able to contribute to increased harmonization of support to maternal health at country level depended on the extent of their operationalization, i.e., the creation of operational plans, and mechanisms for implementation and monitoring and evaluation on the basis of the road maps; and their actual integration in health sector policies.

The desk phase of this evaluation had already found that the Maputo road maps had only been operationalized in a minority of countries,<sup>78</sup> a finding that is supported by the results of the field phase of the evaluation, as most of the country case studies in African countries found that the Maputo road maps had either not been operationalized, or had been operationalized with significant delay.<sup>79</sup>

Turning the maternal health road map into a widely accepted and supported strategic document to guide government investment and harmonize donor support to maternal health was difficult and often did not happen. In many of the case study countries, this is linked to the fact that the Maputo maternal health road map was essentially “superimposed” on already ongoing policy making processes and existing policy frameworks, policy making processes, and it was not clarified, neither by government, nor by UNFPA or other development partners, how these different policy frameworks should be unified.<sup>80</sup> “Integration” of the Maputo road map with existing policy frameworks often therefore happened merely nominally, in a very general and formulaic way. In Madagascar, for example, the maternal health road map had already been developed in 2004/ 05. However, it was never operationalized, in that the Government or development partners developed concrete projects or programmes to put the road map into action. Instead, the objectives of the road map were picked up in the H4+ business plan that was developed 5 years later and also in the UN own strategic vision – again, without specifying the operational implications of the road map for either UNFPA or its partners. Similarly, the maternal health road map in Zambia was “integrated” (i.e., referred to) in the Government “National Health Strategic Plan” (2006 – 2010), but again, without stating any of the operational implications that would arise from this additional strategy. In addition, UNFPA did not actively promote the road map as a central document for donors to rally around, with the result that it was virtually unknown among development partners, and thus had no effect on the extent of aid harmonization in the donor community.

The country case studies also found that capacity challenges related to the implementation of the road map have kept the maternal health road maps from becoming a relevant strategy for guiding harmonized maternal health support among development partners. For example, the Ethiopia country case study cites the necessarily limited absorption capacity of the Federal

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<sup>77</sup> As discussed in the desk report of this evaluation, UNFPA support of the Maputo initiative might have helped to create new opportunities for harmonizing donor support along the new national maternal health road maps as a focal point for donor support.

<sup>78</sup> A minority of countries (16 out of 35 responding) had a plan for scaling-up or an operational plan at the district level. Several strategic elements of maternal health planning have still to be developed and incorporated in the existing maternal health road maps of a number of countries, in particular EmONC planning, Human resources planning and monitoring and evaluation (UNFPA, 2009).

<sup>79</sup> In Ethiopia, the Maputo road map, along with other similar plans was shelved before being endorsed; In Kenya, the translation of the Maputo road map from policy or strategy to operational plan was not addressed, neither by Government, nor by development partners; In Madagascar, the Maputo maternal health road map was already developed in 2004; but since then had not been operationalized; in Zambia, the road map also was not operationalized (e.g. not costed); and was largely unknown among development partners.

<sup>80</sup> This was the case, for example, in Ghana, Kenya, Madagascar and Zambia.

Ministry of Health as one of the reason for the delayed endorsement of the strategy. In principle, the process of adapting the Maputo Plan of Action to national contexts had not systematically considered the existing capacities of the national governments or of the donor community that is present in a country for absorbing, translating and funding these strategies.<sup>81</sup> A more extreme case that illustrates this omission in the process is Sudan: Here, the Maputo process and the corresponding Sudanese maternal and newborn health road map that was developed with UNFPA support have only little potential to significantly increase the degree of aid harmonization in Sudan. The main limiting contextual factor is the low presence of international donors in the country and the corresponding low availability of donor resources that could be used to fund the US\$118 million of required external resources.<sup>82</sup>

Nonetheless, UNFPA experience in other countries has shown that investments into the promotion of high-level maternal health strategies can help to mobilize support of these strategies by other donors; and that it thereby can contribute to an increased harmonization of donor support to maternal health. In Lao PDR, for example, the UNFPA country office had spent significant effort on technical support and advocacy to promote the Integrated Package of Maternal, Neonatal and Child Health (MNCH) Services 2009 – 2015. The Strategy and Planning Framework for MNCH package provides clear directions that development partners have begun to use to harmonize their support. Moreover, UNFPA plays a key role in technically supporting the Ministry of Health programming at national level and supporting the implementation of the package in collaboration with the other development partners”.<sup>83</sup>

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<sup>81</sup> This is the case for Zambia, Madagascar, Kenya, Ethiopia, for example.

<sup>82</sup> The projected costs to implement the strategy exceed the estimated amount that is currently spent on reproductive health by the Sudanese Government by a factor of approximately 165. While the projected costs for implementing the Maternal and Newborn Health Road Map is US\$118 million, the estimated amount spent on reproductive health annually is US\$236,000, or 0.3 percent of Sudan's annual health budget of approximately US\$ 79 million, according to estimates of the Health Economics Department of the federal Ministry of Health.

<sup>83</sup> The MNCH package is the key strategy for maternal health and was developed with WHO and UNFPA as well as other partners' support. All development partners are harmonizing their support based on this strategy. It is integrated in the Health Sector Plan which is also coordinated under the sector working group. See evaluation question 9 in this report for more details on UNFPA role in advocating for this strategy.

### 8.1.3 Evaluation question 3: To what extent has UNFPA support contributed to a stronger involvement of communities that has helped increase current levels of demand and utilization of services, in particular through its partnerships with civil society?

#### Judgment criterion 3.1.: Governments commitment to involve communities translated in sexual and reproductive health and maternal health strategies through UNFPA support

UNFPA country offices have utilized a variety of approaches to facilitate the increased involvement and empowerment of communities in maternal health planning, management and awareness raising. The range of concepts include *community conversations*,<sup>84</sup> community based maternal health committees, such as *Safe Motherhood Action Groups (SMAGs)*,<sup>85</sup> the use of Community Health Workers (CHWs) or community midwives,<sup>86</sup> or the mobilization of traditional leaders, such as elders, chiefs, traditional initiators or others.<sup>87</sup>

In some countries, UNFPA choice of mechanism for community involvement was determined primarily by the prevailing strategies of the respective partner governments. In Kenya, for example, community dialogues and the mobilization of traditional leaders were both components of the official strategies of the relevant line ministries.<sup>88</sup> However, more often, UNFPA country offices have played important roles in shaping the official strategies for community involvement in programme countries. In some cases, popular participation and empowerment were parts of larger maternal health strategies whose development had been promoted by UNFPA. In Burkina Faso, for example, the notion of community involvement was introduced into Governmental strategies as part of the Maputo Maternal and Newborn Health Road Map.<sup>89</sup> In Lao PDR, community mobilization is part of the national maternal, newborn and child health package, which also had been promoted by UNFPA during a comprehensive campaign.<sup>90</sup> However, UNFPA country offices also advanced specific individual concepts for community mobilization that subsequently were progressively integrated into national maternal health strategies.<sup>91</sup>

Unfortunately, UNFPA community mobilization approaches were neither thoroughly monitored nor evaluated over the last decade,<sup>92</sup> which makes it difficult to definitively determine their added value to UNFPA maternal health support. An examination of the theory of change underlying community mobilization suggests that the success of these approaches should depend in large part on their comparative ability to equally mobilize maternal health awareness of beneficiaries, empower communities to assist individuals and families in emergencies and finally, to link communities, families and individuals to the resources that are available in the health system, to

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<sup>84</sup> For example in Ethiopia and Kenya.

<sup>85</sup> E.g., in Zambia.

<sup>86</sup> E.g., in Kenya or Sudan.

<sup>87</sup> E.g. in Kenya, Sudan, Zambia.

<sup>88</sup> I.e., in the case of Kenya, the Ministry of Health, the Ministry of Gender and the Ministry of Youth.

<sup>89</sup> E.g., the as the priority strategy No. 4 of the *Plan d'Accélération de la Réduction de la Mortalité Maternelle et Néonatale*, which had been introduced to Burkina Faso primarily by WHO. However, UNFPA had supported the Maputo process at regional level.

<sup>90</sup> The Strategic Objective 3 of the MNCH package is about "Mobilizing individuals, families and communities for MNCH at different levels". UNFPA took part in the coordination of the community mobilization and awareness and demand creation interventions and the development of respective capacities at national level.

<sup>91</sup> This has been the case for the concept of *Safe Motherhood Action Groups (SMAGs)* in Zambia. The concept was introduced by UNFPA and was promoted by the country office in a comprehensive advocacy campaign with development partners and the Government. UNFPA also piloted the use of SMAGs in its own three focal provinces in Zambia (see Annex C for details).

<sup>92</sup> Country offices neither collected data on the increase of community involvement in their project areas; nor did the evaluators have access to any evaluations that singled out the contributions of community mobilization campaigns to maternal health outcomes.



make sure that once aware and assisted by their families and communities, expectant mothers can in fact access the services they require during pregnancy and delivery.

The country case studies suggest that the different approaches supported by UNFPA over the last decade have differed in their ability to tackle all of the above issues in an integrated way. The Safe Motherhood Action Groups (SMAGs), for example, that UNFPA helped to establish and continues to support in its three focal provinces, have allowed UNFPA and its implementing partners to reach communities, families and individuals with information, education, communication (IEC)/ behavioral change communication (BCC) campaigns on family planning, skilled birth attendance and EmONC and other maternal health topics, but have not helped to address some of the other significant barriers that have been preventing women from actually accessing maternal health services in health centers, such as lack of transport or the absence of lodging at health centers.<sup>93</sup> In fact, negative trends in the percentage of births attended by skilled personnel in two of UNFPA's focal provinces, i.e. North-Western and Luapula Provinces<sup>94</sup> also indicate that the presence of SMAGs might have increased maternal health-related awareness among beneficiaries, but that this increased awareness has not yet helped to increase the number of women who are seeking out professional services during their pregnancies, which allows for the possibility that the above-mentioned barriers or other factors have prevented women, families and communities from acting on their increased awareness and knowledge.

However, UNFPA has also supported community mobilization approaches that, in addition to targeting low levels of maternal health awareness, also undertook to provide communities with resources to assist individual and families throughout pregnancies and to establish closer linkages between communities and the health system. In particular its experiences in Cambodia, Lao PDR and Burkina Faso, where UNFPA has supported community mobilization through decentralized governance structures (i.e., in Cambodia), and through forms of WHO Individuals, Family and Communities (IFC) approach (i.e., in Burkina Faso and Lao PDR) suggest the importance of coupling awareness raising with the provision of complementary support to empower communities to act; and to link communities more strongly to health centers or other components of the health system:

- In particular in Burkina Faso and Cambodia, where UNFPA has facilitated the creation and strengthening of community-based organizations (CBOs), i.e., in the form of *cellules villageoises de gestion des urgences obstétricales* (Burkina Faso); and *Village Health Support Groups* (Cambodia) to organize communities and to raise awareness of individuals and families, these community-based organizations have access to additional *external resources* to help their constituents to access maternal health services if needed. In Burkina Faso, families have access to *EmONC grants* of up to 80 percent of the costs of childbirth that have effectively decreased the risk of excessive expenses, in particular for poor households;<sup>95</sup> in Cambodia, the *Village Health Support Groups* can access resources from the *Health Equity Fund*, among other things to provide transport costs to pregnant women who need to access health service.

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<sup>93</sup> Based on feedback from focus groups with SMAG members, UNFPA, development partners, local authorities.

<sup>94</sup> In two of the three Provinces where UNFPA is directly working in training and service delivery (Luapula, North-Western), the rate of births attended by skilled personnel has actually decreased between 1992 and 2007, i.e. from approximately 36% (1997) to 34% (2007) in Luapula; and from approximately 50% (1992) to 41% (2007) in North-Western Province (UNDP Zambia, 2011). These figures are based on the Zambian Demographic and Health Survey (ZDHS) from 2007.

<sup>95</sup> Based on findings from a study was carried out in Ouargaye district. The analysis was based on two distinct cross-sectional household surveys, conducted before (2006; n = 1170) and after (2010; n = 905) the policy, of all women who had had a vaginal delivery in a public health centre. Medical expenses for delivery decreased from a median of 4,060 F CFA in 2006 to 900 F CFA in 2010 (p,0.001). There was pronounced contraction in the distribution of expenses and a reduction in interquartile range. Total expenses for delivery went from a median of 7,366 F CFA in 2006 to 4,750 F CFA in 2010 (p = 0.001). The greatest reduction in risk of excessive expenses was seen in women in the bottom quintile living less than 5 km from the health centres (Ridde, Kouanda, Bado, Bado, & Haddad, 2012).

- In Cambodia, another comparative advantage of UNFPA support of community mobilization through the emerging decentralized governance structures is apparent: Here, the *Village Health Support Groups* are represented in the *Health Centre Management Committees* (also supported by UNFPA). The Health Centre Management Committees in turn are linked into Cambodia *Commune Councils* that are responsible for management the *Health Equity Fund* that families can access to finance pregnancy related expenses. This integration of committees at local level also strengthens the link between communities and the health system.<sup>96</sup>

As is detailed in evaluation question 7, both Burkina Faso and Cambodia have been able to increase the percentage of facility-based delivery over 5-6 year periods that coincide with the introduction of the above-mentioned community-based structures; and the launching of the additional support mechanisms, i.e. the EmONC grants and the HEF. It is therefore reasonable that both mechanisms are credited to have contributed to these improvements.<sup>97</sup>

**Judgment criterion 3.2.: Civil society organizations involvement in sensitization on maternal health issues and facilitating community based initiatives to address these issues supported by UNFPA**

Over the last decade, UNFPA has partnered with both national and international non-governmental organizations (NGOs) in various ways and for various purposes, and also has helped to forge closer partnerships between NGOs and its governmental partners.<sup>98</sup> More specifically, UNFPA country offices have played an active role in setting up partnerships between NGOs and governments to enable civil society organizations to play a more active role in the promotion of maternal health. Most often, this concerned responsibilities for maternal health outreach and advocacy, but also for service delivery and the management of community based delivery of contraceptives. Partnerships like this were set up by UNFPA in countries like Burkina Faso,<sup>99</sup> Cambodia,<sup>100</sup> Ghana,<sup>101</sup> Madagascar and Zambia.

At the same time, UNFPA experience has shown that partnerships with international or national NGOs are one possible, but not in all cases a necessary component of successful approaches to mobilize and involve communities in maternal health planning and service delivery. In fact, UNFPA has scaled back the support of NGOs; in an effort to increase government ownership of the related campaigns and to strengthen emerging governance structures at local levels. Among the ten case study countries, this was in particular the case in Cambodia, where UNFPA successively shifted its resources to support the Government *Community Investment Plan* and the associated representative bodies at local level.<sup>102</sup> By UNFPA third country programme

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<sup>96</sup> See evaluation question 7 (EmONC) and evaluation question 10 (integration of sexual and reproductive health, population and development and gender) on additional information on Cambodia's local governance structures, and their role in linking families to communities, and communities to the health system.

<sup>97</sup> See evaluation question 7

<sup>98</sup> UNFPA has worked with NGOs in all of the ten case study countries, even in country contexts that have been difficult for civil society organisations, such as Sudan.

<sup>99</sup> During UNFPA sixth country programme, the component 'Communication in Reproductive Health has been executed by the Directorate of Public Hygiene and Health Education (DHPES) that created partnerships with civil society organizations (CSO) for the implementation of outreach activities. Capacity building of DHPES and some NGOs and community-based organization (CBO) was part of the approach.

<sup>100</sup> UNFPA country programme II (2001-5) saw the highest funding of NGOs through non-core earmarked funding – 62% from the European Union for 5 years (Reproductive Health Initiative for Youth in Asia - RHIYA 2001-2005). Core funding of NGOs in the same years was 16.2% and 12% for reproductive health and Gender component respectively.

<sup>101</sup> E.g., in Ghana, UNFPA has supported partnerships between NGOs and Government / local authorities in issues such as emergency transport for obstetric emergencies (involving *Ghana Private Regional Transport Union* and *Time with Grandma*); the engagement of youth, Government, traditional authorities through civil society organizations (CSO) such as *Curious Minds*; or the training of doctors on fistula repair and awareness raising (involving *Ghana Health Services* and a CSO in the Northern Region)

<sup>102</sup> I.e., such as Commune Councils (CC), Village Health Support Group (VHSG), Village Health Committee (VHC), Health Centre Management Committee (HCMC), the Women and Child Health Committee (WCHC).

(2006-10) non-core reproductive health funding to NGOs was reduced drastically to 13 percent and core funding to 9 percent, from previously 62 percent of non-core funding and between 12 percent and 16.2 percent of core funding.<sup>103</sup> UNFPA has shifted finances and management responsibilities from NGOs to government also in other countries.<sup>104</sup> These changes helped to increase ownership of UNFPA partner governments of the respective programmes, but also weakened the role of civil society, not only as service providers, but also as independent advocates for maternal health concerns.<sup>105</sup>

In Lao PDR, an example of a country where no established civil society had existed for much of the last decade, UNFPA started to collaborate directly with provinces and districts to mobilize communities and to build their capacities to take action to improve maternal, newborn and child health, such as reactivation of village health committees that can manage saving funds and transportation schemes that can be issued at time of child birth or in case of emergencies. However, even in Lao PDR, the campaign has been facilitated through an international NGO (*Health Poverty Action*).<sup>106</sup>

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<sup>103</sup> Information from UNFPA country office.

<sup>104</sup> While during the 5th country programme (2002 – 2006), UNFPA had still assigned the role of “executive agency” for its PPP Programme, a programme supporting peer education, service provision and supports the role of parents in maternal/ sexual and reproductive health education, the country office transferred the responsibilities for managing these projects to the Government of Zambia with the beginning of the 6th country programme (2007 – 2010), and left only the implementation in the hands of NGOs.

<sup>105</sup> Concerns of this nature were expressed both in Cambodia and Zambia, where UNFPA had shifted support away from civil society.

<sup>106</sup> Interviews with UNFPA and implementing partners.

### 8.1.4 Evaluation question 4: To what extent has UNFPA contributed to the strengthening of human resources for health planning and human resource availability for maternal and newborn health?

#### Judgment criterion 4.1: Development/ strengthening of national human resources for health (HRH) policies, plans and frameworks (with UNFPA support)

One of UNFPA's strategies to help its partner countries to address weaknesses in their maternal health-related has been to help these countries to integrate reproductive health / maternal health issues into national human resources for health (HRH) policies and frameworks. These policy changes were meant to become the basis for Government-driven reforms of the HRH systems.

In particular during the second half of the reference period for this evaluation, UNFPA country offices were engaged in evidence-based policy dialogue on human resources for health, with the aim to ensure that maternal health-related human resource issues were considered appropriately in related policy frameworks and plans. UNFPA country offices have commonly supported the implementation of needs assessments or situation analyses of the MH-related human resource situation in partner countries. Among the country offices visited during the field phase, the UNFPA offices in Burkina Faso, Kenya, Laos PDR, Madagascar and Sudan had conducted different types of needs assessment or situational analyses of the HRH situation in their host countries, as is illustrated in Table 400.

**Table 40: Existence of HRH needs assessments**

Scenarios	Assessments used (sustainably)
No MH-related HRH needs assessments	<u>Ghana</u> : The MoH and UNFPA both use health service annual reports to determine human resource needs; no separate HRH needs assessment; Only the recent EmONC needs assessment (carried out with support from UNFPA and UNICEF) also discussed human resource shortages and needs in a set of special meetings, and the draft final report contains an entire section on human resources needs in reproductive/maternal health
MH-related HRH needs assessment prior to MHTF (without UNFPA support)	<u>Zambia</u> : Development partners had carried out a maternal health related HRH assessment in Zambia prior to the launch of MHTF (i.e., in 2008), but UNFPA had not been involved
MH-related HRH needs assessment prior to MHTF (w UNFPA support)	<p><b>Burkina Faso</b>: Situational Analysis Services Reproductive Health conducted in 2006 and the Situational Analysis of the profession and midwife maieuticien (2009) (SF / ME) (MHTF supported) has identified the need for human resources. They are used for operational planning annual UNFPA since 2007 and all schedules for the DSF / DSME and other partners.</p> <p><b>Cambodia</b>: UNFPA supported Midwifery Review in 2006 and the launch of the wide reaching and updated national Midwifery Programming. Led to policy change in 2007, helping to promote the prestige of midwives, enabling the training and incentives scheme</p> <p><u>Ethiopia</u>: Several health worker needs assessments have been performed either by UNFPA or in conjunction with other agencies since 1997</p> <p><u>Ghana</u>: Country office conducted situational analysis, found that majority of MoH midwifery training schools did not have full time tutors; but contract with practicing midwives and nurses in private sector on part time basis to provide teaching assistance. UNFPA successfully advocated for MoH to set up reproductive health course at university to train midwives as tutors for midwifery schools, and supported GHS to provide them with preceptorship skills and improve their teaching capacity</p> <p><b>Laos PDR</b>: Lao PDR: UNFPA's strong contribution to HRH materialized through supporting the SBA assessment in 2008</p> <p><u>Kenya</u>: Several needs assessments (reproductive health, obstetric fistula, service provision, Kenyan Demographic Health Survey) which were supported by UNFPA included Human Resource for Health indicators and the results have been reported to have fed into the Government planning</p> <p><u>Sudan</u>: UNFPA conducted the update of a mapping of village midwives (2008) that guided the development of the national strategic plan for scaling up of midwifery services</p>
MH-related HRH needs assessment only with MHTF	<u>Madagascar</u> : Technical support for HRH survey (evidence creation for planning);

Similarly, sexual and reproductive health teams had commonly used evidence from these assessments to inform the strategic dialogue with national Governments on HRH issues<sup>107</sup>; or had based their technical contribution to drafting Government-owned HRH policies or plans on the findings from these studies<sup>108</sup>. For example, the Sudan Country Office had prepared an update of a previously existing “Mapping of Village Midwives”<sup>109</sup> and used this assessment to inform its input into the development of the “National Strategic Plan for Scaling up of Midwifery Services”. The UNFPA office in Laos PDR had supported an SBA assessment in 2008 and subsequently used its findings to inform the development of a corresponding SBA plan (see Table 41). These are only some examples, but overall, the nexus between initial HRH needs assessments and subsequent policy advocacy or technical policy support seemed relatively well established in UNFPA’s practice<sup>110</sup>, even before the launch of the MHTF in 2008.

**Table 41: Main types of UNFPA mechanisms to promote integration of reproductive and maternal health in HRH policies and frameworks of selected case study countries**

Elements of support	No / small effect <sup>111</sup>	Medium (potential) effect <sup>112</sup>	Large (potential) effects <sup>113</sup> (best practice)
<b>Needs assessments / situation analysis on HRH</b>	Yes, but not supported by UNFPA	<u>Madagascar</u> : Country office provided technical support for HRH survey (evidence creation for planning) <u>Burkina Faso</u> : Country office has supported HRH needs assessments since 2000 <sup>114</sup> ; however, to date Burkina Faso has no HRH plan <u>Kenya</u> : Country office has supported relevant surveys & needs assessments <sup>115</sup> ; results were used for Government planning on HRH <u>Sudan</u> : UNFPA conducted update of mapping of village midwives that guided development of National Strategic Plan for Scaling Up of Midwifery Services	<u>Laos PDR</u> : UNFPA supported SBA assessment in 2008
<b>Participation in health SWAP on HRH</b>	<u>Zambia</u> : formal membership by country office, but irregular participation in meetings; only few substantive contributions		<u>Cambodia</u> : UNFPA part of technical working groups for Health; including subgroups <sup>116</sup>
<b>Policy development (often TA driven)<sup>117</sup></b>	UNFPA contribution to HRH / midwifery only after launch of MHTF and placement of Country Midwifery Advisor (CMA) and	<u>Sudan</u> : Authorship of number of high-level & relevant policy documents <sup>119</sup> ; however, implementation of documents is uncertain ( <i>Context</i> :	<u>Laos PDR</u> : UNFPA played large role in development and implementation of SBA plan. To help in the plan’s implementation,

<sup>107</sup> E.g., through their participation in technical working groups linked to sector support in Cambodia

<sup>108</sup> See Table 41 on the types of mechanisms used by country offices to promote the integration of reproductive health / maternal health into HRH policies and frameworks

<sup>109</sup> In spite of their official title, Village Midwives are community health workers without formal midwifery training.

<sup>110</sup> This notwithstanding, not all country offices used their potential for evidence-based policy advocacy on HRH issues. In Zambia, for example, UNFPA was involved in human resource issues at a technical level (i.e., in relation to curriculum review for midwifery trainings), but had not conducted complementary advocacy on HRH at policy level, despite the fact that UNFPA was formally a member of the SWAp-related technical working groups and policy-level coordination forums

<sup>111</sup> “No / little effects”: no policy dialogue on HRH or only few small scale initiatives without adequate follow-up

<sup>112</sup> “Medium effects”: UNFPA achieved integration of maternal health / sexual and reproductive health issues into relevant national HRH plans, policies or other frameworks, but fell short of ensuring their implementation, either because UNFPA failed to consider the implementation challenges or because context factors prevented the implementation of the HRH policies or plans.

<sup>113</sup> “Large (potential) effects”: policy advocacy / policy-related technical assistance was complemented with technical support and other support for the implementation of HRH policies and plans, to increase the chances of a successful implementation of the HRH strategy

<sup>114</sup> L’Analyse situationnelle des services de santé de la reproduction réalisée en 2006 et la l’Analyse situationnelle de la profession sage femme et maieuticien (SF/ME)

<sup>115</sup> I.e., on reproductive health, obstetric fistula, service provision, Kenyan Demographic Health Survey

<sup>116</sup> No information on degree / quality of contributions

<sup>117</sup> Including, for example, the placement of LTTA in Ministries of Health or other relevant ministry

	Country Fistula Advisor (CFA) in country office <sup>118</sup>	<p><i>Weak federal MoH and State MoH, together with lack of financial resources make implementation of policies unlikely) context conditions in Sudan)</i></p> <p><u>Burkina Faso:</u> CO contributed to policy development standards and protocols (PNP) in 2000; update in 2010; however, to date, HR Division of MoH has not developed HRH plan</p>	<p>UNFPA broadened its partnership with the Ministry of Health and started to collaborate with the Department of Organisation and Personnel (DOP) and other departments instead of only partnering with its traditional partner, the National MCH Centre.</p> <p>Implementation of SBA plan is coordinated by UNFPA</p> <p><u>Cambodia:</u> UNFPA supported development of Health Workforce Development Plan (HWDP; 2006-2015) that preceded formulation of HSSP II (2008 – 2015)</p>
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However, UNFPA country offices have had differing degrees of success to integrate their support for improvements of the regulatory frameworks for human resources for reproductive health with the overall HRH policy frameworks in its partner countries. One important prerequisite for the ability of country offices to influence not only the HRH provision for reproductive health, but to affect these changes in view of the condition of the overall HRH systems was the establishment of close working relations with the HRH Directorates in the respective Ministries of Health. Here, only some country offices have made the needed inroads: In Cambodia, for example, UNFPA has been financing the full-time position of an HRH adviser in the Human Resource Development Department (HRD) of the Ministry of Health since 2002, which has served the country office as the focal point in the Government to represent UNFPA interests in a coordinated manner<sup>120</sup>. In Lao PDR, UNFPA was able to broaden its partnership in HRH from the Department of Organization and Personnel (DOP) of the Ministry of Health, which earned UNFPA the official endorsement of the national SBA plan (2008 – 2010) it helped to develop; and led DOP to assume responsibility for implementing the plan<sup>121</sup>. Finally, in Madagascar, UNFPA also has adopted a more comprehensive role to help develop the national HRH survey; as input into an eventual overall HRH plan of the Ministry of Health<sup>122</sup>. While HRH plan is being developed<sup>123</sup>, UNFPA has been supporting the development of other, MH-specific regulatory frameworks<sup>124</sup>.

In many cases, however, UNFPA's support was limited to policies and frameworks that were specific to reproductive health without making this work part of a larger advocacy campaign that also targeted overall HRH provisions and the associated stakeholders, i.e. HRH Departments in partner countries. None of the country teams in Burkina Faso, Ghana, Kenya or Zambia had well-established relations with the human resource departments in the national Ministries of Health, which made it more difficult to link reproductive health HRH advocacy with the overall HRH framework: In Burkina Faso, for example, issues such as retention of midwives, which is linked to retention policies for health staff overall, had not been addressed; nor had the Human Resource Division of the Ministry of Health started to develop an HRH plan that would address this and other issues in an integrated manner. In Ghana, where UNFPA had so far not

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<sup>119</sup> Midwifery up-scaling, reproductive health policy stressing "health workforce development", etc  
<sup>118</sup> See Country Note Zambia  
<sup>120</sup> UNFPA and its partners have been able to use the proximity to the human resources department to successfully push for a number of salary increases for reproductive health staff since 2006, incl. 20% annual increases of base pay to midwives to slow down dual practice by health workers. Also, the partnership with the Personnel Department was important to maintain the recruitment and transfer policy, which limits recruitment and transfers to Phnom Penh and is the basis for providing more money to pay health staff in the Provinces; UNFPA has also been able to achieve an increased placement of midwives in this way.  
<sup>121</sup> Interviews with UNFPA, Government, Development Partners  
<sup>122</sup> Clearly, the fact that UNFPA is one of the few remaining development partners in the health sector has made this easier to achieve than in other countries.  
<sup>123</sup> It was projected to be finished by the end of 2011  
<sup>124</sup> Such as an updated Public Health Code for midwives, accreditation capacity for midwifery council; standardized curricula for in-service and pre-service training

established an in-road into the powerful Human Resources for Health Development Directorate (HRHDD), the country office has so far been unable to influence budget allocations for reproductive health staff or to develop a cohesive strategy to increase the number of qualified midwives, qualified tutors, training sites, clinical sites, as these were also linked to the work of the HRHDD<sup>125</sup>. In Zambia, UNFPA was not involved in development of HRH strategic plan (2006 – 2010)<sup>126</sup>; UNFPA's bonding mechanism for midwives is not mentioned as strategy in strategic plan, although UNFPA was part of respective working group at time when the HRH Strategic plan was developed. In Zambia, where adequate deployment and retention of reproductive health staff has seriously limited the effectiveness of UNFPA's training support of reproductive health staff, UNFPA has nonetheless not been involved in the development of the overall HRH strategic plan (2006 – 2010)<sup>127</sup>, although UNFPA had been part of the respective technical working group at the time. Finally, in Kenya, the country office has not been involved with overall HRH policy or strategy development during 5th or 6th country programmes, and was not even expected to do so, as this was considered to be the responsibility of other agencies<sup>128</sup>.

**Judgment criterion 4.2: Strengthened competencies of health workers in HIV/AIDS, family planning, obstetric fistula, skilled birth attendance and EmONC to respond to sexual and reproductive health/ maternal health needs**

Logistical and financial support of technical training of nurses, midwives and doctors in HIV/AIDS, family planning, obstetric fistula, SBA and EmONC has been one of the major components of UNFPA's maternal health-related support for the entire reference period and has been widely provided by UNFPA country offices around the world<sup>129</sup>. At the same time, the trainings, workshops and other reproductive health skill-related projects were often neither sufficiently linked to larger improvements in the Human Resources for Health systems in partner countries nor sufficiently needs oriented, i.e., based on specific needs assessments to meet the needs of trainees in specific circumstances and to allow UNFPA's intervention of limited scope to make lasting improvements in the wider HRH environments<sup>130</sup>.

The effectiveness of UNFPA's support for skill building and training of health staff in partner countries was greater the more country offices succeeded to work on specific components of national HRH training systems and sub-systems. For example, the tendency in country programmes to shift some of its resources from in-service training to pre-service training in the second half of the previous decade<sup>131</sup> entailed that UNFPA projects became necessarily more

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<sup>125</sup> Interviews with implementing partners, development partners, Government, UNFPA

<sup>126</sup> No specific input of UNFPA to HRH strategic plan mentioned in interviews (neither UNFPA nor Development Partners); UNFPA not mentioned in the "Proposed Ministry of Health 2006 Budget Estimates for Human Resources Activities" (Annex 9 of HRH Strategic Plan). Note: WHO is mentioned even though it only pledged a small amount, i.e., 76,000,000 Zambian Kwatscha (US\$16,170) for "Coordinating human resource planning across health sector based on the best available data".

<sup>127</sup> No specific input of UNFPA to HRH strategic plan mentioned in interviews (neither UNFPA nor Development Partners); UNFPA not mentioned in the "Proposed Ministry of Health 2006 Budget Estimates for Human Resources Activities" (Annex 9 of HRH Strategic Plan). Note: WHO is mentioned even though it only pledged a small amount, i.e., 76,000,000 Zambian Kwatscha (US\$16,170) for "Coordinating human resource planning across health sector based on the best available data".

<sup>128</sup> Final Evaluation Report on the UNFPA 5<sup>th</sup> Country Programme of Assistance to the Government of Kenya (1997-2001);

<sup>129</sup> A review of AWP's during the desk phase of this evaluation confirmed that financial and logistical support for maternal health-related technical trainings (skills related to HIV/AIDS, family planning, obstetric fistula, SBA and EmONC) had been one of the major types of support activities of UNFPA country offices. For more information, please see the Desk Report for this evaluation.

<sup>130</sup> This had been analysed during the desk phase of this evaluation. The field phase confirmed that in particular UNFPA supported in-service trainings that UNFPA predominantly had supported between 2000 and 2005 were lacking the needed strategic coherence to make lasting improvements in the availability of skilled staff.

<sup>131</sup> During the latter half of the period covered by this evaluation (i.e., approximately the period between 2005 and 2010), many UNFPA country offices shifted more of their resources from in-service trainings to the support of pre-

closely aligned with the training systems (nursing schools, midwifery schools, etc.) that already existed in partner countries. Many country offices also successfully assisted with the development and review of training curricula, for in-service and also for pre-service trainings<sup>132</sup>. For this purpose, many country offices developed partnerships with the Government agencies that were responsible for regulating and overseeing HRH-related training of health cadres<sup>133</sup> and generally made valuable technical contributions to the review process<sup>134</sup>. In many cases, MHTF-financed staff members at country level, i.e. CMAs, ICMAAs and other advisors in other disciplines, were able to raise UNFPA's capacity profile in these processes<sup>135</sup>.

In many of UNFPA partner countries, the national Governments, UNFPA and the other partners faced difficulties to make trained RH staff available in those regions and health centres of the country where they were needed most. The most prevalent challenges were:

- *Difficulties with appropriate staff deployment*, i.e. the posting of staff with improved skills in those areas where they are most urgently needed, or their posting in clinics that have the necessary equipment to allow the trainees to utilize the full range of their newly acquired skills has been a problem in several of the partner countries<sup>136</sup>.
- *High staff turnover and staff mobility* that have often added to the problems with deployment, as health workers often have not remained in the positions they had been assigned to, but found it to be in their best interest to move elsewhere<sup>137</sup>.

These types of challenges have generally been linked to inadequate planning capacities in national human resource departments; difficulties with coordination, communication and cooperation between national human resources departments and their counterparts in local administrations, or the lack of reliable data to track the availability of health workers across the country. They therefore affect the deployment and retention of reproductive health staff, while they are being caused by deficits of the HRH system that are outside of the immediate sphere of reproductive health.

Many UNFPA country offices have found it difficult to position themselves in the HRH arena in a way that accommodates both, the requirement to improve the availability of skilled reproductive health staff in health centres across their partner countries, and the necessity to keep UNFPA's involvement in reforms of the overall HRH system at a level that remains manageable for the already often over-burdened sexual and reproductive health teams. In fact, many UNFPA offices ended up not expanding their support to help solve these challenges; and to address these bottlenecks, even though they often impeded the successful implementation of the reproductive health-specific HR policies UNFPA had helped to develop. In Burkina Faso, where UNFPA had not established firm working relations with the human resources department of the Ministry of Health, mobility of the reproductive health personnel it helped to train has remained a problem, and staff is often transferred from their original posts to another area after just a few months<sup>138</sup>. Effects from UNFPA's trainings in Ethiopia are also affected by high staff turnover and poor the

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service trainings. E.g., in Ethiopia, UNFPA shifted its focus towards supporting pre-service training in 2005/06, after having supported in-service trainings in various disciplines prior to that. Similar change in focus occurred in Burkina Faso, Cambodia, Lao PDR, Zambia.

<sup>132</sup> Most, if not all of the country office visited during the field phase had engaged in curriculum development and review.

<sup>133</sup> For example in Sudan, UNFPA had started to cooperate with the Sudanese Academy of Health Sciences, the federal body in charge of overseeing the training of lower level health cadres, like nurses or midwives. In Zambia, UNFPA, represented by the MHTF-funded CMA, contributed to a curriculum review process that was being led by the General Nursing Council (GNC).

<sup>134</sup> I.e., among the case study countries, this has been the case in Burkina Faso, Cambodia, DRC, Ethiopia, Ghana, Lao PDR, Sudan and Zambia.

<sup>135</sup> E.g. in Lao PDR and Zambia; for details, please see the report of the MHTF mid-term review.

<sup>136</sup> E.g., in Burkina Faso, Cambodia, Ethiopia, Laos PDR and Zambia.

<sup>137</sup> E.g., these problems existed in countries like Burkina Faso, Zambia, among others.

<sup>138</sup> See Country Note Cambodia



poor capacity of the health system to retain employees. UNFPA's skill building efforts in Zambia have been facing similar challenges<sup>139</sup>.

Country offices that had invested time and effort to build stronger relations with HRH departments (also see Judgment Criterion 4.1 above) were able to also use these relationships to place their reproductive health-specific skill-building projects more firmly in the institutional context of the wider HRH systems. In Cambodia, UNFPA has been providing technical support directly to the Human Resource Department of the Ministry of Health (2002-2008) and has thereby directly involved the Department in the development and harmonization of midwifery curricula for pre-service and in-service training. The same Department was then also supported to improve the recruitment of midwives, and currently to work on their registration and licensing. In Lao PDR, the Ministry of Health Department of Organization and Personnel (DOP) assumed responsibility for the implementation of the entire SBA plan, under which UNFPA has now been supporting the training of Community Midwives and a 3-module Life Saving Skills training. These kinds of integrated partnerships have increased the likelihood that resources invested in training of staff will eventually also increase the presence of skilled staff in health centres.

Findings of the country case studies suggest a number of possible reasons for the resistance of *some* country offices to pro-actively engage with their partner governments on these types of issues more comprehensively:

- Most if not all of UNFPA country offices at some point referred to their limited staff capacity as an important reason why UNFPA was not able to address many of the challenges that affected the implementation of EmONC scale-up plans<sup>140</sup>. For example, staff constraints often prevented country offices to use their membership in maternal health-related coordination forums to coordinate with other development partners to initiate more comprehensive programmes that could deliver the required complementary support<sup>141</sup>. To respond to these shortcomings, one UNFPA country office, i.e., the one in Cambodia used some of its MHTF funds to finance the recruitment of an EmONC officer to bolster the capacity of UNFPA for interacting with the Government at a technical level.
- At least in some country offices, staff and managers questioned if UNFPA's mandate allowed the organization to promote reforms in areas like deployment of trained staff, referral, or other administrative matters that had not been specifically requested by the government<sup>142</sup>.
- Limited financial resources were another reason that was often cited. In Sudan, for example, as a country with an unstable, low capacity contexts, the implementation challenges were simply so vast, and UNFPA's own resources, and the resources it could mobilize from other development partners so limited that the country office could not possibly address all the challenges that stood in the way of the implementation of the national EmONC plans and policies<sup>143</sup>. Although the constraints in the Sudanese scenario went beyond the remit of UNFPA's influence, the situation still raises the same questions as the previous examples, i.e., if it was strategically coherent to support the development of EmONC scale-up plans in situations where UNFPA was not equipped to also support their implementation to their fullest effect.

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<sup>139</sup> Based on Visits to project sites, interviews with development partners, Government and local authorities

<sup>140</sup> These points were specifically made in Burkina Faso, DRC, Ethiopia, Sudan, Zambia, among other things

<sup>141</sup> This was the case in a number of country offices, e.g., in Burkina Faso, Cambodia, Ethiopia and Zambia. In Zambia, for example, the reproductive health team in the country office was so thinly staffed (1 national reproductive health advisor; and two additional MHTF funded staff members) that the country office was not able to attend most of the relevant meetings or to provide significant substantive inputs.

<sup>142</sup> E.g. in Ethiopia and Zambia, Kenya

<sup>143</sup> In Sudan's case, these documents were in particular the reproductive health policy and the MNH Road Map that had been written with UNFPA support

### 8.1.5 *Evaluation question 5: To what extent has UNFPA anticipated and responded to reproductive health threats in the context of humanitarian emergencies?*

#### **Judgment criterion 5.1: Inclusion of sexual and reproductive health in emergency preparedness, response and recovery plans**

In its global reproductive health strategies, UNFPA has advocated and supported the institutionalization of sexual health in emergency preparedness, humanitarian response and during post-conflict recovery as an important prerequisite for being able to address maternal health/ sexual and reproductive health needs in emergency situations. For example, the reproductive rights and sexual and reproductive health strategic plan 2008-2011 stressed that the sexual and reproductive health package should include the same services in emergencies and humanitarian crises as it does in other situations.<sup>144</sup>

At global level UNFPA has in fact made substantial contributions to tools available to advance the International Conference on Population and Development (ICPD) within humanitarian response and in humanitarian crises. Among others, these include the Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings (2009), IASC guidelines on gender-based violence (2005), the Inter-Agency Standing Committee (IASC) Gender Handbook in Humanitarian Action (2006), and a distance learning module on Minimum Initial Service Package (MISP) for reproductive health in crisis situations (2007), all having been developed by UNFPA and its partners.

At national level, UNFPA strategy foresaw that its country programmes helped to include sexual and reproductive health in relevant emergency and humanitarian policy frameworks, and in fact, the country case studies have found many examples where UNFPA country offices had played a leading role in adapting emergency plans to better take into account the sexual and reproductive health needs of women.<sup>145</sup>

UNFPA country teams have also been members of the respective disaster management and coordination committees that exist within the UN system and the international humanitarian community overall, such as the UN Disaster Management Teams (UNDMT),<sup>146</sup> the various clusters and sub-clusters that are tasked to coordinate humanitarian responses in emergencies<sup>147</sup> and other committees. In some cases, UNFPA joined ten or more different coordination forums, which inevitably put considerable strain on UNFPA scarce staff resources.<sup>148</sup>

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<sup>144</sup> This was reflected in all five outcomes that refer to the humanitarian context.

<sup>145</sup> For example, UNFPA country offices have been involved in the preparation or review of emergency response plans and the integration of sexual and reproductive health components in Burkina Faso, Cambodia (preparation of emergency preparedness protocols for sexual and reproductive health already in 2002, in coordination with the Ministry of Health, Care International), Ethiopia (country office supported the development of Disaster Risk Management Strategy, focusing on mainstreaming reproductive health, gender-based violence, management of rape survivors, reduction of HIV transmission in programmes and documents; Lao PDR, Madagascar, Sudan (eg., the country office worked towards inclusion of sexual and reproductive health in response plans of State Ministries of Health in five focal states)

<sup>146</sup> E.g., in Cambodia and Ethiopia

<sup>147</sup> E.g., UNFPA has been a member of clusters for health and protection in DRC, Ethiopia, Ghana, Kenya, Madagascar, Sudan

<sup>148</sup> In Ethiopia, for example, UNFPA had joined the Health and Protection cluster, Strategic Disaster Management Team, UN Technical Officers Group, Emergency Health and Nutrition Task Force, HIV/AIDS Emergency Task Force, Early Warning Working Group, UN/ NGO coordination meeting, Humanitarian Response Fund Review Board, UN Communication Officers Group, and others.

## Judgment criterion 5.2: Accessibility of quality EmONC, family planning and reproductive health/ HIV services in emergency and conflict situations

In order to help increase the capacity of governments and their partners to ensure the accessibility of EmONC, family planning and other reproductive health related services in emergencies, many UNFPA country teams have financially and technically supported national emergency management agencies or other relevant national stakeholders to prepare for the eventuality of humanitarian disasters. In Cambodia, for example, where UNFPA provided seed funding to the Secretariat for National Committee for Disaster Management (NCDM), this money was used by NCDM and the Ministry of Health to develop a joint plan of action for emergencies. Commonly, UNFPA also supported these types of agencies by providing them with data for planning of emergency responses.<sup>149</sup> However, most commonly, UNFPA country offices trained counterparts in delivery procedures, pre-positioning requirements and other aspects of the Minimum Initial Service Package (MISP) and the provision of commodities and supplies in support of the MISP (see below).<sup>150</sup>

Many country offices have only recently intensified their efforts to make emergency preparedness a fixed component of their country programmes. Also, the status of preparedness among UNFPA country offices in this regard differs. Among the case study countries, in particular Ethiopia and Kenya had “stepped up” their involvement in humanitarian issues only since 2007/08. In Kenya, the country office reacted to the humanitarian fall-out from the post-election violence in 2008. Some country offices<sup>151</sup> have since integrated humanitarian issues in their core programming, albeit to differing degrees.<sup>152</sup> Other country offices, with lower prevalence of recurring or persistent emergencies had merely adopted internal contingency plans for disasters, such as Lao PDR and Burkina Faso.<sup>153</sup>

Country offices encountered a number of challenges in their efforts to establish humanitarian issues firmly in UNFPA programmes. Insufficient staffing levels were among these challenges, in particular in view of the various humanitarian coordination forums that had to be attended.<sup>154</sup> Maybe the best illustration, though, of the operational challenges that country offices have faced in their efforts to integrate humanitarian and development support is UNFPA experience in a country like Sudan. Here, humanitarian emergencies have existed alongside more stable situations throughout much of the last decade. In Darfur, UNFPA had joined the international humanitarian response, and had been fully integrated in the cluster-coordination mechanisms,

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<sup>149</sup> E.g., in Madagascar, UNFPA supported the Bureau de Gestion Risk de Catastrophe with production and dissemination of relevant data for emergency management; in Ethiopia, UNFPA conducted or supported several assessments or baseline surveys on reproductive health, HIV, and gender-based violence in humanitarian settings

<sup>150</sup> Related activities were reported from most if not all of the country case studies.

<sup>151</sup> E.g., among the case study countries, these were DR Congo, Ethiopia, Ghana, Kenya, Sudan

<sup>152</sup> Starting in 2007, the Ethiopia country office had integrated humanitarian issues in its country office advocacy strategy; and also had integrated its staff group for humanitarian issues (1 national programme officers, 2 UN Volunteers) into its reproductive health sub-programme; the team in Ghana had in place a Policies and Procedures Manual for UNFPA Support to Emergency Preparedness, Humanitarian Response and Transition/ Recovery. It has also committed core funds to support capacity development for National Disaster Management Organisation (NADMO) on provision of MISPs; procurement, prepositioning of reproductive health/ hygiene kits. The office in Kenya had contracted a humanitarian focal point in response to the 2008 riots, which had caught it unprepared. The focal point now works towards mainstreaming humanitarian issues, gender, and gender-based violence at all levels of service provision (UNFPA interview). The country office in Sudan had in place two separate programmes; one for humanitarian support in Darfur; the other one for “development” support for Sudan other, Eastern states. This formal separation notwithstanding, UNFPA development resources were commonly used to respond to humanitarian/ emergency situations outside of Darfur, i.e. to ensure the provision of maternal health services and commodities in internally displaced persons and refuge populations in Sudan.

<sup>153</sup> In Lao PDR, the country office developed “internal contingency plan for disaster for reproductive health; plan to build “strategic partnerships” and to only focus on technical assistance (because of its limited resources). In Burkina Faso, the country office developed a contingency plan; which is reviewed annually.

<sup>154</sup> See the example from Ethiopia; with 10+ coordination fora that UNFPA was party to. Staffing was also mentioned as a bottleneck in Kenya.

the common appeals process, etc. Internally, the humanitarian support for Darfur has essentially been managed like a separate country programme, with very little linkages or overlap with UNFPA's support in the Eastern States.<sup>155</sup> However, even in the Eastern States of Sudan, UNFPA has had to frequently address development concerns and humanitarian concerns in parallel. However, the experiences of the country office have shown that UNFPA global standard procedures for maternal health support in development contexts are not appropriate for this kind of context, where the logistical and financial infrastructure and other prerequisites for project management and financing are often not in place, and where the social, political and security situation is often in flux.<sup>156</sup>

### **Judgment criterion 5.3: Accessibility to medical products in emergency and conflict situations**

UNFPA has provided a range of medical products and reproductive health commodities to populations in emergencies, both as part of international humanitarian response mechanisms, and under its regular maternal health programming that also include emergency preparedness support. Supplies that were provided include delivery and hygiene kits, contraceptives and other reproductive health commodities, i.e., in particular those that were required for the delivery of the Minimum Initial Service Package (MISP), whose availability UNFPA has also supported with corresponding training of service providers and emergency coordination agencies (see above).<sup>157</sup>

UNFPA country offices have also worked towards increasing the availability of reproductive health commodities in emergencies by assisting countries with the prepositioning of supplies and the creation of commodity stockpiles. For example, Ethiopia has established a stock of emergency reproductive health-kits stock in 2007 with UNFPA support; in Ghana, UNFPA supported capacity development with the national disaster coordination agency (NADMO) on the prepositioning of supplies for MISPs; in Sudan, UNFPA has helped the Ministries of Health in its five focal states to preposition basic supplies, such reproductive health kits, and personal hygiene kits to prepare for the provision of MISPs.

One interesting example of an ad-hoc response to an emergency situation is provided by the UNFPA country office in Kenya: in response to the humanitarian fall-out from the 2008 post-election violence, UNFPA became involved in MISP distribution in an ad-hoc fashion, i.e., without having prepared for this kind of eventuality. Still, UNFPA was able to provide family planning commodities and emergency kits to the affected population on very short notice.<sup>158</sup>

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<sup>155</sup> This evaluation has for the most part not analysed UNFPA's humanitarian support in Darfur

<sup>156</sup> Problems have included financial accountability requirements that foresee quarterly advances and limit the possibility of roll-over of funds from one quarter to the next are not appropriate for a situation in Sudan where financial transfers from UNFPA to implementing partners in the States can take up to 2 quarters, and the where the volatile situation makes implementation delays nearly unavoidable. Specific challenges include the procurement of supplies that has been made more difficult due to the embargo against Sudan .

<sup>157</sup> E.g., in Burkina Faso, UNFPA has provided commodities during the floods of 2009; Ghana relies on UNFPA ability to quickly mobilize delivery kits, i.e. within a week or less, from its procurement branch in Copenhagen; in Lao PDR, UNFPA has helped to distribute delivery kits (from a budget that is included in the country office's emergency contingency plan for emergencies)

<sup>158</sup> I.e., the country office supported a six-month project with a total budget of US\$ 3,238,980; to support te immediate health needs of 300,000 to 500,000 IDPs in 42 designated camps and 500,000 other affected people (UNFPA information). UNFPA was commended by the provincial health administration for its quick response in 2008

### 8.1.6 Evaluation question 6: To what extent has UNFPA contributed to the scaling-up and increased utilization of and demand for family planning?

#### Judgment criterion 6.1: Increased capacity within health system for provision of quality family planning services in UNFPA programme countries

At least formally, family planning has been an established component of reproductive health strategies in UNFPA programme countries, including most of those visited during the field phase of this evaluation. UNFPA has contributed to this phenomenon by having consistently advocated that family planning was included in major national health strategies. This applies both to countries that were able to improve many of their family planning related indicators in the last few years; as well as to countries that have had a relatively weak performance in that regard:

- Cambodia, Ethiopia, and Madagascar, for example, are all countries that have achieved relatively large improvements in key family planning indicators in the recent past, such as increases of their Contraceptive Prevalence Rates (CPR) between 7 percent and 10 percent over a period of 5-6 years<sup>159</sup> or a reduction of the “unmet need for family planning”.<sup>160</sup> Consistent with these achievements is the fact that family planning has been a component of the national reproductive health policy frameworks for many years, such as in Madagascar, where UNFPA, together with WHO and USAID developed the first national family planning plan already in 1991; and where the Government has included family planning, along with reproductive health, in its national development plan.<sup>161</sup> Most recently, UNFPA, through the Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS), contributed to the elaboration of the *National Plan for Reproductive Health Commodities Security (2008 – 2012)*.
- However, similarly, other countries with significantly smaller improvements of family planning indicators, such as Burkina Faso,<sup>162</sup> Ghana,<sup>163</sup> or Kenya<sup>164</sup> also have a long history of family planning commitments in key reproductive health policy frameworks that also were advocated for by UNFPA. Burkina Faso, for example, as GPRHCS Stream 1 country had made relatively little progress (see above), although the government, with support from UNFPA, among others, had set priorities to the strengthening of family planning in a series of national strategies.<sup>165</sup> Family planning in Ghana also has had a long history and has been part of strategic documents in health for over a decade.<sup>166</sup> Among other things, UNFPA, in

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<sup>159</sup> E.g., Cambodia improved its Contraceptive Prevalence Rate (CPR) from 24.1% in 2005 to 31.4% in 2010 (+7.3%); Ethiopia (GPRHCS Stream 1) improved its CPR from 10.3% in 2005 to 19.6% in 2010 (+9.3); Madagascar (GPRHCS Stream 1) improved its CPR from 21.6% in 2003/04 to 31.6% in 2008/09 (+10.1%);

<sup>160</sup> Cambodia reduced its unmet need for family planning from 25.1% in 2005 to 16.6% in 2010 (-8.5%); Ethiopia (GPRHCS Stream 1) achieved a reduction from 33.8% in 2005 to 25.3% in 2011 (-8.5%); Madagascar (GPRHCS Stream 1) reduced its unmet need for family planning from 23.6% in 2003/04 to 18.9% in 2008/09 (-4.7%)

<sup>161</sup> Similarly, family planning has been identified as a priority under Ethiopia's Reproductive Health Strategy; Reproductive health commodity security is mainstreamed into national health policy and programmes, all with UNFPA support; in Cambodia, UNFPA has advocated for family planning consistently over the last decade and has worked on anchoring family planning in a number of different national policies, such as the NRSR Strategy (2006-2010), which reflects the difficult environment for family planning in Cambodia and explicitly mentions need to expand existing family planning services and available methods, to build capacity of specific health workers, and to track the results of these efforts, among other things, through the Cambodian DHS

<sup>162</sup> Burkina Faso only improved its Contraceptive Prevalence Rate (CPR) in seven years only by 2.2% between 2003 (14%) and 2010 (16.2%), despite the fact that Burkina Faso is one of only 11 Stream One Countries of the GPRHCS.

<sup>163</sup> Ghana CPR actually decreased by 1.4% between 2003 and 2008, from 20.7% to 19.3%; the country's unmet need for family planning increased slightly by 1.3%, from 34% in 2003 to 35.3% in 2008.

<sup>164</sup> The CPR in Kenya decreased only little in 5 years, from 28.4% in 2003 to 32% in 2008/09 (+3.6%)

<sup>165</sup> Such as the Strategic Plan for Contraceptive Security (2006-2015) and a Strategic Plan to Secure Reproductive Health Products (2009 – 2015), both of which had been supported by UNFPA. UNFPA also facilitated the drafting of the Maternal Health Road Map that contained a significant focus on family planning. Family planning had also been integrated in the National Health Plan 2006 – 2010 as an *intervention à gain rapide* with support from UNFPA.

<sup>166</sup> E.g.; the UNFPA supported National Reproductive Health Policy and Standards (1996) to remove medical barriers to family planning and sexual and reproductive health services (1996); the development of national protocols for family planning (1999). In 2003, the Ghana AIDS Commission was established, and the National Reproductive Health Service Policy revised, however, as many felt to the detriment of family planning quality assurance. In 2004, Ghana

cooperation with Pathfinder International, supported the drafting of the Ministry of Health strategy document “Road Map for Repositioning Family Planning in Ghana (2006 – 2010)”<sup>167</sup> with broad support, both from development partners as well as government stakeholders.<sup>168</sup>

The above shows that in the reference period, policy support for family planning has been one of the well-established disciplines of UNFPA that by and large has allowed country offices and the organization overall to anchor the approach as a birth-spacing and maternal health approach in policy frameworks of its programme countries.<sup>169</sup> In particular the cases of Burkina Faso and Ghana, show, however, that policy support for family planning has not been sufficient, to directly contribute to a reduction of maternal mortality. Other factors are important to increase the prevalence of family planning that is necessary to reduce the maternal health risk to women from unwanted pregnancies.

In addition, family planning training courses; with and without appropriate strategic integration have been implemented:

With strategic integration:

- Burkina Faso (see above on strategic integration): Many training courses on family planning organized in clinics to expand availability of contraceptives in health interventions areas, such as implants, IUDs (intra-uterine devices), introduction of female condoms.
- Kenya: Family planning training/ capacity development supported by UNFPA are conducted within government framework and according to standardized training curricula that are being used within country wide by Kenya Medical Training College (KMTC) (largest trainer of nurse and clinical officers) – “training / capacity development is strategic”
- Cambodia: The Fast Track Initiative for Reduction of Maternal and Newborn Mortality includes trainings in family planning and comprehensive abortion care; UNFPA training in Adolescent and Sexual and Reproductive Health Programme is highly insufficient in terms of contraceptive services.
- Madagascar: Public health service providers and community health workers were trained through UNFPA non-governmental partners on family planning methods, according to jointly developed curricula by development partners and the Ministry of Health (curricula for medical staff have to be validated by the Ministry of Health; are nationally implemented)

Without strategic integration:

- DR Congo: Goal – gradually strengthen the Department/ Ministry of Health ability to take responsibility for its own planning and assume management of national reproductive health. At time of evaluation, progress towards this goal was hampered by difficult relationships between UNFPA and National Programme of Reproductive Health (NRHP).
- Sudan: No viable national strategy on family planning; national sensitivity to family planning; UNFPA has had limited options for designing its family planning support to align strategically with Sudanese strategies/ mechanisms.
- Zambia: “Without sustained and systematic support to bind these isolated activities together, the support has not translated into a sustained capacity improvement in Zambia health system to deliver family planning services”.

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became one of the first African nations to introduce a *National Contraceptive Security Strategy* to ensure a reliable supply system and prevent the common outages of various contraceptives.

<sup>167</sup> The road map identifies gaps in service delivery, research and evaluation, sets targets and defines roles and responsibilities of various agencies and stakeholders with regard to family planning. It defines eight strategies for strengthening family planning services in the country.

<sup>168</sup> I.e., a *National Leadership Group on reproductive health/ family planning* (an expert/ stakeholder group); it received Presidential support; and also was assigned a 17 member task force, commissioned by the Director General of Ghana Health Service (GHS)

<sup>169</sup> In some contexts, agenda setting has been more difficult, such as in Sudan, where UNFPA has had to confront strong cultural sensitivities against family planning. UNFPA has been able to draft a number of policy documents that have anchored also family planning at least formally in the policy tool box of the Government, such as the current reproductive health policy; and the maternal health road map. However, the Government ownership of these documents is low (see country note Sudan for more information).

- Nurses and midwives who were trained in family planning at times lacked the necessary supplies for staff to apply their skills.<sup>170</sup> UNFPA staff has advocated with government partners for the improvements in the deployment of trained staff. However, beyond this, UNFPA has not been involved in systematic efforts and technical support to improve the mechanisms and processes for deployment of staff in accordance with their training.<sup>171</sup>

#### Some monitoring / supervision / quality assurance technical support from UNFPA

- Lao PDR: UNFPA has assisted National Maternal, Newborn and Child Health (MNCH) Centre to reinforce supervision of implementation of MNCH package (provision of tools and technical support; financial support for supervisory visits to service delivery points); BUT: supervision needs to be strengthened further; follow-up mechanisms to ensure quality services not yet systematically in place.
- Madagascar: District and regional level staff trained to perform their own monitoring and evaluation of parastatal distribution system (Salama) and of health workers.

#### Monitoring occurs, but every development partner for himself; without centralized tools from governments

- Ethiopia: Technical working groups on family planning take UNFPA (together with others, such as Packard, Pathfinder, FGAE, Engenderhealth, etc.) to monitor service provision. UNFPA performs “supportive supervision visits”, using “Health Facility Pharmacy Service Assessment Tool” addressing drug supply management. All development partners and the Federal Ministry of Health monitor own programmes (jointly in joint review missions with Federal Ministry of Health), according to development partners own monitoring standards. The Federal Ministry of Health has not yet developed standardized monitoring and evaluation tools; nor are quality assurance mechanisms in place.

#### **Judgment criterion 6.2: Increased demand for and utilization of family planning services in UNFPA programme countries, particularly among vulnerable groups**

Information, education and communication (IEC) and behavior change communication (BCC) have been part of UNFPA strategy increase demand for and utilization of family planning services in its programme countries. IEC and BCC interventions were supposed to be evidence-based, i.e., messages, targeting as well as dissemination of messages were meant to be based on research to identify the most significant barriers to family planning utilization that needed to be addressed with communication and mobilization strategies. UNFPA financial, logistical and technical support, including training was meant to help partners in the design and printing of communication/ IEC materials and campaigns.

As had been foreseen in UNFPA reproductive health strategies, financial, logistical and technical support to IEC or BCC interventions on family planning has been a standard component of family planning support of most, if not all, UNFPA country offices throughout the reference period of this evaluation. These kinds of campaigns have become a standard component of UNFPA country programmes, and by and large, the campaigns had taken on similar forms across different countries,<sup>172</sup> without great differences between country programmes.

However, country programmes differed in the extent to which they had based their family planning communication campaigns on explicit research into the prevailing cultural and social barriers to family planning that needed to be addressed. Some country offices had based the design of individual communication campaigns on prior research on the kinds of messages that needed to be communicated. UNFPA office in Burkina Faso and Lao PDR, for example, had

<sup>170</sup> Training of health staff in family planning is following an overall “training plan” that is managed by MoH. UNFPA has been funding trainings in two provinces (North-Western, Luapula) in accordance with this training plan.

<sup>171</sup> UNFPA interviews.

<sup>172</sup> Such as design and dissemination of posters, brochures, TV and radio production, community theatre, etc.

designed either their entire communication strategy for reproductive health<sup>173</sup> or individual message related to family planning<sup>174</sup> on individual or series of studies. The country office in Cambodia had conducted a Knowledge Attitude and Practice (KAP) survey to establish a baseline on prevailing attitudes towards family planning before the start of a series of communication initiatives, followed up with a second KAP survey at the end of the campaigns. However, the use of research to design communication campaigns was not standard practice in all country programmes.<sup>175</sup> Country offices typically had established long-time relationships with national governmental counterparts to carry out the campaigns.<sup>176</sup>

Whereas research and data collection for the design of campaigns and messages was practiced at least in some country offices, the use of monitoring and evaluation to assess the effectiveness, i.e., the results of family planning communication campaigns has not been widely practiced in UNFPA country programmes. Among the country offices that were visited for this evaluation, only Cambodia had followed-up on its communication campaigns with some form of monitoring and evaluation.<sup>177</sup>

UNFPA country offices have embraced the support of community-based distribution of contraceptives, in particular since the middle of the last decade.<sup>178</sup> In some country offices, this has been in line with the priorities of UNFPA partner governments and forms part of a larger strategy to make available family planning commodities and services to communities. In Kenya, for example, the Government has promoted family planning as one of 5 “high impact interventions”. The distribution of contraceptives by Community Health Extension Workers (CHEWS) is one of several channels supported by UNFPA, e.g., in addition to the distribution of commodities through youth centers and peer education to target the family planning needs of adolescents. .

Challenges encountered by UNFPA in launching community based distribution schemes included in particular the varying organizational capacity among its counterparts to partner in and carry such a scheme and the related task to provide appropriate training and guidance to these partners. In Burkina Faso, for example, the community-based distribution scheme had been off to a relatively slow start, because of the highly varying organizational capacities of the NGOs that UNFPA had chosen as implementing partners; and in addition a lack of guidance from the country office on the concrete implementation process of the scheme, which led individual NGOs experiment with and develop their own approaches. In the end, the first year of the scheme was mainly devoted to awareness raising, without actually achieving a significant

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<sup>173</sup> In the case of Burkina Faso, where the country office had supported the Directorate of Public Hygiene and Health Education (DHPES) to develop a strategic communications plan for reproductive health (2007 – 2010), including family planning. Studies provided information that suggested to target communications strategies, among others, on a greater involvement of men and opinion leaders.

<sup>174</sup> E.g., in the case of Lao PDR.

<sup>175</sup> In Zambia, for example, the country office did not identify any specific studies that had been used to inform the communication message of their long-time partner in IEC / BCC campaign, the *Zambia News and Information Services* (ZANIS).

<sup>176</sup> In Cambodia, for example, communication initiatives had been carried out through the National Health Promotion Centre (NHPC) from 2002 until 2008; and the Communication in Health Education and Media Services (CHEMS). In Lao PDR, UNFPA had supported a number of different organisations for this purpose, e.g., the National Maternal Health Centre & Centre for Information Education for Health to develop IEC materials (posters, leaflets...) and the Lao Women Union and Lao Youth Union networks, to promote family planning in target geographical areas. More recently, the GPRHCS started to support the development of IEC/BCC material for reproductive health promotion and media activities with the Centre for Information, Education and Hygiene (CIEH).

<sup>177</sup> The Cambodia country office, as mentioned above, had conducted KAP (Knowledge, Attitudes, and Practices) baseline and end-line surveys that showed that “family planning messages were getting through, but that the messages were not sustained enough, especially in rural areas”. Cambodia was also the only country office that had conducted a separate evaluation of its programme on “Community-Based Distribution” of reproductive health commodities (see country note for Cambodia for details).

<sup>178</sup> E.g., among the case study countries, UNFPA has supported community based distribution in Burkina Faso, Cambodia, Ethiopia, Kenya, Lao PDR.



distribution of contraceptives. However, overall, UNFPA has demonstrated the expertise to successfully establish community-based distribution programmes in high need countries. Some of the earlier programmes are by now well established in their programme countries,<sup>179</sup> are seen as good practices for up-scaling in other regions<sup>180</sup> and have achieved at times significant increases in the prevalence of contraceptives.<sup>181</sup>

Despite the successes of community-based distribution, one danger is a possible overreliance on this approach. In Cambodia, for example, where UNFPA had introduced the concept of community-based distribution in 2004, UNFPA has not launched any other major initiative in family planning since then, and community-based distribution seems to have “crowded out” a more system-wide response to family planning needs. For example, there has been no assessment of the family planning capacities in the public sector since the introduction of community-based distribution, nor has UNFPA advocated with the Government for an updating of family planning protocols in clinics and health centers. As a result, the rate of Cambodian health centers that can provide access to a mix of family planning methods is still low and the capacity of midwives to introduce family planning at antenatal care/ prenatal care or even to record the prevalence family planning care is still highly problematic. This has limited the possibilities to accurately monitor an important procurement indicator, i.e. the rate of Couple Year Protection (CYP), and has thus limited the ability of UNFPA and the country to properly project contraceptive demand.

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<sup>179</sup> In Cambodia, for example, UNFPA introduced the concept of community based distribution of contraceptives, and initiated a respective programme that started implementation in 2004, targeting areas that were far from health centres, i.e., 10 kilometres or more. After initially only providing basic training to the community-based distribution in 2004 and 2005, UNFPA discussed and developed a training manual for community-based distribution with the National Health Promotion Centre (NHPC). The training consists of a 5 day accredited package that all implementers have to follow. NGOs now use the community-based distribution manual, and the National Maternal Newborn Child Health Centre (NMNCHC) is responsible for all community-based distribution programming. UNFPA and USAID updated the CBD guidelines in 2008. The programme was evaluated in a joint evaluation with USAID in 2010.

<sup>180</sup> E.g., in Lao PDR, community-based distribution of contraceptives started in 2006, during UNFPA’s 4<sup>th</sup> country programme in three provinces in the South. In 2008, the programme was expanded to five more provinces. Other provinces in Lao PDR are interested in using this approach in their remote districts.

<sup>181</sup> In the community-based distribution project areas of UNFPA in Lao PDR, which are very remote and underprivileged areas, use of contraceptives has increased from 17.5% at the beginning of the project to 43.1% in 2010 (UNFPA data).

**Table 42: DHS data for total demand for family planning; and percentage of family planning satisfied for selected case study countries**

	Need for family planning			Need for family planning		
	Need for family planning: % demand satisfied			Need for family planning: Demand - total		
	Total	Residence		Total	Residence	
Urban		Rural	Urban		Rural	
<b>Burkina Faso</b>						
DHS 2003	32.3	60.1	25.2	42.6	56.9	40.1
DHS 1998-99	31.5	54.9	26.4	37.7	53.5	35.4
DHS 1993	50.4	52.3	49.9	49.4	61.5	46.8
<b>Cambodia</b>						
DHS 2010	75.6	82.8	74.1	67.8	67	68
DHS 2005	61.5	69.4	59.8	65.1	71.2	63.9
DHS 2000	44.5	56.5	42.1	53.5	57.9	52.7
<b>Congo Democratic Republic</b>						
DHS 2007	45.9	52	40.6	45	51.8	40.4
<b>Ethiopia</b>						
DHS 2011	53.1	77.8	46	53.9	67.5	50.9
DHS 2005	30.6	73.5	23.7	48.7	64.1	46.9
DHS 2000	18.7	58.8	10.4	43.2	60.5	40.9
<b>Ghana</b>						
DHS 2008	40	45.6	35.7	58.9	59.4	58.4
DHS 2003	42.5	52.9	35.5	59.2	59.4	59.1
DHS 1998	39.6	51.7	33.6	55.5	58.8	53.9
DHS 1993	35.7	47.8	28.8	56.8	64.1	53.4
<b>Kenya</b>						
DHS 2008-09	64	72.4	61.3	71.1	73.3	70.4
DHS 2003	62.8	74	59.6	65.8	66.1	65.8
DHS 1998	63.2	74.8	59.9	64.8	68.4	63.9
DHS 1993	48	63.6	45.2	68.2	68.3	68.2
<b>Madagascar</b>						
DHS 2008-09	67.9	75.6	66.1	58.8	71.8	56.3
DHS 2003-04	53.4	68.1	48.1	50.8	60	48.1
DHS 1997	43.2	64	34	45	53.9	41.9
DHS 1992	34	61	26	49.2	65.1	45.8
<b>Zambia</b>						
DHS 2007	60.6	67.5	56.5	67.2	71.6	64.8
DHS 2001-02	55.5	64.2	49.5	61.6	71.2	56.4
DHS 1996	49.4	55.6	44.1	52.4	59.9	47.4
DHS 1992	33.1	39.5	25.7	45.9	52.6	39.9

The demand situation for family planning in UNFPA programme countries around the middle of the previous decade (i.e., between 2004 and 2006) varied, albeit on a high level. For those case study countries for which DHS demand data was available, between 42 percent (Burkina Faso) and 65.8 percent of women expressed demand for family planning (see table above). In most of these countries, demand for family planning among women increased until the end of the

decade, i.e., between 2.7 percent (Cambodia) and 8 percent (Madagascar).<sup>182</sup> Unfortunately, it is not possible to attribute a specific percentage of this increase in demand for family planning to UNFPA's demand creation activities.<sup>183</sup> On the other hand, UNFPA has consistently provided information on family planning options through different channels over the last decade. UNFPA country offices have also utilized channels that allowed the organization and its partners to reach women in more remote communities of its target regions (i.e., community-based distribution; the use of community health workers). These are tangible and accepted elements of awareness campaigns. It is therefore legitimate to argue that UNFPA has made a contribution to the increased family planning demand in its targeted areas.

### **Judgment criterion 6.3: Improved access to contraceptives (commodity security)**

UNFPA has played an important role in funding and procuring contraceptives on behalf of government partners. In all but two of the case study countries, UNFPA has either been the only donor who has provided funds for contraceptives,<sup>184</sup> or has been one of relatively few providers.<sup>185</sup> Beginning with its launch in 2007, the Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS) has provided the majority of funds for the provision of family planning commodities. Between 2007 and 2010, the GPRHCS had contributed over US\$101.9 million on commodities in UNFPA programme countries.<sup>186</sup> UNFPA contribution in the acquisition of commodities did not only consist in the finances it provided. Partner countries also benefitted from UNFPA technical know-how related to the procurement of commodities that was at times lacking in partner agencies.<sup>187</sup> With its central position in providing finances for health commodities in many of its programme countries, UNFPA has played an important role in making available resources and know how to ensure the central availability of commodities at country level.<sup>188</sup> An additional strength of the GPRHCS has been its ability to make up for the short-term, unforeseen shortfall of commodities in programme countries.<sup>189</sup>

UNFPA has also made significant contributions in the development of capacities in its programme countries for the management of health commodities, i.e., in particular in the forecasting, financing, procuring and also the distribution of contraceptives. Here, the GPRHCS has again intensified UNFPA efforts with its launch in 2007,<sup>190</sup> i.e. in particular in its "Stream 1 countries".<sup>191</sup> However, even outside this group of countries, UNFPA has invested in long-term capacity development of national reproductive health commodity security systems, such as in Kenya (see below).

As mentioned above, in particular the GPRHCS intensified UNFPA support to the development of capacity for health commodities management in programme countries. One common focus

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<sup>182</sup> For Burkina Faso, no data for the total demand for family planning are available for 2010.

<sup>183</sup> The lack of monitoring data is one of the factors that prevent this conclusion.

<sup>184</sup> E.g., this has been the case in Sudan and Madagascar. In Madagascar, the Government had established a budget line for family planning; however, its funding is close to zero. In practice, the Government has not purchased any family planning commodities; instead this has been done solely by UNFPA and partners, at least until 2009. In 2009, other donors have dropped out of family planning, which has made UNFPA the sole provider of reproductive health commodities (Interviews with UNFPA).

<sup>185</sup> This has been the case in Cambodia, Ghana, Lao PDR, DRC.

<sup>186</sup> See mid-term evaluation of Global Programme to Enhance Reproductive Health Commodity Security (Chattoe-Brown, Weil, & Braddock, 2011).

<sup>187</sup> This has been the case for isolated countries like Sudan or DRC, but also for other countries that were lacking the know-how for the procurement of certain types of contraceptives.

<sup>188</sup> As mentioned above, contraceptives for family planning in Madagascar and Sudan have been nearly exclusively supplied by UNFPA. In other countries, UNFPA has played a significant role among partners.

<sup>189</sup> For example, in Cambodia, the Cambodia: The Global Fund to Enhance Reproductive Health Commodity Security (GPRHCS) covered some of the contraceptive shortfalls in the public health sector in 2009. For more details on the GPRHCS, please see the mid-term review of the programme (Chattoe-Brown, Weil, & Braddock, 2011).

<sup>190</sup> See GPRHCS mid-term review for details (Chattoe-Brown, Weil, & Braddock, 2011).

<sup>191</sup> Burkina Faso, Ethiopia, Haiti, Madagascar, Mali, Mongolia, Mozambique, Nicaragua, Niger, Lao PDR, Sierra Leone.

has been to help in the creation of or strengthening of national commodities agencies to manage the logistical aspects of family planning. In Ethiopia, the Government created the *Pharmaceutical Fund Supply Agency (PFSA)* in 2009, in response to an UNFPA supported review of procurement and distribution. PFSA was charged with reforming forecasting, establishing a quality controlled procurement system, improving storage and distribution, reducing waste and improving the Logistics Management Information System (LMIS). The agency has since been supported by UNFPA/ GPRHCS with technical support and equipment, in line with PFSA 5-year strategic plan. UNFPA in Lao PDR supported a similar initiative. Here, family planning logistics used to be managed through the National Maternal and Child Health Centre which faced difficulties in ensuring a regular supply and availability of contraceptives in health facilities. UNFPA/ GPRHCS helped forge a partnership with the country Medical Product Supply Centre (MPSC) that now allows a more focused capacity and systems strengthening and increased coordination with the other development partners in setting-up a unified commodities system.<sup>192</sup>

The strategy of supporting these types of central logistics agencies for commodities has provided UNFPA with opportunities to apply its support for reproductive health commodity security in its programme countries at critically important nodal points of the national reproductive health commodity security systems. In principle, this enables UNFPA to broaden its support to address commodity gaps in national health commodity systems in a more integrated way. This was the case in Ethiopia, where the creation of PFSA in 2009 (see above) triggered UNFPA to expand its support from only reproductive health commodities to a system that managed all health commodities. GPRHCS funds were used to provide computers for regional health commodity warehouses and also used the PFSA to channel support to the national Logistics Management Information System (LMIS). Work in 2011 continues with further training to warehouse managers and more support to the automation of LMIS, the development of a supply chain management and quantification manual, and monitoring and evaluation. In addition to these activities which provide broad support to PFSA, and which acknowledged the importance of creating synergies between the management of different types of health commodities, the GPRHCS has retained its focus on reproductive health by financing a number of activities geared specifically at reproductive health commodity security.<sup>193</sup> Another common strategy to bolster the organizational capacities in reproductive health commodity security units in programme countries was the provision of funding for “National Programme Administrators” or other family planning/ reproductive health commodity security programme staff to federal ministries of health.<sup>194</sup> No information was available to assess the long-term effectiveness of this approach.

UNFPA has used joint government-development partner steering committees to help harmonize donor support to reproductive health commodity security,<sup>195</sup> and has even initiated the creation of these kinds of committees in some of its programme countries, albeit with varying success. In

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<sup>192</sup> At the time of the evaluation, there were still stock outs in some health facilities in the periphery, but Government, development partners and UNFPA agreed that the new system held promise for a better, more unified approach.

<sup>193</sup> For example, GPRHCS contributed to the MoH Commodity Tracking and Stock Management Survey for reproductive health commodities provided by the Protection of Basic Services programme (2009). The purpose was to provide information on the availability of essential commodities. UNFPA also carried out two joint field monitoring visits with regional health bureau staff to regional health bureau warehouses and health facilities to assess stock levels and the application of LMIS to reproductive health commodities (2009). UNFPA has provided technical support to the annual forecasting process for reproductive health commodities throughout the programme, and supports a national technical adviser who will be in post from mid-2011 for one year, to assist with donor coordination.

<sup>194</sup> GPRHCS funds were used for this purpose in Burkina Faso and Zambia, for example. In Burkina Faso, the country office provided a “National Programme Administrator for family planning/ reproductive health commodity security” that was placed within the DSME (that is also otherwise supported by UNFPA) to assist in the management of reproductive health commodities.

<sup>195</sup> E.g., in Ghana, UNFPA is member of Ghana Interagency Coordinating Committee for Contraceptive Security that oversees the implementation of the country new “Reproductive Health Commodities Security Strategy” of 2011, which replaced the old Health Commodity Security Strategy of 2004.

Burkina Faso, the country office helped to create a steering committee to guide the implementation of the country *Plans Stratégiques de Sécurisation des Produits en Santé de la Reproduction* of 2006, which had also been drafted with UNFPA support. In Cambodia, UNFPA created a “Contraceptive Security Working Group” in 2001, with support and involvement of multilateral, bilateral and private stakeholders, which has been in operation since then. In both these cases, the creation of these bodies was part of a long-term strategy for reproductive health support that allowed UNFPA to mobilize sufficient support to launch these committees; and also to sustain the support in the follow-up of their creation.<sup>196</sup> In Zambia, where the UNFPA country office attempted to launch a similar committee,<sup>197</sup> the reproductive health commodity security committee ceased to function after only four meetings. Reasons provided for the demise of the committee were “time constraints of the intended members”, “difficulties with finding committed committee leaders”, both of which point to a lack of support among government and development partners, i.e. a lack of willingness of stakeholders to “buy into” the initiative. Findings from the country case studies suggest that the Zambia country office spent less time on advocating for the committee and supported its creation with a less diverse range of tools than was the case for the two successful initiatives in Burkina Faso and Cambodia.<sup>198</sup>

How sensitive the support of commodity security is to context conditions is illustrated in the example of UNFPA reproductive health commodity security support in Sudan: UNFPA is faced in Sudan with a fragmented, non-functional commodity procurement and supply system that has not allowed UNFPA to systematically build capacity in the government for commodity management. Although the Ministry of Health has in principle been willing to work towards improving this situation, the weaknesses of the overall system, and the vagaries of the political climate have been so great that the concept capacity development is not applicable to Sudan and other crisis or post-crisis countries in the same way as it has been applied in other more stable countries. UNFPA support has had to rely on mechanisms and infrastructure that were owned and provided by UNFPA itself. Without viable national strategy; and given overall sensitivity of family planning, UNFPA has had only limited options for designing its family planning support in alignment with Sudanese strategies and mechanisms. UNFPA has channeled family planning support through federal and state MoHs; but capacity weaknesses there have prevented to really use these Ministries for delivery of services or to partner with them to develop a comprehensive and strategic approach in this area.

While in many ways, UNFPA has contributed to the development of organizational and administrative capacities for reproductive health commodity security, the financial sustainability of these commodity security systems remains a lot less certain. Financing for reproductive health commodity security has become almost exclusively dependent on external support from development partners; and neither UNFPA nor its development partners have found a reliable approach to change this. In crisis or post-crisis countries, this situation is acceptable and even inevitable.<sup>199</sup> What is more worrisome, however, is that even in many more stable situations, UNFPA and its partners have often not foreseen a phase-in strategy<sup>200</sup> or have otherwise not

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<sup>196</sup> See the assessment of the comparative advantages of the UNFPA country offices in Burkina Faso and Cambodia in evaluation questions 1 (relevance), 7 (EmONC) and 9 (integration of maternal health into national policy framework).

<sup>197</sup> I.e., the “Reproductive Health Commodity Security Committee” (RHSCS) to put commodity security into the hands of the Government (UNFPA interview)

<sup>198</sup> See country notes on Zambia, Burkina Faso and Cambodia for details

<sup>199</sup> E.g. in Sudan, funding for provision of family planning commodities is not secure, and the Government does not have a strategy for addressing shortfalls in family planning services. UNFPA was the only donor to provide them at the time of evaluation. In Madagascar, the Government has established a budget line for family planning, but has not endowed it and it is “not foreseeable that the Government will increase budget for family planning” (UNFPA, Development Partners).

<sup>200</sup> Such as in Cambodia: were many donors (e.g., AusAid and KfW) have prepared or are preparing to phase out their support, but where at the same time no clear neither a clear exit strategy for UNFPA or its partners exists, nor a phase in plan for the Government.

achieved to convince governments to take on a greater share of the financial responsibility for reproductive health commodities.<sup>201</sup> Even in Ghana, that is by now deemed to be a middle-income country, the government has so far refused to take on a greater financial responsibility for family planning commodities, despite past efforts of UNFPA and other development partners to the contrary.<sup>202</sup> The only countries that were part of the field phase of this evaluation that had assumed more financial responsibility for reproductive health commodities were Burkina Faso and Kenya. In Burkina Faso, the proportion of funding from the national budget for the purchase of contraceptives has increased from 24 percent in 2006 to 40 percent in 2008.

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<sup>201</sup> E.g., in Lao PDR, UNFPA advocacy efforts for increased government commitment to invest in family planning commodities have been insufficient and the national budget share for contraceptives has remained very small. At the time of the evaluation, the country office continued to take part discussions for the creation of a national budget line for contraceptives.

<sup>202</sup> UNFPA, DFID and USAID together provide about \$4million for contraceptive security, leaving a national funding gap of about \$8.5million per annum. Over the last couple of years Government pledge to provide about \$1million per annum to partially fill this gap has not been fulfilled. After the maiden launch of family planning Week in September 2011, the Minister pledged around \$3million to support contraceptive procurement. "UNFPA and partners are following up on this pledge to ensure that it is implemented" (Interview with UNFPA).

**Table 43: Contraceptive prevalence ratio for selected case study countries**

	Current use of contraception		
	Contraceptive method: Any method		
	Unmarried sexually active	All	Currently married
	Total	Total	Total
<b>Burkina Faso</b>			
DHS 2010	N/A	16.2	N/A
DHS 2003	58	14	13.8
DHS 1998-99	52.1	12	11.9
DHS 1993	34.9	22.2	24.9
<b>Cambodia</b>			
DHS 2010	25.9	31.4	50.5
DHS 2005	32.3	24.1	40
DHS 2000	35.4	14.2	23.8
<b>Congo Democratic Republic</b>			
DHS 2007	47.4	20.1	20.6
<b>Ethiopia</b>			
DHS 2011	56.7	19.6	28.6
DHS 2005	54.9	10.3	14.7
DHS 2000	40.7	5.9	8.1
<b>Ghana</b>			
DHS 2008	50.4	19.3	23.5
DHS 2003	43.4	20.7	25.2
DHS 1998	37	18	22
<b>Kenya</b>			
DHS 2008-09	50.3	32	45.5
DHS 2003	54.4	28.4	39.3
DHS 1998	46.5	29.9	39
<b>Madagascar</b>			
DHS 2008-09	43.2	31.7	39.9
DHS 2003-04	37.7	21.6	27.1
DHS 1997	26.3	16	19.4
DHS 1992	20.9	13.3	16.7
<b>Sudan</b>			
DHS 1989-90		8	8.7
<b>Zambia</b>			
DHS 2007	47.3	29.9	40.8
DHS 2001-02	32.6	24.6	34.2
DHS 1996	24	19.2	25.9

As can be seen in the table above most of the countries that were included in the field phase of this evaluation achieved an increase of the contraceptive prevalence rate (CPR) between 3.6 percent (Kenya) and 9.3 percent (Ethiopia)<sup>203</sup> over a five to six year period. Due to the constraints under which this evaluation was carried out, it is not possible to determine the specific attribution of this change to UNFPA interventions. However, the above analysis of the

<sup>203</sup> Rate of sexually active women aged 15-49 that used contraception (modern or traditional).

different components of UNFPA support in family planning provide insight into the components that have made a contribution to the improvement of contraceptive prevalence in UNFPA programme countries. Among the case study countries, in particular the reproductive health support in Cambodia, Ethiopia, Kenya and Zambia is likely to have made an overall positive contribution to family planning.

Ghana is the only country among the case study countries where the prevalence of contraceptives has actually worsened between 2003 and 2008, i.e., by -1.4 percent. The specific reasons for this development are hard to identify, however, the information from the country case study highlights a few possible factors that might have contributed to the situation, and helps to exclude others:

- Although contraceptive prevalence rate among all women has decreased between 2003 and 2008 (see above), the problem does not seem to be related to a lack of demand: Demand among Ghanaian women for family planning services is one of the highest among the field phase countries, i.e., 35.3 percent in total; 32.3 percent for women in urban areas; and 37.6 percent for women in rural areas. Also, the percentage of the existing demand could be satisfied is particularly low in Ghana (as it is in Burkina Faso), i.e. with 40 percent overall; 45.6 percent in urban areas and 35.7 percent in rural areas.
- The above data suggest that the low contraceptive prevalence rate is related in large part to a lack of availability of contraceptives at the level of communities and beneficiaries, and might be, in large part, a problem of supply. This would also be supported by the alleged funding gap of US\$ 5.8 million that has persisted in the Ghanaian reproductive health commodity budget, i.e., the resistance of the Ghanaian Government to take on more responsibility for financing reproductive health commodities.
- Another possible factor is that to date, family planning payments had not been included in Ghana National Health Insurance Scheme (NHIS), but required direct payment to the service provider. A change of this policy was being discussed at the time of the evaluation;<sup>204</sup> however financial constraints might have kept in particular poorer people from using modern contraceptives.
- A third possible factor might after all point to demand-related issues: Regional disparities in fertility rates have been particularly high in Ghana, with birth rates several times higher in some regions than others<sup>205</sup>. At the same time, there has been no drive to be more strategic in educational and other approaches to family planning, to overcome these regional disparities.<sup>206</sup>

Finally, the relatively slow increase in Contraceptive Prevalence Rates in Burkina Faso also presents a slight puzzle. Overall, Burkina Faso only improved its contraceptive prevalence rate (CPR) in seven years only by 2.2 percent between 2003 (14 percent) and 2010 (16.2 percent), despite the fact that Burkina Faso is one of only 11 Stream One Countries of the GPRHCS. Even in the three regions that UNFPA has specifically supported between 2001 and 2010,<sup>207</sup> i.e., the regions of the Sahel, East and Central East, the CPR (all methods) has only increased between 3 percent - 3.5 percent<sup>208</sup> or has even decreased in one of the regions, by 3.5 percent,

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<sup>204</sup> Under this arrangement, family planning is to be added to the cost of services charged under the NHIS rather than require a direct payment to the service provider as is currently done. Some discussions have been initiated by USAID, DFID and UNFPA and it is likely that action will be taken before the next election (2012). Studies conducted by the JSI Deliver Project suggest that it will be sustainable and cost efficient for the NHIS to absorb the cost of family planning in Ghana.

<sup>205</sup> The average birth rate per mother in the Northern Region is 7.0 compared to 2.9 in Greater Accra (UNFPA information).

<sup>206</sup> See Ghana Country Note

<sup>207</sup> I.e., during the fifth (2001 – 2005) and sixth (2006 – 2010) UNFPA country programmes.

<sup>208</sup> I.e., in the Central East region, the contraceptive prevalence rate has increased from 6.2% in 2003 to 9.1% in 2010 (according to DHS data); in the Sahel region, the contraceptive prevalence rate has increased from 3.5% in 2003 to 7% in 2010 (according to data from the two respective DHS).



at least if traditional methods and modern methods for contraception are considered together.<sup>209</sup> However, the use of modern contraceptives has increased during this period in the Eastern Region, i.e. from 2.2 percent in 2003 to 10.8 percent in 2010.

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<sup>209</sup> I.e., in the East Region of Burkina Faso, CPR has decreased from 14.4% in 2003 to 10.9% in 2010, according to data from the two respective DHS.

### **8.1.7 Evaluation question 7: To what extent has UNFPA contributed to the scaling up and utilization of skilled attendance during pregnancy and childbirth and EmONC services in programme countries?**

The main premise of UNFPA global approach to help increase access to emergency obstetric and newborn care (EmONC) services in programme countries was that access had been curtailed by four major factors: a) insufficient national recognition of the importance of EmONC services for maternal health; and the specific prevailing gaps in the availability of EmONC services, that expressed itself in the absence of provisions for EmONC in national health policies and frameworks; b) an insufficient number of well-trained health workers with required EmONC-related skills in health centers and hospitals to manage and refer high risk pregnancies; c) clinics and health centers without the required technical equipment to provide access to quality EmONC services; including the absence of functioning referral systems; d) insufficient knowledge and awareness among communities, both men and women, about common risk factors in pregnancies and the importance of professional health services to manage these risk factors.

Based on this premise, UNFPA approach to respond to the insufficient access to and use of EmONC services in its programme countries has included the following main elements:

- EmONC needs assessments (MHTF) and other subsequent EmONC surveys were meant to raise awareness and knowledge of prevailing EmONC service gaps. These assessments were meant to lead to the development and continuous updating of EmONC “up-scaling plans” and the inclusion of EmONC in relevant health policies and strategies that were in turn meant to facilitate identifying funding sources and mechanism for expanding EmONC services (see judgment criterion 7.1);
- Training of health workers in critical EmONC skills (both basic and comprehensive), also supported through the rehabilitation and equipment of training facilities, were meant to increase the pool of adequately skilled health workers and make their services available in health centers and hospitals around the country (including referral) (see judgment criteria 7.1 and 7.2);
- Rehabilitating and equipping clinics and health centers was meant to provide the trained staff the appropriate work environment to apply their EmONC skills. This goal was also meant to be achieved by improving the capacity of local health administrations and staff of health centers and hospitals to manage the facilities and services (see judgment criteria 7.1 and 7.2);
- Finally, communities should be made more knowledgeable about risk factors associated with pregnancies and the importance of professional health services to minimize and manage these risks and as a result seek out these services at an increased rate (see judgment criterion 7.2).

#### **Judgment criterion 7.1: Increased access to EmONC services**

UNFPA was able to help anchor EmONC more firmly in national policy frameworks, and thereby helped to put in place one important prerequisite for the Government led improvement of access to EmONC services at national level.<sup>210</sup> UNFPA main tools that helped to convince partner governments to increase their attention to EmONC at national level have been repeated EmONC surveys, situational analyses and needs assessments. UNFPA country offices

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<sup>210</sup> In nearly all of the country case studies, UNFPA country offices had been involved in the development of EmONC scale-up plans. The exception in this case is the country office in Zambia, where the EmONC plan had been developed under UNICEF leadership.

succeeded to use these surveys to make visible the existing gaps in the availability of EmONC services, and to use this data in their policy dialogue on EmONC with their partner governments, targeting at times more than one specific counterpart.<sup>211</sup>

UNFPA efforts to establish EmONC on the sexual and reproductive health agenda of governments intensified in the later years of the reference period, brought about by the launching of the MHTF with its strong focus on EmONC. In the years following its launch in 2008, the MHTF seems to have helped to secure the position of EmONC on the agenda of Governments,<sup>212</sup> to speed up already ongoing planning of EmONC needs assessments;<sup>213</sup> and also to leverage additional money for EmONC assessments.<sup>214</sup> As a result, the number of EmONC assessments that were launched by UNFPA country offices increased between 2008 and 2010.

Despite the fact that the MHTF helped to accelerate the development of national EmONC agenda's, it is important to note that some UNFPA country offices had advocated the implementation of EmONC surveys with their partner governments already in the years prior to the launch of the MHTF. In fact, findings from at least two country case studies suggest that advocacy for the needs-based improvement of access to EmONC services has not been a one-off initiative, but that successes in raising government awareness of the severity of EmONC service gaps benefitted from a series of consecutive advocacy attempts. For example, in Ghana, UNFPA had initially funded an EmONC assessment in one region of the country only, i.e. in Upper East Region, in cooperation with Ghana Health Service (GHS). 3 years later, UNFPA and UNICEF jointly lobbied the Ghanaian Government to expand this initial assessment and to conduct the nationwide EmONC assessment of 2010 (MHTF funded).<sup>215</sup> In Sudan, an EmONC survey that had been implemented in 2005 had had a particularly large effect on bringing more Government attention on the poor state of emergency maternal health services. However, the country office followed up with subsequent assessments to further influence strategy development and EmONC-related planning in its focal states.

Sustaining the commitment of governments to implement the EmONC strategies once drafted was not mentioned as a major challenge. Country offices built partnerships with relevant national counterparts to lead the implementation of the EmONC scale-up plan,<sup>216</sup> or worked towards the establishment of a specific budget line for the funding of EmONC services.<sup>217</sup> At least in some countries, UNFPA partner governments did not seek any particular strategic contributions from UNFPA country offices during the implementation of their EmONC scale-up plans. In those countries, UNFPA often did not adopt any specific role in sustaining government commitment to the improvement of EmONC services, even if that meant that at times crucial implementation bottlenecks remained unaddressed.<sup>218</sup>

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<sup>211</sup> To illustrate: In Cambodia, the UNFPA country offices used the findings from the relevant reviews and survey (e.g., the 2006 midwifery review; and the 2009 EmONC needs assessment (MHTF supported)) to approach several stakeholders (parliamentarians, other Government agencies) with their policy dialogue.

<sup>212</sup> Finding of DR Congo country case study.

<sup>213</sup> In Cambodia, UNFPA efforts to carry out a comprehensive EmONC needs assessment had already been ongoing since about 2003/04, but UNFPA had not been able to agree on launching a comprehensive EmONC assessment with the Government until 2008/09, with MHTF funding.

<sup>214</sup> E.g., in Ghana, the MHTF provided \$200,000, which enabled strategic leverage from the World Bank and UNICEF. UNFPA and UNICEF contributed equal funding for the national survey, and UNICEF additionally contributed computers for data analysis.

<sup>215</sup> UNFPA and UNICEF also utilized the momentum created by the focus on EmONC of the UN Secretary General Action Plan for Women and Children' Health of 2010, which just had been published and specifically noted the importance of EmONC assessments to bring about the equitable distribution of EmONC facilities.

<sup>216</sup> E.g., in Cambodia, the National MNCH Centre took the lead for the implementation of EmONC strategy, which increased the chance for appropriate ownership of the EmONC plan by the national Government.

<sup>217</sup> As happened in Burkina Faso.

<sup>218</sup> E.g., in Ethiopia, the UNFPA has not been involved in any management decisions on the deployment of staff or the positioning and repair of EmONC facilities. In Zambia, UNFPA also left the management of the implementation to the

While UNFPA mechanisms, partnerships and tools<sup>219</sup> allowed the organization to effectively contribute to the implementation of EmONC assessments and to support the evidence-based development of EmONC plans, approaches for accompanying and supporting the implementation of these strategies were not as firmly established in country offices. Generally, country offices supported the implementation of EmONC scale-up plans financially,<sup>220</sup> but found it more challenging to adequately define their roles and responsibilities for addressing the more systemic, capacity-related, bottlenecks<sup>221</sup> that hindered the implementation of UNFPA-supported EmONC scale-up plans to their fullest effect. The country case studies suggested that a few typical types of challenges were most common:

- Many of UNFPA programme countries that had completed EmONC assessments and were preparing EmONC scale-up plans had either no appropriate Health Management Information Systems (HMIS) that could be used to monitor the eventual role out of EmONC scale-up plans,<sup>222</sup>
- Due to the lack of monitoring data, i.e., the weak HMIS, UNFPA and its partners often had encountered difficulties to sufficiently coordinate different EmONC-related inputs, such as trained staff, equipment and the refurbishment of EmONC facilities;<sup>223</sup>
- An important contributing factor for inequities in EmONC access and maternal health service access overall had been difficulties with retaining adequately skilled and trained staff in distant service locations.<sup>224</sup> These challenges would not automatically be solved through the up-scaling of EmONC services, but required a more comprehensive approach to address weaknesses in the HRH systems of programme countries.
- Finally, UNFPA programme countries generally have had and at the time of the evaluation still had problems to set-up and maintain adequately functioning referral systems.<sup>225</sup> This is also a problem that cannot be addressed with EmONC scale-up plans alone, but requires a more comprehensive, health system wide initiative.

A number of UNFPA country offices launched efforts to address at least some of these challenges. To improve the tracking of the availability of EmONC services across the country in view of EmONC related monitoring, UNFPA in Kenya partnered with a district medical office to investigate EmONC service delivery at provincial level, and used their findings to map health facilities in its focus regions as a basis for deciding on the most appropriate location of new EmONC facilities.<sup>226</sup> UNFPA country office in Ghana supported the development of a Geographical Information System with the same rationale, i.e., to allow the Ministry of Health to

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Ministry of Health, and saw its role only in responding to specific annual funding requests for EmONC trainings, equipment or facilities, and not in maintaining a strategic dialogue on EmONC priorities. For more details, see below.

<sup>219</sup> Including, in particular, the tools made available through UNFPA partnership with AMDD, initiated under the MHTF.

<sup>220</sup> I.e., by providing funds to the Government to finance EmONC scale-up activities in specific geographic areas, as happened in Zambia, Ethiopia.

<sup>221</sup> Such as gaps in the administrative capacity of Ministries (e.g., Zambia, Ethiopia, Sudan)

<sup>222</sup> E.g., this problem had prevailed at least for part of the reference period of this evaluation in DRC, Burkina Faso, Ghana, Sudan and Zambia.

<sup>223</sup> Again, nearly all country case studies reported problems with the adequate coordination of inputs, at least implicitly: In Kenya, the community midwife programme that UNFPA had started to support in 2007 had helped to increased numbers of patients at UNFPA supported facilities, but had not yet helped to increase the number of institutional deliveries there, as the corresponding refurbishment of these centres had not yet been completed at the time of the evaluation (2011). In Lao PDR, the Government had committed itself to recruit the newly trained midwives whose training UNFPA had UNFPA and to post them in remote health centres. In reality, however, many of these newly trained community midwives ended up being posted in administrative positions, which prevented in increase in access to EmONC services in distant health centres. Similar issues seem to have occurred in Burkina Faso, DR Congo and Ghana, among others.

<sup>224</sup> This challenge was reported, for example, in Ethiopia, where the constant loss of trained staff led UNFPA to shift from purely in-service training to predominantly pre-service training, Kenya and Zambia, but also from Burkina Faso.

<sup>225</sup> E.g., DR Congo, Lao PDR, Sudan and Zambia, among others.

<sup>226</sup> This approach was particularly significant, as the remoteness and large distances are among the main barriers to access to EmONC services in Kenya.

determine where facilities providing EmONC services were located to be able to provide strategic support to the most relevant facilities.

To address problems with access to services and adequate referral, many country offices also worked directly with communities, i.e., to put in place structures and systems that would help to address the “first” and “second” delay<sup>227</sup> in accessing EmONC services. In addition to raising awareness of the risks inherent in pregnancies and the importance to seek help in professional clinics,<sup>228</sup> many of these projects supported the establishment of community based transportation schemes (second delay) and other support mechanisms, such as savings funds, meals or other logistical support, that would make it easier for affected women and families to seek out medical help in maternal emergencies.<sup>229</sup> Many of these interventions were credited with having increased the access of women to EmONC services.

In spite of the positive examples above, the country case studies show that many country offices favored relatively simple and short-term interventions over projects that would have required a more intensive, sustained and detail-oriented engagement with partner governments. For example, the well-acknowledged gaps in national referral systems tended to be addressed with the provision of ambulances,<sup>230</sup> despite the fact that basic prerequisites for their sustained use and usefulness had not been addressed;<sup>231</sup> and also despite the fact that the provision of hardware was an intervention that was not suited to address the more comprehensive and far-reaching shortcomings that affect appropriate and on-time referral.<sup>232</sup>

EmONC trainings and the equipping, rehabilitation and readying of health facilities to deliver EmONC services were two components of EmONC plans that UNFPA has directly supported in its programme countries. In particular in countries where EmONC support was provided without the involvement of the MHTF, these contributions were often delivered in the form of financial contributions to the budget of national EmONC plans, while the actual implementation of the activities was done not by UNFPA, but by its partnering Health Ministries or their implementing partners, albeit often with the technical support of UNFPA.<sup>233</sup>

Similar to the implementation of EmONC assessments and the development of EmONC policies and plans, the development of curricula and courses for the training of health cadres was one of

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<sup>227</sup> The first delay being the delay at family and community level in making the decision to seek medical attention for pregnant women, and the second delay being the delay that occurs on the way to the EmONC facility.

<sup>228</sup> Discussed in judgment criterion 7.2.

<sup>229</sup> Projects in Burkina Faso, Lao PDR, Zambia and Sudan are good examples of this approach. In Burkina Faso, UNFPA helped to set up community mechanisms (“cellules villageoises de gestion des urgences obstétricales”) that assisted families to prepare for childbirth; and in particular also to anticipate and prepare for possible risk factors. In Burkina, this intervention was credited to have increased the proportion of births attended by trained health personnel. In Lao PDR, UNFPA was piloting approaches aimed at involving communities to establish their own transportation mechanisms through the Community Empowerment Project and the Working with Individuals, Families and Communities. In Zambia, UNFPA has supported the establishment of the SMAG mechanism to mobilize communities to support women in demanding access to EmONC services. The SMAG element of the country programme, which addresses the first EmONC delay, i.e. the delay at the family /community level, has even been integrated in the National Development Plan as a pilot strategy for community involvement, and the Ministry of Health has been allocating funds toward SMAG interventions. Other implementing partners of UNFPA in Zambia have also started to integrate the SMAG concept into their maternal health/ EmONC programmes. In Sudan, UNFPA has used data from the EmONC assessment, reproductive health situation analyses and other relevant studies to demonstrate the gaps in EmONC service provision and access to EmONC services in Sudan, both at national level, but more significantly in its five focal states (outside of Darfur). UNFPA staff in the five focal states used the data to inform the EmONC planning it conducted with its partner State-Ministries of Health.

<sup>230</sup> Most countries had provided ambulances to their counterparts at some point during the reference period. In some countries, this was all that UNFPA had done to support in an improvement of the referral systems, e.g. in Burkina Faso, Ethiopia or Zambia.

<sup>231</sup> E.g., in Zambia, evaluators saw a number of ambulances that had been provided relatively recently but that were no longer operational because funds for their maintenance were not available.

<sup>232</sup> E.g., in Zambia (Solwezi & Kasempa, North-Western Province), even a far bigger pool of ambulances would likely not have made a difference in reducing the second delay, because the distances would have still been too great to transport most emergency pregnancies to the nearest EmONC centre in time for a medical intervention.

<sup>233</sup> E.g., in Sudan, as a country with low administrative capacity in the federal and state-level health ministries.

UNFPA well-established core-competencies. Country offices developed and implemented a number of well-appreciated in-service and, more recently, pre-service EmONC training courses,<sup>234</sup> ventured into the development of new kinds of health cadres to fill existing capacity gaps in national health systems,<sup>235</sup> and worked on scaling-up successful training programmes, at least in some countries.<sup>236</sup>

At the level of individual health workers, or even at the level of individual health care facilities, this support has helped to increase the skill-levels of nurses, midwives and doctors and also has helped to improve the availability of EmONC services in at least some of the targeted facilities. However, at least in some countries, system-wide and sustained improvements of the availability of EmONC services were delayed or hindered by the challenges of UNFPA country offices to address problems with deployment of trained staff or the coordination of EmONC related inputs (see above).

### **Judgment criterion 7.2: Increased utilization of EmONC services**

Only few UNFPA country programmes have started to address economic and social barriers that have prevented women from using maternal health services in the past and, such as costs of services, distance or lack of transportation.<sup>237</sup> As mentioned in evaluation question 1 (relevance) the first important step for those country offices, e.g., the offices in Burkina Faso, Cambodia or Lao PDR, was to target their maternal health support not just geographically, e.g., by district, but to also consider the particular challenges that present themselves to care-seeking women from particular socio-economic groups. Moreover, these country offices have also used the partnerships that they had established by means of persistent and long-term cooperation with key stakeholders<sup>238</sup> to promote laws or policies they believed would benefit these populations. The best examples of these types of initiatives that are directly relevant for EmONC are the EmONC law in Burkina Faso that established the EmONC grant<sup>239</sup> or the Health Equity Fund in Cambodia that provides transport costs to pregnant women at the community level who need to access EmONC services or other maternal health care. Another approach that has added value to the push for increased access to EmONC services was the IFC approach (“Working with Individual, Families and Communities”) that UNFPA applied in Burkina Faso and in Lao PDR. Similar to the effect of the Health Equity Fund, and complementary to the EmONC law in Burkina Faso, the IFC approach helped to establish mechanisms, both at community level and in the public sector, that helped families to prepare for childbirth, including the identification and mobilization of transport emergencies<sup>240</sup>.

Another aspect that likely has added value in creating demand for EmONC services in countries like Burkina Faso, Cambodia or Lao PDR was that both the IFC approach as well as the well-developed local governance structures allowed the targeted raising of awareness raising, e.g. on warning signs of complications in pregnancies, and to impress how important it is to seek medical help, if one of those complications arise, *in combination with* the ability of health workers and other outreach personnel to suggest specific and tangible ways to overcome the barriers that typically keep women accessing services in case of emergencies. In other words, health

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<sup>234</sup> I.e., often in relation to the training of midwives.

<sup>235</sup> E.g., the development of a new cadre for integrated emergency obstetrics and surgery, i.e., the nurse anaesthetist training and midwifery training courses in Ethiopia

<sup>236</sup> E.g., the Community Midwifery Programme in Kenya. Following the distribution of best practices to key stakeholders, the Kenya country office started this programme in its four focus regions.

<sup>237</sup> I.e., transportation other than referral-related transportation, for example, transportation to the primary provider in case of emergencies.

<sup>238</sup> Such as the National Committee on Population and Development (NCPD) in Cambodia, for example

<sup>239</sup> The EmONC grant that now ensures that patients and their families pay only 20% of EmONC costs. The law evolved out of a series of different policy initiatives that had been supported by UNFPA.

<sup>240</sup> See analysis of components of EmONC demand creation.

and outreach workers are able to point out possible problems along with corresponding solutions. The IFC approach has been shown to effectively link individuals with communities; and communities with the health system; and the local governance structure in Cambodia, centered on the commune councils as liaison between communities and various committees at local level that hold different responsibilities with regard to maternal health (such as the Women and Child Health Committee<sup>241</sup> or the Health Centre Management Committees) (see table below).

A correspondence between trends in rates of delivery-based facilities and the presence of the above-mentioned factors, i.e., policies or programmes such as Cambodia's Health Equity Fund or the Burkina Faso's EmONC subsidy and the capacity to link targeted IEC / BCC campaigns to the marketing of these mechanisms in communities suggest that UNFPA has been able to contribute to increased numbers of facility-based deliveries in these two countries; and in countries that have used similar strategies. Both Burkina Faso and Cambodia have been able to increase their share of facility-based deliveries over a five to six year period. In Burkina Faso, facility-based delivery has increased by 27.4 percent overall, between 2003 and 2010. Facility-based deliveries in Cambodia have even increased by 37.8 percent overall, between 2005 and 2010. Maybe most significant is that the increase has been strongest in rural areas in both cases,<sup>242</sup> where the above-mentioned cultural, social and economic barriers typically are the most severe (see table 31 below).

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<sup>241</sup> See also the evaluation question 10 on the coherence between sexual and reproductive health and gender, among other things.

<sup>242</sup> In Burkina Faso, facility-based deliveries in rural areas have increased by 28.9% between 2003 and 2010. In Cambodia, they have increased by 37.9% in rural areas between 2005 and 2010, as opposed to an increase of 34.3% in urban areas.

**Table 44: Components of EmONC demand creation in selected case study countries**

Components	Burkina Faso	Cambodia	Lao PDR	Zambia
Assessments of “barriers”/ socio-cultural aspects of EmONC access	UNFPA supported "situational analysis for services in reproductive health (2006); “Analysis of perceptions of reproductive health (2007)” to clarify barriers to access EmONC services.	See evaluation question 3	PEER study, supported by UNFPA, leading to Community Empowerment Project, Working with Individuals, Families and Communities	See evaluation question 3
Communication plans / projects	Communication plan developed based on previous assessments	See evaluation question 3	Community Empowerment Project; Working with Individuals, Families and Communities; projects have also worked on establishing better linkages between communities and health care providers	See evaluation question 3
Community counterparts	Community mechanisms set up ( <i>cellules villageoises de gestion des urgences obstétricales</i> ) that help families prepare for childbirth including the identification and mobilization of transport emergencies Advocacy, communication conducted by <i>community-based organizations</i> in the form of lectures targeting couples, community theater	<u>Independent of UNFPA support:</u> Existence of “Village Health Support Groups” that are represented at <i>Health Centre Management Committees (HCMC)</i> and play various other roles in communities Commune Councils	UNFPA piloting approaches to help communities establish their own transportation mechanisms, savings funds (Community Empowerment Project; Working with Individuals, Families and Communities (IFC) approach)	Safe Motherhood Action Groups (SMAGs), established with UNFPA support
Awareness campaigns		[No information]		IEC campaigns through public communication agency (ZANIS); SMAGs (see above)
Community capacity development	Use of “IFC approach” (Working with Individuals, Families and Communities), to support participatory planning of community action for maternal health Also: <i>cellules villageoises de gestion des urgences obstétricales</i> (see above)	<u>Independent of UNFPA support:</u> Existence of “Village Health Support Groups” that are represented at <i>Health Centre Management Committees (HCMC)</i> and play various other roles in communities <i>Commune Councils</i> (capacity development component)		Safe Motherhood Action Groups (see above), however, SMAGs generally have weak administrative capacity
Integration of community and health system mechanisms	IFC approach (see above)	UNFPA has supported <i>Health Centre Management Committees (HCMCs)</i> ; structure is integrated with Cambodia’s <i>Commune Councils</i>		Linkage of Safe Motherhood Action Groups and health system not well established; weak capacity of SMAGs (see above)
Concrete	UNFPA lobbied for EmONC law that	Health Equity Fund (supported by		N/A



initiatives to overcome identified barriers (cost, distance, etc.)	established the EmONC grant that now ensures that patients and their families pay only 20% of EmONC costs (law evolved out of Maternal Health Road Map)	Health Sector Support Programme / UNFPA), managed by <i>Commune Council</i> (see above), providing transportation cost to pregnant women at the community level		
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**Table 45: Trend of facility-based delivery for selected case study countries**

	Place of delivery			Assistance during delivery			Assistance during delivery			Assistance during delivery			Assistance during delivery		
	Place of delivery: Health facility			Assistance during delivery: Doctor			Assistance during delivery: Other health professional			Assistance during delivery: Traditional birth attendant			Assistance during delivery: Relative or other		
	Births in three years preceding the survey			Births in three years preceding the survey			Births in three years preceding the survey			Births in three years preceding the survey			Births in three years preceding the survey		
	Total	Residence		Total	Residence		Total	Residence		Total	Residence		Total	Residence	
Urban		Rural	Urban		Rural	Urban		Rural	Urban		Rural	Urban		Rural	
<b>Madagascar</b>															
DHS 2008-09	34.8	61	31.7	14.7	29.7	12.9	28.6	52.1	25.9	49.1	16.5	52.9	6.6	1.3	7.2
DHS 2003-04	30.5	42.3	27.9	8.8	10.1	8.6	36	60.5	30.6	44	24.4	48.3	10.2	4.1	11.5
DHS 1997	34.2	40.1	32.7	12.4	9.2	13.2	34.9	59.1	28.8	39.2	22.5	43.4	11.6	6.8	12.8
DHS 1992	43.8	53	42.5	7.8	13.9	6.9	48.7	70.2	45.6	30.8	12.8	33.5	11.3	2.6	12.5
<b>Zambia</b>															
DHS 2007	47.7	83.2	32.8	3.5	7.1	1.9	42.8	75.5	29.1	24.1	5.8	31.8	24.6	9.1	31.1
DHS 2001-02	42.9	78.4	27.5	3	6.8	1.3	39.5	71.3	25.8	12.5	4.1	16.1	38.4	14.9	48.6
DHS 1996	44.9	75.3	25.7	3.5	7.5	0.9	41.4	67.8	24.7	5.7	1.4	8.5	42.5	19.1	57.3
DHS 1992	50.6	78.7	25.7	4.4	7.5	1.7	45.9	71.3	23.3	9.5	4.7	13.7	32.6	11.6	51.3
<b>Ethiopia</b>															
DHS 2005	5.8	45.2	2.6				6.3	47.7	3	28.9	24.3	29.3	59.3	26	61.9
DHS 2000	4.9	32.4	1.8				5.6	35.6	2.3	30.9	35.7	30.3	58	24.5	61.8
<b>Ghana</b>															
DHS 2008	58	82.8	42.5	10.4	18.4	5.3	49.2	66.7	38.2	29.8	11.8	41.1	7.7	1.8	11.5
DHS 2003	45.1	79	27.8	6.7	14.6	2.7	39.8	65.2	26.9	31.7	12.5	41.5	19.4	5.9	26.3
DHS 1998	44.2	75.9	33.7	7.6	17.5	4.3	37.3	58.5	30.3	41.5	17.8	49.3	8.5	3.1	10.3
DHS 1993	42.1	79	27.9	6.6	16.4	2.8	37.2	64.3	26.7	30.7	10.1	38.6	20.8	6.4	26.4
DHS 1988				6.5	11.1	4.8	34.3	58.3	25.3	27.5	13.9	32.6	25.4	11.8	30.6
<b>Kenya</b>															
DHS 2008-09	43.4	75.2	36	15.9	26.8	13.4	29.3	48.6	24.8	27.1	13.9	30.2	21.1	8.5	24
DHS 2003	39.8	70	32.8	11.5	22.6	8.9	30.1	49.6	25.6	28.2	12.1	32	22.7	12.1	25.1
DHS 1998	42.1	68.3	36.2	12.3	23.6	9.8	32	47.2	28.6	21.2	11.1	23.5	23.9	13.1	26.4
DHS 1993	42.4	75.9	37.4	12	24.3	10.2	31.8	53.1	28.7	21.8	7.2	24	23.6	12.5	25.3
DHS 1989				16.7	24	15.6	33.8	54.8	30.5	15	5	16.6	22.3	10.6	24.2
<b>Burkina Faso</b>															
DHS 2003	38.9	87.6	31.9	1.4	6.5	0.7	36.7	81.6	30.2	32.7	5.7	36.7	22.9	4.4	25.6
DHS 1998-99	33.5	90.9	26.9	0.8	4.1	0.4	31.5	87.6	25	41.2	4.2	45.5	19.6	2.7	21.5
DHS 1993	42.6	91.4	34.5	1.5	4	1.1	39.4	88	31.3	30.7	2.3	35.5	24.5	3.9	27.9
<b>Cambodia</b>															
DHS 2010	61.8	88.6	56.9	12.8	43.6	7.2	63.1	51.8	65.1	23.5	4.4	27	0.3	0.2	0.3
DHS 2005	24	54.3	19	7	18.4	5.1	39.8	55.3	37.2	52.3	26.1	56.7	0.5	0.1	0.6
DHS 2000	9.8	32	6.5	2.2	6.7	1.6	30.9	50.3	28	65.6	42	69.1	0.5	0.7	0.5
<b>Congo Democratic Republic</b>															
DHS 2007	72	89.4	60.9	5.3	10.4	2	70.6	81.2	63.8	9.7	3.5	13.7	11.1	3.5	16

### **8.1.8 Evaluation question 8: To what extent has UNFPA use of internal and external evidence in strategy development, programming and implementation contributed to the improvement of maternal health in its programme countries?**

**Judgment criterion 8.1: Integration of relevant evidence and UNFPA results data during global strategy development and implementation (MYFF 1 and 2, Strategic Plan; Sexual and reproductive Health Framework)**

At global level, UNFPA integrated some key lessons on maternal health/ sexual and reproductive health from an independent review of the second MYFF when developing the 2008 – 2013 Strategic Plan. Among other things, UNFPA adopted the recommended health systems approach, as well as the corresponding focus on ensuring the provision of human and other resources to strengthen health systems in programme countries. The Strategic Plan also puts UNFPA partnership approach, i.e. in particular the role of the IHP+ and the steps of the “IHP+ work plan” in the context of health system strengthening. The recommendation to enhance UNFPA support of commodity security in programme countries might have facilitated the decision of the Fund to launch the Global Programme to Enhance Reproductive Health Commodity Security in 2006.

**Judgment criterion 8.2: Consideration and integration of relevant maternal health/ sexual and reproductive health evidence and results data during development of country strategies**

An assessment of country programme action plans (CPAP)<sup>243</sup> showed that UNFPA country offices have only rarely made explicit use of lessons from evaluations of previous support or are using external evidence to customize UNFPA maternal health strategy in their respective countries. Only five out of 18 examined country programme action plans specifically referenced previous evaluations and only six out of 18 documents drew specific lessons from the maternal health components of the previous programme, albeit often without citing the evidence base supporting that decision.<sup>244</sup>

The country case studies largely confirmed these earlier findings. While lessons from previous evaluations are at times referenced in country programmes and CPAPs, the studies also showed that the low or at least highly variable quality of country programme evaluations is often a barrier that prevents country offices from considering lessons from evaluations. Often, the lessons to be drawn are themselves relatively unspecific and do not provide a concrete foundation for changes to country programming.<sup>245</sup>

However, the root causes for the low value-added from UNFPA country programme evaluations reach beyond the evaluations themselves back to UNFPA own monitoring system. Informative monitoring data that are accessible to users and provide insights into the implementation process and the results of past UNFPA projects are all but absent in country offices.<sup>246</sup> Indicators of country programmes are in most cases not sufficiently specific to the types of interventions whose results they are meant to measure to provide relevant information. Data that do exist

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<sup>243</sup> Conducted during the desk phase of this evaluation.

<sup>244</sup> Only two documents, from the Lao PDR and the Nepal country office, provided some concrete information on the operational implications from the identified lessons. The authors of these documents attempted to link the lessons to specific elements of the past programme, during the description of the programme. This also means that the lessons in these documents were more specific and concrete; and provide more information on operational implications for the future.

<sup>245</sup> The low or uneven quality of evaluations was specifically mentioned as a problem in Burkina Faso, for example. In Ethiopia, lessons take on board were very general (“Lessons learned include the need to focus programme interventions thematically so that resources are made available where needs are greatest”).

<sup>246</sup> This is discussed in more detail under judgment criterion 8.3 below.

have not been adequately compiled to make them accessible for UNFPA staff members and external evaluators for use in programming exercises or evaluations.<sup>247</sup>

Evidence from sources other than evaluations played a more important role in the development of country programmes. This is in spite of the fact that the quality of analysis of specific deficits of maternal health and barriers to reproductive health services in common country assessments (CCAs) has been very low (see findings from the desk phase): Only less than half of the situational analyses in CCAs<sup>248</sup> explicitly identified gaps in national capacities as a basis for formulating specific responses or recommendations for UNFPA support or attempted some kind of “root cause analysis” for maternal health challenges.<sup>249</sup> Most documents merely covered the health sectors in general and disregarded specific maternal health/ reproductive health issues.

However, country offices used data from other studies and surveys that were not referenced in the common country assessments<sup>250</sup> to inform the development of country programmes. The types of studies or surveys most often used were Demographic and Health Surveys, censuses and a range of other, more maternal health specific studies, such as skilled birth attendance or EmONC assessments<sup>251</sup>. Among the most severe deficits of the programming process was that these data were in many cases only used to target UNFPA support geographically, i.e., by selecting specific focal states, and only to a lesser extent to identify and target more systemic barriers that prevented entire socio-economic groups in national populations from accessing maternal health services, such as rural poor in remote communities, etc.<sup>252</sup>

### **Judgment criterion 8.3: Results- and evidence based management of individual projects throughout project life**

UNFPA country offices have not been able to collect data on the outcomes that are specifically linked to their projects to gauge and understand the contributions they have made to larger, i.e., higher level maternal health outcomes.

The deficiencies of UNFPA monitoring and evaluation system are ultimately linked to deficits in UNFPA processes and templates for project planning, i.e. the annual work plans (AWPs). The templates used to develop the AWPs do not allow elaborating consistent and complete theories of change for individual projects that explain how the projects are intended to contribute to specific country programme outputs and the higher-level country programme outcomes<sup>253</sup>. Also, planning on the basis of annual work plans has not allowed formulating multi-year strategies for individual projects, and related expectations on the types of project specific results a project should be able to achieve in year 1, year 2, etc.

The absence of coherently formulated intervention logic in UNFPA projects then made it difficult to define appropriate indicators that could be used to measure achievements along the expected chain of project effects. As a result, country teams generally defined indicators or selected

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<sup>247</sup> This applied to all country offices visited during the field phase.

<sup>248</sup> UNFPA is formally responsible for ensuring the inclusion of maternal health and sexual and reproductive health issues in the common country assessments of the UNDAF process.

<sup>249</sup> I.e., by identifying the structural causes of persisting problems (such as “lack of resources”).

<sup>250</sup> In fact, in many countries, UN agencies had not conducted a common country assessment (CCA) in a number of years. In Kenya, the most recent CCA was done in 2001, in Ghana, the most recent CCA was done in 2004. Similar situations occurred in Burkina Faso (2004), Ethiopia (1999), Zambia (2000), etc.

<sup>251</sup> Also see evaluation question 1 (relevance). To illustrate: The most recent country programme in Burkina Faso was developed on the basis of data from the NHIS, the DHS and the census; in Ethiopia, the country team based the country programme “on existing data, surveys and assessments, including census and DHS data”; in Lao PDR, country programme development was based on the 2005 Census, the Lao Reproductive Health Survey (LRHS, 2005), the skilled birth attendance assessment (2008), the PEER Study (2008), the Assessment of Condom Programming (2008) and annual stock availability surveys.

<sup>252</sup> See evaluation question 1 on the difference between geographic targeting and socio-economic targeting.

<sup>253</sup> Based on review of AWPs from case study countries.

measures from the country programme action plan monitoring framework often considering if these indicators had a clear logical relationship to the country programme output of the AWP in question.<sup>254</sup> These kinds of weaknesses existed in AWP in all of the country case studies.

In addition to the problems with the monitoring tools, the weakness of UNFPA monitoring system was exacerbated by the fact that country offices have not had the staff capacity to make appropriate use of the data that were available.<sup>255</sup> According to UNFPA internal project guidelines, the responsibility for monitoring has rested primarily with UNFPA implementing partners, on the basis of the annual work plan monitoring tool. The Programme Component Manager, typically a government agency, was supposed to consolidate these reports into annual Standard Progress Reports (SPRs) and is also responsible for periodic field monitoring visits (FMVs) and forward these to the country offices.<sup>256</sup> The UNFPA country office was supposed to merely validate the reported achievements through its own field monitoring visits and to forward the annual Standard Progress Reports to UNFPA headquarters.<sup>257</sup>

This system has proven to be problematic at least in three ways:

- Outside of UNFPA country offices, the implementing partners did not have the capacity to develop appropriate monitoring mechanisms for their projects, i.e., to develop fitting indicators and to design appropriate procedures to collect information on the indicators.
- Internally, country offices did not built up sufficient staff capacity to compensate for the weaknesses of the implementing partners, i.e. to redact reports of insufficient quality, or more importantly, to build monitoring capacity in implementing partners over time.<sup>258</sup>
- Lastly, UNFPA country offices have remained without the required staff capacity to appropriately analyze the data from monitoring exercises, to disseminate the results in the country team and to draw corresponding lessons for individual projects and the country programme overall.<sup>259</sup>

Overall, the analysis of annual work plan monitoring tools focused on compliance issues, to prepare the release of additional funds.<sup>260</sup> Monitoring was generally not used to track results,

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<sup>254</sup> To illustrate, a Sudanese project of 2010 was meant to contribute to output 3 of UNFPA country programme (“Increased awareness of reproductive health information and improved knowledge or preventing HIV / AIDS, especially among out-of-school youths”). However, the indicators selected for this project were neither designed to measure awareness and knowledge in these areas; nor focused in particular on out of school youths. Two of the indicators only captured activities or other “inputs” to changes in awareness (“No of sessions conducted”, or “established radio / TV broadcasting network with monthly public session”) or captured higher-level behavioural changes that might or might not have to do with any changes in awareness brought about by the project (“% of pregnant women with regular antenatal care visits”; or “% of pregnant women immunized”).

<sup>255</sup> Seven out of 14 reviewed country programme evaluation reports found that monitoring at country level had been very weak, in that either no regular monitoring had been taking place, reports had been of extremely varying quality and data were generally not used by country offices to make corrections to project implementation (Bangladesh, Burkina Faso, Ghana, Lao PDR, Sierra Leone, Sudan, Zambia). Two additional reports found at least slight deficiencies (Country programme evaluations for Tanzania and Malawi).

<sup>256</sup> See the desk report of this evaluation for a more detailed description of the monitoring set-up.

<sup>257</sup> The PPM notes that the note on CPAP monitoring and evaluation has to be updated substantially; however, without a new version yet in place, it is presumed that the corresponding guidance is still relevant.

<sup>258</sup> None of the UNFPA offices in case study countries had been providing its implementing partners with consistent technical support on monitoring, aside from standardized workshops on “results-based management” that were organized by the regional office and headquarters.

<sup>259</sup> The case studies showed that country offices often have not had any staff members specifically responsible for monitoring and evaluation or had assigned the responsibility for monitoring to staff “focal points”, who had to work in this area in addition to their other responsibilities. In Burkina Faso, for example, there was no person responsible for monitoring and evaluation during the 5th country programme (2001 – 2005). Only during the 6th country programme one person in charge of programme monitoring and evaluation was recruited. The country office in Zambia worked for a long time without an monitoring and evaluation officer. Eventually, the responsibility for monitoring and evaluation was assigned to the population and development NPO, without providing him with the required training or guidance on what kinds of tasks that responsibility would entail.

<sup>260</sup> E.g., in Sudan, Lao PDR, Cambodia, DRC, Kenya.

i.e., the specific effects of UNFPA interventions.<sup>261</sup> These deficits also meant that annual review meetings with implementing partners could not be used to make informed decisions on necessary changes in implementation set-ups or project objectives.<sup>262</sup>

Although UNFPA country offices implemented a large number of mid-term evaluations of country programmes, thematic evaluations or project level evaluations,<sup>263</sup> the quality of evaluation reports in UNFPA has been relatively low. Over 50 percent of reviewed evaluations for the years 2007 and 2008 were thought to be methodologically so weak that the weakness called into question the validity of any findings, conclusions and recommendations. Also over 50 percent of evaluations failed to support their findings and results by the data. The suitability of these studies for evidence- and results-based management of UNFPA projects was therefore low. Without current progress data on activities and outputs, the opportunities for evidence-based management of UNFPA maternal health interventions must have been limited.

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<sup>261</sup> To illustrate, in Cambodia, the responsibilities for internal monitoring were assigned so that the National Programme Officers (NPO) was in charge of tracking the CPAP outputs and the Finance Officer provided the absorption and implementation rate on a month-by-month basis. This meant that the monitoring system only generated project specific data on finances and implementation progress, as the CPAP indicators were not project specific, and thus could not provide any information on the actual contribution of the projects to the CPAP objectives. The monitoring and evaluation systems in all other case study countries had the same deficits.

<sup>262</sup> Annual Joint Review Meetings with IPs in all country case studies focused primarily on flow of finances and implementation progress, not on the specific outcomes of the projects.

<sup>263</sup> The evaluation team collected over 100 evaluations for the 22 countries included in the desk phase of this evaluation that were either directly concerned with or thematically closely related to sexual and reproductive health and maternal health. These evaluations had been conducted mostly in the period between 2006 and 2010; suggesting that the actual number of evaluations for the entire evaluation period (2000 – 2010) is far higher. The main types of evaluations conducted (apart from final / end of period country programme evaluations) were: a) Country Programme Mid-Term Reviews; b) SRH Component Evaluations; Thematic Evaluation / Review of SRH specific topic; Programme/ Project Evaluation of SRH interventions.

### **8.1.9 Evaluation question 9: To what extent has UNFPA helped to ensure that maternal health and sexual and reproductive health are appropriately integrated into national development instruments and sector policy frameworks in its programme countries?**

In order for UNFPA-supported maternal health studies to have affected the quality of the overall analysis of reproductive health issues in the national health policies, the following conditions must be observable:

- The studies must have been discussed in national policy fora, i.e. for policy planning or review;
- UNFPA must have been an active and regular participant of the corresponding policy meetings, also to allow it to follow-up on the implications of study findings on the policy design;
- At least some of the barriers to reproductive health service that UNFPA studies identified must be reflected in the national health policy; and also the programmes derived from it.

UNFPA support of participatory events to facilitate the drafting or dissemination of sexual and reproductive health/ maternal health policies was meant to increase the knowledge, ownership and consequently the acceptance of these documents by the key stakeholders; and to base the development of these policies on a transparent and consultative process.

For UNFPA support to have contributed to the participatory and transparent review of maternal health policies and frameworks, the following conditions must be observable:

- The participatory events must have included **a balanced selection of representatives** from the key stakeholder groups from Government and civil society (incl. “multi-level approach”)
- They events must have **been appropriately followed up**; i.e. information must have been made available to the relevant decision makers and subsequently integrated into the policies.
- (Different initiatives should have been **linked/ coherent with each other to create synergies**; and to be effective).

#### **Judgment criterion 9.1: UNFPA support improved comprehensiveness of analysis of causes for poor maternal health and of effectiveness of past maternal health policies / strategies**

Through its support of national censuses, the national Demographic and Health Surveys and other macro-level surveys and studies, UNFPA has helped to make disaggregated data on maternal health more available to governmental and non-governmental partners. All country case studies as well as evidence from the desk analysis for this evaluation have shown that this kind of support is well established in country offices and part of the population and development sub-programme; and that the clear majority of country offices also ensures that sexual and reproductive health and maternal health relevant indicators are collected in these exercises. To illustrate, in Madagascar, the household surveys and demographic health surveys include MDG and ICPD indicators. UNFPA lobbied successfully to include additionally gender, HIV and maternal health, reproductive health commodity security indicators into the 2008/2009 DHS. The Lao Social Indicator Survey (LSIS), which is being undertaken with UNFPA support, is the largest survey undertaken in Lao PDR to measure progress on social development. The indicators and data to be collected (including maternal health related information) were discussed at length; In Burkina Faso, the types of data collected (by the NHIS, DHS and the census) were revised with support from UNFPA and other partners to meet the needs of maternal health programming. However, the extent to which data from these surveys and studies are eventually used to amend and complete the national maternal health policy

framework is influenced at least in part by the ability of each specific UNFPA country office to tie the implementation of these studies to longer term campaigns on particular issues (see judgment criterion 9.2).

It was not possible to collect data on the effects of data analysis skills trainings on the demand for reliable and properly disaggregated data in UNFPA partner organizations.

**Judgment criterion 9.2: Maternal health and sexual and reproductive health integration into policy frameworks and development instruments based on (UNFPA supported) transparent and participatory consultative process**

UNFPA has been able to achieve the inclusion of maternal health issues in policy frameworks in a way that provided the basis for subsequent action in countries where UNFPA country offices have been able to work intensively with a wide range of different types of stakeholders/ partners (national, state and local level stakeholders; media, civil society/ community representatives, legislators & representatives of the executive) over an extended period of time (i.e. several years). In these cases, country offices were able to use these long-term relationships (established at several levels) to promote specific maternal health-related causes (e.g. EmONC grants) on several levels (i.e. nationally, state, locally) using different types of support. Only country offices that were able to bring all of these elements into play in an interrelated fashion were able to improve the maternal health policy framework in a way that translated into concrete improvements of service availability and access to services on the ground.

UNFPA country offices generally have engaged with a relatively wide selection of different types of partners, such as parliamentarians, representatives of line ministries, representatives of local authorities and other sub-national entities, civil society and media, etc. on issues of maternal health.<sup>264</sup> Engagement with a wide variety of stakeholders has been part of UNFPA self-image and has been reflected in the importance assigned to *partnerships* in the various strategic documents of the organization throughout the reference period of this evaluation.<sup>265</sup>

However, the success of country offices to use these partnerships for amending and extending national policies to better reflect maternal health requirements differed widely. While some country offices were able to promote specific maternal health-related policy changes and amendments that subsequently proved to be instrumental in improving the access of mothers to maternal health services,<sup>266</sup> others were not able to affect these types of policy changes.<sup>267</sup> The analysis of the specific kinds of partnerships that helped UNFPA country offices e.g., in Burkina Faso, Cambodia or Lao PDR, to promote policy changes more successfully and with greater long-term significance, suggested that the main factors that promoted these successes were the following:

One important factor was the country offices' ability to lobby for and address one specific issue, such as the EmONC subsidy in Burkina Faso, with different types of stakeholders. In all of the three countries (Burkina Faso, Cambodia, Lao PDR) successful campaigns were based on often long-term and well-established relationships with different partners, such as parliamentarians,

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<sup>264</sup> All country studies provided evidence of country office relationships with different types of organizations and partners (academia, civil society, government, etc.).

<sup>265</sup> See, for example, the high significance assigned to *partnerships* with organisations from different sectors of the society in UNFPA strategic documents.

<sup>266</sup> E.g., after it had been recognized in Burkina Faso in 2004/05 that cost presented a barrier to many mothers to access EmONC services, the UNFPA country office provided technical assistance to the Ministry of Health Direction de la Famille (DSF) and advocated with parliamentarians, which helped to convince the Government to pass laws to finance the implementation of an EmONC subsidy for patients. At the same time, a plea at different levels resulted in a priority given to maternal health by the government and a budget commitment with the creation of several related budget lines, including one to fund the EmONC subsidy. Similar examples can be cited from Cambodia and Lao PDR, among others.

<sup>267</sup> E.g. Zambia.



line ministries, the Ministry of Finance, civil society and the media.<sup>268</sup> The example of Cambodia illustrates that another factor helped the country office to carry out its policy campaigns successfully, namely the quality of the relationship it had built with several strategically important organizations over time, i.e., in particular the "National Committee on Population and Development" (NCPD) and the "Cambodian Association of Parliamentarians for Population and Development" (CAPPD). UNFPA has provided technical and financial assistance to both organizations consistently for many years and has fallen back on them to support specific advocacy efforts.<sup>269</sup> Over the years, these relationships have been used to push for budget increases for health, delivery incentives for providers, the Health Equity Fund, among others.

Another important element was that the country offices were able to address the same issue with different types of interventions. One key achievement of the UNFPA country office in Lao PDR, for example, was to contribute to the development of the integrated MNCH strategy / package, i.e., a comprehensive, nationally-owned maternal health strategy. The country office had made this contribution by pursuing maternal health issues and the passing of this package a) consistently over a number of year and b) by using different types of assistance:

- Financing the participation of the Ministry of Health officials in a number of international conferences and workshops on maternal health;
- Subsequently organizing a national level workshop on the topic that resulted in the decision of the Ministry of Health to conduct a skilled birth attendance assessment a first step in the development of a comprehensive MNCH strategy) (2007);
- Financing and technically supporting the skilled birth attendance assessment itself (2008);
- Conducting related advocacy and capacity development of the media and parliamentarians on the maternal and newborn health;
- Organizing the celebration of the International Midwife Day, i.e., among other things to help raise the commitment of the public and the national assembly towards midwifery.

Whereas it is doubtful if any of these activities by themselves would have amounted to the passing of a policy like the MNCH strategy (passed in 2009),<sup>270</sup> the purposeful combination of direct advocacy with decision makers, technical support/ studies and media-based information, education and communication created a drive towards the passing of the package. UNFPA country offices were able to create a similar dynamic also in Burkina Faso and Cambodia, i.e., by pursuing related issues using different types of assistance over time, in Burkina Faso in

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<sup>268</sup> For example, the UNFPA country office in Lao PDR promoted the development of the MNCH strategy / package in the country over a number of years, working with partners like the Ministry of Health, representatives of the media, targeted advocacy with Parliamentarians, etc. In Cambodia, the country office has pushed issues like the Health Equity Fund (to fund subsidies for EmONC patients, among other things), or the financial incentive to skilled birth attendants to deliver babies using a broad coalition of partners, including the Prime Minister, the Council of Administration Reform (CAR), the Ministry of Economy and Finance. In addition, UNFPA had established a long-standing relationship with the country's *National Committee on Population and Development (NCPD)* which was also used to promote the above issues. The country office in Burkina Faso also used its partnerships with the *Direction de la Famille (DSF)* of the Ministry of Health in combination with advocacy workshops with parliamentarians, among other things, to lobby for the passing of the law on the EmONC subsidy (see also footnote 266 on the passing of the EmONC subsidy).

<sup>269</sup> E.g., when there was a need for midwives and additional political commitment was required, UNFPA and MoH approached NCPD to conduct a small campaign on Midwifery for All (2004), which culminated in a Midwifery Forum (2005), the two campaigns "Giving Birth with Skilled Attendants" and "No One Should Die Giving Birth" (2009). Within CAPPD, UNFPA contributing role has been well recognized. In the last fifteen years of "co-operation between UNFPA, UN and relevant ministries, Parliament has helped to pass important laws relevant to expanding maternal health activities" (Interview with government partner). Key parliamentarians who are members of the Health, Women and Children Committees have participated in developing strategies and policies that have been presented in various co-ordination meetings, NGO forums and public gatherings. When Government halted new recruitment into the civil service in 2007, CAPPD helped increase trainings and recruitment of midwives and nurses.

<sup>270</sup> I.e., many other country offices could not point to a similar strategic relevance of advocacy workshops with parliamentarians; or the financing of national decision makers to participate in international maternal health conferences and workshops.

relation to the EmONC subsidy,<sup>271</sup> and in Cambodia in relation to health funding and support for midwifery.<sup>272</sup>

Cases like Burkina Faso, Cambodia or Lao PDR show how advocacy, technical support and the creation of evidence on the maternal health situation can successfully build on each other over time to influence policies, provided that these individual elements (advocacy, technical support and the creation of evidence) are timed and linked appropriately to each other to create synergies. Observations from other country cases and other initiatives where the strategic element of follow up to individual events and linkages between initiatives was less evident are in keeping with this finding. The UNFPA country office in Zambia, for example, supported many of the same types of initiatives as had been supported in Burkina Faso, Cambodia and Lao PDR; i.e. studies to examine certain determinants, advocacy events with parliamentarians, technical support and IEC events. However, efforts to strategically link these different activities to support a strategically selected cause and to follow-up on maternal health related studies or other technical support investments with complementary initiatives were much less evident.<sup>273</sup> Also, at least in the later years of the reference period of this evaluation, the country office was not very active in strategic, high-level policy advocacy and donor harmonization to publicize and promote some of the achievements of the UNFPA staff at technical level in policy circles. All of these elements translated into a relatively low visibility of UNFPA in maternal health policy debates in Zambia, including the absence of the country office from efforts to finalize the countries reproductive health policy that had been lying dormant for many years.<sup>274</sup>

The lack of follow-up was also one of the factors that limited the significance of the Maputo maternal health road maps for reproductive health and maternal health policy formulation in UNFPA programme countries. The Maputo Plan of Action had been supported by UNFPA and other UN organizations at regional level; and UNFPA had taken responsibility for translating the Plan of Action into national maternal health road maps in many of its African programme countries. However, with the exception of Sudan and Madagascar among the case study countries, the national road maps coming out of the Maputo Plan of Action were rarely costed in the case study countries, nor used systematically by UNFPA to lobby for increased resources for maternal health support among development partners.<sup>275</sup> Their influence on the de-facto policy agenda and actions of UNFPA partner Governments was therefore small.<sup>276</sup> In the case of

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<sup>271</sup> E.g., in Burkina Faso, after the cost of services had been recognized as a barrier to access in 2004-2005, UNFPA technical assistance to the MoH and advocacy with parliamentarians allowed the government to pass laws to finance the implementation of the EmONC subsidy. At the same time UNFPA pleas at different levels resulted in a priority given to maternal health by the government and a budget commitment with the creation of several budget lines: sexual and reproductive health products, the EmONC grant, free preventive care for children and women, PMTCT inputs, etc. Advocacy on the issue of maternal health also involves journalists and members of civil society organizations.

<sup>272</sup> In order to raise political support and financing for midwifery in Cambodia, UNFPA and MoH approached NCPD to conduct a small campaign on Midwifery for All (2004), which culminated in a Midwifery Forum (2005), the two campaigns "Giving Birth with Skilled Attendants" and "No One Should Die Giving Birth" (2009). UNFPA has supported these forums every 4 years since then. In 2010, MoH was provided a 13% increase in health funding, and a large part of this funding is to be allocated to reproductive health/maternal health.

<sup>273</sup> For example, several UNFPA partners in Zambia felt that UNFPA was not making optimal use of the results they had achieved, such as studies whose findings were not used for evidence-based advocacy, high-performing projects that were not documented and publicized to lobby for their duplication, etc.

<sup>274</sup> UNFPA Zambia had supported the development of the reproductive health policy initially, but had not followed up this engagement with efforts to finish the policy. At the time of the evaluation, the policy was still not finished, and no date for its finalization had been set.

<sup>275</sup> It needs to be pointed out that an interview review of the status of the MNH Road Maps, carried out by UNFPA in 2009, found that 26 out of 35 countries who had responded to a UNFPA survey had costed their MNH plan / road map (de Bernis & Wolman, 2009).

<sup>276</sup> An UNFPA review of the status of the Maputo road maps found that only a minority of countries (16 out of 35 responding) had a plan for scaling-up of maternal health services or an operational plan at the district level; and that several strategic elements of maternal health planning still had to be developed and incorporated in the existing maternal health road maps of a number of countries, in particular EmONC planning, human resources planning and monitoring and evaluation (de Bernis & Wolman, 2009), which limits the significance of the road maps.

CARMMA, the African Union “Campaign for Accelerated Reduction of Maternal Mortality in Africa”, African UNFPA country offices supported the launching of the campaign in the programme countries, but then generally did not consider it to be their responsibility to follow-up on the campaign. In nearly all of the African case study countries, CARMMA was therefore seen to be a “one-off” campaign, without great significance for future maternal health programming or support.<sup>277</sup>

### **Judgment criterion 9.3.: Monitoring and evaluation of implementation of sexual and reproductive health/ maternal health components of national policy framework and development instruments**

The contribution of UNFPA to the revision and strengthening of national monitoring and evaluation systems, such as Health Management Information Systems to ensure that revised, maternal health-relevant policies were appropriately monitored, have been small. Country offices generally were involved in defining appropriate indicators for policies, which they helped to review or formulate,<sup>278</sup> most often with resources from the population and development sub-programmes. However, many monitoring and evaluation systems in programme countries have long suffered from weaknesses that have prevented them from being usable for collecting reliable data on these indicators. In spite of this situation, UNFPA country offices rarely offered more comprehensive support to address and resolve these weaknesses of monitoring and evaluation systems.<sup>279</sup> In countries where UNFPA did try to bring about improvements of national monitoring and evaluation systems, the technical contributions were often to small scale to lead to sustained improvements of the national monitoring and evaluation provisions, or were not put to use by partner governments at all.<sup>280</sup>

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<sup>277</sup> Also see EVALUATION QUESTION 2 on UNFPA’s contributions to aid harmonization in the field of maternal health.

<sup>278</sup> Such as in Burkina Faso, Lao PDR or Sudan (see Annex C for details).

<sup>279</sup> Among the 10 case study countries, country offices in Burkina Faso, Sudan and Kenya had offered some capacity development support in this area; however without achieving clear improvements. In Burkina Faso, HMIS system was not fully operational at the time of the evaluation and did not allow the collection of reliable data on the basis of the maternal health indicators that had been refined with UNFPA support (Interview with UNFPA, Development Partners). Similarly, none of the country offices in Ethiopia, Ghana, Madagascar or Zambia had invested significantly in overall systems-strengthening in M&E.

<sup>280</sup> In Sudan, the country office funded some capacity development at the level of its focal states on monitoring, which was too small-scale to address the overall weakness of monitoring provisions in the country (see Annex C). In Cote D’Ivoire, newly developed M&E templates that UNFPA had financed under its population and development sub-programme had not been adopted for the national M&E system, even though they had been developed for that purpose. In Malawi, the new national database whose development UNFPA had supported had yet to be established (see desk phase report for more information).

### 8.1.10 *Evaluation question 10: To what extent have UNFPA maternal health programming and implementation adequately used synergies between UNFPA sexual and reproductive health portfolio and its support in other programme areas?*

#### **Judgment criterion 10.1: Linkages established between programmes (reproductive health with gender and population and development) in intervention design**

UNFPA country programmes have supported the increased collection of gender-disaggregated data and have achieved that gender-disaggregated data on sexual and reproductive health; and also data on specific gender-related maternal health challenges, such as gender-based violence, are increasingly available in UNFPA programme countries. This type of assistance was financed and supported predominantly through the population and development sub-programmes at national level.<sup>281</sup>

However, far fewer country programmes were able to systematically use the data they helped to collect to support country-specific and context-specific analyses of gender constraints in their programme countries that could be used to guide the development of integrated programmes for reproductive health and gender. Among the country programmes that had been visited during the field phase of this evaluation, only the offices in Ethiopia and Madagascar had produced the clearest examples of these types of specific analyses. The UNFPA team in Madagascar had already early analyzed the gender constraints that affected and impeded reproductive health programmes in the country, i.e., in 2004, in an effort that had been meant to lead up to the development of a *National Action Plan on Gender and Development*.<sup>282</sup> The country office in Ethiopia had included a fairly detailed analysis of gender-related maternal health barriers and constraints in the national country programme document and the country programme action plan.

Maybe most significant for the capacities of individual country offices for integrated programming of the gender and reproductive health sub-programmes has been the existence of organizational mechanisms for integrated planning and programming. Again, most country offices had not established such a mechanism that ensured that all new projects are aligned with the objectives of each of the sub-programmes; and that they take advantage of existing opportunities to create synergies between these programmes. The only country offices in the group of ten that were visited during this evaluation that had a mechanism for joint programming were again Ethiopia and Madagascar: The office in Ethiopia has been using an internal, country-level Project Appraisal Committee (PAC) that has functioned as an advisory committee that has allowed heads of the thematic units of the office to review and endorse project proposals prior to their approval by the country representative. In addition, the office procedures foresee the selection of joint implementation sites for reproductive health and gender sub-programmes. In Madagascar, the UNFPA team has been working with a similar approach, i.e., the organization of joint

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<sup>281</sup> All country offices visited during the field phase of the evaluation have advocated including more gender-specific data in censuses or, most commonly, the Demographic and Health Surveys (DHS). For example, the country offices in Kenya and Ghana spearheaded the inclusion of gender-based violence indicators in the country DHS, the country office in Ethiopia helped to develop maternal health, HIV/ Aids and family planning indicators for the 2005 DHS; the Cambodian country office facilitated gender-specific data collection and compilation through several surveys (Cambodia Gender Assessments (2004, 2008), jointly funded by UNFPA, UNDP and several other donors, benefited from availability of number of UNFPA-supported surveys, including the Cambodian Inter-census Population Surveys (CIPs, NIS 2004) and the Cambodia DHS); and also supported a central database for storing gender-disaggregated data.

<sup>282</sup> The plan was ultimately not adopted and implemented by the national Government.

planning sessions.<sup>283</sup> In both cases, the mechanisms have helped to achieve a closer integration between reproductive health projects and gender support than in the other country offices.<sup>284</sup>

While other country programmes also financed some integrated reproductive health & gender projects, this occurred generally on a smaller scale and, more importantly, depended on external “pull” factors that created opportunities for integrated programming that the country office merely had taken advantage of. In Sudan, for example, individual staff members were acutely aware of the importance of integrating reproductive health and gender programming in light of the particular cultural context of Sudan. However, the country office had not yet developed a firmly established mechanism that would help to translate this awareness on the individual level to integrated programmes. The few annual work plans that did attempt a conscious integration of both topics had been written and proposed by implementing partners with long and established records and experiences in integrated programming.<sup>285</sup> Another illustration of the importance of external “pull factors” for bringing about an integrated, i.e., “gendered” approach to maternal health is UNFPA experience in Cambodia, where UNFPA has been relatively more successful in integrating gender, population and development and reproductive health, largely facilitated by better suited, i.e. more integrated organizational structures at provincial level to integrate reproductive health & gender. These existing structures at provincial level provided a suitable mechanism for UNFPA to support integrated programming.<sup>286</sup>

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<sup>283</sup> Another factor that was emphasized in Madagascar were the good interpersonal relationships between staff members.

<sup>284</sup> Extent of integration in the Madagascar reproductive health sub-programme is illustrated by project titles such as “Right Based approach to Adolescent Sexual Health” (2008 – 2010), “Awareness about SRH/ Reproductive Health/Gender” (2007 – 2010), “Capacity to Manage Integrated Reproductive Health Programmes” (2007 – 2010); “Capacity Development to integrate maternal health” (2008 – 2009), Child Marriage Project (2006 – 2010), etc.

<sup>285</sup> One of these projects was designed to specifically contribute to the population and development sub-programme of the UNFPA country programme, as well as the reproductive health sub-programme (Note: gender was not a separate sub-programme in UNFPA country programme when this project was carried out), and addressed the social and economic position of women, e.g., through income-generating activities, as well as the awareness of gender and reproductive health issues among communities and leaders. Another project had used UNFPA funding to conduct awareness raising campaigns against female genital mutilation, for which they organized workshops and open forums for men and women together and approached doctors, religious and community leaders. The implementing partner for this project also had an already established profile outside of the medical field.

<sup>286</sup> These structures consisted among other things of gender focal persons (from Ministry of Women’s Affairs) at provincial level, who chaired the “Women and Child Health Committee” and who received training from UNFPA. This training also had great relevance for reproductive health issues, as they were part of the structure of the Department of Local Administration under the Ministry of the Interior, the same department that was responsible for the process of decentralization, de-concentration and the Commune Investment Plan. The WCHC Chair was also the Gender Adviser to the Commune Council and a member of the Health Centre Management Committee that UNFPA supported, for example, in relation to EmONC (see discussion on the role of the Health Centre Management Committees under evaluation question 7 on EmONC).

**Table 46: Analysis of integration of gender, reproductive health and population and development sub-programmes in selected country offices, UNFPA**

Countries	Analysis of gender-based constraints to maternal health supported by UNFPA	Mechanisms to integrate programme components at country office level	Reproductive health/ maternal health programme designs address gender-related needs / constraints of target groups	Overall judgment on integration of reproductive health and gender
Cambodia	<p>(+/-) UNFPA support has increased availability of gender-disaggregated data and information as basis for analyzing gender-based constraints to maternal health: UNFPA supports database in which information is increasingly disaggregated to improve gender analysis for health (as reflected in more recent census and DHS) The Cambodia Gender Assessments (2004, 2008), jointly funded by UNFPA, UNDP and several other donors, benefited from availability of number of UNFPA-supported surveys, including the Cambodian Inter-census Population Surveys (CIPs, NIS 2004) and the Cambodia DHS.</p>	<p>(-) No clearly identified UNFPA planning mechanisms to integrate gender &amp; reproductive health (other than increased data availability)</p>	<p><u>(-) National level:</u> Only small number of interventions recently addressed gender-related challenges to maternal health (funding of quarterly meetings of gender focal points of line ministries; provision of “Master Trainer” who developed manual, guidance notes, etc.). Reproductive health, population, gender still operate separately because of funding flows, synergetic mechanisms are just evolving.</p> <p><u>(+) Sub-national level:</u> UNFPA more successful in integrating gender, population and development and reproductive health; also due to better suited admin. Structure at provincial level to integrate reproductive health &amp; gender that can be supported by UNFPA.<sup>287</sup> Many initiatives funded through common pool, managed by Provincial Governor with wide authority on health and development</p>	<p>(-) UNFPA country office has helped to increase availability of gender-disaggregated data for planning. However, programmatic support of gender &amp; reproductive health integration still has relied primarily on “pull” factors; i.e. the existence of suitable admin, planning and management structures at national and sub-national level that can be supported by UNFPA. No UNFPA-internal mechanism has been established to further the integration of gender &amp; reproductive health programming.</p>

<sup>287</sup> Gender focal person (from Ministry of Women’s Affairs) at provincial level, who chairs the “Women and Child Health Committee”, which is part of the structure of the Department of Local Administration under the Ministry of the Interior. This is the same department that is responsible for the process of decentralization, de-concentration and the Commune Investment Plan. The WCHC Chair is the Gender Adviser to the Commune Council and a member of the Health Centre Management Committee (see discussion on the role of the Health Centre Management Committees under evaluation question 7 on EmONC) and receives training from UNFPA.

Countries	Analysis of gender-based constraints to maternal health supported by UNFPA	Mechanisms to integrate programme components at country office level	Reproductive health/ maternal health programme designs address gender-related needs / constraints of target groups	Overall judgment on integration of reproductive health and gender
Ethiopia	<p>(+) <u>Analysis of gender-related maternal health constraints in CPD/ CPAP; advocacy and technical support for gendered data collection / availability:</u> While revising the Health Management Information System, UNFPA has pushed for gender disaggregated data at all levels. The population and development programme developed maternal health, HIV/AIDS, and family planning indicators together with the reproductive health programme to be included in the DHS 2005.</p>	<p>(+) Existence of several mechanisms for sub-programme integration in country office: Project Appraisal Committee (PAC; advisory committee for heads of units to review and endorse project proposals prior to approval by representative); Joint implementation sites for reproductive health and gender sub-programmes</p>	<p>(+) <u>National level:</u> UNFPA supported adaptation of community conversation guideline to include sexual and reproductive health and gender issues; all of this was incorporated into the health extension worker manual.            (+) <u>Sub-national level:</u> Through “push-factors” (joint planning mechanisms in country office, see on left), UNFPA interventions are designed based on evidence from all sub-programmes; integrated into annual work plans.</p>	<p>(+) Country office helped to increase data availability on gender-related constraints; also by drawing on resources of population and development staff/ programme; and was able to use this data in internal joint planning / coordination mechanism (PAC, joint implementation sites)</p>
Ghana	<p>(+/-) <u>Support of various data-collection activities that can help to analyze gender-based constraints to maternal health:</u> assisted MoWAC to review data collection instruments and ensure better integration of gender concerns, for 2008 DHS. UNFPA achieved inclusion of module to collect data related to Domestic Violence in DHS 2008.<sup>288</sup></p>	<p>(+/-) Various new initiatives for stronger integration (too new for performance assessment):            (+/-) UNFPA senior management and reproductive health advisor promote sub-programme integrations; interest is increasing            (+/-) Piloting of “coherence programming”; which started a year ago. Quarterly meetings to bring all implementing partners together to share experiences; limit duplication. There are detailed exercises to discuss programme activities. Already done for</p>	<p>(-) No clearly identifiable integrated programming, nor strong advocacy for gender aspects of maternal health,<sup>289</sup> meanwhile, gender sub-programme supports various initiatives, including gender related capacity development.<sup>290</sup></p>	<p>(+/-) While “gendered” data as basis for integrated planning on maternal health have been produced &amp; made available by UNFPA for some time; the practice of integrated programming and advocacy on linking maternal health and gender is just emerging in country office. Currently, integration is dependent on leadership (country representative), i.e. the ability to</p>

<sup>288</sup> I.e., this resulted in establishment of Domestic Violence Victim Support Unit (DOVVSU) by the Police Department (Ministry of Interior)

<sup>289</sup> UNFPA lead role in coordination around gender has not been so clear and remains a challenge with several agencies all of whom have gender as a cross-cutting issue. It is not been apparent as to who is actually leading the interagency coordination on gender since UNIFEM was coordinating only as a project and UNDP was for some time playing a more leading role on the subject. UNFPA current mandate would require it to play a more leading and proactive in maternal health/reproductive health programming around gender.

<sup>290</sup> E.g., since 2009, UNFPA has provided resources to Department for Women for a three year Action Plan for gender-mainstreaming and capacity development for gender responsive budgeting.

Countries	Analysis of gender-based constraints to maternal health supported by UNFPA	Mechanisms to integrate programme components at country office level	Reproductive health/ maternal health programme designs address gender-related needs / constraints of target groups	Overall judgment on integration of reproductive health and gender
		HIV and Safe motherhood. Coherence Meeting is now starting to invite other components at regional level.		institutionalize integration mechanisms (coherence programming) that is currently being piloted
Kenya	(+/-) UNFPA country office promoted increased “gendered” data collection: E.g., spearheaded inclusion of gender-based-violence indicators in DHS	(-) No clear & institutionalized mechanisms for integration identified; however, strong commitment to gender & reproductive health integration stated	(+/-) Integration of gender & reproductive health programming on specific issues (gender-based violence (GBV) and female genital mutilation/ cutting (FGM/C)), but w/o establishing systemic procedures for integrated programming (+) UNFPA has addressed GBV and FGM/C as specific maternal health-related issues, i.e., via joint programme with UNICEF; establishment of information management system on GBV in five pilot health facilities; support of standard operating procedures for GBV response and prevention with UNFPA support; Advocacy for legal reform on FGM/C. <sup>291</sup> (-) difficult external conditions, i.e. in coordinating country office work on youth: Three ministries are involved (Education, Gender, Youth and Health), all of which with conflicting approaches and no assignment of clear leading roles.	(+/-) Gendered data analysis supported; availability of gendered data improved, in particular on specific issues (e.g., GBV); accompanied by integrated programming on this issue & FGM/C. However, no firmly institutionalized mechanism to promote integrated planning of gender/maternal health.
Lao PDR	(+/-) Data generated to some extent (i.e., also through “Working	(-) <u>no specific mechanism</u> for integrated planning & programming	(+/-) Integration of reproductive health and gender on some	(+/-) Despite some data generation on maternal

<sup>291</sup> With various partners, i.e. Federation of Women Lawyers (FIDA), Kenya Women Parliamentarians (KEWOPA), etc.



Countries	Analysis of gender-based constraints to maternal health supported by UNFPA	Mechanisms to integrate programme components at country office level	Reproductive health/ maternal health programme designs address gender-related needs / constraints of target groups	Overall judgment on integration of reproductive health and gender
	with Individual, Families and Communities” or “Empowering Communities”; one other individual study <sup>292</sup> ), but little analysis of data in country office to develop customized “gendered” reproductive health approach in Lao PDR		specific issues / in some specific campaigns, but no systematic integration of gender / reproductive health based on good understanding of specific gender-related maternal health constraints (+) Advocacy on maternal health with women’s groups to achieve integration of maternal health in “National Strategy for Advancement of Women” (+/-) Support of community-based programming approaches (IFC, Empowering Communities) that foresee male involvement as integral part; however, w/o adequate analysis of experiences from UNFPA support by country office staff	health / gender; support of specific campaigns, integration of gender & reproductive health not firmly institutionalized in country office
Madagascar	(+) Gender constraints affecting & impeding reproductive health programmes identified early (2004), leading up to development on National Action Plan on gender and Development (Note: Plan not implemented by Government).	(+) <u>Linkages between sub-programmes well established</u> , based on good interpersonal relations between & joint planning sessions and joint field missions.	(+) <u>Various programmes to address gender-related barriers to maternal health service access:</u> e.g., Sensitization campaign family planning (directed at men) (2009); Stakeholder meeting to develop framework for action on gender & reproductive health (2011); Development of treatment protocol for GBV; counseling centers, etc.	(+) Good programmatic integration of gender / reproductive health based on directed research; supported by internal coordination mechanisms (joint planning sessions; joint field missions).
Sudan	(+/-) less research specifically	(-/+ ) No particular mechanism for	(+/-) Only few annual work plans	(+/-) Individual awareness

<sup>292</sup> Study on Gender and Ethnic Issues that Affect the Knowledge and Use of Reproductive Health Services in Six Ethnic Villages of Lao PDR - conducted in August 2005 - Committee for Planning & Investment - Department of General Planning National University of Lao PDR - Population Studies Center - Supported by UNFPA Lao PDR - April, 2007.

Countries	Analysis of gender-based constraints to maternal health supported by UNFPA	Mechanisms to integrate programme components at country office level	Reproductive health/ maternal health programme designs address gender-related needs / constraints of target groups	Overall judgment on integration of reproductive health and gender
	directed at analyzing gender-related maternal health constraints in Sudan, primarily due to difficult political & cultural context	integrated planning / management of gender & reproductive health, despite high level of awareness of interconnectedness of both aspects in Sudan	that specifically integrated maternal health and gender; written and proposed by implementing partners with long history in integrated programming. Acted as “pull” factor for integrated programming, in absence of “push” factors from inside country office.	of staff members on importance of linkages has not yet translated into systematic integrated programming mechanisms, and integrated programmes.
Zambia	(+/-) Logistical & financial support for collection of gendered data; only little specific research into gender-based barriers to maternal health.	(-) No institutionalized mechanism for integrated planning and coordination	(-) Only few deliberate programmatic linkages between reproductive health and gender.	(-) Limited support for gendered data collection has not been translated into comprehensive integrated programming; absence of institutionalized planning and coordination mechanism

**Note:** For information on the integration of population and development and reproductive health, please see evaluation questions 1 (relevance) and 9 (integration of reproductive health into policy frameworks)

### **Judgment criterion 10.2: Integration of monitoring and reporting of UNFPA operations**

UNFPA monitoring, evaluation and reporting system were meant to capture the maternal health related situation of the poorest of the poor.<sup>293</sup> One of the supportive roles of the population and development components of country programmes was to facilitate the improvement of the technical capacity of reproductive health and gender programmes, i.e. their implementers, to improve their evidence-based policymaking, programming, implementation and reporting and to facilitate the integration of maternal health issues into national policies, plans, programme and budgets.

Assistance offered by the population and development sub-programmes at country level in this area has evolved from mere data collection to a greater emphasis on the UNFPA-assisted development of integrated monitoring and evaluation systems.

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<sup>293</sup> Especially disadvantaged adolescents and youth, women and survivors/victims of violence and abuse, out-of-school youth, women living with HIV, women engaged in sex work, minorities and indigenous people, women living with disabilities, refugees and internally displaced persons, women living under occupation and ageing populations.

### **8.1.11 *Evaluation questions 11: To what extent has UNFPA been able to complement maternal health programming and implementation at country level with related interventions, initiatives and resources from the regional and global level to maximize its contribution to maternal health?***

#### **Judgment criterion 11.1: Clarity of division of labor and delineation of responsibilities between UNFPA global, regional and country offices**

The existing operational rules for the delineation of responsibilities and division of labor between the GRP and the country programmes are relatively broad. The Global and Regional Programme Guidelines of the PPM broadly state that the GRP is meant to “complement country programmes” and to “contribute towards implementing the UNFPA Strategic Plan” (i.e., 2008-2011). GRP programming is meant to be based on a situation analysis that determines needs and gaps at the global level; and identifies the required complementarity of the GRP with country programmes. Regional offices are called to consult with country offices concerned in the approval and implementation of regional activities to ensure synergies between regional and country programmes.

The complementarity that is called for in the Global and Regional Programme Guidelines is only partly reflected in the corresponding Programme Action Plans (i.e. programme action plans at global, regional and country level). The intended outputs of UNFPA’s Global Programme<sup>294</sup> are broadly complementary to the MNH outputs of Country Programmes: The Global Programme focuses on mobilizing support from “global actors” and on developing programming tools & guidelines to be applied by country offices and their partners at country level. For example, the GP had committed itself to making available “programming tools & guidelines to facilitate integration of SRH into national policies” and to provide “models” for up-scaling of SRH packages at the national level. Similar outputs are mentioned for commodity security and demand creation for MNH and SRH services

The complementarity between programming at the regional and country level<sup>295</sup> is less evident, judged on the basis of a comparison of the regional outputs of the African Regional Programme; and the MNH outputs at country level<sup>296</sup>. For example, the ARP pledged to build MNH-relevant capacity not only among regional and sub-regional stakeholders, but also among UNFPA partners and stakeholders at national level. The programme does not clearly state, however, how the ARP capacity building efforts are meant to complement the UNFPA efforts at country level. This observation applies to different subject areas, including the up-scaling of the essential SRH package, i.e. in commodity security, RH demand creation and “health system strengthening”.

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<sup>294</sup> For the period 2008 – 2013.

<sup>295</sup> Exemplified here by the African Regional Programme (2008 – 2013) and the African countries among the desk phase sample (18 out of 22 of the desk phase countries are African countries).

<sup>296</sup> I.e. from the African Regional Programme (ARP)) and at all African countries in the desk phase sample.

## **Judgment criterion 11.2: Alignment of UNFPA organizational capacities at country level and the (intended) division of labor and delineation of responsibilities**

Levels of technical and management staff have been inadequate to allow country offices to respond to maternal health programming requirements. About half of the case study country offices reported different types of problems with fulfilling their programming responsibilities due to insufficient staffing levels<sup>297</sup>. Also, a majority of the 55 country offices who participated in the online survey<sup>298</sup> considered their staffing levels to be insufficient to respond to all responsibilities linked to the implementation of their sexual and reproductive health sub-programme<sup>299</sup>.

In particular the number of staffing positions funded with core resources has not been adapted to changing programming priorities. At technical level, these shortfalls prevented country offices from being adequately represented in key technical working groups and other coordination forums, and from consistently providing sound technical contributions to their partners<sup>300</sup>, which contributed to low profiles and visibility of UNFPA in maternal health at least in two cases, i.e. in Kenya and Zambia. Staffing gaps at management level, i.e., long-term vacancies of the positions of country representatives and deputy country representatives, also lowered UNFPA's profile in policy dialogue and affected the capacity of the respective office, overall<sup>301</sup>. The findings confirm the earlier results from the desk phase of this evaluation<sup>302</sup>.

Vacancies of existing positions have been a significant cause for the insufficient staffing capacities of UNFPA country offices. A little over 1/3 of country offices, i.e., 36 percent, in the 55 UNFPA partner countries with high maternal mortality ratios<sup>303</sup> indicated that a vacancies in the area of sexual and reproductive health in their staffing roster. Technical reproductive health positions make up the biggest share of these vacancies. This high vacancy rate is even more damaging for the staff capacity of country offices because of the long times it has been taking country offices to fill the open positions. On average, positions of National Programme Officers have been open for 18.5 months, or one and a half years. Management positions, such as those of Deputy Country Representative or Country Representative have been vacant for a slightly

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<sup>297</sup> E.g., Cambodia, Ethiopia, Kenya, Lao PDR, Zambia.

<sup>298</sup> 49% of responding country offices disagreed with the statement "The number of staffing positions in maternal health in the last three years has been fully adequate to fulfill all of our responsibilities related to the overall MH component of the country programme"; 47.2% agreed with the statement; 3.6% saw found the statement "not applicable" (see Survey Report).

<sup>299</sup> Discontent with the staff capacity varied among UNFPA's regions: Whereas 7 out of 10 responding country offices from the Asia and Pacific region thought their staff capacity, i.e. the number of staffing positions, were insufficient to respond to all of the offices maternal health related responsibilities, the level of discontent was somewhat lower in country offices in Sub-Saharan Africa; where only 41% of responding offices were of this opinion.

<sup>300</sup> Problems like this were specifically reported from Ethiopia, Kenya, Lao PDR and Zambia

<sup>301</sup> 36% of country offices questioned in the online survey considered their staffing capacity for technical contributions in maternal health to be insufficient, 38% of country offices saw gaps in their staffing capacity for high-level policy advocacy (see Survey Report).

<sup>302</sup> The corresponding findings from the field phase of this evaluation are in line and confirm the results results of the previous desk analysis that had found several examples of at times severe imbalances between operational requirements and staff allocations. In Tanzania (CP6, 2007 – 2010), the dual responsibilities of country office staff for managing the UNFPA country programme as well as the acting as lead agency for a "One UN Joint Programme" overstretched the staff capacity of the office. At the same time, efforts to recruiting additional staff in reproductive health to the UN Zanzibar office were unsuccessful, despite repeat advertisements of the position, so that in the end, UNFPA on the mainland had to deploy one of its reproductive health NPOs to the office. The Zambia country office (CP6, 2007 – 2010) experienced delays in recruiting staff for its sub-offices; and also was found to require more technical staff to be able to strengthen its "programme implementation, management and monitoring & evaluation". Country offices in Sierra Leone (CP4, 2008 – 2010) and Burkina Faso (CP6; 2006 – 2010) were thought to be significantly under resourced. Programme officers in Sierra Leone were thought to be overloaded; while various vacancies existed, in particular among "middle management". In particular the SRH / HIV sector was found to be "too large for a lone Programme Associate" (recommendation to employ SRH / HIV National Programme Officer).

<sup>303</sup> I.e., MMR above 300 deaths in 100,000 life births, according to estimates of the MMR in the year 2000 (WHO, UNICEF, UNFPA, World Bank, 2010).

shorter period of time, i.e. a little less than 16 months. The longest vacancies, i.e. for National Programme Officers in reproductive health in two countries, have been four years.

The MHTF has made a noticeable contribution to the improvement of the skill mix that is available at country offices for promoting UNFPA's maternal health agenda. About 88% of country offices that had received MHTF assistance since 2008<sup>304</sup> thought that the MHTF had led to at least "limited improvements" in the maternal health skill mix that was available at country office level. Still 72.5 percent of MHTF recipients among the country offices thought that the MHTF had led to "considerable improvements" in the skill mix available for maternal health programming. The importance of the MHTF for improving the staff capacity of country offices is also supported by the results of the country case studies (see Table 47). The availability of resources to hire additional technical expertise to respond to new programming priorities that the MHTF offered was an important asset for UNFPA at country level<sup>305</sup>. For example, the country office in Cambodia initially hired an international midwifery expert with MHTF resources, and then, upon the launching of the EmONC assessment in the country in 2009 (also MHTF funded) re-dedicated the resources to hire a full-time EmONC advisor to manage and supervise the future EmONC support of UNFPA. The country office in Lao PDR used MHTF resources to hire a fulltime SBA coordinator to supports its intensified involvement in this subject area in the country. In most of the country offices, the hiring of MHTF funded CMAs or other advisors represented the only bolstering of staff capacity to better be able to respond to programming requirements that country offices had seen in the recent past. Please see Table 47 below for more detailed information on the different aspects of staff capacity. MHTF resources also have been used to make up for losses in staff positions that had been funded with core funds. In Ethiopia, for example, overall staff numbers have been reduced in the last three years from about 65 to about 55 in 2011. One of the positions that had not been filled again was the International reproductive health advisor. The country office used MHTF resources to hire two midwifery advisors, who now cover the midwifery, nurse anesthetist and obstetric fistula programmes.

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<sup>304</sup> I.e., 40 country offices of the 54 country offices that had participated in the online survey had received MHTF assistance in either 2008, 2009 or 2010.

<sup>305</sup> E.g., in Cambodia, Ethiopia, Lao PDR, Madagascar and Zambia.

**Table 47: Overview of HR capacities of selected country offices (country cases studies)**

Country Office	Ability of country office staff to fulfill responsibilities	Links between program and staffing	Presence of open positions & status of recruitment	Overall assessment of CO staff capacity
<b>Cambodia</b>	(+/-) <u>Coordination:</u> Under previous Representative, country office was actively involved in coordination under HSSP I & II <sup>306</sup> Interim shortfalls and gaps in staffing	(++) <u>Good internal cooperation:</u> very strong combination of Country Representative, Reproductive Health Manager and international Midwife expert, who were participating actively in the debates and influencing outcomes for UNFPA's three mandate areas <u>Adaptation to programme changes:</u> Recruitment of EmONC officer in 2009 (MHTF, i.e., replacing international midwife) at start of national EmONC assessment (MHTF)	(+/-) <u>Major delays</u> in replacement of senior management posts, incl. Country Representative (Recent) losses of key long-time reproductive health staff Eventually, <u>successful recruitment</u> of new reproductive health Manager, P&D Manager, upgrading of Gender post	(+) For the most part, strong leadership and human resources management by country representative, who fostered good cooperation between staff members (e.g., "strong combination of Country Representative, Reproductive Health Manager, International Midwife). Despite tight staffing levels and interim shortfalls, dedicated & well managed staff was able to fulfill important programme related responsibilities (e.g., coordination of HSSP) <b>MHTF allowed adaption of staffing structure to changes in programming</b>
<b>Ethiopia</b>	(-) <u>Capacities at country level stretched</u> to cover all aspects of work; situation might worsen with upcoming devolution, whereby regional health bureaus will require more technical input.	(-) <u>Weak link between of staffing and programming requirements:</u> Country Office was assigned broad mandate with difficult issues but not enough staff to cover all issues. Capacities stretched, e.g., not all fora or TWG could be attended; guidelines on family planning written without presence of UNFPA in working group <sup>307</sup>	(-) <u>In last three years staff reduced</u> from about 65 to about 55; international reproductive health advisor post not filled and other vacant positions had not been re-filled. MHTF funds <u>two midwifery advisors</u> , who cover the midwifery, nurse anesthetist and obstetric fistula programmes.	(-) Weak link between programming needs and (reduced staffing levels meant that country office has not been able to fulfill its responsibilities (e.g., participation in working groups). <b>In absence of core-funded reproductive health advisor, MHTF played important role in providing reproductive health staff (two midwifery advisors)</b>

<sup>306</sup> "UNFPA was the first chair of HSSP2 with a strong leadership technical as well as astutely political in the process of harmonization and alignment" (Interview External Development Partner).

<sup>307</sup> Also based on feedback from external development partner.

Country Office	Ability of country office staff to fulfill responsibilities	Links between program and staffing	Presence of open positions & status of recruitment	Overall assessment of CO staff capacity
Ghana	(-) No one in UNFPA to <u>drive core mandate at policy, sector and budget level decision making</u> , due to lack of two high-level decision making staff. Was felt by Ministries and UN agencies <sup>308</sup> (UNFPA was represented by UNDP Resident Coordinator)	[No information]	(-) No full-time <u>UNFPA Country Representative</u> for almost two years; <u>no Deputy Representative</u> in place for six months and none had been identified at the time of this evaluation Unsuccessful recruitment of M&E officer in 2011 (critical position) <u>Challenge:</u> Other UN agencies provide better starting levels and grades for similarly qualified and experienced professionals	(-) Absence of country representative and deputy representative weakened the capacity of country office to assume leadership role in reproductive health / maternal health. Difficulties in recruiting adequately skilled and experienced staff (also due to insufficiently funded positions)
Kenya	(-) With current staff level, country office not able to ensure adequate capacity for supporting its programmes and catalytic role in implementation of Country Programme and other UN programmes in country <sup>309</sup>	(-) Additional high level technical expertise may be required to be available to participate in and follow up on current technical working groups.	(-) Staff recruitment has been taking long time; often staff remains for years on Special Service Agreements; e.g., recruitment of humanitarian officer had not been finalized at the time of evaluation.	(-) Lack of sufficient numbers of technical staff in reproductive health curtails country office's capacity to manage its programme appropriately; follow technical working groups, as required.
Lao PDR	(-) Gap in the capacity for providing necessary technical support because of limited staff capacity; large workload of SBA coordinator who has a large range of responsibilities. (-) Staff is overwhelmed with large number of international partners and annual work plans to manage; spends considerable time in managing funds rather than providing technical expertise. (-) Management of GPRHCS fund is heavy and quite demanding on	(-) Needs for provision of technical support are larger than can be fulfilled by UNFPA staff; much energy absorbed by administration (+) Following the development of the SBA plan a position of International SBA Coordinator was created. It was initially funded with Luxemburg funds and completed by MHTF funds in 2011. (-/+ ) Recently a short term MNCH Advisor position was created to provide additional support to the reproductive health component.	(-) Deputy Representative post had been vacant for more than a year at the time of the mission. (-) The RHCS/MNCH Technical Advisor has not been replaced. The SBA International Coordinator has been replacing them.	(+/-) Good management of available staff resources, but core staffing levels are too low to fulfill UNFPA programming requirements and to respond to technical support needs; too much energy absorbed by administrative matters. Staff fixes are temporary (e.g., maternal health advisor position left vacant; replaced by MHTF funded international SBA Coordinator) <b>Use of MHTF allowed some reaction to changing staffing</b>

<sup>308</sup> Also based on feedback from external development partner.

<sup>309</sup> Based on feedback from Government partners and external development partners.



Country Office	Ability of country office staff to fulfill responsibilities	Links between program and staffing	Presence of open positions & status of recruitment	Overall assessment of CO staff capacity
	staff.			<i>requirements (i.e., recruitment of SBA coordinator)</i>
<b>Madagascar</b>	(++) UNFPAs human resources at country level seem to enable sufficient effective engagement in current level activities.	(+) Implementing, development and government partners of UNFPA commended the increased availability of technical staff in the last two/three years. (+) Additional staff has been recruited to cope with direct payment mechanisms currently in place.	(+) In 2010 UNFPA reported 62 staff, with just over 50% on SSA, and currently one position for a SRA expert is open and no problems with recruitment were mentioned.	(+) Appropriate (and improved) availability of technical staff; recruitment of both technical and administrative staff to respond to changing programming & administrative requirements; no problems with recruitment <b>MHTF helped to boost staff capacity</b>
<b>Zambia</b>	(-) UNFPA country office not sufficiently staffed to support implementation of past country programmes, specifically in SRH sub-programme. (-) Prior to launch of MHTF in Zambia, SRH adviser was only staff member to manage the SRH/ maternal health portfolio. (-) Number of staff members still insufficient to respond to requirements of MH programming; attendance of many MH-relevant technical working groups (SWAp structure) and other coordination meetings has not been possible, given staffing bottlenecks	(-/+) Recruitment of Country Midwife Advisor (CMA) and Country Fistula Advisor (CFA) has improved situation somewhat; both CMA and CFA have taken on some responsibilities for overall MH portfolio beyond their main responsibility for midwifery and fistula programming; (-) No bolstering of staff capacity from core funds (-) Little specific programmatically defined linkages between reproductive health advisor and country representative	[No information]	(-) Inappropriate staffing levels hamper implementation of reproductive health / maternal health sub-programme; UNFPA's participation in maternal health policy discourse. Little coordination between country office management and technical staff (reproductive health advisor)
<b>Overall Assessment</b>	(-) Large majority of case study country offices (9 out of 10) had insufficient staffing levels / capacity to fulfill their programming requirements; gaps both at technical level but also at management level	(+/-) <b>Majority of examples of adaptations of staffing levels to programming requirements are MHTF funded positions;</b> no examples of adaptation of core positions	(-) Several examples of vacancies of key positions, i.e., country representative, deputy representatives and sexual and reproductive health advisors. Recruitment often difficult, at least in some cases also due to non-competitive resourcing of positions	(-) Inadequate staff capacity in UNFPA country offices has been a major bottleneck that has prevented the adequate implementation of reproductive health / maternal health sub-programmes. Both levels of technical and often also

Country Office	Ability of country office staff to fulfill responsibilities	Links between program and staffing	Presence of open positions & status of recruitment	Overall assessment of CO staff capacity
				<p>management staff have been inadequate to allow country offices to respond to maternal health programming requirements; Core-funded staffing levels have not been adapted to changing programming priorities; this has happened only with the help of MHTF funds.</p>

### **Judgment criterion 11.3: Enhancement / improvement of UNFPA country level programming and interventions through technical and programmatic support from global and regional level**

Regional offices have been focused on supporting country offices in family planning and RHCS<sup>310</sup>, and have comparatively neglected the needs of country offices in other technical areas, such as the prevention and treatment of obstetric fistula or EmONC<sup>311</sup>, midwifery and Human Resources for Health overall<sup>312</sup>. Between 50 percent and 60 percent of country offices in countries with high maternal mortality ratios have not received technical support from regional offices in these areas. The integration of Gender and Population & Development with maternal health was also only rarely addressed in technical support from regional offices<sup>313</sup>. These gaps in technical support coverage in many of the technical areas that are at the centre of UNFPA's maternal health strategy have limited the ability of the regional programme to adequately support the implementation of sexual and reproductive health sub-programmes in partner countries. The quality of support from regional offices has been adequate overall<sup>314</sup>, with little differences in levels of satisfaction between the different technical areas<sup>315</sup>.

One of the causes for the insufficient coverage of technical support has been low staffing levels at regional and sub-regional level<sup>316</sup>. Regional offices have tried to deal with the issue of scarce staff resources by selecting priority countries they focus on with their support<sup>317</sup>. Findings from the survey suggest, however, that this approach has left many country offices without needed assistance.

Regional offices have supported country offices primarily through standardized workshops on topics that had been proposed by the regional office, the provision of guidance documents in issues related to maternal health and corresponding programmes, and through technical support over phone, Skype or e-mail<sup>318</sup>. More customized forms of assistance, such as in-country technical support (other than workshops) by regional office staff or by external consultants; or on-demand workshops, have been less common<sup>319</sup>.

An interesting finding from the online survey is that UNFPA Headquarters has been at least as active, and in some areas even more active, than UNFPA regional offices in providing technical support to country offices. Country offices have not just benefitted from technical guidance documents that had been published at headquarters, but have also sought assistance from New

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<sup>310</sup> 82 percent of country offices had received support in family planning and RHCS from their regional office in the recent past.

<sup>311</sup> Only slightly more than half of country offices had received technical support from country offices in EmONC and obstetric fistula; 58 percent in the case of obstetric fistula; and 53 percent in the case of EmONC. 75 percent of country offices that had received support in these areas had found the support useful; 25 percent had not found it useful.

<sup>312</sup> 47 percent of country offices had received support in midwifery; only 42 percent had received support in HRH overall.

<sup>313</sup> Less than 50 percent have received support on these issues (see Survey Report, Question 8).

<sup>314</sup> Overall, i.e. across different thematic areas and types of support, 66 percent of country offices have been "rather satisfied" (53 percent) or "very satisfied" (13 percent) with technical support from regional offices. 31 percent have been dissatisfied (i.e., 22 percent "rather dissatisfied"; 9 percent "very dissatisfied") (see Survey Report, Question 10).

<sup>315</sup> See Survey Report.

<sup>316</sup> Based on feedback from interviews with regional and sub-regional offices.

<sup>317</sup> Interviews with regional office staff.

<sup>318</sup> See Survey Report, Question 5 for the results of the online survey of country offices. 48 out of 55 country offices surveyed (87 percent) had received assistance from regional offices through standardized workshops and through guidance documents; 45 out of 55 country offices (82 percent) had received assistance via phone, e-mail or Skype;

<sup>319</sup> Only 37 out of 55 country offices (67 percent) had received in-country technical assistance (other than workshops) by regional office staff; 31 country offices out of 55 (56 percent) had received in-country technical assistance by external consultants. Finally, only 36 percent of country offices (20 out of 55) had received technical assistance in the form of customized workshops on a topic of their choosing.

York by means of phone calls, skype contacts or e-mail messages<sup>320</sup>. In country assistance, either directly by UNFPA staff or by a consultant has been arranged primarily by regional offices, however, even here, headquarters has supported between 40% and 50% of country offices.

In areas like *Obstetric Fistula, Emergency Obstetric and Newborn Care (EmONC), Family Planning & Reproductive Health Commodity Security and Midwifery*, more country offices appreciated support from headquarters as useful than was the case for support in these areas from regional offices<sup>321</sup>. This suggests that in these thematic areas, country offices tend to value direct contact with headquarters more than support from the regional level. Interestingly, these are also the areas in which country offices have seen the greatest improvements in technical support since the launch of the MHTF<sup>322</sup>. Since most of the technical support from the MHTF has been given directly from headquarters<sup>323</sup>, it is likely that these advantages of headquarters over the regional offices in these four technical areas are also due to the additional staff resources that the MHTF has provided for the Technical Division in New York.

The regionalization of technical support has failed to improve the technical support to country offices for most cases. Only a small number of country teams that have experienced technical support under both set-ups, i.e. 13 percent, think that the transition has led to improved technical support. Especially in the Johannesburg region, 40 percent of the countries state that the technical support has worsened; overall still 27 percent of country offices think that the quality of technical support has declined. For 24 percent of country office, the quality of technical support has remained unchanged<sup>324</sup>.

Suggestions for improvements of technical support from regional offices evolve mostly around topics like more focused and specific feedback from regional offices, closer and more-frequent in-person contacts between regional offices and country teams, and overall, improved communication between both levels<sup>325</sup>.

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<sup>320</sup> 89 percent of country offices, i.e., 49 out of the 55 surveyed, had received assistance from headquarters through e-mails, phone or Skype, in comparison to 82 percent of country offices (45 out of 55) who had received the same kind of support from regional offices.

<sup>321</sup> Approximately 54 percent thought that support from headquarters on obstetric fistula had been useful or very useful, in contrast to only 44 percent that thought the same about obstetric fistula support from regional offices. 27 out of 55 country offices thought that headquarter support on EmONC had been useful, compared to only 24 offices that thought that same for support in this area from regional offices. For the remaining numbers, please see Survey Report, Questions 8 and 15.

<sup>322</sup> See Survey Report, Question 25.

<sup>323</sup> See final report of the MHTF Mid-Term Evaluation.

<sup>324</sup> See Survey Report, Question 23.

<sup>325</sup> See Survey Report, Question 9.

## 8.1.12 *Evaluation question 12: To what extent did UNFPA maternal health support contribute to UNFPA visibility in global, regional and national maternal health initiatives and help the organization to increase financial commitments to maternal health at national level?*

### **Judgment criterion 12.2: UNFPA leadership of maternal health advocacy campaigns at national level**

By and large, UNFPA has been a visible and well-recognized partner and leader of maternal health campaigns in its programme countries. Partners from government, civil society and the development community have overwhelmingly acknowledged the leadership role of UNFPA in Burkina Faso,<sup>326</sup> Ethiopia,<sup>327</sup> Ghana and Lao PDR. In other countries, UNFPA has been all but the sole provider of maternal health support, e.g., in Madagascar and Sudan, as other development partners had discontinued their support.

In countries, where UNFPA has been able to establish itself as a leader or at least a respected partner in maternal health, it has built this reputation first and foremost on pro-active involvement in technical working groups and other similar forums, the drafting of maternal health related strategies and other technical inputs,<sup>328</sup> including also the provision of data for planning and management of maternal health services.<sup>329</sup> Maternal health specific advocacy campaigns, such as CARMMA, or also events like the international day of midwifery have added to the visibility of UNFPA, but not in the same way, and to the same extent as the consistent and knowledgeable cooperation of its country teams in technical and policy forums.<sup>330</sup> In any event, even in countries where UNFPA had maintained a high visibility throughout the years, the effect of CARMMA on UNFPA reputation as a maternal health leader was ambivalent: Although UNFPA role in launching CARMMA was widely acknowledged; many partners criticized the low level of follow-up to the high-publicity launches.<sup>331</sup>

In two out of the ten case study countries, i.e., in Kenya and Zambia, was not regarded as a well-recognized leader in maternal health. In both cases, UNFPA role was often overshadowed by larger and better-funded agencies, at time even in the traditional core areas of UNFPA, such as family planning.<sup>332</sup> The low profile in both countries was largely linked to the fact that country teams have not been able to use donor coordination and policy dialogue forums to launch any specific maternal health initiatives, or to make any other technical contributions in the areas. In fact, in both cases, UNFPA staff was often not even able to send staff members to all relevant working groups and forums.<sup>333</sup> Partners in both countries regretted that UNFPA had not been playing a more pro-active role in maternal health.<sup>334</sup>

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<sup>326</sup> Government and all partners, including UN, recognized the leadership role of UNFPA in maternal health (Interviews with governments, implementing partners, development partners).

<sup>327</sup> For family planning, reproductive health commodity security and obstetric fistula prior to the launch of MHTF; for midwifery and task-shifting only after the launch of the MHTF.

<sup>328</sup> These factors were specifically mentioned in interviews with UNFPA partners in Cambodia, Burkina Faso, Ethiopia, Lao PDR.

<sup>329</sup> "UNFPA funds resources critical to the country which means they are well positioned, have the reputation of involvement, provide proper evidence for their reproductive health/maternal health arguments and are a responsible partner" (External development partners, Cambodia).

<sup>330</sup> In case study countries where partners did not consider UNFPA to have been a leader in maternal health, such as Kenya and Zambia, its partners criticized mostly its absence from technical working groups; and its hesitance to pro-actively launch maternal health initiatives. UNFPA financial and logistical support of events like CARMMA launches or the organization of midwifery days were not able to counteract this negative impression.

<sup>331</sup> This was the case in Burkina Faso, Ethiopia, Ghana, Kenya, Madagascar and Zambia.

<sup>332</sup> This was the case in Kenya, where UNICEF has been taking on a stronger role in this area.

<sup>333</sup> Based on interviews with UNFPA country offices, development partners, government partners.

<sup>334</sup> Feedback from development partners.

The MHTF has increased UNFPA visibility in particular in areas like midwifery/ skilled birth attendance and EmONC.<sup>335</sup>

**Judgment criterion 12.3: Increased financial commitments of partner governments to sexual and reproductive health and maternal health**

In a number of its programme countries, UNFPA advocacy and other reproductive health support has helped to leverage financial commitments from partner Governments to maternal health. However, a direct attribution of funds raised to any individual type of UNFPA maternal health support is difficult in most cases.

Among the mechanisms that UNFPA country teams employed to solicit additional investments from partner governments were the development and costing of comprehensive maternal health strategies, e.g., in Burkina Faso and Lao PDR.<sup>336</sup> In Lao PDR, the maternal, newborn and child health (MNCH) package that had been developed with UNFPA support was costed, and the Government developed a resource mapping for 5 years, according to which infrastructure and salary costs would be borne by government funds. In Cambodia, the Ministry of Health has invested additional resources for health over the last few years (see table below);<sup>337</sup> out of which 13 percent is earmarked for maternal health.<sup>338</sup>

**Table 48: General government expenditure on health per capita (constant US\$ (2005))**

Countries	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	% Change 2000 - 2009
Burkina Faso	6.7	6.3	7.6	9.3	12.1	15.7	14.8	15.7	16.7	15.3	129%
DRC	0.2	0.3	0.3	1.3	1.5	2.2	2.4	2.9	4.7	6.0	2474%
Ethiopia	3.2	3.9	3.6	3.9	3.8	4.1	4.1	5.3	4.7	5.3	69%
Ghana	10.1	14.2	10.7	11.6	18.2	23.1	24.8	32.9	30.9	26.5	162%
Kenya	10.9	10.5	9.7	9.6	9.2	9.7	10.2	10.7	9.4	11.2	3%
Madagascar	7.2	8.0	6.6	6.1	6.6	6.9	7.6	8.1	9.5	7.7	6%
Zambia	16.1	19.2	24.2	23.9	23.1	24.0	24.9	21.8	25.1	26.1	62%
Sudan	5.5	6.0	6.4	7.6	9.0	9.8	12.5	16.6	19.8	17.7	222%
Cambodia	4.2	5.7	7.1	9.1	9.6	7.2	7.7	12.1	13.3	15.6	271%
Lao PDR	4.6	4.6	4.5	6.0	3.6	2.6	2.8	2.7	6.6	7.8	68%

Source: WHO, Global Health Expenditure Database

In many of these cases, increased financial commitments from Governments triggered additional investments from external development partners. In Burkina Faso, for example, the increased financial commitment from Government encouraged a number of donors to provide additional funds for maternal health. New projects are being finalized with the European Union (family planning and maternal health), the World Bank (family planning and maternal health), the French Development Agency (AFD) and the Canadian Agency for International Development (CIDA) (maternal and neonatal health), Ghana;<sup>339</sup> except funding for family planning, which in fact often is decreased to make up for shortfalls in other sexual and reproductive health areas). Also in Cambodia, the share of external, i.e., donor resources invested in maternal health has

<sup>335</sup> See MHTF mid-term evaluation, final report.

<sup>336</sup> E.g., in Lao PDR with the MNCH Package and Burkina Faso, where the MNH Road Map (Maputo Process) was adopted by the Government.

<sup>337</sup> From 2000 until 2009, General Government Expenditure on Health per capita in Cambodia has increased by approximately 271%, i.e. from US\$4.2 in 2000; to US\$15.6 (in constant US\$ (2005)).

<sup>338</sup> According to interviews with UNFPA, Government; MoH staff and Parliamentarians alluded to UNFPA's advocacy role as important for leveraging the funds.

<sup>339</sup> Since 2008, government funds for maternal health have increased fourfold since (Interview with government partners; UNFPA).

increased, according to information from UNFPA and development partners.<sup>340</sup> In Ethiopia, UNFPA midwifery programme has attracted support from SIDA (US\$3 million); also, according to UNFPA information, UNFPA investment of US\$1 million in the country MDG fund is said to have triggered additional investments from WHO.

**Table 49: External resources spent on health per capita (constant US\$ (2005))**

Countries	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	% Change 2000 - 2009
<b>Burkina Faso</b>	2.3	2.2	2.5	4.1	6.0	9.4	7.7	7.8	8.3	8.0	<b>240.3%</b>
<b>DRC</b>	0.2	0.2	0.3	1.2	1.4	1.4	2.6	1.9	3.4	4.6	<b>2811.9%</b>
<b>Ethiopia</b>	1.0	1.4	0.7	1.4	2.7	2.6	2.9	3.9	3.6	3.8	<b>290.5%</b>
<b>Ghana</b>	3.0	4.4	4.7	3.7	6.9	9.0	8.2	7.5	6.3	6.7	<b>123.2%</b>
<b>Kenya</b>	1.9	3.4	3.7	2.5	3.9	5.0	5.1	6.6	6.4	8.8	<b>369.1%</b>
<b>Madagascar</b>	2.2	3.4	3.0	3.5	3.8	4.2	4.4	2.2	1.9	1.8	<b>-18.1%</b>
<b>Zambia</b>	5.6	4.5	9.9	12.4	13.8	18.6	18.3	12.1	15.6	17.1	<b>205.2%</b>
<b>Sudan</b>	0.9	1.0	0.8	1.0	1.4	1.9	3.3	3.0	2.5	2.4	<b>176.4%</b>
<b>Cambodia</b>	1.8	3.8	4.2	6.9	7.3	8.5	6.6	8.0	8.8	9.4	<b>431.9%</b>
<b>Lao PDR</b>	3.8	1.7	2.1	2.5	3.6	3.4	5.1	3.8	4.4	5.1	<b>33.9%</b>

Source: WHO, Global Health Expenditure Database

There is no evidence that CARMMA launches in the African case study countries have helped to increase financial commitments to maternal health.<sup>341</sup>

<sup>340</sup> In 2006, UNFPA joined HSSP II and became its chair. By 2010, 40% of the total pool fund (noted in 2010 at over \$100 million) was being allocated for reproductive health/maternal health and this was due to the evidence provided to the big donors “with the Midwifery Review (2006), Midwifery programming (2007-10), its National Assessments on EmONC (2009) and the Improvement Plan (2010-2015)”.

<sup>341</sup> In Ghana, CARMMA was seen to have raised political commitment, however, without translating into financial commitments. Similar circumstances prevailed in Burkina Faso, Ethiopia, Kenya and Zambia. One important detracting factor was that CARMMA was in these cases mostly a “one-off” affair, which meant that neither the partner government nor UNFPA followed up on the launch.

## 8.2 Finding matrices for MHTE

### 8.2.1 Evaluation question 1: To what extent is UNFPA maternal health support adequately focused on addressing the reproductive and maternal health needs of the vulnerable groups among countries and within countries?

#### Judgment criterion 1.1: Correspondence between levels of UNFPA sexual and reproductive health/ maternal health support and maternal health needs of vulnerable groups across programme countries

Findings from <b>desk study</b>	There is no or little correspondence between the allocation of UNFPA maternal health support among countries and the prevalence and severity of maternal health needs in the countries. An internal UNFPA report (UNFPA, 2011) found no correlation between the reproductive health status in UNFPA programme countries and the levels of UNFPA investment in reproductive health <sup>342</sup> . This is possible because the specific criteria <sup>343</sup> ; and the different steps in UNFPA’s resource allocation (among country groups) and resource distribution system (within each of the three country groups) renders the influence of the quantitative allocation criteria that represent measure of maternal health needs relatively indirect. The resource allocation system merely considers, to what extent a country has reached a series of 8 relatively high thresholds, when assigning it to one of the needs-based country groups <sup>344</sup> . The allocation system does therefore not systematically consider how far the different countries in each group are away from reaching the agreed thresholds. This could in principle result in a situation where the aggregated needs in the high needs group (Group A) are so high that the additional resources that UNFPA allocates to this group are not sufficient to give these countries the intended higher share of support in comparison to the medium need countries in Group B. Also, the Resource Distribution System that is responsible for distributing resources within each of the groups gives considerable leeway to headquarters and the regional offices to base the distribution of resources on considerations other than maternal health related criteria. These include overall socio-economic quantitative criteria (GNI per capita, for example); but also additional qualitative criteria <sup>345</sup> . No information exists at this time to assess to what extent reduced funding to certain high need countries was a result of strategic considerations among maternal health partner organizations (e.g. H4+) that assigned UNFPA a strategically important but less costly role.
Findings from case study in <b>DR Congo</b>	Les critères qualitatifs pour la répartition des ressources semblent obscurs et déséquilibrés et ne semblent pas prendre en compte le poids démographique, l’étendue du pays et/ou les besoins de la population. L’UNFPA en RDC est frustré par sa faiblesse financière qui ne permet absolument pas une participation à la hauteur des autres partenaires.
Findings from case study in <b>Ghana</b>	<i>UNFPA Ghana has not formally defined “vulnerability” or vulnerable groups within maternal health/reproductive health and neither is it a member of the Social Protection Sector Working Group. However the term vulnerable is used widely in its publications regarding</i>

<sup>342</sup> Based on the correlation of the “lifetime risk of maternal death (LRMD) with the proportion of indicative assistance in reproductive health”; the same lack of correlation is also true for other SRH indicators, such as contraceptive prevalence, unmet needs or teenage pregnancy rates and budgets or expenditures” (UNFPA, 2011)

<sup>343</sup> I.e., the set of 8 maternal health and SRH indicators and the associated targets

<sup>344</sup> I.e. the “high needs group” (Group A); the “medium needs group” (Group B), or the “low needs group” (Group C).

<sup>345</sup> Such as “Degree of political support to the ICPD agenda”, “Absorptive capacity” or the “Humanitarian response, transition and recovery situation in each country”.



	<p><i>maternal health in the area of fistula, humanitarian situations and in cases of HIV/AIDS or domestic violence. There is a need to keep a balance between poor regions of high need with scanty population and pockets of extreme poverty, high population density with high MMR but located in rich regions when planning interventions.</i></p> <p>Much of the vulnerability that UNFPA deals with is under HIV, which looks independent in its approach but is aligned to reproductive health component. MoH has UNFPA Ghana targeting 5 of the most difficult regions and districts/sub-districts where MMR is high<sup>346</sup>. UNFPA has been mandated in all the national health documents to focus on hard to reach and hard to convince target groups for awareness raising and sensitization. The entire Northern Region which is rural and remote and where UNFPA is most active is considered poor and marginalized, with limited health resources and limited skilled staffing. Within this context and in a particular geographical area UNFPA addresses complex subjects such as EmONC quality and readiness of health facilities, family planning services (which saves lives, reduces poverty and is affordable)<sup>347</sup>, Adolescent Reproductive Health, domestic/gender based violence, fistula and HIV.</p> <p>Population size of regions and districts is one criterion for funding; there are also several health and social indicators that have priority, and it is this sum total that informs UNFPA Ghana's resource allocation within the country<sup>348</sup>. However when macro data for regions are used to select geographical areas of intervention, often pockets of poverty can be overlooked. For example Accra has poor and deprived population groups but because interventions are done based on regional averages, these groups get overlooked. This happened with the women porters in markets until special attention was brought of their plight by an NGO.</p>
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**Judgment criterion 1.2: (Increased) availability of accurate and sufficiently disaggregated data for targeting most disadvantaged / vulnerable groups**

<p>Findings from <b>desk study</b></p>	<p>The needs orientation of UNFPA support at country level is also not immediately apparent. UN agencies, including UNFPA, are preparing their country programmes for each country in a joint process, working out the United Nations Development Assistance Framework (UNDAF). The UNDAF is developed on the basis of a common needs assessment of all UN agencies, the so-called Common Country Assessment (CCA). UNFPA is responsible for the sufficient consideration of maternal health issues in the CCA as well as later in the UNDAF. However, the extent to which past CCAs have identified the specific maternal health needs was often limited. A number of assessments limited themselves to very basic data and often left out specific information on maternal health/reproductive health. A small number carried out a thorough assessment of reproductive health/maternal health based on the latest data. Niger and Sudan are relatively positive examples of CCAs that meet the UNFPA and UN requirements. Almost all CCA were lacking sufficiently disaggregated data for targeting most disadvantaged and vulnerable groups. Many CCAs were based on old or estimated data and therefore could not capture the country's health-related situation at that moment<sup>349</sup>. Only about half of the examined CCAs contained a specific chapter on maternal health/reproductive health in which maternal health related statistics as well as qualitative data were</p>
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<sup>346</sup> UNFPA Ghana AWP 2009-10

<sup>347</sup> Slogan on government publication on family planning

<sup>348</sup> Results and Resource Framework for Ghana, CPAP 2006-2011

<sup>349</sup> Usually the assessments rely on the national Demographic and Health Surveys (DHS); other sources are the Ministry of Health and international organizations (WHO, UNICEF). Many CCAs fall back on the main indicators of MDG5. As a consequence the indicators MMR, skilled birth attendance and contraceptive prevalence can be found in almost all CCAs where they usually are the crucial quantitative basis for further analysis of maternal health/reproductive health. In some cases further official MDG5 indicators, like antenatal care and adolescent birth rate are used. Only few CCAs bring in additional indicators such as Caesarean rate, FGM or obstetric care. The strong focus on MDGs can also be seen in the structure of some CCAs, which follows the classification of the eight MDGs.

	<p>provided. Some CCAs at least identify maternal health/reproductive health as an important issue and give explicitly information on it in a summarized way. Six out of the 22 assessed CCAs, however, did not provide any specific information on the issue of maternal health/reproductive health but limited themselves to the presentation of general health issues. Only eight out of 22 CCAs contained an analysis of root causes for poor maternal health. Some countries carried out an analysis but only mention immediate causes such as the concrete reasons for maternal deaths, e.g. hemorrhage, obstructed labor, abortion, etc. and ignore the structural root causes or just cover the health sector in general disregarding maternal health/reproductive health issues.<sup>350</sup></p>
<p>Findings from case study in <b>Burkina Faso</b></p>	<p><i>Les données désagrégées disponibles grâce aux Enquête Démographique et de Santé et aux études situationnelles réalisées avec le soutien de l'UNFPA peuvent permettre de cibler les besoins lors de la planification. Toutefois le système de suivi ne prend pas en compte les groupes vulnérables de façon spécifique.</i></p> <p>La planification du 6<sup>ème</sup> programme pays de l'UNFPA (2006 – 2010) s'inscrit dans le cadre de l'UNDAF qui s'appuie sur une analyse de la pauvreté réalisée au Burkina Faso dans le Cadre Stratégique de Lutte contre la Pauvreté (CSLP)<sup>351</sup>. L'analyse de la pauvreté prend en compte les lieux de résidence de la population (urbain et rural), le niveau d'éducation le genre et les zones géographiques. Ces critères ont été utilisés dans l'analyse des résultats de l'Enquête Démographique et de Santé (EDS) 2003 ainsi que l'EDS 2011 comme les résultats préliminaires le montrent<sup>352</sup>. Ces deux enquêtes ont été réalisées avec l'appui de l'UNFPA.</p> <p>Afin de s'assurer que les actions planifiées répondent à des besoins, l'UNFPA appuie la réalisation d'études situationnelles concernant l'offre des services de Santé de la Reproduction (SR) (SONU, sécurisation des produits SR..) ainsi que des études socio comportementale en SR. La plupart de ces analyses informe le processus de planification nationale qui est coordonné par le Ministère de la santé à travers la Direction de la santé de la mère et de l'Enfant (DSME)<sup>353</sup>.</p> <p>Les indicateurs de suivi sont les indicateurs de routine du Système National d'Information Sanitaire (SNIS) et sont collectés au niveau des districts sanitaires. Ce système de suivi ne permet pas de singulariser les résultats parmi les groupes les plus vulnérables.</p>
<p>Findings from case study in <b>Cambodia</b></p>	<p><i>UNFPA Cambodia has supported the disaggregation of data for planning, programming and measuring trends in information and services to the poor and disadvantaged groups. Availability of such disaggregated data at the Operational District (OD) level has increased. Vulnerability assessments specifically for the purpose of reproductive health/maternal health have not been done. The term vulnerable is used only in reference to HIV AIDS and describes the most at risk populations (MARF) and is being expanded to people (women mostly) facing gender based violence.</i></p> <p>In Output 4 of its Country Programme Action Plan (CPAP 2006-10), UNFPA pledged to increase access to high quality, comprehensive; client oriented and gender sensitive reproductive health information and services for the rural poor and vulnerable groups in priority areas. The 2008 census provided trends in total fertility rate (TFR) by province for the first time and examined factors affecting fertility decline linked to the social and economic status of women. The census also provided trends of the maternal mortality ratio, infant mortality rate (IMR) and under five mortality rate (U5MR) based on administrative, geographic, income and remote area differentials.</p>

<sup>350</sup> It is not clear at this point, to what extent UNFPA, and in particular UNFPA country offices have had access to reliable and accurate data from regular monitoring at the activity and output level.

<sup>351</sup> Ministère de l'économie et du développement : Cadre Stratégique de Lutte contre la Pauvreté -Décembre 2003

<sup>352</sup> Résultats Préliminaires - Enquête Démographique et de Santé et Indicateurs Multiples – Burkina Faso - 2011

<sup>353</sup> Entretiens avec l'équipe UNFPA

	<p>UNFPA also supported the dissemination of Cambodian DHS data at OD level in the past two cycles (2005 and 2010). It also funded the training of 144 staff members of the National Institute of Statistics (NIS) to do secondary analysis of data disaggregated by urban/rural, gender and wealth quintile (poor and poorest) of both the census and CDHS<sup>354</sup>.</p> <p>With support from UNFPA, the National Reproductive Health Programme has developed sophisticated costing tools to expand service to rural, remote and poor areas, health equity funds for the poor (HEF) and voucher schemes. A high-level annual conference of Provincial Governors and district health authorities in five regions conducted by the National Committee on Population and Development helped to disseminate and utilize reproductive health/maternal health data. An inter-agency assessment on vulnerability and SRH was conducted in 2011 with implications for expanding maternal health services to the MARP<sup>355</sup>. A new programme (2011- ) to tackle gender-based violence also explores issues of vulnerability and reproductive health/maternal health support services.</p>
<p>Findings from case study in <b>Ethiopia</b></p>	<p><i>UNFPA in Ethiopia is supporting the availability of accurate and sufficiently disaggregated data for planning, implementation and evaluation of population and reproductive health programmes. The DHS and census identify specific vulnerable groups and include data on HIV/AIDS/STI and maternal mortality. Whilst the number of users of those data could not be ascertained, the amount of donors for and partners to these surveys indicates the importance of the data for the development community in Ethiopia.</i></p> <p>The UNFPA in Ethiopia determines its interventions based on the Government's priorities, complemented by diagnostic work undertaken by the GoE, the UN and other development partners. The Government of Ethiopia Growth and Transformation Plan 2011-2015 is aligned with the Millennium Development Goals timeframe and builds on the MDG Assessment Report of the Government of Ethiopia. In July 2010, the Ministry of Finance and Economic Development commissioned a series of situation analysis reports with a special focus on the needs of boys and girls. The Growth and Transformation Plan 2011-2015<sup>356</sup> was prepared with extensive inputs from a wide-ranging consultation with civil society, the private sector, development partners (including UNFPA) as well as communities. Being part of this process ensured that the UNFPA and partners contributed to the setting of national priorities.</p> <p>The Reproductive Health component of the 6<sup>th</sup> Country Programme (CP 2007 – 2011) is hence aligned with the national health sector priorities and addresses vulnerable groups, such as adolescent girls, youth, mothers, newborn, etc. Previously 'women and children' were defined as vulnerable group, but that was abandoned as 75% of Ethiopia's population would be vulnerable<sup>357</sup>. The National reproductive health Strategy mentions female domestic workers, migrants (national and international) hard to reach by the health services, out of school youth, as vulnerable<sup>358</sup>. Depending on the programme, different or additional groups are defined: i.e. women and girls in Afar and Somali regions are considered as vulnerable for FGM. Indicators in the current CPAP are 'target population' and 'affected population'.</p>
<p>Findings from case study in <b>Ghana</b></p>	<p><i>The Fourth and Fifth Country Programmes (CP 2001-5, 2006-10 extended to 2011) of UNFPA Ghana have their roots in Ghana's Poverty Reduction Strategies and a variety of sources of disaggregated data systems supported by UNFPA for use by Road Maps to help identify health and social needs of target groups.</i></p> <p>The Ministry of Health Planning Programme, Monitoring and Evaluation Unit (PPME) mentioned the Road Map Abuja Call for</p>

<sup>354</sup> Government Partner.

<sup>355</sup> External Development Partner.

<sup>356</sup> This is the national poverty reduction plan, following the PASDEP 2005-2010.

<sup>357</sup> Information from government and development partners.

<sup>358</sup> National Reproductive Health Strategy 2006-2015.

	<p>Accelerated Action towards Universal Access and Maputo Plan of Action (PoA) from Operation of Continental Policy Framework for SRH as a central document targeted to meet the needs of the poor and disadvantaged<sup>359</sup>. UNDP and all UN agencies mentioned Millennium Development Goals Acceleration Framework (MAF, which is not just for health but has a large section on maternal health/reproductive health) and the UNFPA Country Action Plan (CAP 2006-2010). The European Union is satisfied that both the Road Maps are sufficiently pro-poor and is committed to funding (not allocated yet but close to a decision) as both MoH and UN Country Team (UNCT) is signatory to the document. The two Road Maps utilize indicators from maternal health survey 2007, DHS data 2008 and Multiple Indicator Cluster Survey (MICS 2008).</p> <p>Targeting of vulnerable groups is usually sector led, for example women who experience gender based violence are defined as a vulnerable group by the Ministry for Women and Children Affairs (MoWAC). HIV AIDS documents refer to the most at risk population or MARP. Population groups in maternal health documents are not defined as vulnerable by MoH or UNFPA but rather as target groups based on their health and social needs like women suffering from fistula<sup>360</sup>. UNFPA's Resource Allocation System (RAS) classifies Ghana in the A category because in spite of economic progress it still lags behind in the achievement 8 ICPD related indicators, one of which is high MMR. The achievement of these 8 ICPD indicators in strategic mandate areas is reflected in the content of the UNFPA Country Programme and the allocations for each component: reproductive health 50.1%, population and development, 21.9% and gender 10.1%.<sup>361</sup> The inclusion of non-core resources from MHTF and Global Programme to Enhance Reproductive Health Commodity Security Trust Fund (GPRHCSTF) raises the allocation for reproductive health/maternal health to nearly 70% (most of the increase is in midwifery). Implementation rate is high for the 3 mandate areas funded by core resources - 74-78%.</p> <p>Civil Society Organizations (CSO) who are especially mandated by UNFPA Ghana to address and ameliorate social issues faced by the poor and disadvantaged receive about 37% of the UNFPA core funds in the reproductive health component. The bulk of the Trust Fund (MHTF and GPRHCS) resources are provided to Ghana Health Service in various regions especially those with high MMR such as Central and Northern Regions and the Midwifery Schools under the MoH for training students from rural and remote areas, equipment and contraceptives.</p>
Findings from case study in <b>Kenya</b>	<p><i>Since the 4<sup>th</sup> CP the country office Kenya increasingly supports the availability of accurate and sufficiently disaggregated data for planning, implementation and evaluation of population and reproductive health programmes. The DHS and census identify specific vulnerable groups and include data on HIV/AIDS/STI and maternal mortality. Whilst the number of users of those data could not be ascertained<sup>362</sup>, the amount of donors for and partners to these surveys indicates the importance of the data for the development community in Kenya.</i></p> <p>UNFPA supports within its PD programme since 1999 demographic health and household surveys which meanwhile data on maternal mortality, antenatal visit, delivery in health facility, modern contraceptive prevalence rate and health seeking behavior are included in addition to the socio-economic data. The DHS 2008/2009<sup>363</sup> disaggregates data on rural and urban population per demographic, socioeconomic and health data down to province level. UNFPA achieved the inclusion of the HIV module in the DHS 2008/9 and the</p>

<sup>359</sup> Interview with Government Partner.

<sup>360</sup> CPAP 2006-2011, UNFPA Ghana.

<sup>361</sup> Core and None Core Resource for CP5 (2006-11), UNFPA Ghana.

<sup>362</sup> Country Programme Performance Summary, June 2008.

<sup>363</sup> Kenya DHS 2009 Final report, <http://www.measuredhs.com/pubs/pdf/FR229/FR229.pdf>, accessed 20<sup>th</sup> Feb 2012.

	<p>collection of data on persons with disability and the elderly. The country office also provided technical and financial support for the Kenya AIDS Indicator survey.</p> <p>National and international strategies and programmes such as the UNFPA Country Programmes, the UNDAF, the MDGs and the Medium-Term Plan (MTP1) of the Kenya Vision 2030 aim at improving maternal health in Kenya and address in their documents and specific projects a broad range of vulnerable population groups, such as women, girls, youth, extremely poor, disabled and elderly etc. or according to geographical location, such as remote, hard to reach, or urban slums population<sup>364</sup>. The 5<sup>th</sup> CP (1997 to 2001)<sup>365</sup> addressed for example in its reproductive health sub programme 'pastoralist communities, slum dwellers, youth and adolescents, widows and orphans' as target groups. Although vulnerable populations can be seen all over the country, the assumptions have been that there will be more vulnerable populations in remote, rural, hard to reach areas, which explains the UNFPAs operational approach of geographic targeting.</p>
<p>Findings from case study in <b>Lao PDR</b></p>	<p><i>The 4th Country Programme (2007 – 2011) (CP4) is aligned with the United Nations Development Assistance Framework (UNDAF) which is based upon the vulnerability analysis of the CCAs and the 6<sup>th</sup> National Socio-Economic Development Plan 2006-2010 (NSED). The various assessments undertaken with UNFPA support allowed generating evidence for more targeted programming towards remote areas and small ethnic groups. However there are no particular monitoring arrangements that gauge if the needs of the most vulnerable groups are addressed.</i></p> <p>The CCAs for the two UNDAF cycles had analyzed the various development gaps in the country and provided general information as regards to vulnerability and its causes. It considers as vulnerable women, children, young people and rural populations, particularly those in remote communities and from smaller ethnic groups<sup>366</sup>. UNFPA supported the Lao PDR Reproductive Health Survey (LRHS) 2005 that provided disaggregated data by level of education, urban, rural with road, rural without road, regions and provinces.</p> <p>UNFPA has also supported different assessments in the area of maternal health. This includes the 2008 Skilled Birth Attendance (SBA) assessment that allowed drawing a clear picture of existing services, e.g., coverage, human resources, facilities and training. The assessment also provided information on the services that needed to be reinforced, particularly in rural areas<sup>367</sup>. The PEER Study undertaken in 2008 focused upon ethnic and rural women's perceptions and needs related to reproductive health. The EmONC assessment, undertaken with MHTF support in 2011, looked at coverage, access, utilization and referral systems for EmONC services.</p> <p>UNFPA selected its geographic areas of interventions based on reproductive health indicators such as maternal mortality, contraceptive prevalence and births attended by skilled personnel but also considered factors like remoteness and poor accessibility; the latter particularly for the Community Based Distribution (CBD) of contraceptives. Although UNFPA had selected particularly poor districts for targeting its support (e.g. the poorest districts in 3 Southern provinces), the UNFPA monitoring system was not designed to track whether the needs of vulnerable groups have been addressed in particular.</p>
<p>Findings from case study in <b>Madagascar</b></p>	<p><i>UNFPA is providing support to collection and analysis of data for programme and project planning on national and sub-national level. Many data from other sources remain unused as they are dispersed and not linked or harmonized on national level, in a database for</i></p>

<sup>364</sup> i.e. UNDAF 2009-2013, CPAP 2004-2008.

<sup>365</sup> Final Evaluation Report on the UNFPA 5<sup>th</sup> Country Programme of Assistance to the Government of Kenya (1997-2001).

<sup>366</sup> GOL/UNDP - United Nations Development Assistance Framework (UNDAF) - Lao PDR - 2007-2011.

<sup>367</sup> Assessment of Skilled Birth Attendance in Lao PDR - Ministry of Health - UNFPA - March 2008.

	<p><i>example.</i></p> <p><i>The level of disaggregation of vulnerable groups seems sufficient for programme planning and management.</i></p> <p>National and international strategies and programmes such as the UNFPA Country Programmes, the Madagascar Action Plan which is the equivalent of a poverty reduction strategy, the Plan Operational pour la Mise en Œuvre de L'Engagement de Madagascar a la Strategie Globale du Secretaire general des Nationa Unies pour la Sante de la Femme et de l'Enfant 2012-2015, the UNDAF, the MDGs aim at improving maternal health in Madagascar and address in their documents and specific projects a broad range of vulnerable population groups, such as pregnant women, pregnant teenagers, adolescent girls, youth, mothers, newborn, and women with fistula etc. or according to geographical location, such as 'remote' or 'hard to reach population'. In the 6<sup>th</sup> CPAP the particular vulnerability of 'les jeunes et les femmes en age de procreer' was noted.</p> <p>UNFPA supports within its PD programme demographic health and household surveys which include apart from socio-economic data, health data on maternal mortality, antenatal visits, births in health facilities, modern contraceptive prevalence rate and health seeking behavior.<sup>368</sup> Furthermore, several surveys and assessments initiated and /or supported by UNFPA (see Judgment criterion 1.2 MHTF) have been providing disaggregated data for programme planning, including for example the Feuille de route pour la réduction de la mortalité maternelle 2005-1015. Also, the Madagascar Action Plan includes indicators for the ICPD agenda based on UNFPAs intervention. UNFPA monitoring tools reflect the project indicators, for example the EMONC reporting tool includes the medical history, and the maternal audit tool includes distance and access route (road, river, and track) between home and health facility in which the death occurred.</p> <p>Whilst countrywide a lot of data is produced through assessments by varied bi-lateral and NGO partners or even by the health administrations to be utilized for their programme planning, these data remain dispersed or not accessible, are not harmonized and are not linked on national level, as the capacity for a strong coordination mechanisms on national level seems to be lacking.</p>
Findings from case study in <b>Sudan</b>	<p><i>UNFPA has helped to increase the availability of data for planning and targeting maternal health support (and support in other sectors), both through the studies and surveys implemented under its reproductive health sub-programme and also through the support of the macro-level survey, such as Sudan's Census or the Sudan Household Health Survey (SHHS).</i></p> <p>In Sudan, UNFPA has not operationalized the term "most vulnerable" with respect to particular demographic groups. Targeting is instead done geographically, by concentrating on UNFPA's 5 focal states. Within those states, UNFPA has provided maternal health support without attention to particular demographic groups, but is specifically supporting IDPs and returnees with maternal health services. Geographic targeting is in line with the focus of Sudan's national reproductive health programme on "red zones for women's health". In accordance with the geographic targeting, UNFPA's monitoring systems have not specifically focused on the maternal health situation of specific demographic groups<sup>369</sup>.</p> <p>In order to ensure needs oriented planning of its support, the UNFPA country office has financed and carried out a relatively large</p>

<sup>368</sup> World Bank, Final Madagascar Health Sector Policy Note 2010.

<sup>369</sup> Interviews at UNFPA country office.

	number of additional needs assessment and ex-ante studies, covering maternal and reproductive health overall, as well as specific areas, such as EmONC, Family Planning and Reproductive Health Commodity Security (RHCS) <sup>370</sup> , and has created a relatively good evidence base for programming, especially for a data-scarce environment like Sudan <sup>371</sup> .
Findings from case study in <b>Zambia</b>	<p><i>UNFPA has been targeting its maternal health support geographically, i.e. by offering service delivery support in three focal regions, without prioritizing any specific demographic group in these provinces and without collecting and making available data on the maternal health situation of specific demographic groups in these provinces.</i></p> <p>The concept of “most vulnerable” is not consciously applied or operationalized in UNFPA planning and implementation in Zambia<sup>372</sup>. Instead, UNFPA has targeted its maternal health support primarily geographically, i.e. by supporting the delivery of maternal health services in initially two provinces; and since 2011, in three of Zambia’s nine provinces (Luapula, North-Western and Western Provinces). Beyond that, UNFPA has addressed maternal mortality broadly and without using survey or monitoring data to deliberately target specific demographic groups, neither nationally, nor within the three provinces. However, it must be noted that the three provinces supported by UNFPA are among the lower-performing provinces in Zambia, at least when judged on the basis of the percentage of births attended by skilled personnel<sup>373</sup>.</p>

<sup>370</sup> Note: In midwifery, UNFPA documents mention an assessment of the “midwifery status in the country” (reportedly financed by MHTF), however, the evaluators were not able to obtain the corresponding document during the country visit.

<sup>371</sup> Document review and UNFPA country office interviews.

<sup>372</sup> Feedback from interviews with UNFPA staff.

<sup>373</sup> The UNFPA-supported Demographic and Health Survey (DHS) still does not provide geographically disaggregated data on maternal mortality (UNDP Zambia, 2011), so that the MDG progress report 2011 can only discuss the inequality in Zambia regarding maternal health in the following terms: “However, there is reason to believe that maternal mortality rate is worse in rural areas, where access to health services is much poorer” (UNDP Zambia, 2011).

### Judgment criterion 1.3: Needs orientation of planning and design of UNFPA supported interventions

Findings from <b>desk study</b>	Needs orientation of planning and design of UNFPA supported interventions was also weak. Along with the annual work plans (AWP), UNFPA's country programme action plans (CPAPs) are the basis for the implementation of the Fund's country programmes. Thus, CPAPs should identify maternal health needs and constraints of (most) vulnerable and disadvantaged groups and develop specific and customized strategies. However, the quality of the CPAPs differs significantly regarding these issues. Whereas some CPAPs identify and name the most vulnerable groups, explain the rationales for identifying these groups as most vulnerable and align their reproductive health strategies with the specific groups, other CPAPs do not provide any disaggregation of the vulnerable groups at all and either refer to vulnerable groups as a whole or do a very superficial breakdown by sex and age (women, men, young people). Positive examples are the CPAPs of Ivory Coast, Ethiopia and Nepal, which initially identify the most vulnerable groups and then align the reproductive health strategies with their needs and constraints. Moreover, Nepal is the only case that provides a specification of vulnerable groups by their social status regarding the caste system in the country. Many CPAPs, however, rather focus on HIV than on maternal health issues and thus specify groups primarily by their vulnerability to HIV.
Findings from case study in <b>Burkina Faso</b>	<p><i>L'UNFPA a planifié plusieurs types d'interventions qui prenaient en compte les besoins des populations mal desservies et de certains groupes vulnérables; entre autre lors de ses efforts dans les zones de convergence. Néanmoins bien que les fonds ciblés soient dédiés à la santé maternelle et visent les femmes et le nouveaux nés des interrogations en ce qui concerne le ciblage des populations les plus moins bien desservies peuvent être légitimes lors du passage à l'échelle nationale à travers le PADS (panier commun) comme dans le 7ème programme.</i></p> <p>Les groupes vulnérables sont définis comme les populations rurales, les femmes, les jeunes... mais il n'y a pas de définition précise des groupes vulnérables<sup>374</sup>. En fait toutes les populations rurales sont considérées comme vulnérables. Au cours des 5<sup>ème</sup> et 6<sup>ème</sup> programmes pays l'UNFPA a agit au niveau national et s'est focalisé sur 3 régions qui on des incidences de pauvreté élevées: les régions du sahel, de l'Est et du Centre Est<sup>375</sup>.</p> <p>La politique de subvention des SONU adoptée en 2006 et mise en œuvre en 2006-2007 qui subventionne les SONU à 80% et à 100% pour les indigents est une illustration de politique visant à prendre en compte les besoins des groupes les plus vulnérables et a eu un impact sur l'augmentation du nombre d'accouchement assistés par une personne qualifiée. L'UNFPA a participé aux groupes de travail lors de la conception de la politique et a appuyé sa diffusion<sup>376</sup>.</p> <p>Le projet de prise en charge des Fistules Obstétricales s'adresse à des femmes très marginalisées et donc très vulnérables. Il a commencé à partir de 2004 avec une étude de la situation, le développement de modules et la prise en charge des cas de FO. Le soutien de la Coopération Luxembourgeoise dans la région du Sahel a permis la mise en œuvre d'une approche intégrée de lutte contre les fistules qui peut être un modèle pour le gouvernement, l'appropriation de cette approche est acquise au niveau national mais les modalités et les ressources pour un passage à l'échelle nationale restent à définir<sup>377</sup>.</p>

<sup>374</sup> Entretien avec l'équipe UNFPA.

<sup>375</sup> Ministère de l'économie et du développement : Cadre Stratégique de Lutte contre la Pauvreté - Décembre 2003.

<sup>376</sup> Entretien avec l'équipe UNFPA et revue documentaire.

<sup>377</sup> Entretien avec l'équipe UNFPA et les partenaires gouvernementaux.



	<p>Depuis 2008 l'UNFPA appuie l'approche Individus, Familles et Communautés (IFC) (Travailler avec les Individus, les Familles et les Communautés) qui permet d'impliquer les populations des zones reculées et de mobiliser un soutien local afin d'améliorer l'accès aux services<sup>378</sup>.</p> <p>L'appui au plan de sécurisation des produits SR permet également d'améliorer l'accès aux soins en assurant la disponibilité des produits SR dans toutes les structures sanitaires. La distribution à base communautaire (DBC), réactivée en 2010 à travers le Programme d'Appui au Développement Sanitaire (PADS) est accompagnée d'activités de sensibilisation sur la SR et permet de toucher des populations isolées et permet d'accroître l'accessibilité de la PF dans des zones rurales<sup>379</sup>.</p> <p>Les Partenaires Techniques et Financiers (PTF), dont l'UNFPA, soutiennent la planification opérationnelle des Directions Régionales de la santé (DRS) et des districts sanitaires lors de revues des plans annuels dans le cadre des financements du panier commun. En 2010, les fonds ciblés représentaient près de 90% des fonds passant par le panier commun et sont destinés à des activités prioritaires pour la santé maternelle. Dans le cadre de la décentralisation chaque district sanitaire a la possibilité de suivre les performances de chaque structure de santé et de planifier ses actions en fonction des résultats et en fonction des populations les plus défavorisées. Toutefois ce type de planification requiert un niveau de compétences que tous les districts sanitaires n'ont pas<sup>380</sup>. Les fonds ciblés contribuent à améliorer la santé des femmes qui sont un groupe vulnérables mais les besoins sont immenses et l'UNFPA n'a pas la possibilité (par manque de personnel) de fournir un appui suffisant à tous les districts sanitaires pour une planification qui cible les groupes les plus défavorisées au sein de chaque district.</p>
Findings from case study in <b>Cambodia</b>	<p><i>UNFPA is highly strategic in how it conducts and utilizes needs assessments/reviews to get attention for planning and designing its pro-poor interventions. Issues of equity and equality in maternal health services remain a critical issue in both urban pockets and rural/remote areas.</i></p> <p>UNFPA has afforded high priority to geographic areas with poor maternal health indicators, amongst other things by promoting the rapid expansion of both the National Safe Motherhood Action Plan (2001-2005) and the Community-Based Distribution Programme<sup>381</sup> to small towns and rural and remote areas. The country office has also frequently utilized the Midwifery Review (2006) to advocate for funding and extending midwifery programming. The efforts focused on numbers, skills and placement of midwives in 14 (out of 18 in 2007-9) of the poorest operational districts to boost access and utilization of district hospitals and Health Centers<sup>382</sup>. The progress in improving maternal health, which was illustrated in the Cambodian Demographic Health Survey (CDHS) in 2010 provided motivation for the Government to sustain its efforts to reach the corresponding MDG targets by 2015. It stands firmly behind the Fast Track Road Map for Reducing Maternal and Newborn Mortality (2010-2015) which targets all periurban and rural ODs showing poor performance<sup>383</sup></p> <p>By working fairly exclusively with Government, UNFPA interventions target the 40% of women and their families who seek primary health care through the public health system. These are usually the poorer women (CDHS 2010)<sup>384</sup>. Commune Council (CC) allocation of</p>

<sup>378</sup> Entretiens avec les partenaires d'exécution.

<sup>379</sup> Entretiens avec l'équipe UNFPA, les partenaires d'exécution et revue documentaire.

<sup>380</sup> Entretiens durant les visites de terrain.

<sup>381</sup> UNFPA Cambodia.

<sup>382</sup> Reproductive Health Costing 2006-2015, MoH, national reproductive health programme, 2007.

<sup>383</sup> NGO Partner.

<sup>384</sup> Cambodia 2010 DHS Key Findings.

	<p>resources for local development, including health has to be based on three criteria: equal share (30%), population size 35% and poverty index 35%.<sup>385</sup> These criteria also apply to UNFPA funding.</p> <p>The benefits of development programming of UNFPA and other development partners have not been equitably distributed in Cambodia, resulting in increased inequality. This is reflected in all the disaggregated national access indicators and maternal health is no different (CDHS 2010)<sup>386</sup>.</p>
Findings from case study in <b>DR Congo</b>	<p>Bien que le programme d'activités de l'UNFPA cible les groupes vulnérables, le programme n'est pas toujours mis en œuvre du fait des difficultés dans le décaissement des fonds. D'autre part le siège impose de nouvelles priorités dont la pertinence pour la RDC n'est pas toujours démontrée. En outre, dans une situation où le gouvernement ne tient pas toujours ses engagements, ceci rend parfois difficile la mise en œuvre de certains aspects du programme UNFPA.</p>
Findings from case study in <b>Ethiopia</b>	<p><i>Needs oriented planning is based on nationwide general or targeted surveys as well as on community level assessments, supported by UNFPA and other partners. Priorities for interventions and geographical locations are set by the governmental partners in collaboration with the UNFPA country office. Whilst some assessments feed predominantly into direct project planning, the UNFPA initiated Emergency Obstetric and Neonatal Care (EmONC) needs assessment (2008) became the basis for the national health ministry's plan to scale-up the EmONC services.</i></p> <p>Various needs assessments have been and are initiated and supported by UNFPA over the years, most are jointly done with the ministry of health (FMoH), implementing (IP) or H4 partners; they form the basis of the GoE health sector development plans, the UNDAF and the UNFPA annual work plans<sup>387</sup>.</p> <p>The UNFPA population and development programme has supported financially and technically the DHS 2005, the census 2007<sup>388</sup> and the DHS 2011. The statistical data that have been collected by the censuses include the following: population size, age, sex, ethnic group, religion, fertility, mortality, migration, literacy and education, marital status, economic activity, migration, and housing. The recent UNFPA supported DHS also includes questionnaires addressed to men and to women to identify specific needs and vulnerabilities.<sup>389</sup></p>

<sup>385</sup> Cambodian Aid Effectiveness Report, RGC 2010.

<sup>386</sup> The group discussion with poor and disadvantaged community women conducted by this evaluation took place about 10 kilometres from a health centre and provincial hospital (Annex 6.5), which illustrates the bias of development work towards urban areas.

<sup>387</sup> Selected samples are: Report on the National Situational Analysis of Pre-Service Midwifery Training in Ethiopia, 2008, National Baseline Assessment for Emergency Obstetric & Newborn Care Ethiopia 2008, Maternal Health Care Seeking Behaviour in Ethiopia: Findings from EDHS 2005 National Survey on availability of Modern Contraceptives and Essential Life Saving Maternal/reproductive health Medicines in Service Delivery Points in Ethiopia 2010, Ethiopia Young Adult Survey A Study In Seven Regions, 2010 Baseline EMONC survey in 2008.

<sup>388</sup> and leveraged further funds for the census.

<sup>389</sup> The Woman's Questionnaire was used to collect information from all women age 15-49. These women were asked questions on the following topics: • Background characteristics (age, education, media exposure, etc.) • Birth history and childhood mortality • Knowledge and use of family planning methods • Fertility preferences • Antenatal, delivery, and postnatal care • Breastfeeding and infant feeding practices • Vaccinations and childhood illnesses • Marriage and sexual activity • Women's work and husband's background characteristics • Awareness and behaviour regarding AIDS and other sexually transmitted infections (STIs) • Adult mortality, including maternal mortality • Knowledge of tuberculosis.

	Needs assessments from other partners (i.e. WHO) are also utilized for programme planning (midwifery schools' and anesthetic schools' assessment). Currently ongoing is the FMOH led joint (UNFPA and many other partners) facility assessment to evaluate preparedness for the new cadre of integrated emergency and obstetric surgeons (IEOS).
Findings from case study in <b>Ghana</b>	<p><i>UNFPA Ghana has not formally defined “vulnerability” or vulnerable groups within maternal health/reproductive health; however the term is used widely in its publications regarding maternal health in humanitarian situations and in cases of HIV/AIDS or domestic violence. MoH does not give special preference to any particular group for delivery of reproductive health/maternal health services. Instead it defines its services as “close to the client” and regards its efficient system of Community Based Health Planning and Service (CHPS) at the sub-district as pivotal to addressing the needs of the poor.</i></p> <p><i>UNFPA Ghana does not give special preference to any particular group for delivery of reproductive health/maternal health services. Instead like the MoH/ Ghana Health Service it defines the services it supports as close to the client. They both regard the Community Based Health Planning and Service (CHPS) which is designed based on evidence from disaggregated data at the sub-district level and closely linked to district referral hospitals as an efficient system and pivotal to addressing the needs of the poor and disadvantaged. Gaps in this system are noted.</i></p> <p>UNFPA Ghana in the last decade normally supports government systems to conduct needs assessment studies rather than develop tools for those assessments (except EmONC). Income levels and poverty data that is relevant for programming is captured by DHS (2003, 2008) and the Multiple Indicator Cluster Survey (2005, 2011) and Household Income and Expenditure Survey (HIES) which forms the basis for Common Country Assessments (CCA) preparation and adaptations in the 5 year period<sup>390</sup>. UNFPA Ghana also utilizes all prior needs assessments/evaluations as documents for CCA. The Ghana Country Assessment (GCA) is not a full blown CCA, but common understanding is reached with Implementing Partners (both government and CSOs) on current programme needs, achievements and gaps especially in areas that are defined as poor or hard to reach before finalization of the Country Programme<sup>391</sup>. The Community Based Health Planning and Service (CHPS) are considered by GHS and UNFPA as an efficient and effective system of service delivery that is geared to the poor and disadvantaged and is well utilized by them. CHPS is linked to district referral hospitals.</p> <p>Maternal health was declared a national emergency in Ghana following the publication of the 2007 Maternal Health survey results which UNFPA Ghana had advocated for. EmONC needs Assessment in the three Northern Regions was carried out in 2007 with support from UNFPA/UNICEF/Government of Ghana (GoG) as part of the High Impact Rapid Delivery (HIRD) strategy. In 2010 the first national EmONC needs assessment was carried out with support from UNFPA/UNICEF/Avert Maternal Death and Disability Programme of Columbia University (supported by MHTF) and GoG. The CHPS quality of service and readiness (highly utilized by poor and rural people) has formed the focal point of the enquiry along with district referral hospitals<sup>392</sup>. UNFPA Ghana rightfully focuses on high risk delivery that affects 15% of pregnant women and has not given sufficient attention to pro-poor programmes that remove socio-cultural barriers or prevent pregnancy in the first place such as family planning<sup>393</sup>.</p>
Findings from case	<i>Needs oriented planning is based on nationwide general or targeted surveys as well as on community level assessments, supported by UNFPA and other partners. Priorities for interventions and geographical locations are set by the governmental partners. Under the</i>

<sup>390</sup> Interview with UNFPA.

<sup>391</sup> CPA 2001-2005 and 2006-11.

<sup>392</sup> EmONC Fact Sheet 2011.

<sup>393</sup> Interview with External Development Partner.

<p>study in <b>Kenya</b></p>	<p><i>assumption that vulnerable population exist country wide, providing the whole spectrum of reproductive health services in four pilot sites may have been the most feasible choice for the UNFPA country office, especially if a high standard M&amp;E follow up provides evidence for a rationale to expand nationally such centers of excellence.</i></p> <p>The design of surveys, needs assessments and interventions has been closely coordinated with the line ministries, agencies or other development partners. The National Coordinating Agency for Population and Development (NCAPD) is the main link between the Kenya country office and the Government and is coordinating all players including all the Implementing Partners in reproductive health. Kenya's overall development is hinged on the Kenya Vision 2030, which is a blue print for transforming the country into a rapidly industrializing middle income nation by 2030. The donor community has to follow the national strategies, needs assessments or surveys on national and regional level are collaboratively designed, planned and conducted with national and development partners. UNFPA has been supporting a number of needs assessments/surveys on different topics related to maternal health; amongst others the baseline assessment of obstetric fistula in 2004, the situation analysis 'Contributing towards efforts to abandon FGM/C, 2007 in Kenya' and 'Can Community Midwives make a difference?' in 2008. Several rapid needs assessments were conducted during the post-election violence period in 2008.</p> <p>Whilst priorities for programming predominantly have been set by UNFPA's Governmental partners (within UNFPA's mandate), the Kenya country office implemented the programme as discrete projects spread in nine districts with an array of concerns in focus (such as adolescent pregnancy, FGM, unsafe abortion, legal and reproductive rights, drug abuse, poverty, food security for widows and orphans, integrated reproductive health services, STI, etc...) but with no provisions for projects to link up. This fragmented approach, even with targeting the identified vulnerable groups, was considered by the evaluators of the 5<sup>th</sup> CP and 6<sup>th</sup> CP MTR as 'very limited to make any significant national impact towards the attainment of the CP goal'<sup>394</sup>. Consequently, the decision was taken (led by the MoH) to reduce the UNFPA sub-national implementation sites to four focus sites, where centers of excellence for maternal health should be/are fully supported by UNFPA.</p>
<p>Findings from case study in <b>Lao PDR</b></p>	<p><i>Vulnerability is taken into consideration in the UNFPA 3<sup>rd</sup> and 4<sup>th</sup> Country Programmes. The reproductive health component of the 4<sup>th</sup> Country Programme seeks to address the needs of the most vulnerable populations by selecting the poorest districts in 3 Southern provinces for its interventions, and also by ensuring that its support at national level ultimately benefits these groups, e.g., by supporting the training of midwives from remote areas, or by promoting free assisted delivery for poor women.</i></p> <p>The above-mentioned assessments helped UNFPA to set priorities and to plan more specific interventions to strengthen reproductive health services, in particular in relation to skilled attendance at birth and during pregnancy in remote areas<sup>395</sup>. The PEER study findings helped identifying and designing interventions to address barriers to effective use of reproductive health services and increasing demand for these services<sup>396</sup>. The findings of these assessments were a basis for advocating for measures in favor of vulnerable groups, such as the provision of incentives for personnel serving in remote areas (midwives in particular) and the introduction of free assisted delivery services for women in the lowest wealth quintile<sup>397</sup>. The SBA assessment had taken into consideration the particular needs of specific</p>

<sup>394</sup> Final Evaluation Report on the UNFPA 5<sup>th</sup> Country Programme of Assistance to the Government of Kenya (1997-2001); Final evaluation report on the UNFPAs 6<sup>th</sup> Country Programme of Assistance to the Government of Kenya, (2004-2008).

<sup>395</sup> E.g., through selecting remote health centre auxiliary midwives to be trained as community midwives.

<sup>396</sup> Reproductive Health at the Margins - Results from PEER Studies in Southern Lao PDR – May 2008.

<sup>397</sup> UNFPA staff and government partners interviews.

	<p>ethnic groups, in recognition of the fact that ethnicity is an important factor for inequitable access to reproductive health services in Lao PDR.</p> <p>During the 3<sup>rd</sup> and 4<sup>th</sup> Country Programme, UNFPA had selected 10 districts as priority geographical areas in 3 Southern Provinces. Six of them were part of the 47 poor districts identified as a priority under the National Poverty Eradication Programme<sup>398</sup>.</p>
Findings from case study in <b>Madagascar</b>	<p><i>UNFPA is carrying out needs assessments within its mandate to inform the planning process of the GoM. The most important assessment, the census could not be conducted though, due to the political situation, but UNFPA utilized the preparatory work already done for the census to support a Demographic and Health Survey 2008/2009 instead. It was published simultaneously with the EmONC survey to provide a link between demography and health.</i></p> <p>Due to delays in conducting the third population and housing census, initially planned for 2005, the country is experiencing problems in data reliability. Most surveys still use estimates derived from the 1993 census. UNFPA has supported the development of the planned census for 2008/2009, but due to the political events in early 2009 a DHS (with UNFPA support) was conducted instead, which serves together with the EMONC survey as basis for the country office and national planning. UNFPA has been supporting a number of needs assessments on different topics related to maternal health; amongst others on gender-based violence, obstetric fistula, a survey on impact on SRA of traditional practices is under way, and a survey on socio cultural reasons for home delivery was conducted in the region of Vakinankaratra. Most important was the above mentioned first national survey on EmONC which became the evidence basis for the MoH to scale-up its EmONC services. In addition to surveys for specific interventions, the MoH together with its development partners initiates further assessments during the annual planning workshops.</p>
Findings from case study in <b>Zambia</b>	<p><i>UNFPA has provided financial and logistical support to the Zambian Government to generate data that could be used to improve the needs oriented planning of maternal health services. However, the country office has generally not followed up on the actual use of the data, but has left the definition of priorities solely in the hands of the Government.</i></p> <p>UNFPA has supported a number of needs assessments on different topics related to maternal health. In 2005, UNFPA supported a needs assessment on fistula<sup>399</sup> that helped to launch the current UNFPA-supported Fistula programme. In midwifery and nursing, UNFPA contributed to a <i>Comprehensive Training Needs Assessment on Education and Practice of Nursing and Midwifery</i><sup>400</sup> that was carried out in 2009<sup>401</sup>. UNFPA's support of EmONC<sup>402</sup> is based on an EmONC needs assessment from 2005 that had been funded and supported by UNICEF and that became the basis for the Ministry of Health (MoH) plan to scale-up access to EmONC services in Zambia's Provinces<sup>403</sup>. Finally, UNFPA has also supported some rapid Socio-Cultural Research as a way for informing its sexual and reproductive health &amp; HIV/AIDS programming in one of its Provinces<sup>404</sup>.</p> <p>In recent years, UNFPA's priorities for programming were primarily set by its Governmental partners, without a clearly identifiable attempt from the country office to maintain an evidence-based dialogue on the needs orientation of this support; or to ensure the strategic</p>

<sup>398</sup> National Growth and Poverty Eradication Strategy (NGPES) – Lao PDR - 2004.

<sup>399</sup> Supported by the Global Campaign to End Fistula.

<sup>400</sup> The needs assessment was led by Zambia's General Nursing Council; in partnership with the Health Sector Support Programme (HSSP), the Clinton Foundation and UNFPA.

<sup>401</sup> It appears that this particular needs assessment was finalized before MHTF (in particular the Midwifery programme) started operating in Zambia.

<sup>402</sup> Again, mostly in the three provinces (North-Western, Luapula, Western) that receive direct support from UNFPA.

<sup>403</sup> Both Basic and Comprehensive EmONC.

<sup>404</sup> I.e., in North-Western Province (Zambia GRZ/UNFPA 2005).

	<p>coherence among the UNFPA-funded activities. As a result, UNFPA's maternal health support has become somewhat diffuse with UNFPA responding to a large number of various small-scale, separate funding requests from the Government<sup>405</sup>. Although the interventions are formally covered by the Country Programme Document (CPD) and the Country Programme Action Plan (CPAP), this practice has prevented the country office from developing a clear and carefully designed operational strategy to bind the individual activities together. The approach also has prevented UNFPA from using its relatively small maternal health / sexual and reproductive health (SRH) budget strategically to exploit synergies with other development partners.</p>
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<sup>405</sup> This trend expressed itself in the structure of the available Annual Work Plans (AWPs) that consisted of a large number of small-scale activities (e.g., "Daily Subsistence Allowance (DSA) and fuel" for national level supervision of reproductive health and maternal, newborn and child health (MHCH) weeks participation; "Participant accommodation, Meals, Participant out of pocket allowances, DSA for facilitators and support staff, Transport refunds", etc. for youth councillor trainings) and in interviews with UNFPA and Governmental partners.

## 8.2.2 Evaluation question 2: To what extent has UNFPA successfully contributed to the improved harmonization of efforts to improve maternal health, in particular through its participation in strategic and multi-sectoral partnerships at global, regional and national level?

### Judgment criterion 2.1: Harmonization in maternal health partnerships between UNFPA and UN organizations and World Bank (including H4+) at global; regional and country level

Findings from <b>desk study</b>	The extent of harmonization of maternal health support depends largely on the quality of the overall coordination mechanisms that UNFPA and its partners employ in their support. Apart from UNFPA's participation in the UNDAF process, the most relevant mechanisms that UNFPA is party to, are sector-wide approaches in health and UN joint programmes that, in partnership with agencies such as WHO or UNICEF, are also used to provide the UN contribution to health SWAps. The actual contribution of these aid modalities to increased harmonization is less dependent on UNFPA's technical expertise in maternal health, but much more tied to the practical experience of UNFPA staff when working with these aid modalities. The extent of past experience also seems to have influenced the capacity of UNFPA country offices and of other participating donors and implementers to make full use of the potential for joint implementation and funding mechanisms (such as pooled funding). UNFPA also participated in and managed <sup>406</sup> in joint programmes in reproductive health in order to harmonize its maternal health support with the relevant support of other UN agencies, often in conjunction with sector wide approaches in health. However, as with SWAps, the extent of actual harmonization depends on the specific mechanisms for planning, implementation and funding that were used. There are reproductive health joint programmes where this has worked relatively well <sup>407</sup> ; and others, where coordination and actual harmonization has remained weak <sup>408</sup> . Pooled funding seems to have remained relatively underused <sup>409</sup> and UNFPA and its partners have often continued to rely on parallel funding, and thereby have foregone opportunities for increased harmonization in maternal health through UN joint programmes.
Findings from case study in <b>Burkina Faso</b>	<p><i>L'UNFPA a toujours été partie prenante des partenariats des Nations Unies au Burkina Faso qui ont œuvré pour soutenir le Ministère de la Santé dans la mise en œuvre de la feuille de route ainsi que dans les zones de convergences des Nations Unies. L'UNFPA a mis en place des procédures compatibles avec celles du panier commun mais qui parfois entraînent des retards dans la mise en œuvre des interventions planifiées.</i></p> <p>Les organismes du système des Nations Unies ont une tradition ancienne de planification commune des interventions (UNDAF 2001-2005 et 2006-2010) qui permet une harmonisation des stratégies, une complémentarité des actions, un partage du coûts des interventions et un soutien coordonné a la Direction de la Santé de la Mère et de l'Enfant (DSME) autrefois appelée la Direction de la Santé de la Famille (DSF)<sup>410</sup>. Ils ont apporté un appui coordonné aux régions sanitaires les plus pauvres, appelées zones de convergence du système des nations unies que sont les régions sanitaires du Sahel, de l'Est et du centre Est. Après la Conférence Internationale sur la Population et le Développement (CIPD), ces organisations ont conduit un plaidoyer pour la prise en compte de la</p>

<sup>406</sup> E.g. in Tanzania, 6<sup>th</sup> Country Programme.

<sup>407</sup> E.g., in Tanzania.

<sup>408</sup> E.g., in Zambia or Sierra Leone.

<sup>409</sup> The reasons for which are not clear at this point.

<sup>410</sup> Maintenant appelée Direction de la Santé de la Mère et de l'Enfant (DSME).

	<p>Santé Reproductive (SR) dans les politiques et programmes de santé ainsi que dans la politique de population. Des éléments spécifiques de la SR ont été introduits dans les Enquêtes Démographiques et de Santé (EDS) (accouchement assistés, lieu d'accouchement) et le recensement général de la population et de l'habitat (taux de mortalité maternelle)<sup>411</sup>. Les indicateurs relatifs aux OMD 4 et 5 (taux de mortalité maternelle, taux de contraception, couverture de soins prénatals) ont été inscrits dans les documents de cadre stratégique de lutte contre la pauvreté qui est devenu la Stratégie de Croissance Accélérée et de Développement Durable (SCADD)<sup>412</sup>.</p> <p>L'approche H4+ a bénéficié de cette prédisposition organisationnelle et n'a fait que la renforcer. Le groupe H4+ du Burkina Faso a récemment élaboré un projet conjoint de santé maternelle<sup>413</sup> qui sera financé par l'Agence Canadienne de Développement International (ACDI) grâce au soutien de l'équipe MHTF du siège de l'UNFPA.</p> <p>Les procédures de l'UNFPA en matière de planification combinent la planification du gouvernement (à différents niveaux) et ses propres priorités (définies par le cadre de l'UNDAF). Les financements transitant par le panier commun sont gérés par le Programme d'Appui au Développement Sanitaire (PADS) et par la Direction Générale de la Coopération (DGCOOP). Les procédures de l'UNFPA sont compatibles, toutefois il arrive régulièrement que la lourdeur de gestion due aux procédures spécifiques à l'UNFPA (en réponses aux exigences des bailleurs de fonds) retarde les paiements et donc les activités<sup>414</sup>.</p>
Findings from case study in <b>Cambodia</b>	<p><i>UNFPA Cambodia's contribution to increased harmonization of maternal health support has been relatively high, in part because the country office has used its membership in key coordination committees for pro-active influence on the maternal health agenda. H4+ is functional, but UNFPA, UNICEF and WHO often meet in the country under a variety of coordinating mechanisms. Development partners did not see an urgent need to have H4 at country level</i><sup>415</sup>.</p> <p>Cambodia does not have a sector wide approach (SWAp) in the true sense of the word<sup>416</sup>, but only a Health Support Sector Project I (2001-2005) and Health Systems Strengthening Programme (HSS) II (2006-2010) under the aegis of the Ministry of Economy and Finance (MoEF) and World Bank. HSSP II has mechanisms for joint planning, programming and monitoring. At the time of the evaluation, UNFPA served as the Chair of HSSP II.</p> <p>UNFPA Cambodia began to contribute funding to HSSP II in 2006, by using its own discrete funding mechanism. In 2010, it shifted to contributing to the pooled fund of the programme, but was already reconsidering this decision at the time of this evaluation, because UNFPA's internal accountability and reporting requirements were thought to be incompatible with the mechanism of a pooled fund<sup>417</sup>.</p>

<sup>411</sup> Entretiens avec le personnel de l'UNFPA et les partenaires techniques et financiers.

<sup>412</sup> Ministère de l'Économie et des Finances: Stratégie de Croissance et de Développement (SCADD) – 2011 – 2015).

<sup>413</sup> Ce projet va être mis en œuvre dans la Région Nord et Centre Nord. Il vise à renforcer les capacités institutionnelles du ministère de la santé et des écoles de formation de base, mettre en œuvre les services SONU, CPN, PF, PCIME et PTME et à améliorer l'accessibilité géographique et financière des SMN.

<sup>414</sup> « Evaluation interne du projet «Appui à la lutte contre la mortalité maternelle» au Burkina Faso qui fait partie de l'évaluation finale du Programme Santé Sexuelle et Reproductive EC/ACP/UNFPA – 2008.

<sup>415</sup> External Development Partner.

<sup>416</sup> UNFPA Cambodia.

<sup>417</sup> Guidance Note on HSSP II Support to the 2012 AOP.



	<p>This plan had drawn a lot of criticism from UNFPA's partners who expressed frustration that UNFPA let its own procedural challenges determine its ability to participate in a joint effort<sup>418</sup>.</p> <p>UNFPA annual work programmes (AWP) for the reproductive health component<sup>419</sup> have reflected the agreed UNDAF/ Country Programme (CP) outcomes and were implemented only through HSSP II (2006-2010)<sup>420</sup>. The HSSP II criteria for resource allocation are an alternative for underfunded priority areas in Maternal New Born and Child Health (MNCH), poorest performing districts and results of evidence based assessments. In accordance with its mandate, UNFPA has been taking the lead in reproductive health/maternal health financing and alignment under HSSP II, and has successfully advocated for "40% of pool fund to be allocated for reproductive health/maternal health".<sup>421</sup> UN agencies in country collaborate in various sectors of reproductive health, with UNFPA and WHO focusing on maternal health, UNICEF and WHO working in newborn health and UNICEF and UNFPA primarily addressing family planning. However, the H4+ concept has not yet led to a more harmonized maternal health support among the partners. So far, H4+ is utilized only for special events such as the UN Secretary General's Joint Plan of Action on Reducing Maternal Mortality (2010) and the utilization of the First Lady by the Parliamentarian Forum as a national champion for maternal health (2010-11). The efficacy and efficiency of such initiatives has not been assessed as yet<sup>422</sup>.</p>
Findings from case study in <b>DR Congo</b>	<p>Le plan conjoint du H4+ a été développé sur la base d'une cartographie des zones d'intervention des bailleurs de fonds. (Voir déclaration conjointe de 22 Juillet, 2008 de OMS/ UNFPA/ UNICEF/ Banque Mondiale sur le lancement du programme H4+, ainsi que « UNFPA EN ACTION », Rapport Annuel 2010, tous les deux citées en Annexe 6.4.)</p> <p>Les démarches H4+ ont commencé dans les 3 provinces cibles (Bas Congo, Bandundu et Kinshasa). Certaines activités de planification, telles la cartographie, ont été lancées mais la mise en œuvre complète se fait attendre. La seule agence qui paraît actuellement être engagée de manière significative en ce moment est l'UNFPA.</p> <p>En dépit du fait qu'ils ont développé un plan conjoint, chaque agence gère son propre budget de manière indépendante. Au sein de ce processus, il est pour le moment difficile de distinguer une vraie coordination. Des problèmes de coordination liés principalement à l'absence d'harmonisation par rapport au décaissement de l'argent (les calendriers pour la mise à disposition des fonds ne coïncident pas) existent entre les différentes agences H4+. Mais comme présenté dans la Matrice des Résultats, Annexe 6.3, l'équipe est confiante que, grâce à des réunions régulières et à leur engagement commun à résoudre ces questions, les membres du partenariat H4+ (OMS/UNFPA/UNICEF/Banque Mondiale) parviendront à une coordination efficace d'ici quelques mois.</p>
Findings from case study in <b>Ethiopia</b>	<p><i>The ECO participates in varied mechanisms of harmonizing health partnerships on national and sub-national level and engages in pooled funding since the advent of the MHTF. The division of labor between UN agencies is not yet always succinct, but as the 'delivering as one' process has only taken off in 2010, the relevant coordination mechanisms are in place to improve this.</i></p>

<sup>418</sup> The country office stated that it intended to continue influencing the reproductive health/maternal health process through its membership in the Joint Partnership Interface Group (JPIG) led by WHO and argues that this group has several other large donors who were not contributing any resources to the pool, and in some cases were not even funding the HSSP II through discrete mechanisms. The country office also intended to use its membership in the Fast Track Initiative Road Map for Reducing Maternal and Newborn Mortality for this purpose.

<sup>419</sup> The reproductive health sub-programme has accounted on average for about 60% of UNFPA's budget.

<sup>420</sup> UNFPA Cambodia, AWP HSSP 2, 2009, 2010 .

<sup>421</sup> External Development Partner.

<sup>422</sup> External Development Partner.

	<p>UNFPA participates in various important committees – Health, Population and Nutrition (HPN) Donor Group, International Health Partnership (IHP), Reproductive Health taskforce, Safe motherhood Technical Working Group (TWG), Family Planning TWG and other sub groups. In addition, the country office has gained the status of regular member in Joint Core Coordinating Committee Meeting. In terms of joint programming under the UNDAF, the H4 partners have an agreement on the division of labor, with some overlap (on <i>preventing mother to child transmission (PMTCT)</i>) and one major gap: neonatal care<sup>423</sup>. Generally, the agreed division of labor applied on country level allocates responsibilities or Policy, Normative, Technical and Health System Strengthening to WHO, which is also chairing the H4 group. The World Bank is in charge of the areas concerning financing, inclusion in national development frameworks and strategic planning. UNFPA and UNICEF primarily act on the level of service delivery. In spite of the joint planning, the UNDAF has no harmonized M&amp;E plan, and no pooled funding for joint programmes UN is in place. Joint implementation though is facilitated through a variety of technical working groups.</p> <p>UNFPA has contributed to the Health Sector Development Programme, particularly it achieved the incorporation of International Conference on Population and Development (ICPD) indicators in the results framework<sup>424</sup> and has ensured that key maternal health interventions such as EmONC, a master’s programme for Health Officers and reproductive health commodities are considered as eligible expenditure items under the Millennium Development Goal Fund (MDG). UNFPA joined as first UN organization into the MDG fund followed by WHO and the World Bank contemplates providing a loan as well, due to the good example set.</p>
<p>Findings from case study in <b>Ghana</b></p>	<p><i>There was contradictory information on the state of the Health SWAP in Ghana. MoH and the Planning Programming Monitoring and Evaluation Unit (PPME) said SWAP is alive and well but UNFPA staff noted it was in a state of collapse, even dead as more bilateral donors moved into Multi Donor Budget Support System (MDBS, commonly known as pool funding). With the implementation of MDBS, UNFPA and World Bank remain the only partners contributing to the SWAP. There were no meetings held as H4 but UNFPA and WHO meet often with UNICEF.</i></p> <p>UNFPA Ghana has a strong harmonization with MoH/Ghana Health Service, which is the standard bearer for maternal health in the country and there are monthly, quarterly business meetings with UN agencies and bi-annual national Health Summits in which UNFPA participates actively. UNFPA Ghana is also an active member of Health Sector Working Group co-chaired by MoH and WHO. UNFPA co-chairs with the National Development Planning Commission (NDPC) in the Sector Working Group on Data Collection and M&amp;E which it helped set up, and is a member of the Gender Sector Working Group.</p> <p>UNFPA contributes \$500,000 per annum to the SWAP, but in 2010 the funds were re-prioritized based on demands of the nation to support the 2010 census, which has a maternal mortality module<sup>425</sup>. Since 2008 there has not been any SWAP meeting and UNFPA has not received any invitation from the Government of Ghana to attend SWAP meetings. UNFPA is waiting further decisions from Country Representative and headquarters<sup>426</sup>. MoH regards pool funding as progressive, but multilateral agencies like UNFPA have refrained from it, while others lamented the potential demise of the Health SWAP<sup>427</sup>. Agencies all agree however that participating in SWAPs (which many did) was different from funding it (which only two did) and that importance of SWAPs are on the decline as Multi- Donor</p>

<sup>423</sup> The FMOH mentioned overlaps and gaps concerning the geographical area covered by the H4 partners.

<sup>424</sup> Such as teenage pregnancy, skilled birth attendance, contraceptive prevalence rate (CPR), maternal mortality ratio, antenatal care (1<sup>st</sup> and 4<sup>th</sup> visit).

<sup>425</sup> Interview with UNFPA.

<sup>426</sup> Interview with UNFPA.

<sup>427</sup> Interview with External Development Partners.

	<p>Budget Support (MDBS) is on the ascendency.</p> <p>There are meetings held under the H4+1 (includes UNAIDS) but not referenced as such for the agencies still meet under all the numerous coordination mechanisms currently existing among development partners. UNFPA continues to work most closely with WHO and UNICEF but does not pool funds with either of them.</p>
Findings from case study in <b>Kenya</b>	<p><i>The harmonization of maternal health partnerships is enforced by donors and the GoK. The KCO participates in the H4+ and the relevant donor coordination mechanisms and implements some programmes jointly with other UN organizations, but does not seem to take the lead in launching coordination mechanisms, joint programmes or working groups.</i></p> <p>Donor contribution has been strongly regulated on national and district level by the Government and all higher coordination mechanisms are now chaired by representatives of its line agencies. Specific sub-working groups have been chaired on a rotational base. Annual work plans including their M&amp;E components are developed by all partners in line with the Government strategies and monitoring has jointly been done on all levels and on a regular basis (quarterly and annually)<sup>428</sup>. A sector-wide approach is existent in theory, while no basket funding on a large scale exists. The World Bank, DANIDA and the Government have however pooled their funds for commodity purchases.</p> <p>The H4 group is being led by UNICEF. While UNFPA was reported to be absent to some important meetings by some stakeholders<sup>429</sup>, the KCO has confirmed that they do attend and are actively participating. The KCO is participating in three joint UN programmes, female genital mutilation and cutting (FGM/C), gender and HIV/AIDS, and it contributes to 50% of the overall budget of the FGM/C programme. The joint HIV/AIDS programme of UNFPA and UNICEF has been put in place due to the fact that DFID made joint programming and implementation conditional for provision of funds. The implementation was reported to be successful but the external push seemed to be needed for this collaborative agreement<sup>430</sup>.</p> <p>In the FGM/C joint programme, Kenya has geographically been divided between UNFPA and UNICEF, the argument was: to make optimal use of funds<sup>431</sup>. A working group on the 'reproductive health programme business plan design' was launched in January 2011 by DFID with local and international partners (DRH, KfW, GIZ, DANIDA, USAID, and UNICEF). Regrettably UNFPA was not present; nor seemed to have been informed by UNICEF as the lead of the H4.</p>
Findings from case study in <b>Lao PDR</b>	<p><i>In Lao PDR UNFPA is one of the 7 development partners working in the health sector. Since the Vientiane Declaration in 2008, harmonization and coordination have been improving. A Health Sector Working Group (SWG) as well as Technical Working Groups (TWG) was set up to support the implementation of the MNCH strategy. Although these mechanisms has greatly increased the harmonization, the decision making process still has to improve. The different TWGs still function vertically without sufficient coordination.</i></p> <p>Harmonization started before the UNDAF process, with UNFPA and WHO having worked at sector level for maternal health for many years before its introduction in 2002. At the time of the evaluation, "H4+ was actually H7 in Lao PDR"<sup>432</sup>, with all major partners</p>

<sup>428</sup> Information from international and development partners.

<sup>429</sup> Information from development partners, government partners.

<sup>430</sup> Information from development partner.

<sup>431</sup> Information from development and government partners.

<sup>432</sup> UNFPA staff interviews.

	<p>supporting the Ministry of Health for improving maternal health i.e. UNFPA-JICA-the World Bank-ADB-UNICEF-WHO-Lao Lux<sup>433</sup>. Lao PDR largely depends on external aid and all development partners work closely together; however, H4+ is not considered to be a very significant concept in Lao PDR.</p> <p>Although UNDAF provides a framework for coordination, coordination and harmonization take place at sector level beyond UN agencies and involves all the development partners supporting MNCH in Lao PDR. Support used to be fragmented but following the Vientiane Declaration on Aid Effectiveness (2006), UN agencies, donors and INGOs have increasingly harmonized their support. Agencies like WHO, UNFPA and UNICEF provide technical and financial support, while the other partners fund the MNCH package. In 2008, sector coordination mechanisms were set up with JICA support, with one Sector Working Group (SWG) for Health and Technical Working Groups (TWG) involving relevant MOH departments, development partners, and only recently, NGOS). Although there was a slow start, these mechanisms are becoming progressively more operational and development partners and the Ministry of Health started developing combined TWG annual work plans. However, coordination issues still remain between development partners and between the MOH Departments<sup>434</sup>.</p> <p>More recently a Joint United Nations project (UNFPA, UNICEF, WHO and WFP), funded by the Grand Duchy of Luxembourg, was designed to support Ministry of Health's implementation of the National Integrated Package of MNCH Services. In this project UNFPA is responsible for midwifery education and training.</p>
Findings from case study in <b>Madagascar</b>	<p><i>UNFPA has achieved the leadership position in the H4+ group and thus is well positioned to promote its priorities. Harmonization is envisaged through the joint H4+ operational plan, which has yet to be financed and implemented. Close cooperation between UN partners, especially UNFPA and UNICEF seems to be rather the norm, possibly due to good personal interrelations and lack of competitiveness (no crowding of agencies).</i></p> <p>The UNFPA CoM works within the framework of the UNDAF, 2008-2011, which is aligned with the Madagascar Action Plan, ICPD Programme of Action, the Millennium Development Goals, and the Beijing Platform for Action. The health sector-wide approach applies, including both the Maputo Plan of Action and the road map for newborn and maternal health. In 2007 the Plan de Developpement du Secteur Sante et de la Protection Sociale 2008-2011 has been developed and based on UNFPAs technical support during the process includes for example national directives to improve gender equity.</p> <p>UNFPA is partner in several joint UN programmes and participates effectively in relevant fora and working groups. Its presence is strengthened through the additional MHTF funded officer. Amongst other initiatives, UNFPA contributed to the Multi Cluster Rapid Assessment Mechanism and provided technical support for the multi-sectoral evaluation of the humanitarian situation in the South<sup>435</sup>. The road map was jointly developed and approved by the Ministry of Health and Family Planning, WHO, the World Bank, UNFPA, UNICEF, USAID and JICA. (see also Judgment criterion 2.2)</p> <p>A major step in the harmonization of reproductive health partnerships on country level was initiated in 2010 by UNFPA: the H4+ (extended) group; guided by the MoH and national priorities and lead by the UNFPA. It utilizes this leadership position in promoting its agenda, such as the integration of the obstetric fistula programme.</p> <p>The H4+ partners have included the currently available donors and stakeholders (JICA, Ambassade de France and USAID) in their monthly meetings and the planning of the costed operational plan to achieve the MDG 4 and 5. This operational plan (2012 to 2015) is being considered by the GoM for extension to other MDGs. Financial commitments of the extended H4 partners do not suffice for the</p>

<sup>433</sup> UNFPA staff and development partners interviews.

<sup>434</sup> e.g. MNCH services supervision is an area that is not coordinated very clearly between different Ministry of Health departments.

<sup>435</sup> UNFPA Country Profile Information 2010.

	<p>planned activities; therefore it is also used as an advocacy tool for potential new partners. Financing modalities have not been decided yet; most likely it will be parallel and not pooled funding. Good personal interrelations seem to enhance the willingness of cooperation and coordination, equally the relatively few numbers of stakeholders in maternal health due to the political situation (the GoM is not internationally recognized, hence there are bi-lateral donor agreements) may facilitate the cooperation as there is less competitiveness.</p>
Findings from case study in <b>Sudan</b>	<p><i>Country-level harmonization between UNFPA and other development partners that have supported maternal health in Sudan has been relatively weak, due to the fact that UNFPA has seen few opportunities to coordinate its support with other development partners. The Government firmly claims the leadership of donor groups that have been supporting maternal health and expects to be involved in most if not all exchanges between development partners. This factor, together with staffing bottlenecks in the UNFPA country office, limits the opportunities of UNFPA to engage with the other agencies to engage to elaborate a harmonized and coordinated approach in Sudan. The H4+ initiative, which had been introduced by WHO only relatively recently, had not yet changed this dynamic.</i></p> <p>Overall, coordination of development support of maternal health has been minimal in Sudan<sup>436</sup>. Also, UNFPA in Sudan has not implemented joint UN programmes in the last 4-5 years. Main reasons for this weak coordination have been in part political: The Sudanese Government was seen as being often wary of meetings that were held independently of them. The Government is seen to be in the lead, which in practical terms means that UN agencies has only convened in joint meetings that were chaired by the Government. In addition, however, UNFPA has felt it had too little time and staff resources to devote a significant share of them to coordination. It has to be noted that in the humanitarian component of the UNFPA programme in Sudan, coordination has been significantly stronger. Here, inter-agency coordination has been able to fall back on established standard coordination and implementation arrangements in humanitarian settings, such as the cluster approach, and the related coordination bodies and forums.</p> <p>Up to this point, the practical significance of the H4 group in Sudan has been low. The group had only been organized a few months prior to the country visit, in an effort led by WHO. However, at the time of the evaluation, the initiative had not yet translated into any concrete joint interventions or other joint initiatives.</p>
Findings from case study in <b>Zambia</b>	<p><i>UNFPA's contribution to an increased harmonization of maternal health support has been relatively small, in part because the country office has rarely used its membership in key coordination committees to influence on the maternal health agenda. The H4+ concept has not yet led to a more harmonized maternal health support among the partners.</i></p> <p>Apart from the UNDAF, UNFPA has used relatively few additional mechanisms to harmonize its maternal health support with other UN organizations at country level<sup>437</sup>. SWAp structures are the main and most inclusive multi-lateral forum in Zambia for coordination and harmonization between Zambia's Government, development partners, and civil society. They include, amongst other things, a "Sector Advisory Group"<sup>438</sup>, a "Cooperating Partners (CP) Group" and a large number of thematic Technical Working Groups and sub-groups. UNFPA is formally a member of all of these groups. However, its attendance has been relatively irregular and in most groups, UNFPA did not stand out as a vocal, pro-active contributor<sup>439</sup>. At least in part, this has been due to severe staffing bottlenecks at the country</p>

<sup>436</sup> "Not only weak, but minimal" (Interview at UNFPA country office).

<sup>437</sup> UNFPA in Zambia had only used the joint programming approach in one case, i.e., a joint programme on HIV/Aids.

<sup>438</sup> Government of Zambia, development partners, civil society.

<sup>439</sup> Interviews with UNFPA staff, development partners.

	<p>office<sup>440</sup>. In the case of the Family Planning Technical Working Group that has been led by UNFPA, its attendance and input was more regular and appreciated by the members<sup>441</sup>.</p> <p>Introducing the H4+ concept in Zambia has provided some motivation to intensify an already ongoing cooperation between UN agencies in maternal health. The H4+ group was formally constituted in 2009 and consists largely of UN agencies that had already been cooperating under the UNDAF sub-group for health. Since the introduction of the H4+ concept in 2009, members of the group have submitted two proposals for joint programmes related to maternal health<sup>442</sup>. Both proposals have been funded<sup>443</sup>; however, implementation had not yet started at the time of the evaluation. Cohesion of the UNDAF sub-group is being driven to a large extent by long-standing working relationships between national staff members that pre-date the introduction of the H4+ concept<sup>444</sup>. The group continues to meet as the UNDAF subgroup<sup>445</sup>, and does not convene meetings under the H4+ label<sup>446</sup>.</p>
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<sup>440</sup> Before the two MHTF advisors for fistula and midwifery were posted at the country office, the sexual and reproductive health (SRH) portfolio was managed by one national advisor. Considering that the SWAp structure boasts 10+ SRH-relevant Technical Working Groups, it would not have been possible for this advisor to be regularly present in all the meetings.

<sup>441</sup> Interviews with development partners, UNFPA staff.

<sup>442</sup> One programme on adolescent sexual and reproductive health; the second programme on maternal and child health.

<sup>443</sup> The programme on adolescent sexual and reproductive health has received funding from the European Commission; the programme on maternal and child health has received funding from the Canadian International Development Agency (CIDA).

<sup>444</sup> No specific input of UNFPA into the work of this group; or initiatives undertaken by this group were identified.

<sup>445</sup> No specific initiative of the UNDAF sub-group existed.

<sup>446</sup> For details on the introduction of the H4+ concept in Zambia, please see Evaluation question 1 in the MHTF section of the country note.

**Judgment criterion 2.2: Harmonization of maternal health support through partnerships at country and South-South / regional**

Findings from <b>desk study</b>	By engaging in regional and south-south partnerships and initiatives, such as those leading to the development of the Maputo Plan, UNFPA might have helped to create new opportunities for harmonizing donor support along the new national maternal health road maps as a focal point for donor support. However, the extent to which the national maternal health road maps have contributed to increased harmonization of support to maternal health depends on their actual integration in health sector policies and health sector SWAps; as well as on their actual operationalization at country (national and sub-national) level, i.e., the creation of operational plans, and mechanisms for implementation and monitoring and evaluation. As of 2009, only a minority of countries had succeeded to create these structures. <sup>447</sup>
Findings from case study in <b>Burkina Faso</b>	<p><i>Le soutien des partenaires techniques et financier à la mise en œuvre de la feuille de route, et en particulier l'appui technique et financier de l'UNPFA, a contribué à renforcer la Direction de la Santé de la Mère et de l'Enfant (DSME). Il est reconnu que ce soutien bien qu'harmonisé pourrait gagner en synergie si mieux coordonné.</i></p> <p>Les partenaires techniques et financiers (PTF) ont contribué à la mise en œuvre de la feuille de route 'Plan d'Accélération de Réduction de la Mortalité Maternelle et Néonatale au Burkina Faso' (2006) et au ' Plan Stratégique pour une Maternité à Moindre Risque - 2004 - 2008' et soutiennent les différentes composantes sous la coordination croissante de la Direction de la Santé de la Mère et de l'Enfant (DSME) tels que la vulgarisation et la dissémination des SONUs, le développement du plan de sécurisation des produits contraceptifs, la définition de normes et procédures, le renforcement des institutions de formations, les formations de prestataires. L'UNFPA a apporté un appui financier et technique en concertation avec les autres partenaires ce qui a permis de renforcer les capacités de la DSME. Toutefois certains partenaires ont exprimé le besoin d'une coordination plus stratégique permettant une synergie accrue<sup>448</sup>.</p>
Findings from case study in <b>Cambodia</b>	<p><i>The effect of UNFPA membership and lead of the MNCH Taskforce 1 within the Fast Track Initiative Road Map for Reducing Maternal and Newborn Mortality (FTIRM 2010-15) is too early to tell. At sectoral level, UNFPA has gained credibility through experience with MoH and critical line ministries. Most of these public sector partnerships have not been assessed.</i></p> <p>The United Nations Development Assistance Framework (UNDAF) is used to coordinate 23 agencies that are linked to the achievement of Cambodia's MDG targets, based on the country's NSDP 2006-2010. The Government-led Cambodian Development Cooperation Forum (CDCF) is overseeing the development instruments within UNDAF. It contains 19 Technical Working Groups (TWGs), nine of which are being facilitated by UN agencies, including the TWG for Health. The Government-Donor Coordination Committee (GDCC) coordinates the TWGs, provides guidance and resolves problems. UNDAF has 5 pillars<sup>449</sup>, and 11 coordinating mechanisms<sup>450</sup>. UNFPA is a member of the TWG Health; lead on the TWG sub-group for Maternal Health and member of the TWG Human Resource for Health (HRH), and has helped to improve the performance in particular of the maternal health technical working group<sup>451</sup></p>

<sup>447</sup> A minority of countries (16 out of 35 responding) had a plan for scaling-up or an operational plan at the district level. Several strategic elements of maternal health planning have still to be developed and incorporated in the existing maternal health Road Maps of a number of countries, in particular EmONC planning, Human resources planning and monitoring and evaluation (UNFPA, 2009).

<sup>448</sup> Entretiens avec les partenaires techniques et financiers.

<sup>449</sup> Out of which UNFPA participates in 4 (health, education, gender and governance).

<sup>450</sup> UNFPA participates in all of these (UNDAF 2011-2015).

<sup>451</sup> "Maternal health as a sub-group was not operational at policy and budgeting levels, but through discussions, UNFPA has brought it to a higher level" (External Development Partner).

	<p>The Fast Track Initiative for Reducing Maternal Newborn Mortality, under the leadership of the National Maternal Newborn Child Health Center (MNCHC), includes midwifery, EmONC, Family Planning and Comprehensive Abortion Care. UNFPA is an active member of the MNCH Task Force 1, contributes to capacity development and has joint milestones for the implementation of the upgraded Minimum and Complimentary Package of Activities<sup>452</sup>. It was too early for the Road Map to be assessed.</p> <p>As part of its South-South partnerships, UNFPA has sent high-level policy makers and strategic technical staff to advocacy conferences and skills development workshops. UNFPA has brought in Master Trainers to develop Training of Trainers (ToT) in a variety of topics, including midwifery, EmONC and BCC<sup>453</sup>.</p>
Findings from case study in <b>DR Congo</b>	<p>La cartographie des donneurs dans le domaine de la santé reproductive est déjà faite sur la base d'un financement extérieur. La provenance exacte de ce financement n'est pas connue par l'équipe (Judgment criteria 2.2, 2.3).</p>
Findings from case study in <b>Ethiopia</b>	<p><i>The ECO supports the formulation and implementation of national strategies and has successfully attributed to roadmaps, health sector development plans, strategies, etc., some of which have been shelved for a long time before being endorsed. The translation from policy into operational plans seems not sufficiently addressed by government or development partners.</i></p> <p>UNFPA contributes technically to the development of the maternal health Road map and has done the same for the previous strategic documents, such as the health sector development plans. The development of the current national maternal health road map was broadly supported by development agencies<sup>454</sup> who also commit to supporting its implementation. Due to absorption capacity in the FMOH, roadmaps, strategies, etc have a rather long shelf life before they get endorsed and are translated from strategies into operational plans.</p> <p>The 2009 workshop on "Task Shifting" to address Maternal Mortality is an example of partnership between Government, UN agencies, Donors, CSO and an Academic institution. UNFPA country office together with FMOH, UNICEF and AMDD successfully organized an international conference on Human Resource for Maternal Survival: Task Shifting to Non-Physicians Clinician. The conference brought together 42 countries with many years of proven experience deploying non-physician clinicians (NPCs) to expand access to EmOC and countries that are either just beginning this process or have significant interest in utilizing NPCs for EmOC.</p>
Findings from case study in <b>Ghana</b>	<p><i>There are three main Road Maps but currently the MDG Accelerated Framework (MAF) seems to be the basis for increased harmonization of maternal health support among UNFPA, WHO and UNICEF. UNFPA Ghana's activities with MoH are also guided by the Maputo Plan - Abuja Road Map while the Campaign on Accelerated Reduction of maternal Mortality in Africa (CARMMA) has caught the interest of both MoH and Development Partners. The Road Map for Family Planning languished for several years since its initiation in 2006 and is now being revived with the support of CARMMA.</i></p> <p>UNFPA has an important role to play in the MDG Acceleration Framework and Country Action Plan on Maternal Health (MAF). UNFPA is part of the UNDAF Action Plan outcome areas (OC) and is represented in the "Deliver as One."<sup>455</sup> UNFPA participates in 6 out of 12 (50%) outcome areas and takes the co-lead with the WHO in Maternal Mortality and Child Health (OC6) and is the lead on Data</p>

<sup>452</sup> MPA-does not include surgery and CPA-includes surgery.

<sup>453</sup> Unfortunately, the effect of knowledge-sharing seminars and skills training workshops have not been assessed outside the usual pre-post evaluations.

<sup>454</sup> During the Annual Review Meeting of the FMOH in 2011 representatives from the FMOH, WHO, UNFPA, UNICEF, FGAE, DKT, HAPCO, IFHP (Pathfinder), CORHA, ICAP, Engender Health were involved in discussions and able to comment.

<sup>455</sup> Co-ordination Mechanism of UNDAF outcome Areas through the Sectoral Working Groups.



	<p>Collection and Monitoring &amp; Evaluation (OC12). It has no role in Social Protection (OC 7) and Education (OC 9).</p> <p>Several donors and the MoH still consider the Abuja Call for Accelerated Action towards Universal Access and Maputo Plan of Action from Operation of Continental Policy Framework for SRH as the government Road Map rather than the MAF but both are used as critical documents to align support within the Health Sector Plan. Funding from European Union is finding ways to resource both road maps in an integrated manner<sup>456</sup>.</p> <p>MoH has a Road Map called Re-Positioning Family Planning (2006-2010) which seems to be less active until recently. The Ghana DHS (2008) however showed that while MMR is being reduced, the contraceptive prevalence rate (CPR) declined contradicting all expectations. UNFPA takes the lead on the Campaign for Accelerated Reduction of maternal Mortality (CARMMA). UNFPA was financing activities to re-activate the family planning Road Map in 2009 with the support of the First Lady of Ghana and subsequently an annual family planning Week has been launched in 2011 at the district level in the ten regions.<sup>457</sup> UNFPA partners with USAID and Dfid on Commodity Security Fund.</p>
<p>Findings from case study in <b>Kenya</b></p>	<p><i>The KCO supports and facilitates maternal health Roadmaps and relevant national strategies and has successfully attributed to several roadmaps, policies and legal reforms. The translation from policy or strategy into operational plans seems not yet sufficiently addressed by government or development partners, or UNFPA.</i></p> <p>UNFPA KCO has supported the development of the first National Reproductive Health strategy in 1996 and the reproductive health policy (which incorporates the Maputo plan of action). The current National Roadmap was put on hold in 2011 and replaced by the Government High Impact Initiative which has as main focus Family Planning, Emergency Obstetric Care, Insecticide Treated Bed Nets and Vaccination and under the leadership of UNICEF. The first Medium Term Plan (MTP) of the Kenya vision 2030 includes explicit programmes on PD, reproductive health and gender.</p> <p>According to the MoH, policy development in Kenya allows external partners only as 'silent observers' to the policy making discussions. Nevertheless, UNFPA KCO has been instrumental in the advocacy and working on legal reform on FGM/C in conjunction with the Federation of women lawyers (FIDA), Kenya Women parliamentarians (KEWOPA), and the Ministries of Health and Education. From these efforts the national act against FGM/C has been passed into law in October 2011. A further example of UNFPAs impact on policy level is its work on the advocacy to parliamentarians to invest in maternal health. This initiative lead to the GOK allocating funding dedicated to reproductive health for the first time (during the 5<sup>th</sup> CP). According to a development partner, plenty of strategy and policy documents exist, some overlapping, but no operationalized business plans to direct programme and finance flow. This could be recognized and addressed by UNFPA.<sup>458</sup></p> <p>UNFPA supports - mainly on the operational level - various need-based trainings in EmONC; obstetric fistula management, gender-based violence, gender and the equipment/supplies at health facilities which contribute towards addressing some of the gaps outlined in the maternal health roadmap.</p>
<p>Findings from case study in <b>Lao PDR</b></p>	<p><i>The Strategy and Planning Framework for the Integrated Package of Maternal, Neonatal and Child Health Services - 2009-2015 (MNCH package) provides clear directions that stakeholders can use to harmonize their support. UNFPA plays a key role in technically</i></p>

<sup>456</sup> Interview with External Development Partner and UNFPA staff.

<sup>457</sup> Road Map for Re-positioning family planning in Ghana 2006-2010, GHS, GoG.

<sup>458</sup> Information from development partner.

	<p><i>supporting MoH programming at national level and supporting the implementation of the package in collaboration with the other development partners.</i></p> <p>The MNCH package is the key strategy for maternal health and was developed with WHO and UNFPA as well as other partners' support. All development partners are harmonizing their support based on this strategy. It is integrated in the Health Sector Plan which is also coordinated under the Sector Working Group. The 7<sup>th</sup> Five Year Health Plan has recently been approved and costed. However, resource mapping is still to be finalized<sup>459</sup>.</p> <p>UNFPA also supports the implementation of many of the components of the MNCH package, in particular the Skilled Birth Attendance (SBA) Plan, and contributes to the its 3 Strategic Objectives (Improving governance and management capacity, Strengthening quality of health service provision and Mobilizing individuals, families and communities for MNCH) through actively participating in the above-mentioned working groups and through supporting the MoH at implementation level as described below.</p>
<p>Findings from case study in <b>Madagascar</b></p>	<p><i>UNFPA has been supporting the development of the maternal health road map and other strategic documents together with other UN partners. The objectives of the maternal health road map have been taken up in the business plan of the H4+ and operationalized, as well as in the UN Strategic Vision 2010-2011.</i></p> <p>Irrespective of the H4+, which is a rather new coordination mechanism, UNFPA has been partner since the first CPAP to the GoM in a variety of technical working groups and annual planning workshops. UNFPA was involved in the development of several reference documents, such as the</p> <ul style="list-style-type: none"> <li>National maternal health road map 2005-2015 (developed in 2004<sup>460</sup>, but not operationalized<sup>461</sup>)</li> <li>guidelines for family planning actions in Madagascar</li> <li>guidelines for PMTCT</li> <li>update of the National Strategic HIV / AIDS plan</li> <li>Midwives curricula</li> <li>Maternal death audits</li> </ul> <p>Since 2007 there has been an increasing alignment to the Government's Madagascar Action Plan (MAP) by UNDAF and other partners; the MAP being the reference strategy for all partners, even though it has not been ratified by the current government- nor has it been officially annulled. The objectives of the maternal health road map remain valid for the donor community and have been taken up in the H4+ plan, operationalized and costed. Also, the Strategic Vision 2010-2011 of the UN partners in Madagascar prioritizes EmONC, provision of medical equipment and commodities similarly as the national maternal health road map.</p> <p>South-South cooperation activities focus on exchange of technical expertise. For example, in 2004 UNFPA participated in an HIV/AIDS initiative by the Commission de l'Océan Indien, which includes the following countries: Madagascar, Mauritius, the Comores, La Réunion</p>

<sup>459</sup> Government partner interviews.

<sup>460</sup> « A Madagascar, la réduction de la mortalité maternelle et néonatale devient une priorité politique de premier rang. Et cette dynamique de changement stratégique se traduit par la signature de la déclaration commune en janvier 2003, conjointement par le Ministère de la Santé et de Planning Familial, l'OMS, UNFPA, UNICEF et la Banque Mondiale sur « La réduction de la mortalité maternelle à Madagascar ». Ministère de la Santé et du Planning Familial de Madagascar, Feuille de route pour la réduction de la mortalité maternelle 2005-2015.

<sup>461</sup> African maternal health Road maps, Assessment Report, Luc de Bernis, Yaron Wolman – July 2009.

	and the Seychelles.
Findings from case study in <b>Sudan</b>	<p><i>The Maputo process and the corresponding Sudanese Maternal and Newborn Health Road Map have only little potential to significantly increase the degree of aid harmonization in Sudan. The main limiting contextual factor is the low presence of international donors in the country and the corresponding low availability of donor resources that could be used to fund the US\$118 million of required external resources.</i></p> <p>The process of developing the Road Map has been quite drawn out. A draft Road Map had been produced in 2005/06, but was never finalized. In 2010/11, a UNFPA financed maternal health expert posted in the MoH was charged by Director of the National Reproductive Health Programme to finalize the Road Map. The Road Map is now costed (this has been done with UNFPA support and has included costing capacity development for key ministry staff) and is meant to be used for fund-raising. “Word has been spread” to different development agencies about the Road Map, but most of the US\$ 118 million in projected costs still have to be raised from external donors, while only a small number of development partners were working in Sudan at the time of the evaluation.</p> <p>UNFPA has supported the costing of the Road Map. The biggest remaining hurdle is to find financing for the US\$ 118 million of the projected road map costs that has to be financed from external sources, in particular given the low presence of development donors in Sudan.</p>
Findings from case study in <b>Zambia</b>	<p><i>Due to low awareness of its existence among development partners, Zambia’s Maternal and Newborn Health (MNH) Road Map<sup>462</sup> has not yet helped to increase harmonization of maternal health support among Zambia’s development partners.</i></p> <p>The Maternal and Newborn Health Road Map was integrated into the last National Health Strategic Plan (2006 – 2010) and was used as a resource document for the launching of the CARMMA<sup>463</sup> initiative in Zambia<sup>464</sup>. The Government also used the Road Map also to showcase the Zambian Government’s commitment to MNH, most prominently during the consultations with the United States (US) Government that led to the “Clinton challenge”, an increased commitment of US resources for reducing maternal mortality in Zambia<sup>465</sup>. However, none of the development partners outside of the UN agencies were familiar with current status of Road Map or considered the document to be a guide for joint donor action. This has prevented the Road Map from making any contribution to an increased harmonization of donor support<sup>466</sup>.</p>

<sup>462</sup> I.e., as the country-specific translation of key principles of the Maputo Protocol, a major regional initiative on the reproductive rights of women.

<sup>463</sup> Campaign for Accelerated Reduction of Maternal Mortality in Africa.

<sup>464</sup> Information from interviews with UNFPA, Ministry of Health (MoH)

<sup>465</sup> Interview with Ministry of Health.

<sup>466</sup> Interviews with 5 development partners.

### 8.2.3 Evaluation question 3: To what extent has UNFPA support contributed to a stronger involvement of communities that has helped increase current levels of demand and utilization of services, in particular through its partnerships with Civil Society?

#### Judgment criterion 3.1: Governments commitment to involve communities translated in SRH and maternal health strategies through UNFPA support

Findings from desk study	<p>The ICPD Programme of Action recognized that in order to implement the conceptual shift to human-centered development and the life-cycle concept of sexual and reproductive health, a broad-based and interactive collaboration among Governments, the international community and civil society<sup>467</sup> was required. To respond to this principle of the ICPD, UNFPA programming is meant to be based on a “participatory process” that includes civil society. In accordance with this requirement, all CPAPs state that the programmes were developed with the full participation of different stakeholders, including Government and civil society organizations<sup>468</sup>.</p> <p>UNFPA has adopted various measures to promote the involvement of civil society groups, particularly national social economy NGOs, in various stages of policy formulation and/or programme implementation, monitoring and evaluation of SRH/maternal health. UNFPA engaged in community consultations, in particular by using specific modes of communication that are culturally familiar, such as focus groups, peer groups (women, youth, MARP), community durbars, community health fairs festivals, and other types of meetings. These types of activities are at least indirectly linked to demand generation and awareness raising activities, as they always entail a two-way communication, so that some knowledge remains with the participating communities. Through the use of such tools, the involvement of partners such as women's groups, advocacy organizations, youth groups, private sector associations, and religious communities in programming has increased.</p> <p>Beyond that, demand generation through CSO partnerships is limited to efforts to enhance organizational capacities of civil society to conduct awareness and sensitization campaigns and needs assessments. UNFPA has relied extensively on the CSO-based delivery of education, training, advocacy campaigns and services to mobilize communities in the Fund's bid to increase access and utilization of services. At the same time, monitoring provisions for these aspects of UNFPA support were weak. Monitoring systems did generally not include any indicators to capture the extent of community involvement in the delivery of government services, or the effects from capacity development or filling the gap for example by private or not for profit third sector. Output or process indicators on CSO partnership also were in UNFPA documents. Indicators used by Government partners tended to merely measure improvements in the accessibility and availability of services, without specifically examining underlying processes related to community participation. There is little or no mention of concepts such as community participation, social ownership, local governance or NGO service accountability; asset based support and community resources, ownership and sustainability in UNFPA country office AWP and COARS.</p>
Findings from case study in Burkina Faso	<p><i>Le renforcement de la participation communautaire en faveur de la santé maternelle et néonatale est une des stratégies prioritaires de la feuille de route. Dans cette optique l'UNFPA a appuyé des interventions telles que l'approche IFC (Travailler avec les Individus les familles et les communautés) ainsi que la mise en place de cellules obstétricales. Les efforts de sensibilisation de l'UNFPA en matière de santé maternelle et néonatale se sont adressés aux personnes influentes dans le pays, en particulier aux représentants de la société</i></p>

<sup>467</sup> "Civil society" in this context refers to non-state institutions, including NGOs; community groups; professional associations; religious communities; the private sector; labour and trade unions; political parties; foundations; academic and research institutions; the media; and women, men and youth groups as well as individuals as members of society.

<sup>468</sup> Often broken down by type - NGOs (INGOs), CBOs and FBOs.

	<p><i>civile ce qui a contribué à une prise de conscience accrue des problématiques liées à la santé maternelle et néonatale.</i></p> <p>Le gouvernement et le ministère de la santé burkinabés considèrent essentielle l'implication des communautés. La stratégie prioritaire n°4 du 'Plan d'Accélération de la Réduction de la Mortalité Maternelle et Néonatale' est le 'renforcement de la participation communautaire en faveur de la santé maternelle et néonatale'. A cet effet, un cadre (Cadre IFC<sup>469</sup>) a été développé pour faciliter l'implication des communautés dans la planification et priorisation des actions (par le biais d'un diagnostic communautaire participatif) au niveau des districts sanitaires pour améliorer la santé maternelle, l'UNFPA soutient sa mise en œuvre. Dans ses zones d'intervention, l'UNFPA a appuyé la mise en place de cellules obstétricales d'urgence au sein de chaque communauté ainsi que la mobilisation des accoucheuses traditionnelles dans leur nouveau rôle d'information et d'accompagnement comme décrit dans la feuille de route<sup>470</sup>.</p> <p>Le travail de plaidoyer auprès de différents réseaux: les parlementaires, les organisations islamiques et l'Union des religieux et coutumiers permet de sensibiliser et d'impliquer les personnes influentes et les populations sur des problématiques de santé maternelle et droits de la SR<sup>471</sup>. L'UNFPA a soutenu la participation de la société civile lors du développement de du plan stratégique de santé des jeunes<sup>472</sup>. La campagne pour l'accélération de la réduction de la mortalité maternelle en Afrique (CARMMA) lancée en Août 2011 avec l'appui de l'UNFPA a cible la société civile et vise à renforcer l'engagement des politiques, des leaders coutumiers et religieux au niveau central et dans les 13 régions en faveur de la santé maternelle et néonatale ainsi que la prise de conscience de la population, de la société civile, des leaders d'opinion et des médias<sup>473</sup>. Toutefois il était trop tôt au moment de l'évaluation pour en apprécier les effets.</p>
Findings from case study in <b>Cambodia</b>	<p><i>UNFPA commitment to working with civil society and communities closely reflects the changes in the public sector's growing involvement in service delivery and the influence of a decentralization and de-concentration strategy that favors the engagement of Commune Councils' (local Government entities) with organized community-based groups over community-based work of independent NGOs and INGOs. Multilateral and bilateral funds for engaging community groups are therefore increasingly being coordinated by Commune Councils.</i></p> <p>The shift from NGOs and INGOs to Commune Councils was furthered by recent changes in the donor and development landscape. For example<sup>474</sup>:</p> <p>UNFPA became an integral part of HSSP II in 2006, and from thereon channeled all its reproductive health funds through this mechanism. HSSP II mostly funds national and sub-national public sector entities.</p> <p>Greater emphasis has been placed on Commune Council engagement in creating awareness and demand for maternal health.</p> <p>At the same time, some major bilateral donors like USAID and international private foundations have expanded their involvement with NGOs and INGOs, counteracting the above-described trend.</p> <p>Like most multilateral donors, UNFPA looks for synergy with the Government's current policy implementation. Currently, this synergy is reflected in the Decentralization and De-concentration Strategy that supports local commune authority and development<sup>475</sup>. By Country</p>

<sup>469</sup> 'Travailler avec les Individus les familles et les communautés'.

<sup>470</sup> Entretiens avec le personnel de l'UNFPA et les partenaires d'exécution et revue documentaire.

<sup>471</sup> Discussions de groupe avec Union des religieux et coutumiers du Burkina Faso et entretiens avec le représentant du Réseau des parlementaires en population et développement et Réseau Burkinabé des organisations islamiques en population et développement .

<sup>472</sup> Plan stratégique de santé des jeunes 2004-2008.

<sup>473</sup> Campagne pour l'accélération de la Réduction de la Mortalité Maternelle en Afrique (CARMMA), Plan de mise en œuvre au Burkina Faso, Avril 2001.

<sup>474</sup> UNFPA Cambodia.

	<p>Programme III, UNFPA was working with 446 Commune Councils in 14 provinces. Growing Government confidence in its capacity to expand information and service delivery in maternal health has led UNFPA to shift its support towards the public health sector, instead of channeling support through NGOs. Commune Councils are considered a tactical mediator for supplying health information to the community<sup>476</sup>. However, UNFPA and NGOs still co-ordinate their work at District level<sup>477</sup>.</p> <p>On the other hand, it was also noted that UNFPA is relying too much on the Commune Councils and Health Centre Management Committee to raise awareness and create demand, when in reality most of the communication is done by NGOs and not Commune Councils. The concern was that neither the Commune Councils nor UNFPA had the required capacity to empower women for service delivery<sup>478</sup>. While the major reproductive health NGOs that were contributing large funds to SRH did not necessarily need extra financial support, they did need UNFPA's voice on critical issues of SRH to be raised in places that most NGOs cannot reach<sup>479</sup>. The small and non-reproductive health NGOs funded by UNFPA felt they lacked topical capacity development during implementation<sup>480</sup>. Youth NGOs felt under-utilized by UNFPA and criticized that the Adolescent Sexual and Reproductive Health (ASRH) programme focused more on nutrition than on preventing teenage pregnancy.</p>
Findings from case study in <b>DR Congo</b>	<p>L'UNFPA a encouragé et soutenu le Ministère de la Santé dans ses tentatives de faire supprimer la loi interdisant la contraception en RDC.</p> <p>Il a soutenu des associations de femmes et de la jeunesse dans leurs efforts de formation, visant un renforcement des compétences en matière de santé reproductive et sexuelle. Il a également fourni des équipements et des contraceptifs. L'UNFPA a également milité en faveur d'une inclusion plus complète des organisations confessionnelles dans les programmes gouvernementaux et soutient ces dernières dans le domaine de la formation, dans l'approvisionnement des équipements, des médicaments et des contraceptifs.</p>
Findings from case study in <b>Ethiopia</b>	<p><i>UNFPA has contributed/contributes to community and civil society engagement through its support to the national outreach strategy which includes community conversations and Health Extension Workers capacity development and through strengthening the midwives association. Whilst UNFPA is well integrated in these initiatives, specifically targeted evaluations are required to measure impact of the interventions -and possibly the attribution- of UNFPA.</i></p> <p>Community Conversation' was introduced as a tool by UNDP in 2002 for HIV; the FMoH adapted the tool for the HEW and relevant training material was supported by UNFPA and UNICEF. Meanwhile, the Community Conversation as means to include the civil society has been institutionalized on every administrative level and topics addressed during the meetings are for example reproductive health, HIV, FGM, but also sanitation, vaccination, and other health promotion activities. Currently UNFPA provides technical support to the FMoH to develop a community facilitator's guide, and tries to participate in the fora that develop guidelines and promote maternal health, obstetric fistula and youth components, if the staffing situation allows covering all the work.</p> <p>The ECO was involved in the formulation of the Youth and Women section of the new GTP. The 'Empowerment of youth and women' is</p>

<sup>475</sup> External Development Partner.

<sup>476</sup> UNFPA Cambodia.

<sup>477</sup>"If UNFPA is there, NGOs will not support and vice versa, it is quite efficient" (NGO Partner)

<sup>478</sup>"Support at commune level and below needs much knowledge, supportive supervision, monitoring and participatory evaluation. As a large NGO we are not sure of UNFPA's capacity to do this" (NGO Partner).

<sup>479</sup>"We feel we are not getting this kind of support" (NGO Partners).

<sup>480</sup> NGO Partner.

	<p>one among the seven pillars prioritized by the government in the GTP, which will ensure the active participation and empowerment of young people.</p>
Findings from case study in <b>Ghana</b>	<p><i>Civil Society Organizations (CSO) who are UNFPA Implementing Partners (IP) always participate in Common Country Assessment (CCA) and processes leading to the bi-annual National Health Summits conducted by MoH/Ghana Health Service. All participating CSOs are well coordinated under relevant Programme Component Managers.</i></p> <p>The bi-annual National Health Summits are critical avenues for UNFPA lobbying, and CSOs are considered helpful for policy advocacy as they are successful in getting issues included in the final Aide Memoire. This is critical as without inclusion in the Aide Memoire, issues cannot be taken up by MoH, other ministries or government<sup>481</sup>.</p> <p>Larger CSOs like the Christian Health Association of Ghana (CHAG) and Planned Parenthood Association of Ghana (PPG) are well recognized and have been IPs since the very beginning and are renewed across various country programmes; while other CSOs enter in the middle of a country programme, for e.g. Curious Minds and Society for Women and AIDS in Africa<sup>482</sup>. To select a new IP, the country office conducts an online micro-assessment. There are four main criteria for selection for selecting a CSO: It has to be well run, well structured, have both capacity and visibility. Due consideration is given to new and small CSO applicants that is relevant to the mandate areas and UNFPA intervention districts but need capacity development<sup>483</sup>.</p> <p>Each CSO IP is grouped under one of the Programme Component Managers (PCM) located in relevant Ministries i.e. under MoH/GHS, MoWAC and National Population Council. The PCM and CSO coordination is set out accordingly: NPC for population and development IPs, MoWAC for Gender IPs and MoH/GHS for reproductive health IPs respectively. Ministries however are not involved in CSO IP selection, but there is mutual agreement when the IP is registered by UNFPA with the relevant PCM<sup>484</sup>. Each PCM has the responsibility of engaging the CSO IP in programme reporting, supervision and budgeting aspects. Capacity development is available through UNFPA for those CSOs that show promise but may be weak in certain areas of programme and project management. In case of non-performance, there is a provision of removal but that has rarely happened except in two cases (birth and death registry and a research institution).</p> <p>UNFPA has a CSO Monitoring Tool that has three sections: monthly disbursement, quarterly report and bi-annual report. Submission of the Funding Authorization Certificate of Expenditure (FACE) in an appropriate and timely manner is critical.<sup>485</sup> There is dual track reporting for sake of coherence; the CSO is required to send a copy of all its results report simultaneously to both UNFPA and the relevant PCM. Each Programme Component Manager shares CSO results with Ministry of Finance &amp; Economic Planning (MoF&amp;EP) as the overall coordinating authority. NPC also chairs the coordinating meeting among the three PCMs and the UNFPA Assistant Representative attends this meeting with relevant UNFPA National Programme Officer (NPO). MoF&amp;EP attends this meeting too. All CSO IPs who work at district level are represented in District Health Management Team (DHMT).</p>
Findings from case	<p>UNFPA is supporting the community based approach of the Government of Kenya; it has initiated with its IPs (such as the MoGender and MoYouth) community dialogues at all levels with women, youth and children to mobilize and sensitize on reproductive health issues,</p>

<sup>481</sup> Interview with government.

<sup>482</sup> Interview with CSOs.

<sup>483</sup> Interview with UNFPA.

<sup>484</sup> Interview with CSOs.

<sup>485</sup> Interview with UNFPA and government, CSO.

<p>study in <b>Kenya</b></p>	<p>including gender based violence. Whilst some positive results can be linked to UNFPA interventions, lack of well-designed baseline studies prevent attribution to UNFPAs work.</p> <p>The Government of Kenya is committed to community participation, especially in the areas of gender and youth. The mobilization of significant persons, such as elders is a key strategy for behavior change which is backed by political leadership and Development Partners. UNFPA supported the formulation of some chapters of the National Youth Policy as well as the creation of a National Youth Council, although the latter is not yet functional. At the ministry level, capacity development for youth officers, the current placement of focal persons within the Ministry of Youth Affairs and the Ministry of Gender and children affairs contributes to confidence building and sustainability. There is also the development of a dialogue tool for engaging policy makers and development of youth empowerment centers. The Ministry of Health with technical and financial support from UNFPA is in the process integrating Obstetric Fistula management services in sites where Safe Motherhood Initiatives are on-going. This is more evident in the districts implementing the community midwifery project where retired midwives are involved in monitoring and conducting deliveries in the community and in creating awareness on Obstetric fistula.</p> <p>In 2008 the issue of male involvement in reproductive health was picked up as priority area while in the sphere of FGM/C elders have been mobilized and sensitized to the point where they are making declarations against the practice of FGM/C and gender-based violence<sup>486</sup>. They also address issues of gender and obstetric fistula. In response to increasing access and providing skilled birth services, UNFPA facilitated the community midwifery programme and the creation of Centers of Excellence for reproductive health. The community midwives serve their communities and participate in relevant dialogues, including formulation of annual work plans.</p> <p>Whilst the KCO has been supporting community participation since its earliest CP, in absence of baseline studies in the respective communities (with appropriate audience segmentation) it is not possible to demonstrate whether those interventions led to formulation of national strategies/policies or to the expected outcomes (reduction of early marriage and obstetric fistula, etc). Nevertheless, community participation is well demonstrated in Naivasha, where UNFPA initiated a reproductive health coordination mechanism in 2008, which is still ongoing and which includes the community in developing the annual work plan<sup>487</sup>.</p>
<p>Findings from case study in <b>Lao PDR</b></p>	<p><i>UNFPA has supported the operationalization of the Strategic Objective 3 of the MNCH package, which is about “Mobilizing individuals, families and communities for MNCH at different levels At national level it took part in the coordination of the community mobilization and awareness and demand creation interventions and in the development of national capacities. It also developed and piloted tools to institutionalize community mobilization for MNCH improvement. .</i></p> <p>The government Strategic Objective 3 of the MNCH package is about “Mobilizing individuals, families and communities for MNCH”. It foresees fostering community involvement and institutionalizing it through creating an enabling policy environment, building the capacity of provincial and district-level health care providers to involve communities, to promote MNCH effectively and to provide services to remote areas. The participation of all partners, including UNFPA, in the Strategic Objective 3 Technical Working Group (TWGs) allowed harmonizing interventions such as community mobilization and IEC/BCC activities for awareness and demand creation although further harmonization maybe necessary<sup>488</sup>. Also, UNFPA advocacy work done with the National Assembly has raised awareness around reproductive health and MNCH issues among the decision makers.</p>

<sup>486</sup> in Baringo, Meru, Pokot, and Kuria.

<sup>487</sup> Information from IP.

<sup>488</sup> Development partners.



	<p>More recently UNFPA has adapted and piloted WHO guidelines of the approach 'Working with Individuals, Families and Communities for improving maternal health' (IFC) and provided technical support to build the capacity of the MoH (Centre for Information, Education and Hygiene - CIEH) to support provinces for the implementation of the Participatory Community Assessment (PCA). The PCA outcome is an IFC plan that outlines community mobilization activities for improving maternal health that will be integrated in the District MNCH action plan<sup>489</sup>.</p>
Findings from case study in <b>Madagascar</b>	<p><i>UNFPA has been strengthening the participation of civil society and the communities in health awareness directly with health promotion campaigns, training of community health workers and inclusion of community leaders in the formulation of annual work plans. UNFPA participated in the formulation of the national strategy for community health, but research on the impact of the community participation on policy issues in view of a follow up of the 2003 survey has not been reported.</i></p> <p>The engagement of the community is supported by UNFPA through the development of the cadre of community health workers, the inclusion of CSOs and communities in the annual work plan development on 'commune' level and through technical support to the National Strategy for Community Health which was validated in November 2009. Research on impact of the community involvement on policy formulation has not been reported, whilst the uptake of family planning is measurable through the UNFPA institutionalized national tracking system.</p> <p>A district-level study undertaken in 2003<sup>490</sup> (funded by the World Bank) identified that community involvement in Madagascar in the provision of health care is limited to: (i) community contributions in labor for the construction of health centers; (ii) financing through the local authorities for health center staff, housing, and equipment; and (iii) providing human resources or volunteers to help with vaccination campaigns. Overall, the providers (district authorities, health centre staff) did not perceive the consumers (patients and communities) as groups with important views on quality of service delivery, and therefore this accountability link is non-existent. The study did not identify any role for communities in providing critical assessments of service quality. The results fed into the maternal health road map, (supported by UNFPA) with one of the objectives being: « Renforcer les capacités des individus, des familles et de la communauté sur la prise en charge de leur santé. »</p>
Findings from case study in <b>Sudan</b>	<p>In Sudan, the significance of civil society organizations as implementing partners is relatively small. Nonetheless, UNFPA has supported the awareness raising work of individual NGOs such as ZENAP, which has been working with communities on changing the attitudes towards female genital mutilation. According to feedback collected by the organization itself, communities are changing their attitudes, albeit slowly<sup>491</sup>.</p>
Findings from case study in <b>Zambia</b>	<p><i>UNFPA helped to establish the creation of support of community-based Safe Motherhood Action Groups (SMAGs) in Zambia's maternal health policy as a way to organize communities around the issue of maternal health and to create a link between communities and health centers. Since their introduction in 2003/04, SMAGs have helped to increase the awareness of and knowledge on maternal health amongst beneficiaries. However, they were not able to address many of the other remaining barriers, such as transport, that continue to</i></p>

<sup>489</sup> Implementing partners interviews.

<sup>490</sup> Brinkerhoff, D. W., & Keener, S. C. (2003). District-level Service Delivery in Rural Madagascar: Accountability in Health and Education. Research Triangle Institute.

<sup>491</sup> Interviews with IPs, UNFPA, beneficiaries (project visits).

*prevent women from accessing maternal health services in remote rural areas.*

UNFPA has worked with Zambian civil society at different levels and on different issues. UNFPA's support to *Safe Motherhood Action Groups* (SMAG) is the most prominent example of UNFPA's engagement with civil society at community level<sup>492</sup>. The scaling-up of the SMAG model from one province (i.e., North-Western Province) to all 9 provinces and to over 50 of Zambia's 72 districts evolved out of UNFPA's initial support of a grass-roots initiative to create a support group for mothers to better address the prevailing maternal health needs in the community. UNFPA adopted the concept of Safe Motherhood Action Groups (SMAGs) as an advocacy cause at the national level and, during the 5<sup>th</sup> Country Programme, lobbied intensively for the replication of the model in other districts and provinces; and for the integration of the concept in national frameworks, policies and guidelines<sup>493</sup>. At the time of the evaluation, the SMAG concept had firmly taken hold in Zambian Government policy, implementation plans; and also in maternal health initiatives of other development partners<sup>494</sup>.

SMAG and other community education initiatives (with parent elders, peer educators, traditional initiators) have helped to increase the awareness and knowledge about maternal health issues in communities, e.g., with regard to bleeding as warning signs for complications during pregnancy, or to the importance of relieving pregnant women from some of the more arduous household tasks, such as fetching water or collecting firewood<sup>495</sup>. However, in spite of positive examples of improved behavior and attitudes towards pregnant women and mothers, the continued popularity of traditional practices in medicine and inequitable attitudes towards women continued to constrict women's choices and opportunities for accessing maternal health services<sup>496</sup>. Moreover, the trends in some key indicators in North-Western and Luapula Provinces<sup>497</sup> suggest that either the improvements in the awareness of (some) beneficiaries were not sufficient to reverse an overall negative trend in these areas; or that despite the improved awareness in the population of these two provinces, other barriers<sup>498</sup> so far have prevented women from improving their access to maternal health services, including the delivery in health facilities with skilled personnel.

<sup>492</sup> I.e., in this case communities are targeted directly, through the formation of community based organizations, the SMAGs.

<sup>493</sup> Based on information from UNFPA staff; but supported with information from other stakeholders (Ministry of Health (MoH), Ministry of Finance and National Planning (MoFNP), Country Programmes).

<sup>494</sup> To illustrate: the 2011 work plan of the MoH foresees support to SMAGs from Government budget resources (e.g., the "scale-up of SMAGs to 10 districts"; supported with approx. 89 million Kwacha (approx. US\$ 18,000); other SMAG related activities are to be financed with donor funds); UK Department for International Development (DfID), and USAID are utilizing the SMAGs in their maternal health-related interventions in Zambia.

<sup>495</sup> Focus groups with SMAG members.

<sup>496</sup> In focus groups, male and female members of the SMAGs conceded that the positive examples of attitude and behavioural change in men and women notwithstanding, the influence of traditional practices, such as the use of herbs for stopping bleeding instead of using health services in a health centre; or the attitude of men that fetching water and collecting wood was "women' work" remained strong.

<sup>497</sup> In two of the three Provinces where UNFPA is directly working in training and service delivery (Luapula, North-Western), the rate of births attended by skilled personnel has actually decreased between 1992 and 2007, i.e. from approximately 36% (1997) to 34% (2007) in Luapula; and from approximately 50% (1992) to 41% (2007) in North-Western Province (UNDP Zambia, 2011). These figures are based on the Zambian Demographic and Health Survey (ZDHS) from 2007.

<sup>498</sup> Such as the far distances to health centres from many remote communities, for example.

**Judgment criterion 3.2: CSOs involvement in sensitization on maternal health issues and facilitating community based initiatives to address these issues supported by UNFPA**

Findings from <b>desk study</b>	UNFPA has worked extensively with CSOs as intermediary organizations but has been relying more and more on NGOs within the social economy especially locally registered INGOs than national community volunteer and membership based organizations. When it did work with local or indigenous organizations there was a tendency to work with the same organization over several years. No appraisals of UNFPA supported mechanisms to build CSO capacity for community involvement to increase (improve) demand, access or utilization was provided. There is little evidence of systematic M&E of UNFPA-CSO-community partnerships. There are however some mention of sharing population data, service franchising, social marketing and equity funds but their actual existence is few and far in-between.
Findings from case study in <b>Burkina Faso</b>	<p><i>L'UNFPA a facilité un partenariat entre le gouvernement et les ONGs pour la mise en œuvre d'action de sensibilisation pour la santé de la reproduction. Le manque de suivi systématique n'a pas permis d'obtenir de données quant aux résultats de ces interventions. Plus récemment, avec au soutien du Programme Global pour la Sécurisation en Produits de Santé (GPRHCS), des ONGs ont été mobilisées au niveau national et régional afin de mettre en œuvre le programme de Distribution à Base Communautaire et de sensibilisation a travers le panier commun.</i></p> <p>Au cours du 5ème (2001-2005) et 6ème (2006–2010) programmes de coopération l'UNFPA a collaboré avec des ONGs pour des activités mise en œuvre avec les communautés (sensibilisation, partage des coûts, fistules obstétricales) et pour certaines formations. Par exemple un partenariat avait été mis en place avec <i>Family Care International</i> pour des formations au niveau régional sur l'outil COPE (client-orienté, provider-efficent)<sup>499</sup>. Durant le 6ème programme, la composante 'Communication en Santé de la Reproduction' a été exécutée par la Direction de l'Hygiène Publique et de l'Éducation pour la Santé (DHPES) qui a créé des partenariats avec des Organisations de la Société Civile (OSC) pour la mise en œuvre d'activités de sensibilisation dans les zones d'interventions. Le renforcement des capacités de la DHPES ainsi que certaines ONG/OSC et Organisation à Base Communautaire (OBC) faisait partie de l'approche. Toutefois les résultats de ces interventions n'ont pas été mesurés de façon systématique et peu d'informations sont disponibles sur leur impact<sup>500</sup>.</p> <p>En 2009, 10 ONGs<sup>501</sup> ont été sélectionnées en fonction de leur expérience (sensibilisation, services à base communautaire) pour mettre en œuvre le programme DBC (distribution à base communautaire) récemment initié dans le cadre du panier commun. La DBC est couplée avec une sensibilisation sur les enjeux de la SR dans la zone d'intervention de ces ONGs. Ce partenariat est de grande ampleur et requiert un suivi important d'autant plus que peu de données sont disponibles en ce qui concerne les expériences similaires précédentes<sup>502</sup>. L'UNFPA en collaboration avec le PADS a mis en place un système de suivi et de rapportage qui est en train d'être testé<sup>503</sup>.</p>

<sup>499</sup> Entretiens avec les partenaires de mise en œuvre.

<sup>500</sup> Évaluation de la Composante Sante de la Reproduction (Burkina Faso – UNFPA ; Programme de coopération 2006 – 2010), Août 2009.

<sup>501</sup> Avec entre autres la Fondation pour le Développement Communautaire (FDC), AES/B, ADRK, Projet Bobo, Initiative privée communautaire (IPC), Association Burkinabé pour le Bien-être Familial (ABBEF), SOS Sahel International, SOS Jeunesse et Défis.

<sup>502</sup> Entretiens avec le personnel de l'UNFPA.

<sup>503</sup> Entretiens avec les ONGs Rencap (renforcement des capacités).

	<p>Une collaboration plus spécifique a été mise en place avec <i>Family Care International</i> (FCI) qui travaille avec des Organisation à Base Communautaire (OBC) locales pour la prévention, la détection, de la prise en charge et de la réinsertion des femmes ayant des fistules obstétricales dans la Région du Sahel<sup>504</sup>.</p>
<p>Findings from case study in <b>Cambodia</b></p>	<p><i>Currently UNFPA does not have direct programme partnerships in reproductive health/maternal health with independent CSOs but they are contracted for specific activities related to awareness raising and sensitization as and when needed. UNFPA finds this more strategic and flexible arrangement. There was a general feeling among the larger NGOs that UNFPA had over the last three years disengaged from the civil society forums where many discussions on policy, community sensitization on rights based approaches and reproductive health/maternal health service delivery happen.</i></p> <p>This was not the case in 2001-2005 where UNFPA helped develop national framework for civil society involvement focusing on protocols, guidelines and training curriculum and materials related to Community-based Distribution (CBD), Youth Friendly Services (YFS), counseling and Behavior Change Communication (BCC). Today the very same protocols, guidelines and training tools have been accredited by MoH and all NGOs and Commune Councils are required to utilize them. Between 2010 and 2011, guidelines have been made for EmONC and maternity waiting homes but they were not targeted to NGO involvement but the latter uses it nonetheless.</p> <p>UNFPA Country Programme II (2001-5) saw the highest funding of NGOs through non-core earmarked funding – 62% from the European Union for 5 years (Reproductive Health Initiative for Youth in Asia - RHIYA 2001-2005). Core funding of NGOs in the same years was 16.2% and 12% for reproductive health and gender component respectively. By Country Programme III (2006-10) non-core reproductive health funding to NGOs was reduced drastically to 13 % and core funding to 9%. A large part of the non-core reproductive health funding (2002-8) was provided to a joint communication initiative between MoH and Cambodian Health Education and Media Services (CHEMS)<sup>505</sup>. This communication initiative was meant to improve maternal health by increasing coverage and competency of midwives, strengthen pre-service education and in-service training, increase recruitment, retention and deployment of midwives in rural areas, maintain and strengthen midwifery as an attractive profession and implement behavior change interventions to increase awareness and utilization of reproductive health/maternal health services.<sup>506</sup></p> <p>Currently in the area of reproductive health/maternal health, UNFPA interacts with CSOs mostly through the Fast Track Initiative Road Map on Reducing Maternal Newborn Mortality and with communities as part of the wider Commune Investment Plan (CIP) which includes support to Commune Councils (CC), Village Health Support Group (VHSG), Village Health Committee (VHC), Health Centre Management Committee (HCMC), the Women and Child Health Committee (WCHC) and the CBD are being consolidated and expanded. Much of the communication and advocacy materials being developed these days by UNFPA are “<i>really to bridge with community and policy change of Decentralization and Deconcentration in the implementation of reproductive health related activities.</i>”<sup>507</sup></p>
<p>Findings from case study in <b>DR Congo</b></p>	<p>Certaines tensions existent entre le gouvernement et la société civile quant au choix de l’UNFPA d’allouer ses ressources aux associations à cause d’inquiétudes relatives à la gestion des fonds au sein de la fonction publique. Une autre preuve de ces tensions se trouve, par exemple, dans le mécontentement de la part de la Direction des Programmes des Adolescents du Ministère de Santé quant à la décision de l’UNFPA de financer certaines activités des Organisations de la Société Civile (OSC) (BOMOTO, RAJECOPOD, SCEV)</p>

<sup>504</sup> Entretiens avec les partenaires de mise en œuvre.

<sup>505</sup> 2008 Progress Report on “Support for Cambodian MDG 5”, MoH and CHEMS.

<sup>506</sup> NGO Partner.

<sup>507</sup> UNFPA Cambodia.

	<p>qui s'occupent des programmes de promotion de la santé parmi les jeunes au même temps que, alors même qu'il ne finance plus les activités de la Direction (Voir Judgment criterion 3.2 dans la Matrice des Résultats; Annexe 6.3, pour plus des détails).</p>
<p>Findings from case study in <b>Ethiopia</b></p>	<p><i>UNFPA involves through its implementing partners a range of CSOs with medical and religious background to sensitize the communities on reproductive health issues and has achieved adapting the community conversation methodology to reproductive health needs. Evaluations of the end-beneficiary up-take are not sufficiently integrated into the programme design.</i></p> <p>UNFPA has taken the lead in adapting the Community Conservation (CC) methodology traditionally used in HIV/AIDS to incorporate gender and reproductive health issues and a tool has been developed i.e. (Comprehensive Community Conversation for Action – CCCA). This was a programme which has displayed the high level of integration and synergy between UNFPA Country Programme components i.e. HIV/AIDS, gender, and reproductive health. The CCCA including gender and reproductive health has been integrated into the HEW training manual which might give it a potential for national level scale up.</p> <p>Together with the Ethiopian Orthodox Church, UNFPA has created (since 2006) a Development Bible, which adds health related messages (including obstetric fistula, harmful traditions, FMG, HIV/AIDS) to every day's readings. It is piloted in three regions currently.</p> <p>UNFPA involved NGOs that promote access to maternal and reproductive health services to vulnerable rural areas; it supported e.g. a project supporting community mobilization on SRH and provision of comprehensive EmONC and management of obstetric fistula through supporting the NGO maternal and child health center.</p> <p>The strongest linkage between the ECO, development partners and the GoE is the Health Population and Nutrition high level coordination group, currently co-chaired by UNFPA. The group is tracking the annual plan of the government and the comprehensive plan for development partners including CSOs. Two NGO umbrella organizations are members of HPN but do not particularly represent their members. For example, their participation in HPN meetings is rare; their strategic plan does not clearly identify tasks towards representation of other their partner NGOs.</p> <p>The Ethiopian Midwifery Association (EMA) is one of the main CSO that benefits from UNFPA consistent support since 2006 but it seems that only since the advent of the MHTF and the two midwifery advisors in the ECO tangible progress has been made <sup>508</sup>(see MHTF).</p> <p>Whilst all these initiatives are important components of the community based approach of UNFPA, the close monitoring of the impact on the end-beneficiaries may be considered to provide evidence for successful strategies. <sup>509</sup></p>
<p>Findings from case study in <b>Ghana</b></p>	<p><i>UNFPA Ghana has no separate formal strategy on community involvement instead it supports innovations among communities through several national CSOs and Regional Health Directorates<sup>510</sup> These innovations remain limited in scope and scale.</i></p> <p>UNFPA works with IPs and strategic partners who may not be IPs. Nevertheless UNFPA's partnership is IP driven and the type and numbers of CSO and community groups involved in CP 4 and CP 5 reflect the importance of the strategic mandate areas and funding allocations made therein<sup>511</sup>.</p>

<sup>508</sup> Only since 2011 the EMA is able to participate increasingly in the support to the FMoH in supervising training of midwives.

<sup>509</sup> For example the monitoring plan of the 'Development Bible' foresees control of church leader utilising those daily messages, and not the knowledge, attitude, practice survey of recipients.

<sup>510</sup> Interview with Regional Health Directorate Staff.

<sup>511</sup> Results and Resource Framework for Ghana, CPAP 2006-2011.

There are 13 CSO/FBO partners: reproductive health (8), population and development (1) and gender (4). The larger national ones like PPAG, CEPED and CHAG (the latter is considered by many as the parastatals service delivery arm of the Ministry of Health but this view was refuted by CHAG) have continued from CP4 into CP5 and seem confident of their inclusion in CP6 and were waiting for notification at the time of the evaluation.<sup>512</sup> Implementation rate is higher for smaller and newer CSO IPs and with capacity development provision, absorption rates are higher too.

UNFPA provides flexibility to CSO IPs and to Public Health Directorate to experiment with strategies for improving service delivery through community partnerships thus improving maternal health. Some examples of community strengthening partnerships are:

Emergency transport for obstetric emergencies started in 2 districts and has expanded to 17 districts of the Central Region through a public/private partnership with Ghana Private Regional Transport Union and Time with Grandma, an initiative against teen pregnancy and school dropout prevention programme.

National public platforms to engage youth, government, traditional authorities and other health stakeholders through such CSOs as Curious Minds, which initiated a campaign to engage community youth organizations in the most recent Census (2010).

UNFPA partnered with both MoH and a CSO in the Northern Region, where GHS provided an office at no cost to the programme due to UNFPA's advocacy to help the CSO that train doctors and also create demand for fistula services.

An IP called COMOG is integrating religious collaboration among three Muslim sects in support of maternal health, gender and women's economic empowerment through Zakat Houses (savings and loans).

Another IP, SWAA, promotes female condoms in markets on a commission basis with retailers and links up a women porter's micro-financing co-operative with safer sex and family planning<sup>513</sup>.

In some rural and remote communities, CHAG hospitals had problems attracting certain groups of traditional women. By being culturally sensitive and allowing the group to dig holes for placenta burial for a nominal sum, CHAG increased hospital visits by pregnant women in that area by nearly 300% within 3 months. The system of churchyard birthing remains prevalent in both poor urban and rural areas but the practice is highly controversial and UNFPA supports CSOs and community groups to discourage it.

While recognizing the importance of increased alignment and harmonization with government priorities, CSOs also note how critical it is for UNFPA to keep a balance in funding them since public health promotion strategies alone cannot shift the socio-cultural change needed to bring down the 30% deliveries still done by Traditional Birth Attendant (TBA) and the fast track integration of culturally sensitive and rights based programming<sup>514</sup>. The question remains as to how UNFPA will play an advocacy role for what is not essentially mainstream practice? Someone needs to play that advocacy role to find out what actually works well (HIRD)<sup>515</sup>. CHAG has districts where it is training TBAs today. This intervention has increased ANC and PNC utilization over 250%<sup>516</sup>. There are areas in Ghana that have a maternal mortality rate of 500 or 600 where certain CSO facilities are already there but sometimes they that do not fall within

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<sup>512</sup> Interviews with CSOs.

<sup>513</sup> Interviews with related CSOs/FBOs.

<sup>514</sup> Cultural Sensitivity and Programming: Case of Government-UNFPA 5<sup>th</sup> CP 2006-10, UNFPA Ghana.

<sup>515</sup> Interview with Government.

<sup>516</sup> Interview with CSO.

	<p>UNFPA programme areas which means activities are not funded but CSOs are instead are asked to work in a facilities located in an area with 300 maternal mortality rate<sup>517</sup>. Outside the Annual Programme Review meeting, UNFPA and CSOs do not meet in forums by themselves where broader issues of programme strategy and planning can be openly discussed<sup>518</sup>.</p>
Findings from case study in <b>Kenya</b>	<p><i>The KCO enhances through its IPs community participation and collaboration the integration of reproductive health services and the prevention of harmful traditional practices. Specific areas of community involvement include training of community midwifery to increase access to skilled care and addressing neglected areas of Sexual and Reproductive Health e.g. Obstetric Fistula (OF), Gender-Based Violence (GBV), Adolescent and Youth Reproductive Health (AYRH), Cervical Cancer, etc. IPs receive some training and are included in the review meetings and M&amp;E missions together with counterparts from the district health administration.</i></p> <p>UNFPA utilizes mainly national NGOs and community based health workers as implementing partners, which is a means to facilitate community based interventions. The IPs receive a training in Results based Monitoring and accountancy, as well as support to study tours<sup>519</sup> and creation of capacity of local networks<sup>520</sup>. UNFPA funds training on family planning, GBV, fistula, maternal health and gender based on needs identified by the IPs, the training is often conducted by staff of MoH, MOPHs or MoG. The mobilization of significant persons in the community such as elders to advocate for abandonment of harmful practices is a key strategy for behaviour change that is backed by public declarations. UNFPA, Ministers and GoK officials attend these declarations to give the process more legitimacy and further publicity.<sup>521</sup></p> <p>Annual Work Plans are monitored jointly by the KCO, the Ministry of Public Health and the National Coordinating Agency for Population and Development (NCAPD). Joint planning meetings for the Annual Work Plans and M&amp;E missions are bringing together Civil Society Organizations and Government through coordination by UNFPA. The M&amp;E officer of the KCO has recently created a 'Programme Recommendation Tracking Tool' which includes all recommendations made during the joint M&amp;E missions to ensure the adequate follow up, adjustment and changes.</p>
Findings from case study in <b>Lao PDR</b>	<p><i>In Lao PDR the civil society is still very little developed and only few CSOs/ NGOs have started emerging. Relying on NGOs for interventions has therefore not been a feasible option. Instead, UNFPA has implemented maternal health communication initiatives with the Government using different approaches over the evaluation period. However, the results of earlier communication initiatives have not been systematically assessed. More recent approaches to mobilize communities for maternal health improvement were adopted with the support of INGOs, with some initial successes. However, the sustainability of these initiatives is unclear as their designs did not include clear exit strategies.</i></p> <p>From its first Country Programme onwards, UNFPA has greatly emphasized the importance of working with communities through reproductive health promotion activities including the promotion of reproductive health rights. As the NGO sector is not developed in Lao PDR, other networks were used such as the Lao Women's Union, the Lao Youth Union or the Lao Front for National Construction, which are mass organizations being part of the Lao PDR system. UNFPA has also built the capacity of the Centre for Information, Education</p>

<sup>517</sup> Interview with CSO.

<sup>518</sup> Interview with CSOs.

<sup>519</sup> CDN and MUMCOP programme coordinators to Sierra Leone.

<sup>520</sup> Christian leaders network under NCKK, gender-based violence networks, FGM networks.

<sup>521</sup> UNFPA supported the launch of the anti- FGM forum in Baringo which brings together UNICEF, GoK, MoG, CDN and local stakeholders and meets every 2-3 months.

	<p>and Hygiene (CIEH) to develop IEC/BCC materials and to train its partners in the field. Unfortunately there is little evidence on the results of this approach as only work plan were monitored thus focusing on activities and did not inform on the outcomes of implemented activities<sup>522</sup>.</p> <p>Later, UNFPA adopted an empowerment approach through collaborating with provinces and districts to mobilize communities and to build their capacities to take action to improve MNCH such as the reactivation of village health committees that can manage saving funds and transportation schemes that can be used at the time of child birth or in case of emergency<sup>523</sup>. This approach was facilitated through an INGO Health Poverty Action (HPA)<sup>524</sup> providing support to provincial health offices, and was relatively input intensive. The results, measured by the project staff using the indicators of the CPAP Planning and Tracking Tool, proved to produce significant results on the improvement of skilled attendance at birth and contraceptive use<sup>525</sup>. However, the lack of a phase over strategy to ensure that actions are continued by partners may hamper the sustainability of positive results.</p>
<p>Findings from case study in <b>Madagascar</b></p>	<p><i>UNFPA engages communities indirectly through its implementing partners, which are the health administrations, NGOs and CSOs, who receive training on RBM. The CSOs additionally are supported throughout the planning and reporting phases by UNFPA staff to facilitate the process. As the GoM rely heavily on the community workers, the sustainability of voluntary community health workers should be a priority subject for all development partners and the MoH initiative further supported.</i></p> <p>UNFPA does not provide direct assistance to the community, but rather through its direct or indirect (contracted via the respective health administration) IPs. CSOs, such as FISA; SAF and SALFA are IPs of UNFPA and are included on national level in a variety of technical working and planning groups and they participate in the biannual and annual review meetings of UNFPA, as well as on regional and district level in coordination mechanisms. UNFPA conducts with all its IPs bi-annual review meetings, M&amp;E reviews and one or two per IP receive RBM training and support to proposal writing and reporting is given by UNFPA staff. The most recent of such RBM trainings were in 2008 and were reported to be resumed soon. New IPs have not been contracted in the last years, most are partners since many (even 10) years.</p> <p>Health promotion through media releases, dissemination of informative leaflets, special campaigns targeting youth, men, community leaders, etc are promoted by UNFPA through the CSOs, who usually use community health workers for the sensitization of the communities on special issues. The MoH (funded by USAID) conducted in October 2011 a conference on community health workers (CHW) to formulate recommendation for the expansion and increased sustainability of the voluntary CHW force, on incentives, motivation, etc. One recommendation was to channel all funds for the CHW to the community as a sort of basket fund. This was in view of the great discrepancy of partners (UN, GF, USAID, and others) in providing incentives, which range from provision of caps, shirts, and small per diems for special campaigns or training, up to an earmarked full salary for a year. Sustainability was considered to improve when the community would be involved in the decision of distribution of incentives.</p>
<p>Findings from case study in <b>Sudan</b></p>	<p>reproductive health and maternal health awareness rising is a regular component of UNFPA's maternal health support in Sudan, at federal level as well as in the 5 focal states. For the most part, however, these activities are implemented through the federal and state</p>

<sup>522</sup> UNFPA staff interviews.

<sup>523</sup> Focus groups with Village Health Committee members.

<sup>524</sup> Formerly Health Unlimited (HU).

<sup>525</sup> RH3 Evaluation UNFPA Lao PDR – Draft – 2011.



	<p>MoH, and not with civil society organizations as implementing partners (with the exception of certain NGOs and academic organizations, such as ZENAP in Gedaref or the Afhad Women's University). E.g. in Kassala State, staff from the State MoH Reproductive Health Programme participated in a training of trainers (ToT) for media representatives that had been organized and financed by UNFPA. Apart from staff members of the Kassala MoH, the training was attended by staff of local newspapers and community radio stations. Participants used the knowledge and skills from the training to organize mobile cinemas, write articles on reproductive health (e.g., on maternal deaths in Kassala) or design informational and participatory radio shows<sup>526</sup>.</p>
<p>Findings from case study in <b>Zambia</b></p>	<p><i>UNFPA previously involved Zambian Non-Governmental Organizations (NGOs) as implementing partners of some of its programmes, but has recently transferred this role back to the Government. This has somewhat weakened the position of the former CSO implementing partners to provide meaningful input and to lobby the Government in the area of maternal health.</i></p> <p>In addition to its support of SMAGs, UNFPA has supported the creation of a professional association of midwives in Zambia<sup>527</sup>; and also has provided funds to NGOs that have functioned as implementing partners of UNFPA-funded interventions. From the 4<sup>th</sup> Country Programme onwards, for example, UNFPA has cooperated with a consortium of NGOs in the “PPP programme”, a programme supporting peer education, service provision and supports the role of parents in maternal / SRH education, with administrative arrangements that changed over time. While during the 5<sup>th</sup> Country Programme (2002 – 2006), a NGO<sup>528</sup> had been designated as “executive agency”<sup>529</sup>, UNFPA transferred the responsibilities for managing these projects to the Government of Zambia<sup>530</sup> with the beginning of the 6<sup>th</sup> Country Programme (2007 – 2010), and left only the implementation in the hands of NGOs. Although this increased the Government ownership of the programme, the role Civil Society partners was weakened, making them less able to provide meaningful input, and to advocate for sufficient coordination between civil society and the Zambian Government, in particular at the national level<sup>531</sup>. Also, with less funds available from UNFPA for Civil Society, some of the NGOs that are active in maternal health found it increasingly difficult to advocate with the Government on the issue of maternal health<sup>532</sup>.</p>

<sup>526</sup> Interviews with IPs, UNFPA, beneficiaries (project visits).

<sup>527</sup> The “Midwifery Association of Zambia (MAZ)”, discussed in more detail in the section on MHTF of this report.

<sup>528</sup> The “Planned Parenthood Association of Zambia” (PPAZ).

<sup>529</sup> Which meant that the NGO was the direct recipient of funds, was responsible for fund management and was in charge of reporting to UNFPA.

<sup>530</sup> Specifically the Ministry of Sports, Youth and Child Development (MSYCD).

<sup>531</sup> Based on interviews with Civil Society Representatives.

<sup>532</sup> One example given in an interview was that without funds given directly to NGOs instead of through Government it was more difficult for Civil Society to advocate against the purportedly ongoing attempt to lower the national MDG target for maternal mortality, to increase Zambia's chance of meeting the formal target.

## 8.2.4 Evaluation question 4: To what extent has UNFPA contributed to the strengthening of human resources for health planning and human resource availability for maternal and newborn health?

### Judgment criterion 4.1: Development / strengthening of national human resources for health (HRH) policies, plans and frameworks (with UNFPA support)

Findings from <b>desk study</b>	While the earlier MYFFS 2000-2003 and 2004 -2007, outputs and indicators did not refer to HRH development, the 2008-2011 Reproductive Rights and SRH in the UNFPA Strategic SRH Plan pledged to ensure that sufficient, adequately skilled and motivated human resources are available to provide integrated reproductive health services. To this end, UNFPA supported competency definition and certification, capacity development of human resources, with particular emphasis on midwives. Priority areas of UNFPAs reproductive health capacity development in terms of topics include clinical and 'soft' skills, especially for EmONC, obstetric fistula and family planning (Judgment criterion 4.1, 4.2).
Findings from case study in <b>Burkina Faso</b>	<p><i>Les analyses situationnelles ainsi que l'élaboration de normes et protocoles réalisées avec l'appui de l'UNFPA ont contribué à informer et à renforcer la planification des services de SR et des besoins en ressources humaines de façon significative au sein de la DSME. Toutefois le personnel de santé est géré par le Département des Ressources Humaines, département avec lequel l'UNFPA a n'a pas établi de relations aussi étroites et de fait des problématiques telles que la rétention des sages femmes dans les zones rurales restent à traiter.</i></p> <p>L'Analyse situationnelle des services de santé de la reproduction réalisée en 2006 et la l'Analyse situationnelle de la profession de sage femme/maïeuticien (SF) ont permis d'identifier des besoins en matière de ressources humaines. Ils sont utilisés pour les planifications opérationnelles annuelles de l'UNFPA depuis 2007 et pour toutes les planifications de la DSF/DSME et des autres partenaires<sup>533</sup>.</p> <p>L'UNFPA a contribué à l'élaboration des politiques normes et protocoles (PNP) en 2000 et à leur mise à jour en 2010. Ces politiques définissent les orientations politiques et les normes en termes de ressources humaines pour les prestations en SR y compris la santé maternelle et néonatale<sup>534</sup>.</p> <p>Jusqu'à ce jour la Direction des Ressources Humaines (DRH) du Ministère de la Santé ne dispose pas de plan de développement des ressources humaines pour la santé et s'active à en élaborer un en 2011 avec l'appui technique des PTF. L'accroissement des besoins en sages femmes lié à la réforme (transformation des Centre de Santé et de Promotion Sociale (CSPS) de chef lieu de commune en Centre Médical avec Antenne chirurgicale (CMA) pour offrir des SONU de base) doit être inclus dans le plan à venir. La DRH est consciente des enjeux de cette réforme et des nombreux écueils liés à cette réforme en particulier la rétention des sages femmes en zone rurale. Ces problématiques doivent être abordées lors des discussions pour l'élaboration du plan de développement des ressources humaines. La participation de l'UNFPA lors de son élaboration était incertaine<sup>535</sup>.</p>
Findings from case study in <b>Cambodia</b>	<i>UNFPA has made clear contributions to the strengthening of Cambodia's National Human Resources for Health policies, plans and framework especially with regard to reproductive health/maternal health. The country office has actively participated in the development of the country's Health Workforce Development Plan, under the leadership of WHO and the Ministry's Human Resources Development</i>

<sup>533</sup> Entretiens avec le personnel de l'UNFPA.

<sup>534</sup> Entretiens avec les partenaires gouvernementaux.

<sup>535</sup> Entretiens avec les partenaires gouvernementaux et l'équipe UNFPA.

	<p><i>Department.</i></p> <p>The Cambodian genocide in the mid to late 70s decimated the country's cadre of skilled health workers. Many of the surviving professionals left in the following decade. Systematic efforts to redevelop Cambodia's national human resources for health started only after the year 2000<sup>536</sup>.</p> <p>UNFPA has been financing the full-time position of an HRH adviser in the Human Resource Development Department (HRD) of the MoH since 2002. This adviser also serves as the focal point in the Government to represent UNFPA interests in a coordinated manner<sup>537</sup>.</p> <p>The Health Workforce Development Plan 2006-2015 (HWDP)* was the second national plan for the health workforce that preceded the formulation of the Health Sector Programme 2 (2008-2015*).<sup>538</sup> The WHO is the lead donor on the Health Workforce Development Plan. UNFPA is a close second, focused specifically in the areas of reproductive health/maternal health. The key activities included the formulation of policy outlining support and vision for the development of the health workforce within the National Strategic Development Plan 2006-2013*, the Serving the People Better Policy 2006, Regulations for Private Practice 2007 and integration into the Fast Track Initiative Road Map for Reducing Maternal and Newborn Health (2010-2015*).<sup>539</sup></p> <p>The recommendations of the HWDP have led to seven MoH salary increases since 2006, including 20% annual increases of base pay to midwives. The Government of Cambodia is committed to repeating these increases until 2013, with the hope of slowing down dual practice by health workers.<sup>540</sup> A Projection Tool is also used to bring the planning information in line with the Health Coverage Plan staffing standards, compensation data, attrition rates and health facility deployment. This has helped to reach the target of having at least one primary midwife in every health center by 2010.</p> <p>HSSP II development partners, including UNFPA, continue to monitor Standard Operating Assessments of MoH, which have introduced rural level incentives in about 20% of the health system. The Personnel Department has also maintained a recruitment and transfer policy, which limits recruitment and transfers to Phnom Penh, enabling an intensification of resources in the Provinces<sup>541</sup>. Furthermore, UNFPA has played a role in influencing placements of midwives. HSSP II places limitations on funding scholastic training, which has been problematic for UNFPA and for enrollment in the Regional Training Centers.</p>
Findings from case study in <b>DR Congo</b>	<p>Grâce à ses échanges réguliers avec le gouvernement au cours de son Troisième Programme de coopération (2008-2012), l'UNFPA a pu sensibiliser le Ministère de la Santé au sujet de la formation des sages-femmes. Il a mis en avant le besoin d'une formation raccourcie (réduite de neuf à trois ans) pour les accoucheuses, et a souligné l'importance d'ouvrir de nouvelles écoles de Sages-femmes, tout en améliorant le contenu de la formation (en mettant l'accent sur la dimension pratique de la formation). L'intervention de l'UNFPA a mené également à une réflexion sur le développement d'une formation permettant la reconversion d'infirmiers polyvalents en sages-femmes diplômées. En 2008-2009 il a soutenu le gouvernement dans la mise au point d'un recensement des sages-femmes et a accompagné l'Association des Sages-femmes dans sa démarche de professionnalisation et dans une tentative de développer un système renforcé de régulation. Il a soutenu aussi, grâce à un partenariat avec l'Hôpital Marie Biamba Mutombo de Kinshasa, la</p>

<sup>536</sup> However, UNFPA had started to support the re-development and strengthening of national human resources for health already in 1998.

<sup>537</sup> Government Partner.

<sup>538</sup> Second National Health Work Force Development Plan, HRD, MoH, 2006. Those with \* supported by UNFPA.

<sup>539</sup> Health Workforce Development Plan 2006-15, MTR, 2011.

<sup>540</sup> External Development Partner.

<sup>541</sup> MoH Reproductive Health Costing 2006-2015, UNFPA and WHO HRD Review 2010.

	<p>formation des médecins Congolais dans la réparation chirurgicale des fistules urogénitales qui touchent les femmes pauvres (Voir Judgment criterion 4.1 dans la Matrice des Résultats; Annexe 6.3, pour plus des détails).</p>
<p>Findings from case study in <b>Ethiopia</b></p>	<p><i>UNFPA has been partner to the development of human resource strategies and documents through technical and financial support, as well as through needs assessments that feed into the reproductive health and HRH strategies of Ethiopia. It has been instrumental in the implementation of task shifting for non-clinical physicians and relevant curricula development.</i></p> <p>At policy level, UNFPA supported the Human Resources for Health (HRH) strategy development through the Joint In-Country UN (WHO, UNFPA and UNICEF) Concept Paper on the Reduction of Maternal and Newborn Mortality in Ethiopia which focused on the need for a concerted focused effort to increase access to skilled birth attendants, Emergency Obstetric Care and Family Planning. The HRH Strategy 2009-2020 recognizes the need for up-scaling of midwives and the new cadre of the integrated emergency obstetric surgeons (IEOS). Several health worker needs assessments have been performed either by UNFPA or in conjunction with other agencies since 1997; a conference on task shifting and the development of the curricula for the new cadres have been substantially supported by UNFPA. Apart from initiating and conducting policy dialogues, needs assessments and workshops/conferences, UNFPA seconded staff to the Federal Ministry of Health for technical support.</p> <p>Curricula development, in-service training and provision of equipment to health facilities to enable newly trained staff to apply upgraded skills have been supported by the ECO since (at least) the 5<sup>th</sup> CP<sup>542</sup>. In 2005/06 UNFPA's focus shifted towards pre-service training and equipping of training facilities. UNFPA supported for example the five year consultative process of the FMOH, academia, and other relevant partners, including the medical associations, to develop a recognized degree for health medical officers, which is now producing its first graduates. (see also MHTF)</p>
<p>Findings from case study in <b>Ghana</b></p>	<p><i>There is no specific committee for reproductive health/maternal health in Human Resources for Health (HRH) planning; however, through the Health Sector Working Group UNFPA also addresses reproductive health/maternal health human resource especially the issues of capacity development, shortages of midwives and gaps in appropriate skills. The MoH and UNFPA both use health service annual reports to determine human resource needs but there is a need for UNFPA to scale up its involvement to influence budget allocation for HRH.</i></p> <p>UNFPA Ghana works directly with two of the biggest service providers in reproductive health/maternal health, which are Ghana Health Service (GHS) and Christian Health Association of Ghana (CHAG). GHS is the recipient of the largest amount of UNFPA resources. In turn the GHS includes UNFPA in the formulation, implementation and monitoring and evaluation of effective HRH policies that guide production, management and training of the maternal health/reproductive health related health workforce. UNFPA and other development partners especially WHO and UNICEF share evidence from other countries and advocate for government to develop the strategies and policies to facilitate implementation of health delivery. For example the biannual national health summits provide such fora from which an Aide Memoire and its accompanying matrix are developed to guide HRH implementation. Funds for trainings are very occasionally provided directly to the private sector, which then collaborates with GHS to organize life-saving training sessions for midwives in the private sector.<sup>543</sup></p> <p>Acute human resource shortages in maternal health are recognized and UNFPA Ghana was realistic that MoH/GHS will not be able to</p>

<sup>542</sup> The earliest available document is the COAR 2004.

<sup>543</sup> Ghana: Implementing a National human Resource for Health Plan, 2008, WHO and Global Health Workforce Alliance.

	<p>meet needs for midwives (and other SBA) in the short term. UNFPA could get a “bigger bang for the buck” if the supplementary non-core funding for GHS provided through MHTF and GPRHCSTF could get UNFPA a seat in the powerful Human Resource for Health Development Directorate (HRHDD) or if the potential to make it an IP could be explored<sup>544</sup>. UNFPA has not yet fully utilized opportunities to investigate public/private partnerships for human resource for health (profit and not for profit) in order to meet the HR and service gaps<sup>545</sup>.</p> <p>UNFPA support is further needed for cohesive strategies<sup>546</sup> within GHS to increase the number of qualified midwives, qualified tutors, training sites, clinical sites, and explore new ways to incentivize remote posting including strategy assessment of how to phase out TBAs and phase in midwives<sup>547</sup>. MHTF has supported the position of the Country Midwife Adviser and related trainings. Key challenges for expanding midwifery school capacity to train more midwives are the tutor qualification requirement at masters’ level and the shortage of clinical practicum sites.<sup>548</sup> This point will be taken up under MHTF section.</p> <p>The recent EmONC needs assessment carried out with support from UNFPA and UNICEF also discussed human resource shortages and needs in a set of special meetings, and the draft final report now has an entire section on human resources needs in reproductive health/maternal health.<sup>549</sup></p> <p><i>There is no specific committee for reproductive health/maternal health in HR planning; however, through the Health Sector Working Group UNFPA also addresses reproductive health/maternal health HR issues. The MoH uses health service annual reports to determine HR needs.</i></p> <p>The recent EmONC needs assessment carried out with support from UNFPA and UNICEF also discussed HR shortages and needs in a set of special meetings, and the draft final report now has an entire section on HR needs in reproductive health/maternal health<sup>550</sup></p> <p>UNFPA provides both MHTF and budget support for maternal health trainings; e.g. in the Central Region supported trainings have included Life Savings Skills (LSS) for Midwives in 2009 and 2011, ASRH training for CHNs in 2010, Comprehensive Abortion Care for Midwives in 2010 and LSS for Private Midwives in 2011.<sup>551</sup></p> <p>UNFPA Ghana works directly with two of the biggest service providers in reproductive health/maternal health, which are GHS and CHAG. Funds for training are provided directly to the private sector, which then collaborates with GHS to organize training sessions.<sup>552</sup> GHS is also an IP of UNFPA and the recipient of the largest amount of UNFPA resources. In turn the GHS includes UNFPA in the formulation, implementation and monitoring and evaluation of effective HRH policies that guide production, management and training of the maternal health/reproductive health workforce. UNFPA and other development partners share evidence from other countries and advocate for government to develop the strategies and policies to facilitate implementation of health delivery. For example, the biannual national health summits provide such fora from which an aide memoire and its accompanying matrix are developed to guide</p>
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<sup>544</sup> Interview with Government Partner.

<sup>545</sup> Interview with CSOs.

<sup>546</sup> Interview with CSOs.

<sup>547</sup> Interview with Government.

<sup>548</sup> Interview with regional Training School.

<sup>549</sup> GHWO: Human Resource for Health Country Profile, 2011.

<sup>550</sup> GHWO: Human Resource for Health Country Profile, 2011.

<sup>551</sup> Interview with staff of Regional Health Directorate Central Region.

<sup>552</sup> Ghana: Implementing a National human Resource for Health Plan, 2008, WHO and Global Health Workforce Alliance

	<p>implementation.</p> <p>Resource Teams and Monitoring Teams are in place at national, regional and district level. UNFPA funds the maternal health/family planning training of these teams at various levels. At sub-district level these teams closely monitor human resources at CBD/CHPs and submit reports to District Health Management Teams, who submit to Regional Health Management Teams, who finally submit to the National Health Management Team who interacts with UNFPA in quarterly meetings on HR. District Health Management Teams include representatives of GHS, traditional councils, FBOs/ NGOs, and CBOs are pivotal. DHMTs are supported by a Regional Resource Team, which in turn is supported by the National Resource Team. National, Regional, District and Sub-district Quality Assurance Teams are all supported by UNFPA through GHS IP budget support.</p>
Findings from case study in <b>Kenya</b>	<p><i>The HRH policy or strategy development was not part of the neither 5th nor 6<sup>th</sup> Country Programme, UNFPA supported the inclusion of HRH indicators in surveys and assessments which have been then been utilized by the GOK for planning and included in the indicator frameworks.</i></p> <p>The human resource situation on technical and managerial level in reproductive health in Kenya was reported to be adequate and it was pointed out that there is little need for additional technical support as sufficient Kenyan specialists have been trained over the years to cover the country's needs and even to provide international technical support to other countries<sup>553</sup>. Similarly, policy development capacity is available within the country. Nevertheless, the KCO and many other partners are included in the policy dialogue and have supported strategies and policies (see Judgment criterion 1 and 2). According to the 5<sup>th</sup> Country Programme Action Plan, the KCO has contributed to the national reproductive health training plan, but was not expected to contribute to formulation of conducive working environment or mechanisms for staff retention, which have been considered as 'other agency based responsibility'<sup>554</sup>. Several surveys or assessments (reproductive health needs assessment (2001), obstetric fistula (2007), service provision (2009), Kenyan Demographic Health Survey (2009)) which were supported by UNFPA included Human Resource for Health indicators and the results have been reported to have fed into the Government planning<sup>555</sup> as well as into country office programme formulation and annual work plan adjustments. The current Country Programme supports the revision of the National Obstetric Fistula Training manual including the development of the training guide, and the development of the Community Midwifery training manual and strategy. This will ensure that the training conducted by different organizations meet the minimum standards and will also contribute to the scale up of Community midwifery programmes.</p>
Findings from case study in <b>Lao PDR</b>	<p><i>UNFPA's strong contribution to HRH materialized through supporting the SBA assessment in 2008 and playing a major role in the development and implementation of the SBA plan. For doing so UNFPA broadened its partnership with the Ministry of Health and started to collaborate with the Department of Organization and Personnel (DOP) and other departments instead of only partnering with the National MCH Centre what had limited its scope of support.</i></p> <p>Based on the SBA assessment supported by UNFPA, the National SBA Plan (2008 – 2012) was endorsed by the Ministry of Health and is part of the MNCH package. It is implemented by the Department of Organization and Personnel (DOP), its objective is to develop the health sector's capacity to deliver culturally appropriate and accessible health services for pregnancy, childbirth and postnatal care, in particular by ensuring the availability of adequate numbers (1500) of competent Skilled Birth Attendants (SBA), as well as the production of midwife cadres. It also emphasizes on recruitment, retention, supervision and the provision of the necessary enabling environment.</p>

<sup>553</sup> Information from KCO and government partners.

<sup>554</sup> Final Evaluation Report on the UNFPA 5<sup>th</sup> Country Programme of Assistance to the Government of Kenya (1997-2001);

<sup>555</sup> National HRH Strategic Plan for 2009-2012.

	<p>The implementation of the plan is coordinated by UNFPA (that has taken the lead of the human resource task force 2) and supported by different Development Partners<sup>556</sup>.</p> <p>UNFPA contributed to the development and dissemination of regulations and clinical midwifery standards and set up a licensing exam for midwives<sup>557</sup>. The licensing mechanism will be adopted by the government for other health care personnel.</p>
Findings from case study in <b>Madagascar</b>	<p><i>UNFPA has provided technical support and financial support to HRH planning, training and strategic documents development including regulatory frameworks for midwives. The translation from strategic plans into business plans for implementation continues to be a slow process, much of it related to the frequent changes in the MoH.</i></p> <p>On policy level UNFPA has been supporting with technical support the 2010 national HRH survey and the development of the HRH strategic plan till 2015, which is being finalized by end of 2011. It reflects not only that in Madagascar nearly 50% of public health sector staff is over 50 years old and will retire in less than ten years, but also the uneven geographical allocation of human resources. This distribution does not meet the needs of rural areas; an overwhelming proportion of doctors (72%) operate in urban centers covering a disproportionately small proportion of the population (21%). The health care personnel to patient ratio in 2005<sup>558</sup> was worse in the public sector than in the private sector, except in large urban centers. The still ineffective allocation, organization, and planning of human resources impacts the delivery of quality health services to the rural population, resulting in wide gaps in health outcomes between rural and urban areas. Whilst the HRH plan is still under development; UNFPA nevertheless supports regulatory frameworks such as standardized curricula (i.e. in-service and pre-graduate training curricula.), an updated Public Health Code for midwives, accreditation capacity for the midwifery council. Assessments related to HRH in family planning have led the full package of training to Community Health Workers (CHW) (including development of curricula, updating, provision of family planning, etc).</p> <p>The main activities on the HRH plan coincided with the advent of the MHTF. Since the EMONC assessment in 2009, the MoH realized more than ever the need for a focus on concerted efforts to increase access to skilled birth attendants, to emergency obstetric care and Family Planning. UNFPA agreed to provide the salaries for one year for up to 50 midwives in remote areas with the aim to transfer those midwives onto the MoH budget for the following year. Budgetary constraints though only allowed employment of 28 midwives, as the MoH cannot guarantee the takeover of more. Whilst the support to salary 28 midwives for one year may not seem as significant for the whole country, it does serve as a catalytic action, as the MoH has now created budgeted positions for remote areas, which otherwise may not have happened at all. Also the process of filling positions (including harmonized contracts) in remote areas and the feedback from potential candidates on motivation and difficulties encountered may serve as lesson learnt for further interventions of agencies and for the MoH. An example given<sup>559</sup> was the difficulty of the midwives to receive their monthly salaries from the bank due to transport and safety issues.</p> <p>In addition to direct support to the MoH for the HRH plan, UNFPA has been engaged in the development of standardized curricula for graduate and in-service training, jointly with other partners (mainly WHO and UNICEF).</p>
Findings from case	<i>UNFPA has helped to expand the policy framework for Human Resources for Health issues in Sudan by assisting the Ministry of Health</i>

<sup>556</sup> SBA development plan, Lao PDR 2008 – 2012 - MOH SBA Collaborating and Responsible Committees with technical assistance from UNFPA, WHO and JICA - Lao PDR 2008 – 2012.

<sup>557</sup> With MHTF support.

<sup>558</sup> 2005 Equity and Efficiency Survey.

<sup>559</sup> By the Human Resource Department of the MoH

<p>study in <b>Sudan</b></p>	<p><i>to finish a number of high level policy documents, such as the Federal Reproductive Health Policy, the National Strategy Document for Scaling-Up Midwifery in the Republic of the Sudan and the MNH Road Map that had laid idle for a number of years prior. It is unclear, however, to what extent these policy documents will really become the basis for Government driven implementation of corresponding HRH activities, given the political context in the country, the low level of donor support and the weak capacity of the Ministry of Health itself. The policy framework was also strengthened for midwifery with UNFPA support, however without bringing required qualifications and curricula in line with international standards<sup>560</sup>.</i></p> <p>UNFPA's main mechanism in the recent past (2009 – 2010) to ensure inclusion of human resources for health into health policy frameworks was the posting of a UNFPA-funded reproductive health programme advisor in the reproductive health programme of the Federal Ministry of Health. MoH tasked the expert to finalize a number of HRH related policy documents that had laid idle for a number of years<sup>561</sup>. The reproductive health policy, authored largely by the UNFPA-financed long-term technical assistant, stresses the importance of “health workforce development”, i.e., in particular on strengthening the role of village midwives<sup>562</sup>. The national strategy document for scaling-up midwifery asserts the importance of establishing a cadre of professionally trained midwives in adherence with international definitions; and of integrating the village midwives into the health system. Also the MMR Road Map includes a costed component<sup>563</sup>, dealing with the expansion of the coverage of midwifery services<sup>564</sup>. In that, UNFPA's approach to supporting HRH issues at policy level in the Sudan was in many ways similar to the approach the organization was taking in other countries with less challenging political environments. In the particular context of Sudan, however, it is not clear to what extent these policy development efforts, in particular if largely driven by consultants, will translate into the effective implementation of corresponding activities by the partner government<sup>565</sup>.</p> <p>In order to provide an evidence-base for needs based planning of midwifery support activities, UNFPA conducted the update of a mapping of village midwives that guided the development of the national strategic plan for scaling up of midwifery services. On this basis, UNFPA has moved the midwifery agenda in the Sudan forward in that the new midwifery up-scaling strategy foresees support training of professional midwives, beyond the existing pool of village midwives. UNFPA also supported the development of new training curriculum for 2-year midwifery training; and for development of curriculum for training of village midwives. However, none of these curricula is meeting international standards of ICM. Progress in ensuring improved regulation of reproductive health cadres, i.e., in particular midwives, is inhibited by weak capacity of HRH system and midwifery sub-system in the Sudan. Sudan still has neither a functioning midwifery association, nor accepted “standardized practice code” for midwives. The health system lacks a budget for supervision of midwifery services and a cadre of supervisors<sup>566</sup>.</p>
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<sup>560</sup> It has to be noted that midwifery had been a neglected discipline in Sudan for several decades, so that any efforts to build up a midwifery cadre start from a very low level

<sup>561</sup> Among these documents were the Federal Reproductive Health Policy, the National Strategy Document for Scaling-Up Midwifery in the Republic of the Sudan and the maternal health Road Map (see above; interviews with MoH, UNFPA)

<sup>562</sup> Review of the maternal health road map

<sup>563</sup> US\$ 26.7 million out of US\$ 198,7 million

<sup>564</sup> Document review, i.e., of the costed roadmap

<sup>565</sup> See Evaluation question 9

<sup>566</sup> Strengthening midwifery is subject to a number of challenges that are linked to the particular context of the country. The challenges include, among other things, the limited literacy at community level and the prior elimination of a midwifery training programme that met international criteria (Interviews with UNFPA and development partners).



Findings from case study in <b>Zambia</b>	<p><i>UNFPA has made no clear contribution to the strengthening of Zambia’s national human resources for health policies, plans and frameworks. The country office neither actively participated in the development of the country’s HRH Strategic Plan, nor ensured that a bonding mechanism<sup>567</sup> propagated by UNFPA was integrated into this plan.</i></p> <p>Zambia has had a “Human Resources for Health Strategic Plan” for the period from 2006 - 2010 (Ministry of Health, 2005). Maternal health and the human resource challenge in relation to maternal health are mentioned in the Plan; however the document makes no mention of any specific maternal health sub-areas and related training requirements, such as EmONC, family planning or fistula repair. For UNFPA, the main mechanism that would have allowed it to influence the development of the HRH Strategic Plan was the respective “technical working group” that was part of Zambia’s Health SWAp coordination structure. UNFPA was member of this working group at the time when the HRH Strategic Plan was developed. However, UNFPA did not play a particularly active role in the development the content of the Strategic Plan<sup>568</sup>. As a consequence, UNFPA is known for promoting the “2-year bonding” of the midwives, but the bonding mechanisms was not mentioned in the HRH strategic plan as a specific strategy<sup>569</sup> that should be replicated by the Government, or by other development partners<sup>570</sup>.</p>
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**Judgment criterion 4.2: Strengthened competencies of health workers in HIV/AIDS, family planning, obstetric fistula, skilled birth attendance and EmONC to respond to SRH/maternal health needs**

Findings from <b>desk study</b>	<p>While the earlier MYFFS 2000-2003 and 2004 -2007, outputs and indicators did not refer to HRH development, the 2008-2011 Reproductive Rights and SRH in the UNFPA Strategic SRH Plan pledged to ensure that sufficient, adequately skilled and motivated human resources are available to provide integrated reproductive health services. To this end, UNFPA supported competency definition and certification, capacity development of human resources, with particular emphasis on midwives. Priority areas of UNFPAs reproductive health capacity development in terms of topics include clinical and ‘soft’ skills, especially for EmONC, obstetric fistula and family planning (Judgment criterion 4.1, 4.2). Although UNFPA also had pledged to assist its programme countries in building their capacity to develop specific policies, plans or frameworks for Human Resources for Health<sup>571</sup>, the Fund’s involvement in supporting the strengthening of administrative and managerial skills health service providers or policy makers was low.</p> <p>In all MHTF countries, needs assessments were planned or already have taken place to inform the Governments about the HRH-related situation and existing gaps. By the end of 2010, at total of 22 MHTF countries had completed a midwifery needs assessment; and all year one MHTF countries had conducted a midwifery needs assessments by the end of 2010. Outside of MHTF countries, human resource or training needs assessments do not seem to be conducted as a regular prerequisite for programme planning or extension of training components. Several evaluations remarked that technical trainings had not been based on initial or regular needs assessments, and that their content or curricula often had not been adapted to the specific needs of the trainees.</p>
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<sup>567</sup> A bonding mechanism would bind graduated midwives to a particular post for a number of years before being allowed to choose their posting freely.

<sup>568</sup> No specific input of UNFPA to HRH strategic plan mentioned in interviews (neither UNFPA nor Development Partners); UNFPA not mentioned in the “Proposed Ministry of Health 2006 Budget Estimates for Human Resources Activities” (Annex 9 of HRH Strategic Plan). Note: WHO is mentioned even though it only pledged a small amount, i.e., 76,000,000 Zambian Kwatscha (US\$16,170) for “Coordinating human resource planning across health sector based on the best available data”.

<sup>569</sup> Bonding was merely mentioned as a way in which UNFPA (prior to 2005, the year the HRH plan was published) had contributed to addressing the human resource crisis in Zambia’s health sector.

<sup>570</sup> One development partner commented on the bonding mechanism by saying that it was a mechanism that was hardly ever enforced.

<sup>571</sup> To define important HR issues such as deployment, skills, training and management.

<p>Findings from case study in <b>Burkina Faso</b></p>	<p><i>L'UNFPA a appuyé de nombreuses formations dans les zones d'interventions aussi bien au niveau des équipes de gestions des services de santé que des prestataires pour des formations techniques en santé maternelles. Il est toutefois difficile d'évaluer les effets de cette large contribution car il n'existe pas de base de données des formations effectuées et de suivi des personnels formés.</i></p> <p>En général l'appui aux formations relatives à l'administration et à la gestion des services de santé est sous la responsabilité de l'Organisation Mondiale de la Santé (OMS). Néanmoins, au cours du 6<sup>ème</sup> programme, l'UNFPA a financé des formations visant à renforcer la gestion sanitaire:</p> <p>Formation en santé publique des médecins travaillant dans la zone d'appui <sup>572</sup></p> <p>Appui au processus de planification des districts sanitaires et des régions par l'UNFPA dans les zones d'interventions (et dans tout le pays à partir du 7<sup>ème</sup> plan)</p> <p>Formations 'Système d'Information et de Gestion de la Logistique' (SIGL) organisées à différent niveaux du système de santé <sup>573</sup></p> <p>Support aux équipes cadre de district en matière de supervision des formations sanitaires et l'intégration de la SR dans la supervision intégrée <sup>574</sup>.</p> <p>Les activités de supervision ont été appuyées par l'UNFPA au cours du 6<sup>ème</sup> programme. Un Guide national de supervision intégrée en santé maternelle et néonatale a été développé en 2009 et disséminé avec l'appui du MHTF.</p> <p>L'UNFPA a fourni un appui technique et financier aux revues de curricula de PF clinique <sup>575</sup> et plus récemment des formations SONU et sage femme avec le support du MHTF en organisant des ateliers réunissant des personnes ressources. L'UNFPA a aussi contribué à la mise en place d'équipes de formateurs sur des thèmes spécifiques en SR (PF clinique, SONU, Prévention Transmission Mère-Enfant (PTME)) au niveau régional. Ces formateurs organisent des formations pour les prestataires de la région. Les bénéficiaires des différentes formations apprécient positivement la formation qu'ils ont reçue <sup>576</sup> et il a pu être observé que certaines compétences acquises sont appliquées, par exemple, des prestataires formés en SONU de base affirment appliquer la gestion active de la troisième phase de l'accouchement (GATPA). Toutefois l'effet de ces formations reste limité car la mobilité des personnels de santé est extrêmement importante et après quelques mois le personnel qui vient d'être formé est transféré dans une autre zone. D'autre part les districts sanitaires et régions n'ont pas réussi à mettre en place des bases de données fiables pour gérer les formations. L'impact des nombreuses formations qui ont eu lieu n'a pas vraiment été mesuré <sup>577</sup>.</p>
<p>Findings from case study in <b>Cambodia</b></p>	<p><i>UNFPA not only provides a range of skills and tools for strengthening competencies for in-service and pre-service midwives, but it also extends additional support for the overall development and engagement of reproductive health/maternal health workers in a systematic</i></p>

<sup>572</sup> Dans chaque région d'intervention (Est, Centre Est et Sahel) 3 médecins ont été sélectionnés chaque année pour suivre une formation de santé publique de 2007 à 2009.

<sup>573</sup> 73 prestataires en 2006, 99 en 2007, 61 en 2008, 15 formateurs en 2009, 175 acteurs (pharmaciens et agents responsables des dépôts de médicaments essentiels génériques) des districts sanitaires, des hôpitaux régionaux (CHR) et universitaires (CHU) et des directions régionales de la santé sur le logiciel CHANNEL.

<sup>574</sup> 12 gestionnaires en supervision facilitant axée sur les soins obstétricaux en 2007, 68 responsables SR des districts à la supervision formative et 50 Infirmier Chefs de Postes en supervision facilitant en 2008, 50 responsables SR des Équipes cadre des districts et des directions régionales de la santé à la supervision formative en 2009 .

<sup>575</sup> Entretiens avec l'équipe UNFPA .

<sup>576</sup> Entretiens avec des prestataires.

<sup>577</sup> Evaluation Finale du 6ème Programme de Coopération UNFPA-Burkina Faso 2006-2010.

*manner. Still, there are many challenges related to appropriateness of pre-service curriculum, the quality of teaching, accountability in recruitment, deployment and replacement of health workers*

While UNFPA Cambodia has supported Human Resource development, its involvement is topical and specific to reproductive health/maternal health. Safe Motherhood protocols included trainings in maternal health services until 2004, when UNFPA began national and sub-national cascade trainings. In 2004, there were trainings on Minimum (no surgery) and Complimentary Package of Activities of reproductive health/maternal health (with surgery) for health centers, district and provincial hospitals. These training modules were upgraded in 2008-2009. Training for EmONC and Skilled Birth Attendants (SBA) started initially in 2002-3 but remained unsatisfactory until the Midwifery Review (2006) which highlighted the low capacity of the MoH<sup>578</sup>. Since 2006, there have been three major ongoing initiatives that have established UNFPA Cambodia as a leader in enabling reproductive health/maternal health workforce development:

UNFPA Cambodia's major achievement is the high-level Midwifery Forum in 2005 (repeated every 4 years), the Midwifery Review in 2006, and the launch of a wide-reaching national Midwifery Programming. In 2007, this led to a policy change that has helped promote the prestige of midwives, enabling the training and incentives scheme that in turn has improved maternal health indicators. The policy change gave focus to the critical role of midwives and high-level promotion on assisted delivery. Technical support has been provided to the Human Resource Department of the MoH (2002-2008) to develop and harmonize midwifery curriculum development, pre-service education and in-service training of midwives (upgraded in 2000, 2005 and 2009). UNFPA has provided inputs into 4 out of 5 Regional Training Centers (RTC), training of teachers and their fees, daily service allowance for students, infrastructure support, training materials and equipment. It also supported the National Health Promotion Centre for trainings in Behavior Change and inter-personal skills of midwives. The Personnel Department of MoH was supported in the recruitment of midwives. Support for supervision has been provided through HSSP II. Currently, the focus is also on registration and licensing of trained midwives, and there is an ongoing process of developing ethics, standards and regulations for trained midwives<sup>579</sup>. The MoH is confident that it will reach the numbers required by 2015, but the applicability of the pre-service curriculum and the quality assurance of midwives coming out of the training and follow-up remains a major problem<sup>580</sup>.

A National Assessment on EmONC was already being discussed in 2006 and 2007, but was launched only in 2008 and 2009 with MHTF support<sup>581</sup>. The assessment covered all hospitals and one-third of the health centers. The results created the awareness among other donors to view EmONC as a priority. In 2010, the EmONC Improvement Plan, again supported by MHTF, was implemented and UNFPA helped to strengthen the EmONC curriculum. The EmONC Improvement Plan has the full backing of MoH and National MNCH Centre, but there are many challenges in PH facilities due incentives and remuneration. For example, the national and sub national trainings have not yet benefited from the improved curriculum, because the national trainers (surgeons) have not been available<sup>582</sup>.

To support capacity development of Commune Council in reproductive health/maternal health promotion (2007), UNFPA has designed and developed reference tools for mainstreaming six areas of reproductive health/maternal health including a gender and population

<sup>578</sup> UNFPA Cambodia.

<sup>579</sup> Government partner at national and sub-national level.

<sup>580</sup> "We do not have qualified teachers and degree holders are difficult to find. I have recommended (and UNFPA agrees) that we slow down on new recruitment and focus on the quality side of teaching and the practical upgrading in pre-service education." (Government Partner).

<sup>581</sup> In the end, however, MHTF funds were under-utilized, due to higher-than-expected commitments from other donors in 2008-09.

<sup>582</sup> These challenges will be further discussed in the MHTF section.

	<p>perspective. These reference tools are currently used by all levels of Government through local administration during training and supervision. The Fast Track Initiative Road Map on Reducing Maternal and Newborn Mortality will provide trainings on EmONC services, Family Planning and Comprehensive Abortion Care.</p> <p>Fistula work started in late 2010. In 2011 UNFPA began a small, pilot partnership with an NGO clinic that does re-constructive surgery. UNFPA also supports the integration of fistula information to Health Centre staff and has funded radio messages in rural/remote areas.</p>
Findings from case study in <b>DR Congo</b>	<p>Dans le domaine de la planification, l'UNFPA a organisé un atelier sur l'évaluation et l'amélioration de la planification stratégique comprenant le besoin d'un changement de la loi sur la contraception. Toutefois, ses efforts visant à encourager le suivi et contrôle conjoints des structures de santé dans les zones cibles, dont un des principaux objectifs est le renforcement des capacités du personnel de santé, s'avèrent parfois insuffisants du fait de l'absence de prise en charge financière ministérielle.</p>
Findings from case study in <b>Ethiopia</b>	<p><i>UNFPA has developed capacity of health workers in response to FMOH requests since at least the 5<sup>th</sup> CP in areas such as family planning, safe motherhood, and obstetric fistula repair. The capacity development component also included support to curricula development and equipment provision to the FMOH for dissemination into the health facilities where health workers with up graded skills were positioned. Currently monitoring is conducted on a project base (number of staff trained and equipment distributed) but a tool capturing processes and appropriate application of skills is required. This has been recognized by UNFPA and its partners and is being developed.</i></p> <p>Institutional capacity development is mentioned in the COAR 2004, but there is no indication that UNFPA was involved at this level to any significant extent. The high staff turnover and poor retention capacity of the government employees are a challenge to capacity development initiatives. Support to capacity development to FMOH staff happens mainly through other partners<sup>583</sup>. Several UN organizations second consultants to the MoH and MoF on federal and on regional level, but rather to 'get things done' than for knowledge sharing purposes<sup>584</sup>. Similarly, UNFPA places one or two per focus region, to provide operational support hence no big impact on capacity development which was considered by development partners as too few for operational purposes.</p> <p>UNFPA's main focus has been on financing the in-service training of doctors, midwives, nurses and health extension workers in response to FMOH requests in areas such as family planning, EmONC, obstetric fistula, STI management, etc. UNFPA has addressed the issues of deployment, including the challenge of matching skilled personnel with appropriately equipped positions that allow staff to utilize their skills through providing equipment for health facilities to the FMOH for further distribution according to needs. The responsibility for coordination of the individual inputs UNFPA has provided is in the hands of the FMOH, which also extends to the issues of ensuring that UNFPA-financed trainees can work in an environment conducive to applying their new skills. Staff distribution, retention initiatives, etc are the prerogative of the FMOH.</p> <p>A technical working group (including UNFPA) is currently developing a monitoring tool for the capacity development; deployment of staff to functioning clinics needs to be ascertained, supervisory visits to newly trained staff needs to be institutionalized, legal and regulatory provisions for new cadres, retaining policies reviewed, etc. None of these were in-built or costed in the initial implementation plans.</p>

<sup>583</sup> But it sponsored nine federal and regional HAPCO officials to attend change management and leadership training in London, UK for a month and also supported 15 federal and regional HAPCO officials to attend the 1<sup>5th</sup> International Conference on AIDS and Sexually Transmitted Infections in Africa (ICASA) for them to gain new insight in the fight against HIV and international experience.

<sup>584</sup> Information from development partners.

<p>Findings from case study in <b>Ghana</b></p>	<p><i>Training for reproductive health/maternal health is the forte of UNFPA Ghana and central to its support of public health IPs. Since 2005, UNFPA has provided capacity development trainings for National Programme Component Managers, Resource Teams, Quality Assurance Teams, and an M&amp;E Team in addition to the maternal health/family planning pre service and in service trainings it supports at various levels of implementation.</i></p> <p>Each of the Programme Component Managers (as described in evaluation question 3, Judgment criterion 3.1) in GHS, MoWAC and NPC receive funds for comprehensive training from UNFPA. Beside this there are Resource Teams and Monitoring Teams that are in place at national, regional and district level. UNFPA funds the maternal health/family planning training of these teams at various levels. At sub-district level these teams closely monitor human resources at CBD/CHPs level and submit reports to District Health Management Teams (DHMT), who submit to Regional Health Management Teams, who finally submit to the National Health Management Team who then interacts with UNFPA in quarterly meetings on human resources. District Health Management Teams include representatives of GHS, traditional councils, FBOs/ NGOs and CBOs all of whom are considered pivotal to collective decision making on human resources. As part of decentralization of health services, UNFPA support to DHMTs is critical to the success of decentralization of health services. DHMT are supported by a Regional Resource Team, which in turn is supported by the National Resource Team. National, Regional, District and Sub-district Quality Assurance Teams are all also supported by UNFPA through Ghana Health Service.</p> <p>The country office conducted a situational analysis and found that the majority of MoH midwifery training schools do not have full time tutors as such; rather they contract with practicing midwives and nurses in the private sector on a part time basis to provide teaching assistance to schools. UNFPA successfully advocated for MoH to set up a reproductive health course at a university to train midwives as tutors for the midwifery schools, and supported GHS to provide them with preceptorship skills and improve their teaching capacity<sup>585</sup>. Other midwives who do not qualify as tutors are hired to practice as preceptors in clinical sites. These are small but critical steps intended to support the GHS goal to increase the number of newly trained midwives from the current number of 600 to the needed goal of 8,000 by 2015. Dual practice by trained midwives in the public sector remains a challenge for GHS in terms of filling the gap and quality assurance especially at the CHPS level<sup>586</sup>.</p> <p>UNFPA provides both MHTF and budget support for maternal health trainings; e.g. in the Central Region supported trainings have included Life Savings Skills (LSS) for Midwives in 2009 and 2011, Adolescent SRH training for Community Health Nurses in 2010, Comprehensive Abortion Care for Midwives in 2010 and LSS for Private Midwives in 2011.<sup>587</sup></p>
<p>Findings from case study in <b>Kenya</b></p>	<p><i>Capacity building paired with provision of equipment and consumables and technical/administrative backstopping has been supported by the KCO since at least the 5<sup>th</sup> Country Programme<sup>588</sup>, however the monitoring of end-beneficiary satisfaction to ascertain if the enhanced skills of the service providers are being fully utilized is only being somewhat addressed in the current (7<sup>th</sup>) Country Programme and not yet consciously institutionalized in all project sites.</i></p> <p>Competencies training for Implementing Partners have included - in addition to the Results-based Management and accountancy - also communication skills training, especially to Community Health Extension Workers (CHEW), to midwives, and to 'ambassadors' for fistula repair which was reported to have increased confidence and quality of services offered at community level. This has been verified by the</p>

<sup>585</sup> Interview with Midwifery Association.

<sup>586</sup> Interview with Government and CSOs.

<sup>587</sup> Interview with staff of Regional Health Directorate Central Region.

<sup>588</sup> No earlier records were available.

	<p>health administration in the Migori District, where indicators such as PMTCT, family planning utilization, SBA and the 4<sup>th</sup> ANC visit improved since the beginning of the programme. Also a slight reduction in maternal mortality was noted.</p> <p>Training on clinical skills of community midwives has been supported by the KCO with renovation, refurbishment and provision of equipment and consumables to the centers of excellence in the four focus regions to allow the newly trained staff to directly apply their skills<sup>589</sup>. Over a hundred community midwives have been trained in 2010 alone. Implementing partners follow-up on the training with supervisory visits and review meetings; occasionally UNFPA participates in such supervisory visits. The review meetings between project nurses and community midwives address challenges and identify further areas of capacity development, which is a means to verify applicability of training. (see also evaluation question 7) The KCO is planning to develop guidelines for centers of excellence that will be based on experiences made in the four pilot projects; this requires a standardized, well developed M&amp;E approach with baseline and repeated surveys, also of the beneficiaries. Currently, the pilots are in the inception phase.</p>
<p>Findings from case study in <b>Lao PDR</b></p>	<p><i>UNFPA has been contributing to the development of the competencies of the health managers at various levels. It has also contributed to reinforce the health care providers' capacity initially through improving their family planning services provision skills and later on focusing upon strengthening midwifery skills by supporting the community midwife education and in service Life Saving Skills training. However, the improvement of midwifery skills in Lao PDR is a long and still ongoing process and will require substantial additional efforts.</i></p> <p>UNFPA through its long standing collaboration with the National MCH Centre (NMCHC) has contributed to develop its management capacity to some extent but its absorption capacity remained low<sup>590</sup>. However, in Lao PDR, MNCH services are still underutilized and of poor quality. This is mainly due to a shortage of health personnel, with staff allocation highly concentrated in urban rather than in rural facilities, and to the poor organization of health services<sup>591</sup>. The MNCH package and the SBA plan recognize management strengthening as an important aspect. The development partners including UNFPA contribute to develop the capacities of the health managers at different levels (national, provincial and district) through helping them in developing operational plans and providing technical support for the implementation of the national strategies<sup>592</sup>.</p> <p>Although UNFPA has been supporting the NMCHC to conduct regular supervision through training and developing tools this is an area that needs to still be improved<sup>593</sup>.</p> <p>Initially UNFPA support focused upon family planning training (see evaluation question 6). Then, in accordance with the National SBA plan, UNFPA has been supporting the training of Community Midwives and the 3 module SBA Life Saving Skills training, which includes antenatal and postnatal care, emergency obstetric care and normal delivery. UNFPA has technically supported the training curriculum review in coherence with ICM competencies, and has supported training institutions by improving teachers' capacity, providing equipment, and financing trainee allowances and delivery kits. The quality of the training institutions is low upgrading training quality is a challenge. A long process and many efforts are still required to ensure high quality of training, particularly practical training in health facilities. The Government's ambitious target to produce 1500 Skilled Birth Attendants by 2012 further compromises the possibilities to</p>

<sup>589</sup> Renovation and refurbishment of the theatre in Kakamega PGH was funded by UNFPA to ensure that trained service providers could practice their skills.

<sup>590</sup> Government partners interviews.

<sup>591</sup> Strategy and Planning Framework for the Integrated Package of Maternal, Neonatal and Child Health service 2008-2015.

<sup>592</sup> Government partners interviews.

<sup>593</sup> Development partners interviews.

	ensure an adequate training quality.
Findings from case study in <b>Madagascar</b>	<p><i>UNFPA aims at strengthening skills of health workers through competency building on clinical and supervision skills, as well as providing some equipment for utilization of newly learnt skills, but the sustainability of provision of commodities, effective supervision and continuous medical education cannot be guaranteed with the current health budget on Madagascar.</i></p> <p>In terms of improving technical skills, UNFPA has been supporting regional IPs in the training of CHWs on family planning, health facilities staff on EmONC (already before 2009) and recently on fistula repair and kryo-therapy for the treatment of cervical cancer. In the humanitarian context similar training -as well as on MISP - is being provided by UNFPA through its IPs. On national level training for technical skills supervision is being performed, (see MHTF).</p> <p>Technical supervision is planned through district health officers. The mission had the opportunity to observe part of the training and considers the health officers probably as too little experienced even after the training to do technical supervision of midwives. When supporting technical skills upgrading, UNFPA supplies initial equipment and consumables to ensure that newly acquired skills can be performed, but the GoM is rarely able to continue supplies on that level. This means that UNFPA has been the provider of contraceptives for years. UNFPA provided in six regions free Caesarean Section and normal delivery kits, which lead to an increase of the Caesarean Section rate<sup>594</sup>. The MoH technical staff had no information/plan/strategy of how the ministry itself will be able to sustain this. UNFPA confirmed that sustainability is addressed during national and H4+ planning.</p> <p>A reproductive health policy advisor was supposed to be based at the MoH, but due to the political situation, he is based in the UNFPA office. The technical collaboration nevertheless has been reported by all partners as very effective, thus the location of the reproductive health advisor may not be important in the current circumstances.</p> <p>Training on management skills has not been provided by UNFPA, this is rather the prerogative of UNDP and the World Bank (on governance etc). Also, very likely any training would have had no effect on the current capacity of the MoH, as the staff in the MoH is reallocated frequently. Since 2009, the UNFPA relevant focal points changed five times, at the time of the mission the Minister of Health was replaced, another round of staff changes is expected. (The UNFPA office addresses letters to the 'Ministry in charge of Health', because the name changes frequently as well).</p>
Findings from case study in <b>Sudan</b>	<p><i>UNFPA has helped to improve the competencies of health workers in Sudan in maternal health relevant disciplines. However, the weaknesses of the HRH system in Sudan have impeded more systematic and comprehensive progress in this regard. Trainings of health workers have been carried out more on an ad-hoc basis and on a scale that has been too small for the overwhelming needs in Sudan, due to UNFPA's resource constraints and also to the ongoing outmigration of skilled health workers.</i></p> <p>The main challenge in the Sudan is to ensure that the midwifery training system itself becomes operational and adheres to accepted standards, i.e. the six ICM standards for midwifery education and training. By providing technical support in form of the Country Midwifery Advisor and policy support through the long-term technical support in the MoH / reproductive health programme, UNFPA has helped to put in place certain prerequisites for improved midwifery training. However, the remaining challenges, such as lack of knowledge of global standards at Ministry level, lack of teaching staff and qualified supervisors lack of managerial staff and the absence of teaching materials that meet accepted standards, are so severe that it is very unlikely that UNFPA alone, with the limited amount of resources it can invest in midwifery in Sudan, can offer enough support to overcome them.</p>
Findings from case	<i>Despite the fact that needs-based deployment of trained health workers has remained a challenge in Zambia, UNFPA so far has not</i>

<sup>594</sup> Information gathered during the field visit from the health administration.

<p>study in <b>Zambia</b></p>	<p><i>worked to address these kinds of systemic challenges to ensure that trained staff with UNFPA support can optimally apply their newly acquired skills.</i></p> <p>UNFPA's main focus has been on financing the training of midwives and nurses in response to requests from the Government. UNFPA has not addressed the issues of deployment, including the existing challenge of matching skilled personnel with appropriately equipped and financed positions that allow staff to utilize their skills<sup>595</sup>. Factors that have kept UNFPA from taking up these issues have been a lack of human and financial resources in the UNFPA country office<sup>596</sup>, as well as UNFPA's tendency to limit itself to providing small scale financing in direct response to specific requests by the Zambian Government that are within the "traditional" areas of intervention for UNFPA in Zambia (such as scholarships for nursing students, equipment, logistics for workshops)<sup>597</sup>. As a result, UNFPA has left the responsibility for coordination of the individual inputs largely in the hands of the Government. For example, while UNFPA has financed the training of nurses and midwives, e.g. by providing scholarships and support for materials, it has not followed up to ensure that UNFPA-financed trainees are deployed in ways that ensure that their newly acquired skills can be appropriately applied<sup>598</sup>.</p>
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<sup>595</sup> All stakeholders acknowledged that these challenge need to be addressed; Challenges included recent problems with absorbing all trained nurses in North-Western Province, retention, and enforcement of the bonding (see Annex for details).

<sup>596</sup> UNFPA interview.

<sup>597</sup> Confirmed by UNFPA, Government Partners and development partners (see Annex for details).

<sup>598</sup> For example, UNFPA also has not been conducting systematic monitoring of the training initiatives; and their effect on the availability of trained personnel in specific underserved locations.



## 8.2.5 Evaluation question 5: To that extent has UNFPA anticipated and responded to reproductive health threats in the context of humanitarian emergencies?

### Judgment criterion 5.1: Inclusion of SRH in emergency preparedness, response and recovery plans

Findings from desk study	
<p>UNFPA advocates and supports the institutionalization of sexual health in emergency preparedness, humanitarian response and during post-conflict recovery as an important prerequisite for being able to address maternal health / SRH needs in emergency situations. The Reproductive Rights and SRH strategic Plan 2008-2011 stresses that the SRH package should include the same services in emergencies and humanitarian crises as it does in other situations. This is reflected in all five outcomes that refer to the humanitarian context. UNFPAs credibility is based on its consistency in promoting SRH mainstreaming in the humanitarian context and in providing technical and commodity assistance directly through its implementation partners or indirectly through coordination mechanisms on country level (IASC, Cluster approach, etc.). At global level UNFPA has made substantial contributions to tools available to advance ICPD within humanitarian response and in humanitarian crises<sup>599</sup>. At national level, UNFPA aims to contribute to inclusion of SRH in relevant emergency policy frameworks. However, the weak M&amp;E provisions of UNFPA<sup>600</sup> do often do not provide sufficient evidence to monitor the performance of these interventions; and to evaluate the eventual success of their implementation. Also, the available documents did not sufficiently clarify the joint operationalization and M&amp;E processes or the inter linkage between the different programmes and funds (regular programme, MHTF, obstetric fistula, GPRHCS) on country level in terms of capacity development, distribution, pre-positioning.</p>	
Findings from case study in <b>Burkina Faso</b>	<p><i>La contribution de l'UNFPA lors des situations d'urgences s'est traduite par la distribution de kits d'urgence. L'UNFPA a appuyé le ministère de la santé pour l'introduction de la SR lors la préparation du plan de réponse aux situations humanitaires.</i></p> <p>Le Burkina Faso n'ayant eu à faire qu'à peu d'urgences (à l'exception des inondations en 2009) peu d'activités ont été entreprises en termes d'urgence humanitaire. L'UNFPA a apporté un soutien au gouvernement lors du développement du plan de réponse aux situations humanitaires pour l'introduction d'une composante SR. Lors des inondations l'UNFPA a fourni les kits d'urgence et fait en sorte que les éléments du <i>Minimum Initial Service Package</i> (MSIP) soient en place<sup>601</sup>. Un plan de contingence a également été développé au niveau de l'UNFPA et est revu chaque année.</p>
Findings from case study in <b>Cambodia</b>	<p><i>UNFPA is active in the inclusion of reproductive health/maternal health issues in emergency preparedness, response and recovery plans at three levels of the UN-Government cooperation.</i></p> <p>UNFPA was an active participant in post-conflict challenges, and MoH and the GoC have expressed their appreciation<sup>602</sup>. In 1998 and 2008 UNFPA Cambodia took a prominent role in supporting the two censuses in post-emergency issues and re-construction. In 2002, UNFPA had co-coordinated with MoH and helped fund the NGO, CARE International, to provide emergency preparedness protocols</p>

<sup>599</sup> Among others, these include the Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings (2009), IASC guidelines on gender-based violence (2005), the IASC Gender Handbook in Humanitarian Action (2006), and a distance learning module on MISIP for Reproductive Health in Crisis Situations (2007), all having been developed by UNFPA and its partners.

<sup>600</sup> See also evaluation question 8 on results / evidence orientation of UNFPA maternal health support.

<sup>601</sup> I.e. collecte de données démographiques et de SR sur les populations affectées, existence de services pouvant assurer la prise en charge des cas de violences sexuelles, distribution de condoms, et de kits d'accouchement et un système de référence fonctionnel.

<sup>602</sup> UNFPA Cambodia.

	<p>related to SRH work. In 2008, it pioneered the use of Global Positioning systems (GPS) to deal with unmapped terrain and to identify areas prone to annual flooding<sup>603</sup>, in cooperation with the National Institute for Statistics<sup>604</sup>.</p> <p>At sector level, the Government of Cambodia has no Technical Working Group for emergency preparedness. UNFPA, however, is a member of the UN inter-agency Disaster Management Team (UNDMT), led by the WHO. In 2009, UNFPA provided some small seed funds to the Secretariat for the National Committee for Disaster Management (NCDM), which has given it leverage in mainstreaming SRH activities<sup>605</sup>. UNFPA also has interacted closely with the Department of Preventive Medicine, MoH, which is responsible for emergencies. UNFPA provides inputs into the UNDMT Disaster Management Plan, which it coordinates with NCDM. UNDMT has supported an application for Central Emergency Response Fund (UN-CERF) to provide much more support to the immediate, medium and longer-term natural disasters in Cambodia. The UNDMT uses CERF funding to meet basic food, agriculture, water, sanitation, health, shelter and education, and UNFPA has access to this support upon request<sup>606</sup>.</p>
<p>Findings from case study in <b>DR Congo</b></p>	<p>L'UNFPA cherche à assurer la prise en compte des intérêts des femmes dans l'approche de la gestion des camps de réfugiés, surtout dans le domaine de la santé reproductive. Cette stratégie inclue un soutien aux structures de santé locales par la réhabilitation, l'approvisionnement en équipement, médicaments et produits contraceptifs, la formation des prestataires de services et la fourniture de kits (maternité, hygiène et violence sexuelle).</p> <p>L'UNFPA participe avec les autres bailleurs de fonds dans des évaluations des situations de crise humanitaire. Dans telles circonstances, il cherche à assurer la livraison dans les délais voulus de commodités, quelque chose qui constitue souvent un problème majeur. Toutefois, l'UNFPA a parfois des difficultés pour mobiliser ses moyens à cause des complexités procédurales internes. Par ailleurs, il se trouve fortement contraint par le manque d'une base de données adéquate par rapport à l'estimation des besoins en commodités. Le personnel est très préoccupé par cette question et cherche à résoudre le problème. La valeur ajoutée de la participation de l'UNFPA dans des situations de crise consiste en le fait que cela attire l'attention directement sur les questions, souvent négligées, de santé reproductive et de violences sexuelles. (Judgment criteria 5.1 and 5.2)</p>
<p>Findings from case study in <b>Ethiopia</b></p>	<p><i>UNFPA has stepped up its presence in the humanitarian field in 2007 with the aim to mainstreaming reproductive health, gender and GBV issues in all preparedness and response activities. It is present in all relevant coordination and working groups without having achieved a satisfactory level of concern or awareness among the humanitarian stakeholders.</i></p> <p>UNFPA has increased its engagement in humanitarian emergencies in Ethiopia since 2007 and integrated the team (1 NPO, 2 UNV) into the reproductive health team, implementation and relevant monitoring of sites is via implementing partners on a project base. It supports the development of the Disaster Risk Management Strategy. UNFPA focused on mainstreaming Reproductive Health, Gender based Violence, management of rape survivors, reduction of HIV transmission in programmes and documents. The team also participated in joint assessments, and provided technical support on-site to humanitarian partners.</p> <p>The other focus is to systematically be represented and active in the numerous humanitarian coordination structures (Health and Protection cluster, Strategic Disaster Management Team, UN Technical Officers group, Emergency Health and Nutrition task force, HIV/AIDS Emergency task force, Early Warning working group, UN/NGO coordination meeting, Humanitarian Response Fund Review</p>

<sup>603</sup> The main disaster faced by the Cambodian Government.

<sup>604</sup> UNFPA website.

<sup>605</sup> UNFPA Cambodia.

<sup>606</sup> UNFPA Cambodia.

	<p>board, UN Communication Officers group, etc.)</p> <p>Humanitarian issues have been integrated in the country office advocacy strategy in 2007, but in 2010 still ‘insufficient concern and awareness among humanitarian stakeholders of ICPD mandate in emergency situations’ was mentioned. Gender mainstreaming in humanitarian response was included in the UN Gender TWG action plan and an inter-agency subgroup was established to address this specific issue. A concept note was developed and a questionnaire was sent to other agencies for mapping. However, lack of commitment and expertise of gender focal points on humanitarian issues challenged the initiative. These challenges may be due to lack of human resources in the country office<sup>607</sup>, but also the choice of implementing partners may play a role. International NGOs may be less inclined to work with the regional health authorities to the extent required to increase ownership and understanding of the issues, thus UNFPA is missing the opportunity to create a knowledge base within the community<sup>608</sup>.</p>
Findings from case study in <b>Ghana</b>	<p><i>UNFPA Ghana is more recently involved in two aspects of humanitarian work: man-made disasters and natural disasters. This humanitarian support deals with refugees and internally displaced persons mainly as a result of conflict in the past from Liberia and presently Cote d'Ivoire and from floods in Ghana. UNFPA has mainstreamed post humanitarian response into its core programme so that the poor and disadvantaged target groups are served in a more sustainable manner.</i></p> <p>UNFPA Ghana is a member of UNDAF Outcome Area 3 (Disaster Risk Reduction and Climate Change), which is also aligned to government Sector Working Group for Environmental and Natural Resource Management. Outcome Area 3 is led by UNHCR and includes UNFPA in a joint response strategy with UNICEF, WHO, WFP, IOM, CARDI, UNESCO and UNU. UNFPA has mainstreamed humanitarian response into its core programme<sup>609</sup>. In 2010 and 2011, the country office committed core programme funds to support capacity development for the National Disaster Management Organization (NADMO) on the reproductive health/maternal health Minimum Initial Service Package (MISP) and data Management, procurement and pre-positioning of reproductive health and availability of hygiene kits. This has allowed UNFPA to actively participate in inter-coordination meetings and joint assessments with government, other UN agencies and CSOs to facilitate timely response to maternal health needs in humanitarian situations. Also the quick delivery (within a maximum of a week of emergency) of reproductive health kits from the Procurement branch in Copenhagen is a facilitating factor in timely response. The availability of an existing emergency relief fund from the headquarters such as Central Emergency Response Fund (CERF) as well as the coordinated support from the sub-regional office (SRO) in Dakar is also noted<sup>610</sup>.</p> <p>UNFPA support for maternal health in crisis situations is also outlined in the national and interagency contingency plans<sup>611</sup>. UNFPA has a checklist for assessing the utilization of provided emergency reproductive health kits for reproductive health service delivery during crisis. This provides data on beneficiary, regions, districts and health facilities. UNFPA has again included in its AWP 2011 field monitoring on supported reproductive health services in humanitarian response.</p>
Findings from case study in <b>Kenya</b>	<p><i>UNFPA is only since 2008 involved in humanitarian action with a dedicated focal point that supports mainstreaming humanitarian issues, gender, GBV and response at all levels of service provision. The well recognized beginnings of the KCO in the emergency response in</i></p>

<sup>607</sup> The lack of human resource to undertake or coordinate regular data collection/research on reproductive health, HIV and gender-based violence in humanitarian context made advocacy and programme design difficult (COAR 2010).

<sup>608</sup> Evaluation of the UNFPA Integrated Reproductive Health Response Project in Food-Insecure Areas, SNNPR, 2009.

<sup>609</sup> UNDAF 2006-11.

<sup>610</sup> Interview with UNFPA.

<sup>611</sup> Interview with Government.

	<p><i>2008 seem not to have led to the full recognition by the humanitarian group of UNFPA's role – at least not in 2010.</i></p> <p>UNFPA is a member of the reproductive health sub cluster of the health cluster, led by the World Health Organization and of the gender-based violence sub cluster in the protection cluster, led by UNHCR. The previous engagement in disaster response was only ad hoc in 2008 when the KCO found itself in a situation where it had to act in response to the emergency. For this quick and effective support, the KCO has been commended by several government partners<sup>612</sup>; also the still ongoing reproductive health stakeholder meetings, initiated by the humanitarian officer, are recognized as commendable and sustainable contribution of UNFPA. The KCO has recently capitalized on working with other organizations such as GIZ, Save the Children, IRC and UNHCR and staff has indicated that they feel better prepared now to react to crisis. This has also improved considerably by the recruitment of a humanitarian focal point in 2008 following the violence situation that is now coordinating KCO response and presence regarding humanitarian emergencies and is monitoring the implementation of any measures. UNFPA has not been able to get its four proposals accepted into the Consolidated Appeal Process (CAP) 2011 reportedly due to procedural issues, thus missing a chance for resource mobilization. The CAP 2011 does not even refer to UNFPA in the chapter on Completed Needs Assessments as a source for the KDHS 2008/2009<sup>613</sup>. Four proposals will be entered for the CAP 2012<sup>614</sup>.</p>
Findings from case study in <b>Lao PDR</b>	<p><i>The role of UNFPA in terms of emergency preparedness and response is relevant considering the type of emergencies that Lao PDR has been facing. UNFPA took the responsibility of developing the maternal health and gender components of the UNDAF disaster management plans and has developed its own contingency plan for disaster. Also, UNFPA staff has participated in humanitarian joint assessments. Its contribution to emergency response consisted mainly in distributing delivery kits.</i></p> <p>Lao PDR is prone to floods along the Mekong River. It faced severe floods in 2008. In 2009, the country was hit by a typhoon. To allow the Government to better respond to these types of emergencies, UNFPA has prepared an action plan focusing on maternal health and gender as part of the UNDAF harmonized disaster management<sup>615</sup>. The agency also played an advocacy role regarding the vulnerability of women and young people in emergency situation. More recently, it developed an internal contingency plan for disaster related to reproductive health in which it seeks to build strategic partnership and to only focus on technical support because of its limited resources<sup>616</sup>. These plans have a monitoring component but it is unclear whether it has been implemented.</p> <p>UNFPA took part in the humanitarian joint assessment with the other development partners (e.g. during the typhoon) in 2009 and advocated so that maternal health/reproductive health is addressed during the humanitarian response.</p>
Findings from case study in <b>Madagascar</b>	<p><i>In the humanitarian response, UNFPA partners seemingly effectively with the UN team, the national partners and within the office with other programmes. Resource mobilization is ongoing and has been successful for a joint UNFPA/WFP programme aimed at improving demand (reducing barriers) for deliveries in health facilities.</i></p> <p>UNFPA participates in the joint UN response and is a partner in the disaster management thematic group. It advocates for the inclusion</p>

<sup>612</sup> UNFPA was commended by the provincial health administration for its quick response in 2008. It could provide immediate family planning commodities and emergency kits to the affected population; individuals and clinics. UNFPA has been facilitating through the Government and Implementing Partners acquisition and distribution of supplies (e.g. Minimum Initial Service Packages, MISP) as well as training on MISP.

<sup>613</sup> MTR CAP Kenya 2011.

<sup>614</sup> Information from the humanitarian officer.

<sup>615</sup> COARs.

<sup>616</sup> UNFPA staff interview.

	<p>of MISP in the national and regional contingency plan and has prepositioned MISP in the affected region, as the MoH is not able to fund sustainably MISPs. UNFPA has mobilized both CERF and Monaco funds for the joint WFP/UNFPA project providing food to health facilities for delivering mothers, which led to a substantial increased birth delivery in those facilities. UNFPA is also part of the health and the protection clusters and was able to include its adapted tools for training in response (predominantly training of RC staff). The curricula has been adapted by UNFPA, WHO, MoH, FISA and RC and includes reproductive health and GBV.</p> <p>Capacity building of national partners is frequently a joint activity of UN partners based on adapted UNISDR tools and UNFPA tools for emergencies. UNFPA has promoted the inclusion of SRH with special mention (and support during emergencies) of maternity care and youth services. The monitoring and evaluation of the implementation is shared within the UNFPA office between the humanitarian, the SRH and the GPRHCS programme, as all are involved the affected regions and also the training component has been with input from all programmes.</p> <p>On national level the counterpart is the multi-sectoral Bureau de Gestion Risk de Catastrophe, which is leading the coordination. UNFPA supports this institution with the production and dissemination of relevant data for emergency management. Sustainability appears to be also in the humanitarian context the greatest challenge.</p>
Findings from case study in <b>Sudan</b>	<p><i>UNFPA has worked towards the inclusion of sexual and reproductive health in cooperation with the State Ministries of Health in its five focal states. In addition, UNFPA has also supported these states by ensuring the pre-positioning of health supplies and commodities and to train Government staff and CSOs for the delivery of the Minimal Initial Service Package (MISPs) during emergencies.</i></p> <p>UNFPA has worked with State Ministries of Health in its five focal states on pre-positioning basic supplies, such as reproductive health kits and personal hygiene kits that are critical for the implementation of emergency reproductive health interventions, i.e., the Minimal Initial Service Packages (MISPs). UNFPA also trained Government staff and staff from CSOs in the delivery of the MISPs and ensured that sexual and reproductive health was reflected in state level emergency preparedness plans<sup>617</sup>.</p>
Findings from case study in <b>Zambia</b>	<p><i>The evaluation team did not collect information for evaluation question 5 (maternal health and humanitarian support) for the Maternal Health Thematic Evaluation (MHTE). Humanitarian support had only been a relatively small component of UNFPA support in Zambia throughout the evaluation period, and it became clear that Zambia as a case study would not be able to contribute substantially to the overall answer to evaluation question 5. The evaluation team therefore decided to focus its efforts on collecting information for the other, more relevant evaluation questions.</i></p>

<sup>617</sup> Interviews with UNFPA.

**Judgment criterion 5.2: Accessibility of quality EmONC, family planning and reproductive health/HIV services in emergency and conflict situations**

Findings from case study in <b>Burkina Faso</b>	<p><i>La contribution de l'UNFPA lors des situations d'urgences s'est traduite par la distribution de kits d'urgence. L'UNFPA a appuyé le ministère de la santé pour l'introduction de la SR lors la préparation du plan de réponse aux situations humanitaires.</i></p> <p>Le Burkina Faso n'ayant eu à faire qu'à peu d'urgences (à l'exception des inondations en 2009) peu d'activités ont été entreprises en termes d'urgence humanitaire. L'UNFPA a apporté un soutien au gouvernement lors du développement du plan de réponse aux situations humanitaires pour l'introduction d'une composante SR. Lors des inondations l'UNFPA a fourni les kits d'urgence et fait en sorte que les éléments du <i>Minimum Initial Service Package</i> (MSIP) soient en place<sup>618</sup>. Un plan de contingence a également été développé au niveau de l'UNFPA et est revu chaque année.</p>
Findings from case study in <b>Cambodia</b>	<p><i>UNFPA has supported the Joint Plan of NCDM-MoH, which includes accessibility of critical EmONC and family planning services during emergencies. This Plan has had its share of teething problems.</i></p> <p>NCDM and MoH have a joint plan of action. Implementation of the plan should have started in 2010, but was hampered by capacity bottlenecks within NCDM. However, there have been trainings on Minimum Initial Service Package (MISP) in Australia and further trainings on Disaster Preparedness and Management in Malaysia and Thailand that were attended by staff from NCDM, MoH and UNFPA.</p>
Findings from case study in <b>Ethiopia</b>	<p><i>UNFPA provided in the humanitarian regions partial or complete MISP packages to improve access for most vulnerable groups to services, but follow-up and monitoring mechanisms seem not be efficiently implemented.</i></p> <p>UNFPA comparative advantage in the humanitarian context is the flexibility to provide short noticed commodities and especially the MISP package, which includes baseline surveys, training, dissemination of clean delivery kits to pregnant mothers and equipment and commodities to health facilities. Commodities are stored and distributed through the Administration of Refugees and Returnees Affaires (ARRA), a governmental institution.</p> <p>Several assessments and baseline surveys on reproductive health, HIV and GBV have been conducted in humanitarian settings by UNFPA or with its support. An emergency reproductive health-kits stock has been established in 2007 in order to have more flexibility and responsiveness in supplying reproductive health-kits. Moreover, the opportunity of assembling Clean Delivery kits locally has been discussed and assessed.</p> <p>Further UNFPA supported trainings of Health Extension Workers in various essential components, such as community conversations and clean and safe delivery. Medical staff was trained on the use of delivery equipment, clinical management of rape cases, post-exposure prophylaxis, distribution of family planning commodities, reproductive health kits, drugs, safe delivery kits. And awareness creation about family planning, sexually transmitted infections, and HIV/AIDS is being supported by UNFPA in the humanitarian assistance regions.</p> <p>UNFPA has been recognized by the government counterparts in its three humanitarian regions for the timely dissemination of reproductive health equipment and essentials drugs and for the appropriate training, but the lack of joint monitoring and project implementation follow-up had been noted as well<sup>619</sup>.</p>

<sup>618</sup> I.e. collecte de données démographiques et de SR sur les populations affectées, existence de services pouvant assurer la prise en charge des cas de violences sexuelles, distribution de condoms, et de kits d'accouchement et un système de référence fonctionnel.

<sup>619</sup> Ibid.

<p>Findings from case study in <b>Ghana</b></p>	<p><i>Being part of UNDAF Outcome 3 and Government Sector Working Group has given UNFPA flexibility in involvement and movement throughout the country. The commodities and contraceptives, tools and resources (including rape kits and counseling) that UNFPA Ghana provides in emergency and humanitarian settings are not provided by any other agency - an important fact in critical times.</i></p> <p>UNFPA Ghana has provided a series of MISP training for NADMO and health coordinators in selected border regions (close to Cote d'Ivoire). The trainings provide tools that enable the incorporation of SRH issues in humanitarian support in Ghana. This includes training in basic gender analysis of vulnerability, gender integrated in humanitarian support and addresses possible sexual violence that may affect especially women and girls.<sup>620</sup> Distribution of different kits normally includes condoms (male and female), clean delivery kits, rape treatment kits, oral and injectable contraception, HIV test kits, STI treatment kits, clinical delivery assurance kits, Intra uterine devices and management of miscarriage and complications<sup>621</sup>.</p> <p>UNFPA Ghana has a Policies and Procedures Manual, Policy for UNFPA Support to Emergency Preparedness, Humanitarian Response and Transition/Recovery. These documents breakdown by mandate areas reproductive health, population and development and gender and are further categorized into four areas – Emergency Preparedness, Acute Emergency Assistance, Chronic Humanitarian Situation and Transition and recovery. Major priority activities in each situation, partners and tools/resources are also defined.</p> <p>Training on MISP for the Central Region NADMO and health coordinators is yet to be conducted. None has been carried out for the Ashanti region either. Training has been done for all district coordinators of NADMO in the three Northern regions. UNFPA will support the training of MISP for health coordinators and NADMO coordinators in more regions as indicated in CP6.</p>
<p>Findings from case study in <b>Kenya</b></p>	<p><i>Since the 2006 and 2008 ad hoc interventions, UNFPA has strengthened its presence in the respective clusters with the aim to programmatic mainstream gender and reproductive health. Implementing partners are present in the refugee camps and are regularly monitored. There is one focal point/humanitarian officer in the KCO covering all aspects of the emergency response, which may not suffice for the tasks at hand.</i></p> <p>In response to the post-election crisis in 2008, UNFPA has supported a six-month project with a total project budget of US\$3,238,890, allocated to support the immediate health needs of 300,000 - 500,000 Internally Displaced Persons (IDPs) in 42 designated camps and 500,000 affected people of Kenya. The services have included all elements of the MISP, as well as: basic surgical and medical care, family planning and management of pregnancies, Post-Exposure Prophylaxis (PEP), HIV prevention and management, Sexual Transmitted Infections drugs and psycho-social support. UNFPA KCO has collaborated with other UN agencies to conduct assessments for the humanitarian crisis, particularly on gender-based violence, which provided a good baseline for further interventions. Up to now the main Implementing Partner has been the Kenyan Red Cross (KRC), who is monitoring quarterly implementation and uptake. The refugee problem that persists has reinforced the commitment for the KCO to get involved and there are plans to establish a health facility in Daadab camp to provide Sexual Reproductive Health services that are not usually given prominence in emergency situations. The focus is usually on food and shelter. These plans are being facilitated by the involvement of the humanitarian focal point in KCO. It is too</p>

<sup>620</sup>Summary of Key Activities for Possible UNFPA Support in 4 Phases, 2006.

<sup>621</sup>Co-ordination mechanism of UNDAF outcome areas through SWG.

	<p>early to assess comparative advantage given the recent entry of UNFPA in the respective clusters and the previous engagements having been only on ad hoc basis (2006)<sup>622</sup>. Currently only a focal point is covering the humanitarian response as well as the emergency preparedness (i.e. CAP preparation) which may not suffice to position UNFPA strongly in the humanitarian arena.</p>
Findings from case study in <b>Lao PDR</b>	<p><i>The main contribution of UNFPA during emergencies was the provision of delivery kits. This contingency plan includes condom and reproductive health equipment as well.</i></p> <p>During the 2008 floods, UNFPA contributed to the health response (led by MOH) by procuring clean delivery kits (4000 kits) that were made available to pregnant women in the flood affected areas.</p> <p>In the contingency plan developed by UNFPA, there a budget provision to procure and distribute delivery kits along with other reproductive health equipment, such as condoms. It was highlighted that the delivery kits are packaged for big emergencies and are not fully appropriate for the scale of emergency in Lao PDR<sup>623</sup>.</p>
Findings from case study in <b>Sudan</b>	<p><i>UNFPA in Sudan has helped to improve the accessibility of quality EmONC and Family Planning services in the particular situation of Sudan that has the characteristics of both a prolonged emergency and a development context. However, UNFPA's global standard procedures have not been appropriate for this context and have hindered the work of the country office.</i></p> <p>As mentioned above, UNFPA has focused its interventions outside of immediate emergency situations on ensuring that reproductive health is included in state-level preparations for emergencies, on providing and pre-positioning basic supplies and commodities, and on training Government and CSO staff in the delivery of Minimal Initial Service Packages (MISPs).</p> <p>However, UNFPA's global standard procedures have not been appropriate for the specific context in Sudan, where development concerns and humanitarian concerns often need to be addressed in parallel, the logistical and financial infrastructure and other prerequisites for project management and financing are often not in place, and where the social, political and security situation is often in flux, and changes from a development situation to an emergency situation relatively quickly. Specific challenges include the procurement of supplies that has been made more difficult due to the embargo against Sudan<sup>624</sup>. Also, financial accountability requirements that foresee quarterly advances and limit the possibility of roll-over of funds from one quarter to the next are not appropriate for a situation in Sudan where financial transfers from UNFPA to implementing partners in the States can take up to 2 quarters, and the where the volatile situation makes implementation delays nearly unavoidable<sup>625</sup>.</p>
Findings from case study in <b>Zambia</b>	<p><i>The evaluation team did not collect information for evaluation question 5 (maternal health and humanitarian support) for the Maternal Health Thematic Evaluation (MHTE). Humanitarian support had only been a relatively small component of UNFPA support in Zambia throughout the evaluation period, and it became clear that Zambia as a case study would not be able to contribute substantially to the overall answer to evaluation question 5. The evaluation team therefore decided to focus its efforts on collecting information for the other, more relevant evaluation questions.</i></p>

<sup>622</sup> Thematic Evaluation of UNFPA's Humanitarian Response 2010.

<sup>623</sup> UNFPA staff.

<sup>624</sup> Interview with UNFPA.

<sup>625</sup> Interviews with UNFPA and implementing partners.



**Judgment criterion 5.3: Accessibility to medical products in emergency and conflict situations**

Findings from case study in <b>Cambodia</b>	<p><i>In case of disaster, UNFPA's discrete funds will cover referrals and complications of pregnancy as part of an MISPP extension<sup>626</sup>. A small fund has been set aside for any emergencies in Country Programme IV (2011-15).</i></p> <p>The NCDM-MoH Joint Plan on Disaster Preparedness was submitted to HSSP II in 2011. There are stakeholders meetings on an ad-hoc basis, and as the reproductive health integration is led by the MoH, UNFPA participates. With the Joint Plan in place, there can be an immediate request for funds to the Government when a disaster occurs, and an additional request can be made through HSSP II. As UNFPA chairs HSSP II, it will ensure SRH issues are included in the request. The Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS) performed an assessment on contraceptive security in 2006; however, the assessment did not include humanitarian efforts. UNFPA and MoH consider HSSP II funding to be sufficient for any foreseen or unforeseen emergency support in the present context of Cambodia. There is currently no request for further donor contribution.</p>
Findings from case study in <b>Madagascar</b>	<p><i>The usually only short term displacements of the population in the natural disaster prone areas of Madagascar do not fundamentally disrupt the health service delivery and hence the UNFPA programme implementation can follow its standard procedures for the HF, the GPRHCS, MHTF, population and development and gender programmes. The 'standard procedures' in the country office though include joint planning, implementing and M&amp;E especially for the southern region.</i></p>
Findings from case study in <b>Zambia</b>	<p><i>The evaluation team did not collect information for evaluation question 5 (maternal health and humanitarian support) for the Maternal Health Thematic Evaluation (MHTE). Humanitarian support had only been a relatively small component of UNFPA support in Zambia throughout the evaluation period, and it became clear that Zambia as a case study would not be able to contribute substantially to the overall answer to evaluation question 5. The evaluation team therefore decided to focus its efforts on collecting information for the other, more relevant evaluation questions.</i></p>

<sup>626</sup> No specific medical products were mentioned.

## 8.2.6 Evaluation question 6: To what extent has the UNFPA contributed to the scaling up and increased utilization of and demand for Family Planning?

### Judgment criterion 6.1: Increased capacity within health system for provision of quality family planning services in UNFPA programme countries

Findings from desk study	<p>In African countries<sup>627</sup>, UNFPA has supported advocacy for the repositioning of family planning in national agendas<sup>628</sup>. This provided a good opportunity to create momentum for the revitalization of family planning programmes and supports the integration of family planning into reproductive health services in programme countries. UNFPA also assisted partner governments in defining quality standards and norms for family planning, and technically assisted family planning service provision, programming and management. The capacity development component of UNFPA support included the revision of training modules and curricula as well as support to a large range of training for health care providers and managers on topics like service provision (including counseling) and on specific contraceptive technologies. In specific geographical areas, UNFPA supported family planning service delivery by helping to adapt infrastructure, provide equipment and specific contraceptives and by providing technical support to functional facilities. Whether such interventions have contributed to the capacity of Governments to scale up family planning services has to be explored during the field phase.</p>
Findings from case study in Burkina Faso	<p><i>L'UNFPA a contribué à repositionner la planification familiale dans les stratégies de santé maternelle comme une des interventions à gain rapide pour atteindre les OMDs. Ce repositionnement a permis un engagement des partenaires du gouvernement. De plus l'appui à la définition des normes et protocoles a créé un cadre clair de prestation de services en PF.</i></p> <p>Le Burkina Faso fait partie des onze (11) pays du groupe 1 qui ont bénéficié de l'appui technique et financier du programme global pour la sécurisation des produits de santé de la reproduction (GPRHCS), cet appui a débuté en 2007. La feuille de route pour accélérer la réduction de la mortalité maternelle (2006-2015), le plan stratégique de sécurisation des produits de santé de la reproduction 2009-2015 (PSSPSR), largement appuyées par l'UNFPA, ont permis le repositionnement de la planification familiale et font la promotion de l'intégration des services de planning familial dans tous les centres de prestation de services. Ces stratégies s'inscrivent dans le cadre du Plan National de Développement Sanitaire PNDS 2006 -2010 qui définit la PF comme une des interventions à gain rapide (IGR) (grâce au soutien de l'UNFPA) qui permettront l'atteinte rapide des objectifs du millénaire pour le développement (OMD).</p> <p>Durant le 6ème programme l'UNFPA a apporté un appui technique et financier à la DSME pour définir des politiques, normes et procédures en SR et des modules de formation continue en SR qui incluent la planification familiale. De nombreuses formations ont été organisées en PF clinique visant à élargir l'offre de contraceptifs dans les formations sanitaires des zones d'intervention, tels que les implants et le Dispositif Intra Utérin (DIU)<sup>629</sup>. L'introduction du préservatif féminin a fait l'objet d'une promotion importante<sup>630</sup>.</p>
Findings from case study in Cambodia	<p><i>UNFPA has pioneered family planning services in various ways, including the Birth Spacing Policy of 1995 and the development of National Strategy for Reproductive and Sexual Health (NRSR 2006 -10) that ensures components related to building capacity for family planning services are planned and implemented and that modern contraceptives are promoted and provided. Some EDPs and NGOs felt that in the last 5 years, UNFPA had focused too much on trainings for delivery and not enough on trainings for family planning services,</i></p>

<sup>627</sup> I.e. countries that face low contraceptive use, high fertility rates in many countries, and high unmet needs for family planning.

<sup>628</sup> Based on the 'Repositioning Family Planning in Reproductive Health Services: Framework for Accelerated Action, 2005-2014' (developed by WHO/AFRO).

<sup>629</sup> Les données concernant ces formations n'ont pas pu être collectées .

<sup>630</sup> Entretien avec l'équipe UNFPA et revue documentaire.

	<p><i>safe abortion and sexual health, hence not ensuring full implementation of the NRSB Strategy.</i></p> <p>In 2000, UNFPA and WHO developed the Minimum Package of Activity (MPA), which includes pre-natal, antenatal and family planning as part of maternal health services. In 2003, the first National Population Policy (NPP) was implemented with UNFPA support.<sup>631</sup> The NRSB Strategy (2006-2010), also supported by UNFPA, reflects the difficult environment for family planning in Cambodia and explicitly mentions the need to expand existing family planning services and available methods, to build capacity of specific health workers, and stresses the importance of CDHS in tracking the results of this effort.<sup>632</sup> Both the WHO and UNFPA support the National Health Workforce Plan (2006-15), where trainings for nurses, midwives and other relevant health professionals are elaborated (including family planning)<sup>633</sup>.</p> <p>Increased capacity from national policy and programming in family planning is reflected in the upgrading of the Minimum Package and Complimentary Package of Activities (2008). The upgrade includes new long-term and permanent methods and defines which health cadres can apply the different methods of contraception<sup>634</sup>. The Fast Track Initiative for Reduction of Maternal and Newborn Mortality includes trainings in family planning and Comprehensive Abortion Care<sup>635</sup>.</p> <p>In the area of unwanted pregnancy and birth spacing, UNFPA has worked both with NGOs and the Government. Both family planning and MCH components have grown and expanded under UNFPA's tutelage. The Contraceptive Prevalence Rate (CPR) was 19% in 2000, 27% in 2005 and 35% in 2010<sup>636</sup>. This is a steady increase in CPR of about 1-2% per year but with an unmet family planning need of 17%, Cambodia will not reach its MDG CPR target of 60%<sup>637 638</sup>. UNFPA's training in ARSH programme is highly insufficient in terms of contraceptive services<sup>639</sup>. It was also pointed out the UNFPA has been hesitant to provide support for Comprehensive Abortion Care, even when the Government has requested it<sup>640</sup>. The team was told this was due to directives from headquarters, as Cambodia's abortion laws are some of the most liberal in the region<sup>641</sup>.</p>
Findings from case study in <b>DR Congo</b>	<p>L'UNFPA a fait des efforts considérables pour s'aligner sur le Ministère de la Santé en ce qui concerne le développement d'une politique de formation dans le but d'assurer l'adoption dans l'ensemble du pays des formations et des normes y afférant. L'objectif est, bien sûr, d'assurer des prestations de qualité mais, étant donné l'énorme demande non satisfaite au sein de ce pays (5.8% taux d'utilisation de la contraception moderne), ceci semble constituer un défi à long terme, un travail de longue haleine. Dans le cadre à la fois des formations relevant du Premier (1998-2002) et Deuxième (2003-2007) Programmes, et de celles planifiées sous le Troisième Programme (2008-2012), l'UNFPA s'est efforcé de remplir les objectifs de formation. Dans le cadre du Troisième Programme, bien que les formations ne</p>

<sup>631</sup> Government Partner.

<sup>632</sup> Government Partner.

<sup>633</sup> Health Workforce Development Plan 2006-15, MTR, 2011.

<sup>634</sup> Government Partner.

<sup>635</sup> Government Partner.

<sup>636</sup> UNFPA Presentation to Evaluation Team based on Cambodian DHS 2000, 2005 and 2010.

<sup>637</sup> In addition, results from focus groups conducted by the Evaluation Team suggest a glaring gap in family planning services (Annex 6.5).

<sup>638</sup> "Cambodia is expected to reach a CPR of only 45% in 2015 with sharp rural – urban differentials and with youth forming a large part of the population that remains un-served" (NGO Partner).

<sup>639</sup> NGO Partner.

<sup>640</sup> Government Partner.

<sup>641</sup> NGO Partner and External Development Partner.

	<p>soient pas jusqu'à ce jour mises en œuvre, elles ont été planifiées en étroite collaboration avec le Ministère de la Santé selon leurs souhaits et dans le cadre de leur stratégie. Ces efforts ont été accompagnés par la réhabilitation des structures sanitaires, pour que les cadres nouvellement formés aient un environnement positif dans lequel travailler. En 2010, 58 structures dans 10 provinces ont été réhabilitées avec le financement de l'UNFPA.</p> <p>Le but de cette collaboration, de la part de l'UNFPA, est de renforcer petit à petit la capacité du Ministère à se responsabiliser pour sa propre planification, et assumer petit à petit la direction effective, ainsi que (si nous voulons être ambitieux) un niveau de financement plus important, du programme national de Santé de la Reproduction (SR). Un obstacle à court terme à cette collaboration est le partenariat central entre l'UNFPA et le Programme National de la Santé de Reproduction (PNSR) qui n'est pas, à l'heure actuelle, aussi constructif qu'on pourrait le souhaiter. Elle est entachée de critiques qui vont dans les deux sens et dont les causes sont vraisemblablement des incompatibilités d'ordre personnel, et une mauvaise gestion entre autres. Il est impératif que la direction – des deux côtés – prenne les mesures nécessaires pour restaurer la collaboration et rétablir une relation de confiance entre l'UNFPA et le PNSR.</p>
<p>Findings from case study in <b>Ethiopia</b></p>	<p><i>Ethiopia is a recipient of the GPRHCS since 2007 and is considered a Stream 1 country. UNFPA supports policy development, procurement and dissemination of contraceptives and capacity development. Coordinated monitoring is not yet taking place, in spite of UNFPA existing tools and its support to such tools.</i></p> <p>Family planning was one of the areas identified under the Reproductive Health Strategy as priority. The GoE provided about 60% of the required funds for family planning and is dependent on external aid for continuity. Reproductive Health Commodity Security has been mainstreamed into national health policy and programmes; the implementation of the national Reproductive Health and the Adolescent and Youth Reproductive Health strategies are fully costed. The TWG on family planning tasks UNFPA (together with others such as Packard, Pathfinder, FGAE, Engenderhealth, etc) to monitor service provision.</p> <p>Health extension workers are providing family planning to their communities and report occasional stock outs or non-availability of some of the methods, but this is regarded as a distributional problem rather than true stock-outs<sup>642</sup>.</p> <p>Curricula are prepared and approved by the respective universities (University senates) and colleges under the guidance and the FMOH, which accredits courses. Often stakeholders' consultation (from the TWG) is part of the process in the form of workshops. Training is provided in a cascade format (ToTs) and 10.000 Decision Making Tool for Health Extension Workers were distributed<sup>643</sup>. UNFPA develops capacity development interventions jointly with the FMOH or other partners, usually based on prior assessments, and according to the national priorities and in participatory consultations with TWGs. In collaboration with School of Public Health of Addis Ababa University, UNFPA trained post-graduate students from the Addis Ababa School of Public Health and warehouse managers on supply chain management systems. From 2007 to the end of 2011 the GPRHCS in Ethiopia<sup>644</sup> will have disbursed approximately US\$5.1m on capacity development activities and US\$27.2m on commodities. The two main areas of support by the GPRHCS have been directed to the supply chain by providing training, technical support and computer equipment, and also to the national programme to scale up long</p>

<sup>642</sup> Information from government partners.

<sup>643</sup> In 2009, UNFPA supported the Policy, Planning, and Monitoring and Evaluation Directorate of the FMOH in training 400 health workers on the use of HMIS registers and forms; the registration and reporting forms were printed and distributed to all pilot regions.

<sup>644</sup> Ethiopia belongs to the 11 *stream one* countries that receive medium term support of up to USD5m per annum, to be spent on commodity supply, developing political commitment to RHCS and capacity development of national systems that impact on RHCS.

	<p>term contraceptive methods, in particular Implanon and IUCD through provision of commodities, and strategy development and training<sup>645</sup>.</p> <p>In conjunction with the training events, UNFPA performs supportive supervision visits, using a Health Facility Pharmacy Service Assessment Tool designed by PFSA addressing all areas of drug supply management. Nevertheless all development partners and the FMOH monitor their own programmes, frequently with a staff member of the FMOH joining review missions, but according to their own M&amp;E standards. The FMOH has not yet developed standardized M&amp;E tools nor are quality assurance mechanisms in place. Currently health centers supervise health outposts (five each), who report monthly on tally sheets on performed activities and distributed family planning commodities. Health centers provide integrated family planning services, including comprehensive abortion care. Tulane University had a programme supporting the FMOH in its supervision tasks, but as no staff has been allocated by the FMOH towards this; nothing seems to have come of it.<sup>646</sup></p>
<p>Findings from case study in <b>Ghana</b></p>	<p><i>UNFPA supports the National Health Information System to update Family Planning (FP) trends on an annual basis and DHS tracks contraceptive usage every 5 years. The latter has used the same questions since 1993. Family planning usage remains a significant challenge in Ghana, and CPR has decreased from 19% in 2005 to 17% in 2010 far short of the 28% that had been proposed by the Road Map on family planning.</i></p> <p>UNFPA has a long history of support to family planning in Ghana and many important population policies that were established in the 1980s and 1990s are still in place. The Ghana Population and AIDS Project (1995-2000 extended to 2002) to the tune of \$45 million was a turning point for comprehensive family planning services that was both advantageous (dual protection) and disadvantageous (family planning services diluted)<sup>647</sup>. UNFPA supported the introduction and dissemination of the National Reproductive Health Policy and Standards (1996) to remove medical barriers to family planning and reproductive sexual health services and National Reproductive Health Protocols in 1999. The next shift in focus was in 2000 with the introduction of the Adolescent Reproductive Health Policy and Protocols to fight social stigma and introduce family planning and sexual health concepts to youth. The same year the government adopted the Community Health family planning services into national Health Policy entitled Community Based Health Planning Service (CHPS). In 2001, Life Choices Behaviour Change Campaign for family planning was launched. 2003 marked another turning point in government involvement with the establishment of the Ghana AIDS Commission within the Office of the President and the National Reproductive Health Service Policy and Standards was revised many felt to the detriment of family planning quality assurance<sup>648</sup>. Just a year later Ghana became one of the first African nations to introduce a National Contraceptive Security Strategy to ensure a reliable supply system and prevent the common outages of various contraceptives. In 2004 NGOs and government reinvigorated their efforts to promote long-term birth control strategies, such as the “get a permanent smile” vasectomy campaign.</p> <p>UNFPA Ghana and Pathfinder International jointly supported the MoH/GHS strategy document The Road Map for Re-positioning family planning in Ghana (2006-2010)<sup>649</sup>. The Road Map identifies gaps in service delivery, research and evaluation, sets targets and defines the roles and responsibilities of various agencies and stakeholders. Eight broad strategies are proposed namely policy and advocacy,</p>

<sup>645</sup> Ethiopia Case Study MTR GPRHCS, 2011.

<sup>646</sup> Information from development partners and ECO.

<sup>647</sup> A Historical Perspective on family planning Services in Ghana, GHS, 2005 .

<sup>648</sup> Interview with External Development Partners and CSOs.

<sup>649</sup> Re-positioning Family Planning, Road Map, GHS 2006-2010.

	<p>behaviour change communication, institutional coordination and collaboration, human resource development and capacity development and expanding access to family planning services, resource mobilization and research and M&amp;E. The Road Map had the timely contribution of the National Leadership Group on reproductive health/family planning (an informal grouping of experts and stakeholders). It had the support of President of the Republic who requested the Minister of Health to provide guidelines. This provided an added impetus to a 17 member multidisciplinary Task Force which had been commissioned by the Director General of the Ghana Health Service.</p> <p>There has been no midterm or final evaluation of the Road Map for family planning. Any new response is mostly supply orientated rather than a focus on demand and utilization but people are hopeful about support from CARMMA which was launched in 2009 and the annual National Family Planning Week which began in 2011 to coincide with world National Contraceptive Day celebrated in every October<sup>650</sup>.</p>
<p>Findings from case study in <b>Kenya</b></p>	<p><i>The KCO supported technically through participation in working groups and financially through procurement of reproductive health commodities the development of the RHCS system in Kenya, which is now enabled to provide regular commodity supplies country wide. The implementation of integrated family planning services including relevant training is ongoing.</i></p> <p>One of the main interventions of UNFPA in the last years has been the strengthening of the Reproductive Health Commodity Security (RHCS) through the establishment of the Commodity Management Unit at the Division of Reproductive Health in the Ministry of Public Health (MOPH).</p> <p>This unit has been able to push the agenda for contraceptive security to the extent that during the 6<sup>th</sup> Country Programme the MoPH had partnered with UNFPA, USAID and KfW in a sector-wide approach arrangement for procurement of family planning commodities whereby the Government was contributing about 50%, UNFPA 25-30%, USAID 10-20% and KfW 10% of the funds. The KCO has achieved through its advocacy particularly aiming at parliamentarians, senior government officials and the media, increased government funding of budget lines for reproductive health commodities. Thus, Kenya is considered a Stream 3 country (GPRHCS<sup>651</sup>) to receive only emergency funds to avoid reproductive health commodity stock-outs that would otherwise occur. The National Contraceptive Security Strategic Plan, 2007-2012, developed with the support of UNFPA, can be regarded as a mechanism towards sustainable budgeting: in 2011 the Government is purchasing 80% of the required family planning commodities. The KCO supports capacity development to enable the national agency responsible for commodity procurement and dissemination (KEMSA) to forecast, finance, procure and distribute quality reproductive health commodities such as contraceptives, maternal health drugs and HIV commodities.</p> <p>Integration of all services including family planning is a national policy; implementation is ongoing and overseen by various Technical Working Groups (TWGs) in which the KCO participates. Capacity building interventions are supported by UNFPA and conducted within the Government framework and according to standardized training and curricula that are being used country wide by the Kenya Medical Training College (KMTTC), the institution, which trains the largest number of nurses and clinical officers. Supportive supervision of skills upgrading is conducted by the district public health nurses. The KCO capacity development interventions - largely the training of service providers and the infrastructure improvements - are strategic as they are within the GoK framework of improving access to and the quality of health care.</p>

<sup>650</sup> Interview with NGOs.

<sup>651</sup> Annual Report 2010, GPRHCS.

<p>Findings from case study in <b>Lao PDR</b></p>	<p><i>UNFPA has contributed to developing capacities to deliver family planning services and to procure contraceptives to ensure that all service delivery points provide family planning services<sup>652</sup>. However, despite UNFPA's long-term involvement in diversifying the range of available contraceptive methods and in training health care providers in family planning, the capacity of health providers is inadequate to provide quality family planning services particularly with regard to family planning counseling. Follow up mechanisms although supported by UNFPA have not sufficiently contributed to improve the quality of family planning services. With the introduction of the GPRHCS family planning counseling was strengthened through in service training. GPRHCS also allowed the provision of IUD and free of charge mini-laparotomy services.</i></p> <p>Under the 3<sup>rd</sup> Country Programme (2002-2006), one of the key strategies was to enhance the quality of family planning (FP) services nationwide through the supply of contraceptives, improvement of logistics management and training of family planning service providers. Under CP4, the Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS) was introduced in 2008 as Lao PDR is a Stream 1 country.</p> <p>Family planning was included in the Integrated Package of Maternal, Newborn and Child Health (MNCH) services 2009-2015 although it does not feature prominently enough<sup>653</sup> as the link with the other maternal health services is relatively weak . It was realized that in general the capacity of health care providers was inadequate to provide appropriate family planning services, that family planning national guidelines had not been updated since 2003, that there was no proper family planning counseling training manual, and that most of health centers staff had not received refresher training on family planning counseling since 2005<sup>654</sup>. In 2010, a manual on family planning counseling was revised based upon the WHO Decision-making Tool and integrated to pre-service and in-service trainings with GPRHCS support. UNFPA also supported training on IUD insertion and female sterilization using mini-laparotomy for selected 1st level health care providers in addition to provincial and district hospital staff. It also supported an IUD (Intra Uterine Device) service quality assurance study and the revision of the IUD training manual</p> <p>UNFPA has assisted the National MCH Centre in reinforcing supervision based upon the MNCH package through by providing tools and technical support as well as financial support for supervisory visits to family planning service delivery points. However, supervision is an area that needs further strengthening<sup>655</sup>. For instance, UNFPA provided equipment to facilities from which personnel have been trained in IUD insertion and mini laparoscopy. and subsidies are provided to the women willing to undergo sterilization. However, even though training and equipment are provided for a certain number of health facilities, follow up mechanisms to ensure quality services are delivered are not systematically in place<sup>656</sup>.</p>
<p>Findings from case study in <b>Madagascar</b></p>	<p><i>UNFPAs support to the increased capacity for provision of family planning services has/is taking place on several levels: on national level UNFPA has supported the MoH in family planning relevant policy making and development of training curricula, whilst on regional, district and communal level the IPs of UNFPA provide skills building to service providers. In addition UNFPA headquarters purchases contraceptives which are distributed through the parastatal organization, which had been empowered to do so through UNFPA support. Currently UNFPA is the only provider of contraceptive commodities for Madagascar, which raises the question of sustainability.</i></p>

<sup>652</sup> The 2011 Stock Availability Survey of MNCH Programme Commodities showed that 94% of service delivery points provide family planning services.

<sup>653</sup> Review of the implementation of the reproductive health policy and maternal, neonatal and child health package - October 2011.

<sup>654</sup> Lao PDR Proposal 2010 for Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS) and Maternal Health Trust Fund (MHTF).

<sup>655</sup> Assessment of Development Results Supported by UNFPA CP4 for Lao PDR: Report and Recommendations.

<sup>656</sup> Development partners interviews.

	<p>UNFPA developed already in 1991 (together with WHO and USAID) the first national family planning plan and supported the development of relevant protocols and guidelines. In 1992, the World Bank launched the integration of family planning into all services and since 2004 the GoM has included family planning and reproductive health in its national plan and purchased family planning commodities with a the World Bank loan.</p> <p>Even though the MoH has a dedicated budget line for family planning, it does not purchase any commodities (the budget line is close to zero). UNFPA together with other partners (Organon, WHO, USAID) has since 2004 funded near to 100% of all family planning, since 2009 other donors have dropped out and UNFPA remains the main providers with near to 100 % coverage and it is not foreseeable that the GoM will increase its budget for family planning<sup>657</sup>. UNFPA supports NGO/CSOs that promote and offer family planning, such as SAF, SALFA and FISA. family planning meanwhile is integrated on all health service levels, starting from the community health worker to youth clinics, primary health facilities, etc. UNFPA has been the lead in all family planning related activities and is -apart from the MoH - the main participant in the family planning working group, which meets quarterly and conducts annual general stakeholder meetings.</p> <p>Capacity building has been provided by UNFPA on service provision (i.e. community health workers on Implanon sensibilization), on supply chain management and on forecasting to all IPs. UNFPA trained on logistics since 1991, and has provided all regions with CHANNEL software to monitor the provision. UNFPA has trained the staff on regional and district levels to perform their own M&amp;E of the parastatal distribution system (SALAMA)<sup>658</sup> and the health workers. Public health service providers and community health workers have been trained through NGOs on family planning methods according to jointly developed curricula by development partners and the MoH<sup>659</sup>. In general, curricula for medical staff have to be validated by the MoH and are nationally implemented. Private providers may add on to the curricula, but have to provide the national standard as a minimum.</p> <p>UNFPA supports with other development partners and its implementing partners several components of a fully-fledged quality assurance system<sup>660</sup>, such as efficiency (competence building and equipping of health care providers), access to services (through community health workers), effectiveness (support to national standards and norms for health care providers), acceptable (support to renovation and refurbishment of health facilities)<sup>661</sup> but does not address a full-fledged quality assurance system which would capture the needs of specific vulnerable groups, such as teenagers<sup>662</sup>.</p>
Findings from case study in <b>Sudan</b>	<p><i>UNFPA has been able to anchor family planning in a number of high level policy documents, such as Sudan's current reproductive health policy and the MNH Road Map. However, this progress at the policy level has not translated into strengthened capacity for the provision of family planning services in Sudan overall. The main bottlenecks are funding to implement the aforementioned policy commitments, the resistance to family planning in parts of Sudan's society and its political class, and the weakness of the health system overall. UNFPA has organized and financed individual family planning training workshops for SMoH and health staff; however, in absence of a supportive and enabling social, political and cultural environment, these efforts were unavoidably too fragmented to make a</i></p>

<sup>657</sup> In the 6<sup>th</sup> CP, supplies are directly purchased by UNFPA HQ, imported, and distributed via a parastatal organisation (SALAMA). The MoH interviewees were not able to provide any suggestion concerning the sustainability of this.

<sup>658</sup> with hard-, software and logistics training.

<sup>659</sup> Information provided by development partner, implementing partner and MoH.

<sup>660</sup> efficient, accessible, acceptable/patient-centered, equitable, safe (WHO, 2006: Quality of care : a process for making strategic choices in health systems).

<sup>661</sup> See for example Country programmes 5 and 6.

<sup>662</sup> The still near to 40 % teenage pregnancy rate may be considered indicative of the failure of the current health care provider system to address the need of a most vulnerable group.



	<p><i>lasting difference in the capacity of Sudan's health system to provide quality family planning services.</i></p> <p>As mentioned above, UNFPA has supported the drafting of Sudan's current reproductive health policy and the MNH Road Map, both of which formally commit the Sudanese Government to promote increased access to Family Planning services as part of its reproductive health and maternal health approach. In particular the MNH Road Map foresees a number of activities for ensuring the availability of family planning services across Sudan.</p> <p>At the same time, it is not at all certain that these formal commitments will eventually guide appropriate efforts of the Sudanese Government to make family planning services available in all or at least most service delivery points. Past, similar policy commitments often have not been honored or acted upon by the Sudanese Government. Also, financing for the provision of family planning services is not secure. This includes also the financing for the implementation of the MNH Road Map; where the projected costs to implement the strategy exceed the estimated amount that is currently spent on reproductive health by the Sudanese Government by a factor of approximately 165<sup>663</sup>. This means that funds from external sources, development partners and others, will have to fill an annual funding gap of approximately US\$ 39.8 million to allow for the implementation of the Road Map overall; and the family planning support in particular. In practice, this means that the Government right now does not have a viable strategy for addressing the shortfalls in family planning services that could not be supported by UNFPA.</p> <p>In the absence of a viable national strategy and the overall sensitivity of and even resistance to family planning in Sudan<sup>664</sup>, UNFPA has only had limited options for designing its family planning support to align with Sudanese strategies and mechanisms (see above; issue on national strategies). Although UNFPA has channeled family planning support, e.g., support for training health care providers in family planning approaches, through the federal and state level Ministries of Health, the capacity weaknesses at these levels have prevented a comprehensive and strategic approach<sup>665</sup>.</p> <p>In principle, UNFPA has been supporting training of health care providers in family planning as well as other complementary activities, such as the provision of commodities. However, UNFPA has not supported demand creation activities in areas where stock outs of reproductive health commodities have been a significant problem (as it has been in many areas of Sudan, in particular recently). Although UNFPA has supported media-based awareness raising campaigns, it could not be determined to what extent these campaigns were evidence-based.</p>
Findings from case study in <b>Zambia</b>	<p><i>UNFPA has supported the strengthening of health system capacity for family planning services in various ways, including the revision of family planning guidelines, the launching of a Reproductive Health Commodity Security Committee (RHCS) and support for in-service training of nurses and midwives in family planning. However, without sustained and systematic support to bind these isolated activities together, the support has not translated into a sustained capacity improvement in Zambia's health system to deliver family planning</i></p>

<sup>663</sup> The estimated amount spent on reproductive health annually is US\$236,000, or 0.3% of Sudan's annual health budget of approximately US\$ 79 million, according to estimates of the Health Economics Department of the federal MoH (UNFPA, 2011).

<sup>664</sup> Feedback in interviews with UNFPA suggested that the practice of family planning is often maligned in some of Sudan's newspapers and the resistance to family planning is expressed in other forums as well. Also, anecdotal evidence from interviews at project sites suggested that the choice of women for different contraceptives was often limited and that the choice was even at times made by male doctors on behalf of women.

<sup>665</sup> Interview with UNFPA.

	<p><i>services.</i></p> <p>UNFPA's approach towards integration of family planning in all service delivery points consisted mainly in: (a) establishing a "Reproductive Health Commodity Security Committee" (RHSC) to put commodity security into the hands of the Government<sup>666</sup>; (b) integrating family planning into the pre-service curriculum for facility-based health workers and training of health care providers<sup>667</sup> particularly for long acting family planning methods like intrauterine devices (IUD) and implants; (c) training community-based volunteer health workers<sup>668</sup> in family planning; and (d) supporting demand creation for family planning through the activities of the SMAGs. However, the first two interventions faced significant challenges: The RHCS committee ceased to function after only four meetings<sup>669</sup>, mainly because of time constraints of the intended members, and because of difficulties with finding committed leadership for the committee<sup>670</sup>.</p> <p>Nurses and midwives who were trained in family planning at times lacked the necessary supplies for staff to apply their skills<sup>671</sup>. UNFPA staff has advocated with Government partners for the improvements in the deployment of trained staff. However, beyond this, UNFPA has not been involved in systematic efforts and technical support to improve the mechanisms and processes for deployment of staff in accordance with their training<sup>672</sup>.</p> <p>UNFPA has supported the revision of the guidelines on "Family Planning in Reproductive Health of 1997" and ensured the integration of HIV and Sexually Transmitted Infections (STIs) into the Guidelines<sup>673</sup>. However, it is not clear to what extent these guidelines have been utilized and applied.</p> <p>Although in theory, systems<sup>674</sup> are in place to monitor the availability of family planning services in all delivery points<sup>675</sup>, in practical terms regular monitoring is severely challenged by insufficient human resources.</p>
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<sup>666</sup>Original members included UNFPA, DfID, National Aids Council (NAC), now others have bought into (Ministry of Finance (MoF), MoH, USAID, UNICEF "and others").

<sup>667</sup> Nurses, midwives.

<sup>668</sup> Safe Motherhood Action Groups (SMAGs), Community-based-distributors, peer educators.

<sup>669</sup> Mainly to inform about it's intended mandate and purpose.

<sup>670</sup> Although the MoH identified a chair and co-chair for the RHSC committee, the individuals had competing priorities; and the RHCS meetings were usually not prioritized (Interviews with MoH, UNFPA).

<sup>671</sup> Training of health staff in family planning is following an overall "training plan" that is managed by MoH. UNFPA has been funding trainings in two provinces (North-Western, Luapula) in accordance with this training plan.

<sup>672</sup> UNFPA interviews.

<sup>673</sup> Using funds from the UNFPA-WHO "Strategic Partnership Programme".

<sup>674</sup>The quarterly monitoring data collected by MoH supervisors/coordinators is processed at the national level and shared with the annual MoH reports.

<sup>675</sup>Integrated Reproductive Health Performance Assessment Tool.

**Judgment criterion 6.2: Increased demand for and utilization of family planning services in UNFPA programme countries, particularly among vulnerable groups**

Findings from <b>desk study</b>	UNFPA contributed to stimulating demand for family planning by supporting communication and community mobilization with research, the design of communication and mobilization strategies, the design and reproduction of communication materials IEC/HE, mass media campaigns and communication training. UNFPA developed partnerships with and supported CSOs that were involved in family planning promotion. However, the extent to which the communication and community mobilization strategies were based upon evidence is not always apparent. UNFPA did not systematically assess the appropriateness of its approaches, also due to the overall weakness of UNFPA's M&E systems in most countries <sup>676</sup> . In some countries, UNFPA supported the community based delivery of family planning services or supported alternative family planning delivery channels in order to increase accessibility. Reaching vulnerable populations remained a challenge.
Findings from case study in <b>Burkina Faso</b>	<p><i>Les taux de prévalence contraceptive ont augmenté durant cette décennie et l'UNFPA a contribué à cet accroissement par ses efforts dans le domaine de la communication bien que leur efficacité n'ait pas été mesurée mais aussi par l'amélioration de l'offre de services de PF.</i></p> <p>L'UNFPA a soutenu la Direction de l'Hygiène Publique et de l'Éducation pour la Santé (DHPES) pour développer un plan stratégique de communication en santé de la reproduction 2007-2010 sur la base des résultats d'un certain nombre d'études préalables<sup>677</sup>. Ces études ont fourni des informations ayant permis de définir des stratégies de communications avec entre autre une implication plus importante des hommes et des leaders d'opinion dans la SR. Des outils multi média ont été produits tels que des posters, brochures, des productions télé, radio et théâtre, en différentes langues nationales, à partir de l'analyse de ces données. Ces outils ont été utilisés dans les zones d'intervention de l'UNFPA et des actions de sensibilisation ont été menées par des OSCs (la Question d'évaluation n°3). L'efficacité de ces outils, toutefois, n'a pas été mesurée. Une enquête Connaissance, Attitude et Pratiques (CAP) a été planifiée mais n'avait pas été entreprise au moment de l'évaluation.</p> <p>Le taux d'utilisation de contraception dans les 3 régions sanitaires appuyées par les agences du système des nations unies (dont l'UNFPA) est passé de 12.33% en 2005 à 19.22% en 2010<sup>678</sup>. Si l'UNFPA a une part importante de responsabilité dans ces résultats ils peuvent être attribués à une variété d'interventions allant de la communication à une offre accrue de service ainsi qu'à l'offre d'un éventail plus large de méthodes contraceptives mais aussi à un à des facteurs tels qu'un niveau d'éducation plus élevé (qui est au-delà de l'intervention de l'UNFPA). Au niveau national l'Enquête Démographique et de Santé 2010 indique que la prévalence contraceptive moderne augmenté de 9% en 2003 à 15% en 2010.</p> <p>L'UNFPA, plus récemment, a appuyé la stratégie de distribution à base communautaire de contraceptifs dans le cadre du panier commun à travers la contractualisation d'ONG. Les mécanismes de gestion ont été définis avec son soutien par lesquels les ONG « rencap » (renforcement des capacités) sont responsable de la supervision et du développement des capacités et les OBC (organisations a base communautaire) qui sont à leur tour responsable de la mise en œuvre. Toutefois il a été noté une insuffisance de directives standardisant le processus de mise en œuvre, laisse la latitude à chaque organisation de développer son propre processus.</p>

<sup>676</sup> See Evaluation questions 8 on the use of M&E and other evidence in UNFPA programming.

<sup>677</sup> Étude socio-comportementale SR (2007), l'étude médias et communication 2007.

<sup>678</sup> Système National d'Information Sanitaire (SNIS).

	<p>La première année de mise en œuvre a été principalement consacrée à la sensibilisation et pas encore à la distribution de produits contraceptifs, elle présente des résultats variables et des capacités différentes entre les ONG<sup>679</sup>. Le suivi semble insuffisant malgré un jeu d'outils développé à cet effet pour les aspects financier mais ces outils ne permettent pas toujours d'obtenir des informations qui reflètent ce qui a été accompli<sup>680</sup>.</p>
<p>Findings from case study in <b>Cambodia</b></p>	<p><i>The National Strategy for Reproductive and Sexual Health (2006-10) notes that Community Based Distribution (CBD) combined with communication will increase demand for family planning services and tackle the issue of access for the poor in priority areas. In introducing or expanding NRSHP package on family planning, CBD agents are mentioned as key players, but UNFPA Cambodia has not scaled up the recommendations of the CBD evaluation that it commissioned in 2010 and as such the role of the CBD programme is not emphasized in the Fast Track Initiative road Map for Reducing Maternal and Newborn Mortality.</i></p> <p>The Community Based Distribution (CBD) programme was introduced by UNFPA and began implementation in 2004 in areas that were far from health centers (10 kilometers or more). The CBD agents received basic training in 2004 and 2005 and are permitted to sell pills and condoms on a commission basis. UNFPA and USAID updated the CBD guidelines in 2008 and performed a joint evaluation of CBD in 2010. In 2006, UNFPA discussed and developed a training manual for CBD with the National Health Promotion Centre (NHPC). The training consists of a 5 day accredited package that all implementers have to follow. NGOs now use the CBD manual, and the National Maternal Newborn Child Health Centre (NMNCHC) is responsible for all CBD programming<sup>681</sup>.</p> <p>For a programme that is so critical for UNFPA's performance like CBD, the country office has relied too much on the Government's own HSSP II monitoring and has not sufficiently considered the findings from its own evaluation and oversight exercises. To illustrate, while NGOs, which are part of the programme, have adopted the recommendations of the 2010 UNFPA-supported CBD evaluation and updated their programmes in 2011, UNFPA and Government have not<sup>682</sup>. The critical role of CBD agents and their appreciation by local Health Professionals at district level contrasted with the lack of support by the national system<sup>683</sup>.</p> <p>Communication initiatives were carried out through NHPC (2002-8) and Communication in Health Education and Media Services (CHEMS). NHPC included two topics, BCC, and inter-personal communication (IPC) to health workers in MCH/family planning. NHPC provided direct trainings in 18 targeted ODs in 14 provinces. CHEMS extensively utilized the electronic media, with support from the German cooperation that was channeled through UNFPA. KAP baseline and end line surveys showed family planning messages were getting through, but that the messages were not sustained especially in rural and remote areas<sup>684</sup>.</p> <p>There has been no major initiative by UNFPA in family planning, outside of introducing CBD in 2004, and there are no public health sector family planning assessments and updating of clinical practices by MoH. Access to a mix of family planning methods at Health Centers and ability of a midwife to introduce family planning at ANC/PNC or even record family planning care is still highly problematic. In particular the difficulties with recording family planning care have limited the possibilities to accurately monitor an important</p>

<sup>679</sup> Entretien avec les partenaires d'exécution.

<sup>680</sup> Idem.

<sup>681</sup> Government partner.

<sup>682</sup> UNFPA's reliance on the leadership of Commune Councils to create demand for family planning, without first implementing the 2010 CBD recommendations came under criticism from several NGO Partners.

<sup>683</sup> This illustrated in group discussions conducted during the evaluation (Annex 6.5).

<sup>684</sup> "The only time one heard about UNFPA and family planning was in 2008-10 when there was German funding or when a new method is being introduced, that's it, the whole range of issues around family planning is hardly discussed from a perspective of enhancing choice and quality" (NGO Partner).

	procurement indicator, i.e. the rate of Couple Year Protection (CYP), and the ability of UNFPA and the country to project contraceptive demand <sup>685</sup> .
Findings from case study in <b>DR Congo</b>	A l'heure actuelle, l'UNFPA encourage fortement le gouvernement à développer des systèmes pour l'estimation des besoins en commodités et pour assurer la continuité dans l'approvisionnement. Un modèle a été développé et testé avec le soutien de plusieurs ONG telle que l'Association de Bien-être Familiale (filiale d'ABEF - Fédération internationale pour la planification <i>familiale</i> (IPPF)) pour la distribution de fournitures au sein de la communauté, mais la mise en œuvre est très insuffisante en termes de suivi et de monitoring. Malheureusement, les ressources requises pour assurer ce processus de suivi formel font très largement défaut. Par ailleurs, étant donné la taille du pays, ces efforts doivent aller très loin pour satisfaire la demande. A l'heure actuelle, la qualité des services est insuffisante et les fournitures les plus recherchées (telles que les implants) sont souvent indisponibles. (Judgment criteria 6.2, 6.3)
Findings from case study in <b>Ethiopia</b>	<p><i>UNFPA has initiated targeted interventions to increase demand for family planning and facilitated the availability of a method mix on community level. A follow up on the change of the baseline indicators and on recommendation made during the events by stakeholders or participants (such as the regional advocacy workshop) may be useful in view of assuring quality and applicability of such interventions. It seems that the GoE relies on its Community Conversations and HEW to create demand, but this may not suffice and barriers need to be identified and addressed.</i></p> <p>In addition to support of the reproductive health commodity security in Ethiopia, UNFPA developed a communication strategy aiming to transform family planning initiatives into a social movement by ensuring participation of clients of family planning and creating demand. Hence, it targets large parts of the population with initiatives, such as</p> <ul style="list-style-type: none"> <li>-the Development Bible which added to Ethiopian Coptic Church daily/weekly prayers reproductive health related topics, (family planning, HIV, early marriage, etc),</li> <li>- advocacy workshops with the objectives of soliciting commitment for continued support in facilitating and protecting women's aspirations and realization of their reproductive health rights towards accessing and benefiting basic SRH/family planning services involving religious, community and political leaders and</li> <li>-a national mass media radio programme, which broadcast is addressing Reproductive Health Commodity Security (RHCS), Family Planning, Maternal Health and Adolescent and Youth Reproductive Health and HIV prevention.</li> </ul> <p>As standardized M&amp;E tools and quality assurance mechanisms were not in place and the FMOH does not allocate resources to this aim it is not possible to evaluate the impact of these initiatives.</p>
Findings from case study in <b>Ghana</b>	<p><i>UNFPA support to the Road Map has not changed family planning demand and utilization in Ghana, in fact situation has worsened. The country reveals some disturbing trends and challenges in expanding family planning: persistent gap between knowledge and use of contraceptives, spatial differences in contraceptive use between rural and urban regions as well as between southern and three northern regions and unmet need for family planning remains high<sup>686</sup>.</i></p> <p>DHS 2008 showed that in spite of the family planning Road Map (2006-2010), Ghana had not managed to continue to keep up the momentum of the 80s and 90s in terms of increase in CPR. Wide participation by variety of stakeholders in the Road Map has not</p>

685 NGO Partner and External Development Partner.  
686 Ghana DHS 2008.

	<p>strengthened the national family planning programmes ability to meet demand. Total fertility rate has not changed by much and while MMR has been reduced significantly, the current rates (350/100,000 live births) remain far short Ghana's MDG target of 185 by 2010.</p> <p>Interviewees referred to a range of key challenges but the one most pointed to was the lack of commitment and support for family planning at programme budget level even with the Road Map in place which has resulted in a lack of comprehensive education and training on quality family planning services (outside the one week received by midwives) accompanying the Road Map<sup>687</sup>. Furthermore, Government has not re-instated family planning (in the way it has ANC/PNC and EmONC) as a priority within national development strategies and health plans and integration has diluted the contraceptive services. District Assemblies have received little or no training from GHS on promoting and financing family planning. Extending coverage and improving quality of family planning services lags behind all other services related to maternal health and there is high dependency on donors to cover contraceptive security<sup>688</sup>.</p> <p>It was noted that National Population Council (which reports to the President) with support from UNFPA continues to advocate for repositioning of family planning and since 2009 under the CARMMA Initiative with the support of the First Lady<sup>689</sup>. The annual Family Planning Promotion Week which is part of CARMMA now covers all 10 regions. The First Lady is directly addressing the District Assemblies to mobilize resources in a decentralized system<sup>690</sup>. However, there has been no drive to be more strategic in educational approaches to overcome regional disparities, with birth rates several times higher in some regions than others. The average birth rate per mother in the Northern Region is 7.0 compared to 2.9 in Greater Accra<sup>691</sup>.</p> <p>Efforts to ensure family planning payments under the National Health Insurance Scheme (NHIS) are ongoing. Under this arrangement, family planning is to be added to the cost of services charged under the NHIS rather than require a direct payment to the service provider as is currently done. Some discussions have been initiated by USAID, DFID and UNFPA and it is likely that action will be taken before the next election (2012). Studies conducted by the JSI Deliver Project suggest that it will be sustainable and cost efficient for the NHIS to absorb the cost of family planning in Ghana<sup>692</sup>.</p> <p>Youth Friendly Services have not kept pace with the communication revolution. While the value of having Youth Friendly Services is still recognized, the content and strategy of services were considered old fashioned by youth and service providers were described as judgmental and less informed at times than the youth themselves<sup>693</sup>.</p>
Findings from case study in <b>Kenya</b>	<p><i>UNFPA is providing support to the community based distribution of family planning through various mechanisms (advocacy, capacity development, provision of some consumables after training), thus enhancing the possibility of demand creation. First reviews indicate the increased demand, but it is too early in the project life of the centers of excellence to substantiate this.</i></p> <p>As family planning is one of the five high impact interventions promoted by the Government, UNFPA traditional work on family planning has fallen well into place: it has supported community based uptake of family planning with special focus on vulnerable groups and youth, peer education activities, advocacy, purchase of female condoms, and community health extension workers (CHEW) training.</p>

<sup>687</sup> Interview with NGOs.

<sup>688</sup> Interviews with External Development Partners, NGOs and UNFPA staff.

<sup>689</sup> Interview with Government.

<sup>690</sup> Interview with GHS Regional Health Directorate.

<sup>691</sup> Ghana DHS 2008.

<sup>692</sup> Interview with External Development Partner.

<sup>693</sup> Interview with CSOs.

	<p>CHEWs are involved in the distribution of contraceptives, health education, counseling and referral for family planning, and Youth centers serve as distribution centers for condoms and reproductive health/ family planning information for youth. Female condoms were introduced in Kenya by UNFPA and now consumption is at 300,000 per year. According to the country office Annual Report 2010 99% of service delivery points provide at least three modern contraceptive methods, without specifying which contraceptives. Male condoms are most widely used and following the UNFPA supported Sure Condom campaigns an increased number of people using condoms during the last sexual encounter have been reported (by UNFPA). Naivasha District-one of the pilot sites for a Centre of Excellence - reports in its Annual Report 2010/2011 in order of frequency: provision of injectable contraceptives, pills, condoms, IUCD and implants. UNFPA funded programmes on fistula and FGM also create awareness for family planning, specifically amongst vulnerable groups such as survivors of fistula.</p>
<p>Findings from case study in <b>Lao PDR</b></p>	<p><i>UNFPA supported Community Based Distribution (CBD) of contraceptives in remote areas resulted in an increased use of contraceptives and is valued by the MoH and other development partners who are committed to expand this approach. UNFPA has been supporting MoH to undertake various communication activities in order to promote reproductive health. More recently, with GRHCS support, it supported IEC/BCC materials development and media activities in target geographical areas. Unfortunately large communication initiatives have not been properly assessed and their actual results are not clear.</i></p> <p>The contraceptive prevalence rate (CPR) has increased over the years in the whole country from 29 to 35% among married women between 2000 and 2005, but unmet need still remains high at 27%<sup>694</sup>. The Lao PDR Social Indicator Survey (LSIS) that was being conducted at the time of the evaluation will provide updated data on CPR.</p> <p>Community Based Distribution (CBD) of contraceptives started in 2006 (during CP4) in 3 provinces in the South and was later expanded to 5 more provinces in 2008. In the project areas, which are very remote and underprivileged areas, the use of contraceptives has increased from 17.5% at the beginning of the project to 43.1% in 2010<sup>695</sup>. Other provinces are interested in using this approach in their remote districts. However CBD is considered by the government as an 'interim measure' until public health facilities can provide family planning services.</p> <p>Over the last decade, UNFPA has supported the National MCH Centre and the Centre for Information Education for Health to develop IEC materials (posters, leaflets...) and to mobilize the Lao Women Union and Lao Youth Union networks in order to promote family planning in target geographical areas<sup>696</sup>. More recently, GPRHCS supported the development of IEC/BCC material for reproductive health promotion and media activities by the Centre for Information, Education and Hygiene (CIEH) with the support of a Japanese NGO that provides technical support<sup>697</sup>. Messages contained in the IEC material were based upon evidence gathered in the target areas but it is unclear whether they are appropriate for the rest of the country and to what extent those materials have been reproduced for other areas. In addition, the intervention has not been systematically assessed and the project monitoring databases that are usually kept by provincial offices concern utilization but do not measure communication initiatives<sup>698</sup>.</p>

<sup>694</sup> Lao Reproductive Health Survey.

<sup>695</sup> UNFPA staff.

<sup>696</sup> See Evaluation question 3 above.

<sup>697</sup> Japanese Organization for Cooperation in Family Planning (JOICEF).

<sup>698</sup> Project Sabai': How access to contraception is improving the lives and livelihoods of poor rural communities in southern Lao PDR - Evaluation of the Family Planning Outreach Project in Salavane, Sekong and Attapeu - On behalf of Maternal and Child Health Centre and UNFPA - May 2010.

Findings from case study in <b>Madagascar</b>	<p><i>Demand creation and utilization of family planning is supported by UNFPA through communication initiatives on community, school and national level, but the high teenage pregnancy rate may require a more focus/or sustained effort by UNFPA and its partners.</i><sup>699</sup></p> <p>The community health worker system is in charge of sensitization, promotion and supply of family planning commodities. Community health workers have been trained by UNFPA, WHO and USAID according to standardized MoH approved curricula and their skills are regularly upgraded. UNFPA was partner in the development of the National Strategy for Community Health, 2009 and UNPFA, UNESCO and UNICEF are promoting education on sexual health in schools through curriculum development.</p> <p>The baseline data utilized for most initiatives by the MoH /UNFPA are derived from the DHS, which takes place every 4-5 years. Contraceptive demand, teenage pregnancy, etc are captured in the regular M&amp;E processes by each implementing partner. UNFPA has provided all regions with CHANNEL software to monitor the provision, distribution, dissemination and uptake. As UNFPA belongs to the few providers of family planning, the MoH attributes the increase in family planning uptake directly to the work of UNFPA<sup>700</sup>. Nevertheless, teenage pregnancy is still very high and the impact of campaigns may need to be more focused on that group.</p> <p>At the time of the mission, there was a campaign (supported by UNFPA) aimed enhancing the knowledge of sexual and reproductive health issues in 3 regions (20 communities).</p>
Findings from case study in <b>Sudan</b>	See 6.1
Findings from case study in <b>Zambia</b>	<p><i>ZANIS, UNFPA's major implementing partner for family planning campaigns and other behavioral change communication on SRH, focused on the national and provincial levels and worked through SMAGs at the district level. As data on the results of these campaigns were not available, it was not possible to gauge, if their financial support by UNFPA had helped to increase demand for and utilization of family planning services.</i></p> <p>Interventions were complemented by MoH funds. No data on the results, i.e., the effects of the campaigns was available. In 2008, UNFPA also supported the development of the maternal health communication strategy, which also included family planning.</p>

<sup>699</sup> The political situation has an important negative impact on the implementation as high level advocacy is difficult for reasons of protocol. (see also Madagascar Case study of GPRHCS, 2011).

<sup>700</sup> Information from MoH, IPs and regional health administration.



**Judgment criterion 6.3: Improved access to contraceptives (commodity security)**

Findings from <b>desk study</b>	UNFPA has also been involved in supporting countries to strengthen their reproductive health commodity security by supplying contraceptives and by strengthening relevant components of health systems in Stream 1 countries. This included the strengthening of the human resource capacity for RHCS management and logistics through training and by providing tools for managing commodity security system and to ensure continuous supply. UNFPA's contribution has served as a catalyst, leading countries to ensure that their commodity supplies meet the needs of their populations. Advocacy for political commitment to sustained funding for reproductive health commodities as well as introducing reproductive health commodities security in national plans and budgets was boosted through GPRHCS.
Findings from case study in <b>Burkina Faso</b>	<p><i>L'UNFPA a doté les zones d'intervention d'une gamme complète de contraceptifs et a soutenu des formations en gestion logistique. L'introduction du GPRHCS en 2007 a permis de mettre l'accent sur la sécurisation des produits de la SR à différents niveaux ce qui a conduit à une amélioration de la disponibilité des contraceptifs dans les structures sanitaires et un budget national croissant pour l'achat de contraceptifs. La question de l'harmonisation des outils de gestion logistique au niveau national, cependant, reste à résoudre.</i></p> <p>Dès 2001 la dotation en contraceptifs de l'UNFPA concernait les 12 districts sanitaires de la zone d'intervention qui disposaient de la gamme complète de produits contraceptifs aux différents niveaux du système de santé. L'appui au niveau national variait en fonctions des besoins. Les formations en SIGL (cf. la Question d'évaluation n°4) ont contribué à l'amélioration du système logistique.</p> <p>Le GPRHCS a permis l'introduction du logiciel 'Channel' dans 63 districts sanitaires. Ce logiciel est apprécié au niveau régional et des districts<sup>701</sup> et contribue à une gestion logistique améliorée (90.8 % des formations sanitaires disposant de contraceptifs en stock en 2010<sup>702</sup>). Toutefois il y a un manque d'harmonisation de la gestion logistique due l'existence de plusieurs logiciels au niveau central<sup>703</sup>. L'enquête de la disponibilité des produits de la SR 2010 indique que 69.9 % des formations sanitaires offrent au moins trois méthodes de contraception moderne<sup>704</sup>. La mise à disposition d'un Administrateur National de Programme PF/SPSR au sein de la DSME par l'UNFPA contribue à un renforcement des capacités et à une gestion améliorée de la sécurisation des produits de la SR. L'UNFPA a appuyé la mise en place de 4 principaux mécanismes: le PSSPSR, le comité de pilotage de la mise en œuvre du PSSPSR qui se réunit 2 fois par an, l'utilisation d'outils standards pour superviser les activités de terrain et l'analyse annuelle de la situation des produits de SR. Cet appui a permis la mobilisation de fonds pour l'achat de contraceptifs auprès des partenaires et de l'état. Le PADS finance également l'achat des contraceptifs et une ligne budgétaire existe dans le budget de l'État pour l'achat des contraceptifs. La proportion du financement du budget national pour l'acquisition des produits contraceptifs a évolué de manière croissante, passant de 24% en 2006 à 40% en 2008<sup>705</sup>. L'engagement du gouvernement à soutenir la sécurité des produits SR est motivé par l'engagement des partenaires qui ont promis leur soutien.</p>
Findings from case	<i>UNFPA is a member of the Contraceptive Working Group and is currently involved in projections, meeting temporary contraceptive shortfalls and working to convince the Government to play a larger role in improving access to contraceptives and in improving</i>

<sup>701</sup> Entretiens avec les beneficiaries.

<sup>702</sup> Mid-Term Review of the UNFPA Global Programme to Enhance Reproductive Health Commodity Security(GPRHCS) - Burkina Faso Case Study.

<sup>703</sup> Enquête sur la disponibilité des contraceptifs modernes et des produits vitaux de santé maternelle/de la reproduction dans les formations sanitaires – GPRHCS - Burkina Faso – 2010.

<sup>704</sup> Idem.

<sup>705</sup> Evaluation de la Composante santé de la Reproduction - (Burkina Faso – UNFPA; Programme de coopération 2006 – 2010).

study in <b>Cambodia</b>	<p><i>management of the national procurement, logistics and distribution system.</i></p> <p>UNFPA Cambodia's operations on commodities and contraceptives began in 1994 with essential medicine and in 1995 with the introduction of Birth Spacing Programme. In 2001, the MoH created the Contraceptive Security Working Group (CSWG) with the support and involvement of multilateral, bilateral and private stakeholders. KfW funding began in 2003, with co-financing by UNFPA<sup>706</sup>. The Global Fund for Reproductive Health Commodity Security (GPRHCS) covered some of the contraceptive shortfalls in the public health sector in 2009. In the beginning, contraceptive security was largely the responsibility of UNFPA, and other donors, such as KfW, were complimentary. This was true until the end of 2004, when KfW took over the support for the Logistic Management and Information System (LMIS), whose purpose is to collect information from national and down to district level. While one system is functioning at the district and provincial levels, there are still two systems operating at the national level (i.e. Central Medical Stores and Department of Drugs and Food, MoH). The Government of Cambodia provides all the micronutrients and essential drugs needed for MCH but not for family planning<sup>707</sup>.</p> <p>The technical support UNFPA provides is generally of good quality and their procurement system is considered effective<sup>708</sup>.</p> <p>KfW will phase out its support in 2012. AusAid agreed to take over KfW role, under the condition that the Government would cover contraceptives from 2015 onwards and that it developed a phase-in plan. However, at the time of the evaluation, the agreement with AusAid had not been signed. There are still outstanding issues on how to maintain and manage the computerized logistics system and there is no exit strategy or Government phase-in plan leading to 2015.<sup>709</sup></p>
Findings from case study in <b>DR Congo</b>	See Judgment criterion 6.2
Findings from case study in <b>Ethiopia</b>	<p><i>Family Planning is high on the agenda of the GoE and the strong support of UNFPA in this field is well recognized by its governmental and development partners. It supports the FMoH to set up an effective system for delivery of family planning and supports recently more the long acting methods.</i></p> <p>Since 2000, the UNFPA supports the Federal Ministry of Health through financial and technical support in the procurement and distribution of various family planning commodities with the aim to ensure availability of a mix of contraceptive methods, including long term and permanent contraceptive methods such as the Intra Uterine Contraceptive Devices (IUCD), Implants, tubal ligation, vasectomy and emergency contraceptives. Since 2007, the Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS) is in place. It launched a woreda<sup>710</sup> mapping exercise of partners' working in areas of Reproductive Health and Family Planning with the objective of (1) reducing overlaps and ensure equitable access to family planning services with special emphasis on the underserved and those in the remotest areas; [2] speeding up implementation of the expansion and delivery of health services; and [3] maximizing the effective use of limited resources to ensure equitable access to family planning services especially taking in to account the underserved</p>

<sup>706</sup>“They (UNFPA) are the ones who always help us” (External Development Partner).

<sup>707</sup>“There is great reluctance from Government side and currently the LMIS receives technical support from an NGO and not UNFPA.” (External Development Partner).

<sup>708</sup>“We feel we can work through their system” (External Development Partner).

<sup>709</sup> External Development Partner.

<sup>710</sup> Each of the 11 geographic regions in Ethiopia is divided into zones and each zone into lower administrative units called woredas. Each woreda is further subdivided into the lowest administrative unit, called a kebele.

	and remotest areas. A parastatal organization is in place (Pharmaceutical Fund Supply Agency (PFSA)) which is responsible for all reproductive health commodities and which has been supported with capacity development and equipment provision (logistics, computers, software, etc) by UNFPA. Stock-outs have not been reported by the government partners, only the occasional lack of several methods <sup>711</sup> .
Findings from case study in <b>Ghana</b>	<p><i>In spite of UNFPA's best efforts, the focus on distribution of contraceptives remains an imperative, and unmet demand for contraceptives is 34% - with 22% for spacing and 12 % for limiting<sup>712</sup>. The national family planning programme in Ghana is only able to meet 43% of the national demand (GDHS 2008). UNFPA's role in improving the method mix and support in introducing long term methods was commended.</i></p> <p>Ghana is a Stream 2 country with a significant GPRHCS role in the past. However, funding for family planning in Ghana faces structural problems that are beyond the control of UNFPA<sup>713</sup>. UNFPA remains the sole UN agency that only supports the provision of family planning services by GHS such as training of service providers in long term temporary methods such as IUD and jadelle insertion. USAID also supports CSOs and social marketing. UNFPA would prefer that the Government take up the responsibility of the provision of contraceptive security in the country but this has met little success<sup>714</sup>.</p> <p>Since 2011, MoH has a new Reproductive Health Commodities Security Strategy (updating the one from 2004) and it works through the Interagency Coordinating Committee (ICC) of which UNFPA is an active member<sup>715</sup>. The Committee has expanded beyond contraceptives to include all health commodities. So far during emergency shortages, development partners sometimes help to fill the gaps together with GPRHCS. The Government has put in a contraceptive proposal to West African Health Organization (WAHO) and received a funding promise. MoH has recently initiated a formal invoice with UNFPA to purchase contraceptives on its behalf<sup>716</sup>.</p> <p>UNFPA, DFID and USAID together provide about \$4million for contraceptive security, leaving a national funding gap of about \$8.5million per annum. Over the last couple of years Government's pledge to provide about \$1million per annum to partially fill this gap has not been fulfilled. After the maiden launch of family planning Week in September 2011, the Minister pledged around \$3million to support contraceptive procurement. UNFPA and partners are following up on this pledge to ensure that it is implemented<sup>717</sup>.</p> <p>Government, CSOs and private companies have continued the drive to distribute contraceptives and education throughout the country. The private sector now sells 54% of contraceptives in Ghana, with CSOs and Government largely focused on education about the plethora of birth control and STI prevention options<sup>718</sup>.</p>
Findings from case study in <b>Kenya</b>	<i>Since family planning is high on the agenda of the GoK it therefore has meanwhile a dedicated budget line for contraceptives, which may be attributed also to the advocacy work of UNFPA. Access to contraceptives is facilitated by UNFPA through continuous technical and financial support to commodity security (i.e. forecasting) and dissemination whilst direct contraceptive support will only be launched in an</i>

<sup>711</sup> Information from government partners.

<sup>712</sup> Maternal Health Survey, MoH, Ghana 2007.

<sup>713</sup> Interview with External Development Partner.

<sup>714</sup> Interview with UNFPA.

<sup>715</sup> Interview with Government.

<sup>716</sup> Interview with External Development Partner.

<sup>717</sup> Interview with UNFPA.

<sup>718</sup> Ghana Trend Analysis of family planning based on DHS 1998, 2003, 2008, USAID.

	<p><i>emergency (as Stream 3 country).</i></p> <p>Apart from direct purchase of female and male condoms, the KCO has supported commodity security through various interventions, i.e. by introducing forecasting, the Logistics Management Information System (LMIS), technical support to the Technical Working Group on condoms, procurement of trucks and dispensers, etc., and it has monitored those programmes through its Implementing Partners and their regular monitoring activities. The Annual Report 2010 of the KCO has reported a national funding gap for family planning as ranging between 30% and 40% and low absorption capacity of donor funding by the Government was considered the main challenge. Therefore, since 2011, the Government commitment to family planning is ensured by the Ministry of Planning and the commodity security by the Kenyan Medical Supplies Agency KEMSA instead of the Ministry of Public Health as previously. This is supposed to improve the absorption capacity and to enhance the Government commitment to commodity distribution as the Ministry of Planning is better positioned to lobby for health with the Government. With the increased commitment to family planning of the GoK, UNFPA has consequently reduced funding for contraceptives since 2008 and foresees none for 2012<sup>719</sup>, whilst at the same time leveraging for funds to fill the 20% funding gap<sup>720</sup>.</p>
<p>Findings from case study in <b>Lao PDR</b></p>	<p><i>UNFPA has provided contraceptives to Lao PDR for the past 10 years. With the introduction of the GPRHCS in 2008 (Lao PDR is a Stream 1 country) additional support was provided for commodity security in terms of assessments, the development of an integrated health logistics system and advocacy. The Government started investing in contraceptives but the share of the investment has not been very significant so far.</i></p> <p>The provision for reproductive health commodities supported by UNFPA at a national scale allows health care providers to provide contraceptives throughout the whole country. This contributed to the provision of family planning service in 94% of the service delivery points<sup>721</sup>.</p> <p>Family planning logistics used to be managed through the National MCH Centre which faced difficulties in ensuring a regular supply and availability of contraceptives in health facilities. The recent partnership with the Medical Product Supply Centre (MPSC) supported by GPRHCS is allowing more focused capacity and systems strengthening and increased coordination with the other development partners in setting-up a Unified Commodities System<sup>722</sup>. Although there are still reported stock outs in some health facilities in the periphery, the new system seems to be promising.</p> <p>Annual stock availability surveys are funded under GPRHCS with high input and provide useful information on reproductive health commodity availability. On the other hand, the government monitoring routine system does not allow following upon the availability of family planning services in all delivery points<sup>723</sup>.</p> <p>Unfortunately, UNFPA advocacy efforts for increased government commitment to invest in family planning commodities are still insufficient and the national budget share for contraceptives is very small. UNFPA is taking part in ongoing discussions for the creation of</p>

<sup>719</sup> Information from KCO.

<sup>720</sup> COAR 2009, 'UNFPA has been able to leverage funds for condom procurement from the World Bank amounting to USD 12 million over the next three years. 30% of the funds will be used to procure female condoms.

<sup>721</sup> 2011 Stock Availability Survey of MNCH Programme Commodities.

<sup>722</sup> Government and development partners interviews.

<sup>723</sup> Mid term Review of the UNFPA Global Programme to Enhance Reproductive Health Commodity Security.

	a national budget line for contraceptive <sup>724</sup> .
Findings from case study in <b>Madagascar</b>	<p><i>UNFPA is currently in a unique and influential position, being the only donor of family planning methods to the public sector. It could take advantage of this window of opportunity to develop more appropriate and sustainable solutions, promoting stronger support to identified vulnerable groups.</i></p> <p>The GPRHCS was launched in Madagascar in 2008, with the decision to include Madagascar as a stream 1 country. The programme contributed to the elaboration of the National Plan for Reproductive Health Commodities Security (2008 – 2012) and led to the signature, in May 2008, of an Agreement between the GoM and UNFPA for the implementation, for a 5-year period of time, of the GPRHCS. It supports the MoH through technical support and procurement of various family planning commodities, distributing to regions with the view of ensuring the availability of varied contraceptives including long term and permanent contraceptive methods such as the IUCD, Implants, tubal ligation, vasectomy and emergency contraceptives. CHANNEL is considered to be an important monitoring tool, although in practice it is more an inventory control system. Sustainability of the strategy is likely, due to the high level commitment of the GoM for the MDG 4 and 5, but sustainability of the provision is questionable, as it is entirely dependent on external funds.<sup>725</sup></p>
Findings from case study in <b>Sudan</b>	<p><i>UNFPA's support has helped to make available a minimum supply of commodities to the Sudanese population. The total demand for contraceptives, however, has far exceeded the amount UNFPA has been able to supply. The distribution of contraceptives procured by UNFPA has been based on a provisional system that UNFPA has had to maintain to make up for the persisting weakness of Sudan's national commodity security system.</i></p> <p>UNFPA is faced in Sudan with a fragmented, non-functional commodity procurement and supply system that has not allowed UNFPA to systematically build capacity in the Government for commodity management. Although the Ministry of Health has in principle been willing to work towards improving this situation, the weaknesses of the overall system have been so great that the concept of “sustaining actual achievements” is not directly applicable to Sudan; UNFPA support has had to rely on mechanisms and infrastructure that were owned and provided by UNFPA itself.</p> <p>UNFPA is the only major donor that has offered support to increase the access to reproductive health commodities in Sudan<sup>726</sup>. At the same time, the support that UNFPA has been able to offer has been insufficient to meet the much greater needs. Due to the weakness of the Government-owned commodity supply and procurement system, UNFPA has had to rely largely on mechanisms and infrastructure that it has created. Possibilities to utilize Government-owned systems and to systematically build them up have been limited to a few initiatives at the state level<sup>727</sup>.</p>

<sup>724</sup> Idem.

<sup>725</sup> UNFPA provides family planning in 2011 worth 3 Mio USD, directly imported from HQ (Interview UNFPA).

<sup>726</sup> UNFPA has been providing family planning commodities for its 5 focal States. However, the Government has been distributing these commodities among all of the 15 States, since no other donor is providing this kind of support.

<sup>727</sup> Document review and interview UNFPA and SMoH.

## 8.2.7 Evaluation question 7: To what extent has UNFPA contributed to the scaling up and utilization of skilled attendance during pregnancy and childbirth and EmONC services in programme countries?

### Judgment criterion 7.1: Increased access to EmONC services

Findings from desk study	<p>The UNFPA strategies for Outcome 2 of the Reproductive Rights and Sexual and Reproductive Health in the UNFPA Strategic Plan 2008-2011 are based on policy dialogue, building strategic and multi- sectoral partnerships, empowering communities and strengthening countries to develop and implement national plans for improving maternal health.</p> <p>Political commitment and the ability of programme countries varies to sustain UNFPA supported EmONC services. In Ivory Coast, for example, political leadership on this issue has been lagging. Kenya and Cambodia, on the other hand, are two examples of countries that were able to develop supportive EmONC policies. However, in both cases, supportive policies at national level did not necessarily translate into improved service provision at facility level<sup>728</sup>; nor was there a correlation between the intensified training staff in EmONC-related skills and availability of those trained services at the facility level.</p>
Findings from case study in Burkina Faso	<p><i>Le plaidoyer effectué par l'UNFPA et les Partenaires Techniques et Financiers a positionné les SONU comme une intervention prioritaire. Des progrès notables ont été enregistrés quant aux taux d'accouchements assistés en particulier dus à la subvention des services SONU. Dans sa zone d'intervention l'UNFPA a appuyé le renforcement des services (planification, formation des prestataires, équipement et engagement communautaire) et une progression importante des accouchements assistés a également été notée. Cependant l'évaluation en besoin SONU exécutée récemment a identifié une large insuffisance au niveau de la disponibilité des services SONU de base dans tout le pays.</i></p> <p>L'UNFPA a contribué a l'élaboration de la feuille de route pour l'accélération de la réduction de la mortalité maternelle qui donne une priorité de premier plan a la mise en place des SONU a l'échelle nationale. Les SONU ont aussi été identifiés comme une des interventions à gain rapide et sont à ce titre considérés comme une priorité. Le plaidoyer de haut niveau avec le gouvernement et les parlementaires ainsi qu'auprès de la Première Dame entrepris par l'UNFPA avec les organismes du système des NU a abouti à la création et l'alimentation régulière et croissante d'une ligne budgétaire pour subventionner les SONU. Grace à la subvention mise en place en 2007 seulement 20% du coût est à la charge des familles ce qui a permis une augmentation du nombre des accouchements assistés. L'UNFPA a joué un rôle important dans la diffusion de la loi de subvention SONU dans les zones d'interventions. L'EDS 2010 indique que 67% des femmes ont bénéficié de l'assistance d'un prestataire qualifié lors de leur accouchement alors qu'en 2003 le taux de naissance ayant eu lieu avec une personne médicalement formée<sup>729</sup> était de 57%<sup>730</sup>. Cependant selon les indicateurs du Plan National de Développement Sanitaire (PNDS) 2006 – 2010 le taux d'accouchements assistés en 2005 était de 38%<sup>731</sup>. Ces progrès sont</p>

<sup>728</sup> For example in Kenya, a survey demonstrated that despite the fact that basic reproductive health services are integrated in districts, the proportion of actual facilities providing at least four services varied from place to place (UNFPA Kenya, 2008).

<sup>729</sup> Il n'est pas clair si la définition de prestataire qualifié est la même entre 2003 et 2010.

<sup>730</sup> Enquête démographique et de Santé 2003.

<sup>731</sup> Plan National de Développement Sanitaire (2006 – 2010) – Ministère de la Santé - Burkina Faso.

	<p>imputés à la subvention du coût des prestations SONU. Toutefois il est reconnu que cette mesure doit être accompagnée par l'amélioration de la qualité des services<sup>732</sup>.</p> <p>Divers mécanismes ont été établis par l'UNFPA (que ce soit dans le cadre du panier commun ou dans le cadres des financements à travers la DSME) afin d'assurer des services de SONU dans la zone d'intervention tels que l'appui à la planification au niveau des les districts sanitaires (DS) et de la Région qui intègre les formations en SONU et l'équipement en matériel (et parfois ambulances) ainsi que l'élargissement de la gamme des produits SR aux médicaments nécessaires lors des SONU dans le système de sécurisation des produits de la SR. Les districts et structures visités au cours de l'évaluation n'ont pas rapporté de rupture de stock d'ocytocine. Sur le plan national seulement 51% des formations sanitaires offrent les médicaments vitaux en SM<sup>733</sup>. Des mécanismes communautaires ont été mis en place tels que des cellules villageoises de gestion des urgences obstétricales qui s'organisent pour aider les familles à préparer l'accouchement y compris l'identification et la mobilisation d'un moyen de transport en cas d'urgence. Grâce a ces interventions la proportion des accouchements assistés par du personnel de santé formé s'est accrue<sup>734</sup>.</p> <p>L'évaluation des besoins en SONU réalisée avec le support du MHTF en 2010 (cf. section MHTF) a cependant démontré au niveau national une répartition géographique des services SONU insuffisante, une faible disponibilité des services de SONU de base principalement à cause du manque de formation des prestataires et d'équipements pour offrir toutes les fonctions SONU, en particulier l'utilisation de forceps et ventouse et la réanimation du nouveau né<sup>735</sup>. Les données recueillies pourront permettre de faire une analyse plus précise des résultats dans les zones d'intervention de l'UNFPA mais n'étaient pas disponibles au moment de l'évaluation.</p>
Findings from case study in <b>Cambodia</b>	<p><i>UNFPA has contributed to increased access to EmONC services in Cambodia through a number of independent initiatives, including the training of service providers in Basic and Comprehensive Emergency Obstetric and Newborn Care (B-EmONC and C-EmONC), improving the infrastructure and strengthening the EmONC referral system through the National EmONC Improvement Plan and the introduction of maternal death surveillance.</i></p> <p>A national assessment for EmONC (NA-EmONC) was discussed by UNFPA in 2003-4, but attempts to introduce it were initially weak as MoH was not ready. The UNFPA-supported Midwifery Review (2006) highlighted the low capacity of the MoH health force and the poor state of emergency care in health centers and district hospitals<sup>736</sup>. The planning and budgeting for NA-EmONC occurred in the latter half of CP III (late 2008 and early 2009) with the arrival of MHTF. The German Fund to UNFPA replaced MHTF for the National Assessment, but MHTF provided the EmONC staff, technical support from regional office and the assessment tool. The NA-EmONC was completed in mid-2009, faster than in most countries, because MoH cooperated with the National Institute for Public Health<sup>737</sup>.</p> <p>In the latter half of 2009 and early 2010, MoH, with the support of UNFPA, engaged in activities related to the development of EmONC (2010-2015). Initially, technical support was being provided through the MHTF, but AusAid Funds ended up replacing MHTF again. In</p>

<sup>732</sup> Entretien avec les partenaires techniques et financiers.

<sup>733</sup> Enquête sur la disponibilité des contraceptifs modernes et des produits vitaux de santé maternelle/de la reproduction dans les formations sanitaires – GPRHCS - Burkina Faso – 2010.

<sup>734</sup> L'Evaluation de la Composante Sante de la Reproduction (Programme de coopération Burkina Faso – UNFPA 2006 – 2010) indique une réelle progression dans la Région de l'Est de 45,41% en 2005 à 62,84% en 2010, la Région Centre Est de 43,69% en 2005 à 72,49% en 2010 et la Région du Sahel de 15,06% en 2005 à 25,75% en 2010.

<sup>735</sup> Evaluation des Besoins en Soins Obstétricaux et Néonataux d'Urgence, coulée à la cartographie de l'offre de soins en santé de la reproduction au Burkina Faso – Rapport de Synthèse – 2011.

<sup>736</sup> UNFPA Cambodia.

<sup>737</sup> Government Partner.

	<p>2010, the \$19 million EmONC Improvement Plan was adopted by the Fast Track Initiative for Reducing Maternal and Newborn Mortality. MHTF funded UNFPA technical support related to the development and implementation of the plan<sup>738</sup>. The National MNCH Centre, which is supported by UNFPA, is overseeing and implementing the EmONC Improvement Plan throughout the country. The Improvement Plan includes upgrading facilities in terms of renovation, supplies, data management, training, and research. Within HSSP II and the JPIG donors, the EmONC Improvement Plan is taking priority<sup>739</sup>.</p> <p>In late 2009, the UNFPA country office recruited an EmONC Officer with the support of MHTF. His role is to interact technically with Government (national and sub-national) and mobilize community stakeholders in support of the Improvement Plan, provide trainings and help remove operational barriers in the implementation process.</p>
Findings from case study in <b>DR Congo</b>	<p>Dans ses démarches destinées à soutenir le Ministère de la Santé Publique, l'UNFPA a mis l'accent sur les services des SONU comme une dimension essentielle des services de santé maternelle. Toutefois, dans l'absence de données fiables, il est difficile de tirer des conclusions sur la distribution équitable (ou non) de ces structures dans le pays. Plus spécifiquement, l'UNFPA a soutenu – dans le contexte du H4+ - une enquête concernant les services SONU dans les trois zones d'intervention. En outre, ils ont mis sur pied un certain nombre de formations pour le personnel des SONU, destinées à prendre en compte le déficit important en matière de capacités. Dans un souci de rendre ces structures plus fonctionnelles et plus attractives pour le personnel, un accord a été conclu en Bas Congo et en Katanga sous lequel la province a accepté la responsabilité de la construction et de la réhabilitation des maternités tandis que l'UNFPA s'est engagé à fournir les équipements. Malheureusement, de manière générale, il n'y a que très peu d'indication de la mise en place de systèmes de référencement. Un autre problème concerne l'insuffisance des ressources pour le monitoring et le suivi du personnel.</p> <p>Pour encourager le recours par les femmes en âge de procréation aux services de santé, l'UNFPA a soutenu la formation de travailleurs communautaires bénévoles qui transmettent des messages de santé reproductive dans leur entourage. L'UNFPA a soutenu également la production d'outils de communication dont l'objectif est de promouvoir la planification familiale et l'accouchement assisté au sein de la communauté. L'UNFPA s'est engagée dans une démarche visant à établir une plateforme médiatique pour les journalistes régionaux y compris des liens avec les écoles de journalisme. Par ailleurs, un accord a été négocié avec l'ONG internationale « Search for Common Ground » pour la dissémination de spots pédagogiques sur les 88 radios communautaires du pays (Judgment criteria 7.1, 7.2).</p>
Findings from case study in <b>Ethiopia</b>	<p><i>Increased access to quality EmONC care is being supported through training, provision of equipment to targeted health centers and through support to the referral system with ambulances. The introduction of Integrated Emergency Obstetric Surgeons (IEOS) for comprehensive EmONC and Midwifery upgrading for basic EmONC is ongoing</i><sup>740</sup>.</p> <p>Emergency Obstetric and Neonatal Care support through UNFPA has shifted since the 5<sup>th</sup> CP from mainly in-service training to predominantly pre-service training. The constant loss of trained staff (through attrition) and the costs were considered too high considering the little impact of the previous approach. A Joint In-Country UN (WHO, UNFPA and UNICEF) Concept Paper on the Reduction of Maternal and Newborn Mortality in Ethiopia<sup>741</sup> demonstrates the need for a concerted effort to increase access to skilled</p>

<sup>738</sup> UNFPA Cambodia.

<sup>739</sup> "UNFPA has helped fund the EmONC assessment and the quality is good so we are using them. This applies to B-EmONC only. We came to know about it because of UNFPA involvement in the Technical Working Group on Health" and "with MoH and HSSP II support now sustainability of the Plan is assured" (External Development Partner).

<sup>740</sup> As most of the implementation of these initiatives is funded by the MHTF, more information will be provided in the final report for the mid-term evaluation of MHTF.

<sup>741</sup> Mid-Term Review (MTR) of the GoE/UNFPA 6th Country Programme (CP) components, 2009.



	<p>birth attendants, emergency obstetric care and family planning. UNFPA therefore (with MHTF and SIDA funds) supported the pre-service master's degree course for a new cadre – integrated emergency obstetrics and surgery- , the nurse anesthetist training and midwifery training courses, based on the national EmONC assessment<sup>742</sup>.</p> <p>The FMoH is fully committed to EmONC, it finances the three year emergency surgical officer training programme to scale up national HRH for surgical and obstetric emergencies and an accelerated MW training, as well as plans to provide health facilities with relevant equipment. Currently UNFPA is supporting facility based training in 10 facilities and 5 facilities for the master degree course.</p> <p>UNFPA has not been involved in decisions on the deployment of staff or positioning/repair of facilities. UNFPA thus only responds to GoE requests, which allocates according to a geographical formula, which is not needs based, nevertheless underserved facilities are ubiquitous and the FMoH is geared towards remote facilities.</p>
Findings from case study in <b>Ghana</b>	<p><i>UNFPA has collaborated with UNICEF on EmONC related advocacy for several years. Since 2007, the two agencies have successfully accelerated collaboration to promote EmONC needs assessment in all ten regions and get EmONC services included in the MAF (Road Map)</i><sup>743</sup>.</p> <p>UNFPA identified the need to support MoH wish for a comprehensive national picture of EmONC services and needs. Together Ghana Health Service (GHS) and UNFPA looked first at surveying Upper East Region only. UNFPA provided initial funding for this regional survey in 2007. The UN Secretary General's Action Plan for Women and Children's Health (2010) specifically notes EmONC assessments and equitable distribution of EmONC facilities. Following up UNICEF and UNFPA worked together on this and presented to GHS. With this joint advocacy, GHS made the decision to expand the assessment and instead conduct a nationwide survey in 2010. UNFPA then brought in AMDD (Avert Maternal Death and Disability, Colombia University) with the support of MHTF to provide technical support on EmONC needs assessment and capacity development of National Institute of Public Health and Ghana Statistical Service (GSS) for conducting, using and monitoring EmONC services. MHTF provided \$200,000, which enabled strategic leverage from the World Bank and UNICEF. UNFPA and UNICEF contributed equal funding for the national survey, and UNICEF additionally contributed computers for data analysis. The national needs assessment has included a GIS System that will allow MoH to know where facilities providing EmONC services are located and allow UNFPA to provide strategic support to facilities where the support can have maximum impact<sup>744</sup>.</p> <p>UNICEF and UNFPA are in the Steering and Technical Committee for EmONC and the MAF writing team included UNICEF, UNFPA, WHO and UNDP (MNCH) to discuss the EmONC indicators. There was a specific meeting on PMCT and EmONC needs assessment between the WHO, UNICEF and UNFPA and UNAIDS when Ghana was unsuccessful with Global Fund Round 10745.</p>
Findings from case study in <b>Kenya</b>	<p><i>The KCO has provided technical and financial assistance to the MoH and to its focus regions to enhance the quality of EmONC services. The assumption is that improved services attract more clients to deliver in health facilities, which is the aim of the MoH. In 2007 the community midwife programme was set in motion and whilst increased numbers of patients at UNFPA supported facilities have been reported, deliveries had not taken place as the refurbishment is not yet completed.</i></p>

<sup>742</sup> National Baseline Assessment for EMoNC , Ethiopia, Final report 2010.

<sup>743</sup> Interview with External Development Partner.

<sup>744</sup> Interview with UNFPA.

<sup>745</sup> Interview with External Development Partner.

	<p>UNFPA has supported since 2001 the development of reproductive health strategy documents and health facilities with training and equipment in initially nine districts (5<sup>th</sup> and 6<sup>th</sup> CP) and now four project sites. The Government is strongly enforcing skilled birth attendance, preferably at health facilities and this is supported by community leaders. Therefore, the Department for Reproductive Health (DRH) in the Ministry of Health, in collaboration with UNFPA, has initiated in 2007 a Community Midwifery programme aiming at empowering midwives who are either retired or out of employment and already living in the communities to assist women during pregnancy, delivery and the postpartum period. The community midwives are considered to have a good understanding of the cultural beliefs and practices that limit utilization of health facilities for deliveries and to be able to provide domiciliary obstetric care without compromising their professionalism<sup>746</sup>. Following the distribution of best practices to key stakeholders, the KCO started community midwife programmes in its four focus regions. After the first 18 months, the programme had trained already about 70 midwives and it is expected that this will increase skilled attendance at delivery within the community. The midwives are supported with continuing medical education and some referral backup (ambulance and mobile telephone sets); they do not receive delivery kits, as they are supposed to guide patients to clinics. As the new centers of excellence are still in the phase of renovation and refurbishment, the uptake cannot yet be fully assessed.</p> <p>The safe motherhood initiatives have been strengthened to address the preventive components of the Obstetric Fistula Management (estimated at 3,000 new cases of Obstetric Fistula annually). Service providers are trained and equipped to repair, sensitize and mobilize the communities to access Obstetric Fistula services (repair and re-integration) in order to address the current backlog of Obstetric Fistula clients estimated by the Ministry of Health to be about 300,000.</p> <p>UNFPA and UNICEF also conducted a joint programme on improving access to Maternal Health services and decongesting provincial maternity hospitals and national referral hospitals in Nairobi whereby UNICEF supported staff training and provided equipment for newborn care while UNFPA equipped health facilities, strengthened referral systems by providing ambulances and communication facilities, and renovated buildings.</p>
<p>Findings from case study in <b>Lao PDR</b></p>	<p><i>Both the SBA assessment and the EmONC assessment undertaken under UNFPA leadership provide a strong evidence base for improving MNCH services including EmONC services. The SBA plan is the document of reference for maternal health human resources strengthening. Support to training institutions, to community midwives training courses and to the 3 core modules, as well as the development of standards and regulations have certainly contributed to the improvement of the quality and the availability of MNCH services. But there had been many gaps in MNCH services in Lao PDR and it will take time to see tangible results.</i></p> <p>The National SBA plan developed with UNFPA support integrates all the elements of EmONC and has been endorsed by the Government. It was costed and the main development partners have committed themselves to support it. The government has a strong ownership of the SBA plan and is committed to achieve its objectives. It has not allocated any budget for the different interventions but it made a commitment to recruit the newly trained midwives and to post the community midwives in remote health centers. However, at times, the selection of trainees and their posting following of the one year course is not always done according to guidelines. For example, newly trained community midwives are posted in administrative positions<sup>747</sup>.</p> <p>Accessibility to referral centers is one of the impediments to having births attended by a skilled birth attendant. The SBA plan seeks to improve the referral system. Mechanisms set up by the government such as Social Equity Funds have been implemented in some areas</p>

<sup>746</sup> This model has already been tried out in a Safe Motherhood Demonstration Project in Western Kenya on DFID initiative earlier in the decade and found to be promising.

<sup>747</sup> UNFPA staff interview.

	<p>and include transportation costs. UNFPA is piloting approaches aimed at involving communities to establish their own transportation mechanisms through the Community Empowerment Project and the Working with Individuals, Families and Communities (IFC) approach (see above in evaluation question 3).</p> <p>The SBA plan and later the EmONC improvement plan allow clarifying the role of each facility at all levels and take into consideration an adequate maternal health services coverage based on international standard. The implementation of both plans will help an equitable distribution of EmONC facilities across the country based on population data.</p>
<p>Findings from case study in <b>Sudan</b></p>	<p><i>UNFPA has helped to put in place a number of important prerequisites for expanding the access to EmONC services for Sudanese women; e.g. by anchoring EmONC in many of the key high level policy documents, by providing evidence on the existing gaps Sudan's EmONC coverage, and by organizing and financing individual EmONC training workshops for doctors, nurses, midwives and traditional birth attendants on EmONC and referral related skills. However, large distances, bad transport infrastructure and the overall weak health system seriously curtail the extent to which the individual UNFPA initiatives can create synergies and produce lasting improvements in the access to EmONC services.</i></p> <p>UNFPA has used in particular the production of research and data that describe the extent of the shortfall in the access to EmONC services in Sudan to lobby for increased support to EmONC. Examples are a national EmONC assessment that was implemented and published in 2005, as well as a series of other studies including a situation analysis on the availability of SRH services that considered EmONC services.</p> <p>UNFPA has used data from the EmONC assessment, reproductive health situation analyses and other relevant studies to demonstrate the gaps in EmONC service provision and access to EmONC services in Sudan, both at national level, and more specifically in its five focal states and in Darfur. UNFPA staff in the five focal states used the data to inform the EmONC planning it conducted with its partner State-MoHs. According to UNFPA information, the EmONC survey in 2005 particularly helped to focus more of the Government's attention on the poor state of emergency services. But the later assessments also helped to influence strategy development (e.g. Road Map) and planning at state level. UNFPA has worked closely at least with some state-level MoHs on using evidence in the planning for the expansion of EmONC services<sup>748</sup>.</p> <p>UNFPA-supported generation of data on the EmONC situation in its focal states also has provided a basis for directing investments to improve the referral system. For example, the above-mentioned reproductive health situation analyses provided information on referral-relevant indicators<sup>749</sup>. The need to strengthen Sudan's weak referral system is also reflected in the relevant policy and strategy documents that UNFPA has helped to draft, i.e., in particular the MNH Road Map and also the reproductive health policy, in which the Sudanese Government commits itself to addressing, among other things, the second and third delays: delay in transporting women to an appropriate referral facility and delay in receiving 'optimal care promptly at the facility'<sup>750</sup>. However, the significance of these policy level commitments hinges on the degree of likelihood that these commitments will actually be implemented<sup>751</sup>.</p> <p>In addition, UNFPA has been addressing the issue of referral by supporting in-service trainings of midwives and traditional birth</p>

<sup>748</sup> Interviews in focal states, UNFPA, document review.

<sup>749</sup> Such as “% of ambulances in good condition”; “% of referral services with paved road” and other indicators that capture the range of EmONC services available at different types of health facilities in each state.

<sup>750</sup> Review of the reproductive health policy.

<sup>751</sup> See evaluation question 9, among other things. See Evaluation question 9, among other things.

	<p>attendants (TBAs). E.g., a hospital that had been supported by UNFPA for many years to help in training midwives, anesthetists and doctors on EmONC services, has been working with TBAs and midwives on increasing their skills and knowledge about when to initiate referrals. This is particularly important as late referrals seem to be one of the main causes of maternal deaths in Sudan.</p> <p>Overall, however, improvements in referral systems are hampered by very difficult context conditions: large distances, bad transport infrastructure (i.e., absence of paved roads, which makes use of motorized ambulances difficult, especially during rainy seasons) and the overall weak health system limit on the extent to which the individual UNFPA initiatives can create synergies and produce sustainable and systemic results<sup>752</sup>.</p>
<p>Findings from case study in <b>Zambia</b></p>	<p><i>UNFPA has contributed to an increased access to EmONC services in Zambia through a number of independent initiatives, including the training of service providers in Comprehensive Emergency Obstetric and Newborn Care (CEmONC), Basic Emergency Obstetric and Newborn Care (BEmONC) and Focused Antenatal Care (FANC), provision of radios and ambulances to strengthen the EmONC referral system, the introduction of maternal death reviews and the strengthening of adolescent-friendly health services</i><sup>753</sup>.</p> <p>The overall effort to increase access to EmONC service in Zambia originated from an <i>EmONC needs assessment</i> in 2005<sup>754</sup> that showed that EmONC and BEmONC services were “essentially non-existent” in Zambia<sup>755</sup>. The Ministry of Health responded by developing a national EmONC scale-up plan that foresaw that, every year, 18 health facilities should be equipped and staffed to deliver BEmONC services. UNFPA has been supporting the scale-up plan by financing the training of staff (midwives, nurses, clinical officers, medical doctors), by financing equipment (notably ambulances) to strengthen the referral system in the three provinces it is operating in, and by training SMAGs for community mobilization and support<sup>756</sup>. UNFPA’s role consisted primarily in responding to specific Ministry of Health requests for EmONC related funding without setting its own priorities for funding<sup>757</sup>. UNFPA therefore missed the opportunity to plan the strategic use of its limited support, e.g. to actively create synergies with other development partners.</p> <p>In addition to fulfilling specific EmONC funding requests (see above), UNFPA has formally been a participant and member of a number of policy-level forums on EmONC. UNFPA has participated in working groups and the sector advisory group during the development of the MoH National Health Strategic Plan (2006 – 2010) and the Ministry’s Annual Work Plans. UNFPA is also member of EmONC relevant Technical Working Groups that are chaired by the Ministry of Health to solicit and coordinate technical input from development partners. Finally, UNFPA has also supported high level policy initiatives such as CARMMA and the development and amendment of the Maternal and Newborn Health Road Map<sup>758</sup>, both of which pledge increased attention to EmONC in Zambia. However, sustained effects from UNFPA’s formal involvement in these forums and initiatives, e.g. with regard to ensuring an equitable distribution of EmONC</p>

<sup>752</sup> UNFPA interviews, interviews with IPs in focal states.

<sup>753</sup> training peer educators in psychological counselling, providing equipment for youth friendly corners located in health facilities

<sup>754</sup> Supported by UNICEF.

<sup>755</sup> Interview with GRZ.

<sup>756</sup> North-Western, Luapula, Western. Other donors, including USAID, DfID, are supporting the implementation of the EmONC scale-up plan in other districts.

<sup>757</sup> Feedback from GRZ and UNFPA interviews.

<sup>758</sup> Interview with UNFPA.

	facilities, have been constrained by the fact that the UNFPA country office has found it difficult to consistently be present and active in the relevant working groups <sup>759</sup> . As a result, CARMMA and the Maternal and Newborn Health Road Map could not yet realize their full potential for affecting commitment and attention to EmONC because of low levels of operational follow-up to their initial launches.
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### Judgment criterion 7.2: Increased utilization of EmONC services

Findings from <b>desk study</b>	<p>UNFPA supports the provision of quality EmONC (midwifery care) within a supportive environment, which includes not only skilled staff and adequately equipped facilities, but also sensitized and informed communities and policy makers who create the social and political safety nets. Linked activities focus on evidence based capacity development, knowledge transfer, and information exchange to enhance empowerment of communities, who in turn should demand quality EmONC and utilize facilities perceived as offering quality services. UNFPA has included supporting the emergency referral systems including elements of transport and communication in its SRH strategy, but the available documentation did not clearly indicate relevant activities.</p> <p>Well-equipped and staffed facilities can only contribute to an increased proportion of births in EmONC facilities, if barriers to access have been recognized and have been dealt with through relevant national policies and community interventions. UNFPA has conducted (at least one) evaluation specifically geared at 'poor people' (Bangladesh 2005). The report underlines UNFPAs aim to support innovative approaches to reach the hardcore poor and vulnerable with affordable quality services. Other interventions supported by UNFPA are cost sharing, offering free deliveries including Caesarean Sections and community sensibilization campaigns.</p>
Findings from case study in <b>Burkina Faso</b>	<p><i>L'UNFPA a joué un rôle essentiel en appuyant des analyses situationnelles et dans l'élaboration du plan de communication SR sur la base de ces analyses ce qui a permis de renforcer les capacités de la DHPES. Il a également soutenu la mise en œuvre du plan dans les zones d'intervention sans, toutefois, assurer un suivi systématique des résultats obtenus.</i></p> <p>L'Analyse Situationnelle des Services de Santé de la Reproduction au Burkina Faso en 2006 et l'Analyse des Perceptions de la santé de la Reproduction par les Populations au Burkina Faso en 2007, financés par l'UNFPA, permettent d'explicitier certaines barrières à l'accès des services de SONU. Le plan de communication en SR élaboré en collaboration avec la Direction de l'hygiène publique et de l'éducation sanitaire (DHPES), basé sur l'analyse de ces données, inclut les aspects de sensibilisation à la consultation prénatale (CPN) et à l'importance de l'accouchement assisté par du personnel qualifié<sup>760</sup>. Les supports multi média de communication développés en plusieurs langues nationales (avec le soutien de l'UNFPA) concernent également ces aspects<sup>761</sup>. L'UNFPA, dans les zones d'intervention, a financé des activités de mobilisation et de communication conduites par les organisations à base communautaire sous forme de causeries ciblant les couples, des causeries de masse, des théâtres forum ainsi que l'approche IFC (Travailler avec les Individus, Familles et Communautés) qui permet une planification participative des actions communautaires en faveur de la santé maternelle. Une des barrières identifiées concernait le coût des services, ce qui a influencé l'adoption de la subvention SONU (cf. ci-dessus). La pertinence des messages de sensibilisation ainsi que les résultats des activités de communication n'ont pas été mesurés.</p>

<sup>759</sup> With the exception of the technical working group on family planning, which is chaired by the UNFPA country office; i.e., by the UNFPA's SRH adviser. For details, see evaluation questions 9 on UNFPA's role in advocacy; and evaluation questions 6 on family planning.

<sup>760</sup> Plan Stratégique de Communication en Santé de la Reproduction (2007-2010) - Ministère de la Santé - Burkina Faso.

<sup>761</sup> Entretien avec les partenaires gouvernementaux.

Findings from case study in <b>Cambodia</b>	<p><i>Since May 2010, each province in Cambodia has an EmONC focal point (often in an MCH province) who is usually a member of the Women and Child Health Committee<sup>762</sup>. Once appointed, the focal person also becomes a member of the Health Centre Management Committee, and is linked to the district hospital referral system. As a result, the MoH Health Centre Utilization Plan now has strong reference to EmONC referrals and incentives to midwives for safe delivery. Much of this is attributed to UNFPA support. The Health Equity Fund provides transportation cost to pregnant women at the community level, and Government provides free service to pregnant women at the Health Centre. At the time of the evaluation, the EmONC Improvement Plan was not yet implemented in remote rural areas, which have no Health Centers.</i></p> <p>The NA-EmONC is MoH response to high maternal and neo-natal mortality, which is affecting one-third of people in Cambodia living below the poverty line (2009), many of whom in remote areas. This is the segment of the population, which utilizes health centers and district referral hospitals. For this reason, the NA-EmONC placed special emphasis on 230 health centers (one third of total), 77 public hospitals and 40 private hospitals in 24 provinces of Cambodia. UNFPA is key coordinator with Ministries of Health, Women, Youth and Sports and Interior, which means that it has access to community working groups at all levels of the system to increase utilization of EmONC services<sup>763</sup>. The chair of the Women and Child Health Committee (under the Ministry of Interior) is the designated EmONC focal point. She or He is a member of the Health Centre Management Committee (HCMC), led by the chair of the Commune Council, who in turn oversees the Health Equity Fund that is used to registered members of the community in case of emergency. The CBD agent and the chair of the Village Health Support Group are members of HCMC, which is funded by UNFPA through the HSSP pool or discrete funds, specifically for increasing health facility utilization and especially for safe pregnancy and delivery.</p> <p>An incentive scheme for Health Centre midwives was introduced in 2008 for safe delivery and referral. The rapid reduction in maternal mortality is greatly attributed to the success of this scheme. There is free service at Health Centers for all pregnant women. As part of the pilot in 2010, EmONC services were initially not rolled out in remote areas, but only introduced in Health Centers and District referral hospitals where there was a minimum infrastructure. <i>"The remote area EmONC roll out is in MoH planning for 2011, they are committed to scaling up and is taken up by the EmONC Improvement Plan already".<sup>764</sup></i> This particular aspect of the roll out, however, has not happened and there is a danger that the implementation of the Improvement Plan may be slowing down<sup>765</sup>.</p>
Findings from case study in <b>DR Congo</b>	See 7.2
Findings from case study in <b>Ethiopia</b>	<p><i>Utilization of health facilities depends on a variety and complex issues; therefore a careful evaluation of the impact of the new cadre in terms of increasing access and utilization of health facilities for deliveries seems important.<sup>766</sup></i></p> <p>Increased utilization by clients has been expected to follow the upgraded clinics, a national study (UNFPA is not partner to this) on barriers is under way. The impression is that development partners including UNFPA wait for the completion of facilities and the new</p>

<sup>762</sup> Government Partner.

<sup>763</sup> Government Partner.

<sup>764</sup> UNFPA Cambodia.

<sup>765</sup> NGO Partner.

<sup>766</sup> As most of the implementation of these initiatives is funded by the MHTF, more information will be provided in the final report of the mid-term evaluation of MHTF.

	<p>cadre and expect increase of utilization, because of availability. 'Barriers are distance, non-equipped facilities, and not-client oriented services'<sup>767</sup>. JHPIEGO is conducting (till mid-2012) a national study on barriers (financed by USAID and requested by the FMOH).</p> <p>Nevertheless, according to a recent survey (2008) the perception of the redundancy of formal health care during delivery is reinforced by the seeming irrelevance of services and advice. The decision over where to give birth is a balance between securing a safe delivery and retaining control and ownership of the process. The formal health sector is often seen to be insensitive to traditional elements of childbirth, and formal health procedures may be considered alienating and inappropriate. In contrast, TBAs and relatives are perceived to provide moral and practical support that is consistent with community beliefs and traditions, a perception that may partially explain the dramatically low utilization of facility-based delivery services. Women distinguish between the practical advice, interventions and material support offered by TBAs, and the theoretical advice given by formal health providers. Moreover, female access to health services is frequently determined by their husbands, which serves to inhibit the utilization of formal health resources. Community recognition and interpretations of complications often differ from bio-medical opinions, and the response to complications may be delayed or inappropriate<sup>768</sup>.</p> <p>Community mobilization of UNFPA is not directly geared towards increasing access but nevertheless, the Safe Motherhood Campaign in 2010 (FMOH, UNFPA and many partners) demonstrated increased uptake by 50% in JHPIEGO led clinics. Having the complexity of the barriers to facility utilization in mind, it seems therefore important to closely monitor the new cadre, its 'hard and soft skills', and its impact on the end-beneficiaries.</p>
<p>Findings from case study in <b>Ghana</b></p>	<p><i>Recommendations from the National EmONC Assessment report will guide UNFPA's next steps and support is anticipated to help GHS equip facilities and retrain providers as part of the Improvement Plan which still has to be formulated.</i><sup>769</sup> Planning was done with the support of MHTF in the later half of 2010, while the survey started in 2011. There have been serious delays in EmONC assessments due to census collection and data analysis in 2010-11. EmONC fact sheet have been provided with a full report anticipated in November 2011 for submission to the Health Summit.</p> <p>The timing of national census data collection overlapped with the EmONC needs assessment in 2010, resulting in a seven to eight month delay in conduct of the survey and the formal release of findings due to lack of time by Ghana Statistical Service for data analysis. A draft report was ready in the fall of 2011 but not disseminated at the time of this evaluation. Fact sheets with key findings had been shared with government stakeholders at the last bi-annual Health Summit in April 2011 and the report was to have been distributed in November 2011 (at the second bi-annual Health Summit). It is expected that the aide memoire will include a call for an EmONC Improvement Plan<sup>770</sup></p> <p>It was noted by almost all interviewees that socio-cultural change has not kept pace with economic progress in Ghana. This means that de-centralization of the health system and the National EmONC Assessment has contributed to a great extent to addressing Delay Three (receiving adequate care in a facility) but not Delay One and Two (deciding to seek care in an obstetric emergency and reaching an</p>

<sup>767</sup> Information from Development partners.

<sup>768</sup> UNFPA, Final Report, Safe motherhood community based survey, 2008.

<sup>769</sup> Interview with Government.

<sup>770</sup> Interview with UNFPA staff.

	<p>obstetric facility on time). UNFPA was the first to reference the Three Delays model with cultural sensitivity programming and the need to address maternal health, gender issues and cultural practices in tandem (2008)<sup>771</sup>. There are good practices of public/private partnership to address Delay Two such as Ghana Private Road Transport Union (GPRTU) in the Central Region, but the initiative remains limited to one region.</p> <p>UNFPA widely disseminated a 2008 study done in collaboration with Ministry of Chieftaincy and Culture (MoCC) that aims to provide guidance on issues, approaches and methodologies in ensuring that reproductive health/maternal health programming such as EmONC Needs Assessment and any Improvement Plan reflects socio-cultural sensitivities and good practices. This multi-sector analysis includes regional nuances, inter-regional comparisons, concept of family, children's place within families and positive aspects of local cultures, community leadership and its relationships to UNFPA's issues/mandate areas. No assessment of this socio-cultural intervention has taken place as yet but has been referenced by EmONC Needs assessment in 2011.<sup>772</sup></p>
Findings from case study in <b>Kenya</b>	<p><i>UNFPA is supporting interventions to increase the utilization of EmONC services, which are based on evidence, nevertheless as the refurbishment and/or construction of the four centers of excellence has not been finalized; hence data are not available to assess the impact.</i></p> <p>Several activities of the KCO are aimed at increasing the utilization of EmONC services; this includes the Community midwifery programme, the extension of CHEWs in the communities of the centers of excellence, the support to centers of excellence, awareness camps and community mobilization. Implementing partners train Community Health workers and volunteers and provide logistical support- transport and meals- when they go out for outreach and community mobilization. Through facilitating the link/relationship between retired community nurses and TBAs, the latter mobilize women and refer them to retired community midwives for skilled attendance. From the discussions it was reported that increasingly more women are delivering with skilled attendance at the community level<sup>773</sup>.</p> <p>Barriers to access are considered mainly to be financial and distant locations. In the evaluation of the 5<sup>th</sup> country programme no correlation was found between staff training in a service area and availability of the service at the facility level, this posing an important challenge to planning of training activities that are needed in order to address the huge unmet need for training in the various reproductive health service areas. This has improved; the KCO has supported assessments which investigated service delivery<sup>774</sup> and it mapped health facilities in its focus regions to decide (together with the district medical office) on the most appropriate approach and location.</p>
Findings from case study in <b>Lao PDR</b>	<p><i>UNFPA, in addition to communication interventions (i.e. IEC/BCC) that are not easily measurable and do not always produce the expected results, has supported innovative approaches to involve communities in improving MNCH through the public system. These approaches have a high potential to increase utilization of skilled attendance during pregnancy and at birth in rural areas provided it is carefully accompanied and its phase over stage carefully planned.</i></p> <p>In order to create demand for maternal health services and to improve health seeking practices, UNFPA started supporting the</p>

<sup>771</sup> Cultural Sensitivity and Programming: The Case of GoG-UNFPA 5th Country Programme 2006-2010

<sup>772</sup> Interview with UNFPA staff

<sup>773</sup> Information from Implementing partner

<sup>774</sup> Kenya Service Provision Assessment, 2009



	<p>production of IEC materials and trained Lao Women Union (LWU), Lao Youth Union (LYU) and the Information and Culture Department to promote maternal health in collaboration with the National MCH Centre and the Centre of Information Education for Health<sup>775</sup>. As mentioned above in evaluation question 6, no evaluation was done on these communication approaches.</p> <p>In 2009, UNFPA initiated the project ‘Empowering Communities to Improve Reproductive Health’ implemented at provincials level with Health Unlimited providing technical support. From 2010, the WHO IFC (Working with Individuals, Families and Communities for improving maternal health) was implemented in 2 districts of 3 central provinces (Funded by Lux development) and 4 districts of the 3 southern provinces by HU and CIEH (funded from core Funds). Both approaches aimed at developing capacities of communities and strengthening community systems to take action to address MNCH issues such as transportation schemes, saving funds, including improved skilled attendance seeking behaviour. They also seek to improve linkages between communities and health care providers<sup>776</sup>.</p> <p>The ‘Community Empowerment’ project started with the PEER study aiming at understanding perceptions and behaviour related to reproductive health among vulnerable ethnic communities in Sekong, Attapeu and Saravan Provinces, in the South. It provided valuable information from communities perspectives related to maternal health<sup>777</sup>.</p>
Findings from case study in <b>Madagascar</b>	<p><i>Previous country programmes (2004, 2006) have focused in their reproductive health related activities on family planning and support to policy development, such as the Maternal Health Road Map<sup>778</sup>. During the 5<sup>th</sup> CP, UNFPA finalized guidelines for the BEmONC and trained on EmONC, but the EMONC survey of 2009 revealed ineffectiveness of this training, as it was based on a rather theoretical approach and not directly applicable. The meanwhile strong commitment from the MoH to MDG 4 and 5 includes the EmONC, also based on the results of the EmONC survey conducted in 2009 with the support of the MHTF.</i></p>
Findings from case study in <b>Sudan</b>	<p><i>By helping to institute maternal death audits in Sudan, UNFPA has helped to increase knowledge of the specific causes for maternal deaths among practitioners and policy makers. In-service trainings of village midwives and traditional birth attendants have increased the awareness of these service providers of potential warning signs for complications during pregnancy.</i></p> <p>UNFPA has been supporting the in-service training of village midwives (VMW) and TBAs to allow them to become more knowledgeable about warning signs that warrant sending pregnant women to health centers. Also, UNFPA has worked with media personnel on communication campaigns on maternal health. Otherwise, UNFPA has supported only little community-based work on EmONC awareness.</p> <p>In addition, UNFPA has helped to institute protocols for maternal death audits in its 5 focal states, by organizing training sessions on MDA, developing and disseminating forms to be used in maternal death audits, and providing an office for coordination of maternal death review in Gedaref state (Miriam, is the correct state where we visited the OB/GYN hospital?). Also, UNFPA supported hospitals are working with midwives during training sessions to review case studies of maternal deaths. Overall, these activities have helped to generate some data and awareness on one the main causes of maternal death, i.e. late referral of pregnant (laboring?) women in distress.</p>
Findings from case	<p><i>UNFPA has supported the mobilization of communities to enable women’s access to EmONC services by supporting Safe Motherhood</i></p>

<sup>775</sup> Government Partners interview.

<sup>776</sup> UNFPA staff interview.

<sup>777</sup> UNFPA staff interview.

<sup>778</sup> COAR 2004: « Sécurisation des produits SR, mise en œuvre de la nouvelle stratégie PF à Madagascar, élaboration et finalisation des modules en SONUB et disponibilité des compétences nécessaires pour son application, élaboration de la feuille de route pour la réduction de la mortalité maternelle à Madagascar ».

<p>study in <b>Zambia</b></p>	<p><i>Action Groups (SMAGs) and through communication campaigns.</i></p> <p>At community level, UNFPA has supported the establishment of the SMAG mechanism to mobilize communities to support women in demanding access to EmONC services. The SMAG element of the Country Programme, which addresses the first EmONC delay, i.e. the delay at the family/community level, has been integrated in the National Development Plan as a pilot strategy for community involvement, and the Ministry of Health has been allocating funds toward SMAG interventions. Other Implementing Partners have also started to integrate the SMAG concept into their maternal health/ EmONC programmes<sup>779</sup>. In addition, UNFPA has supported community-related communication activities, i.e. by providing funding to ZANIS, a Zambian state agency providing News &amp; Information Services. ZANIS has used community radios, plays, video shows, TV and radio programmes to convey messages about maternal health<sup>780</sup>.</p> <p>UNFPA has not directly supported any specific research on identifying barriers to accessing EmONC services in Zambia. Its current support is based on a 2005 EmONC assessment that had been financed by UNICEF.</p>
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<sup>779</sup> For details, see Evaluation questions 3 on community involvement and demand creation.

<sup>780</sup> Interview with UNFPA.

### 7.2.8 Evaluation question 8: To what extent has UNFPA’s use of internal and external evidence in strategy development, programming and implementation contributed to the improvement of maternal health in its programme countries?

#### Judgment criterion 8.1: Integration of relevant evidence and UNFPA results data during global strategy development and implementation (MYFF 1 and 2, Strategic Plan; SRH Framework)

Findings from <b>desk study</b>	At global level, UNFPA integrated some key lessons on maternal health / SRH from an independent review of the second MYFF when developing the 2008 – 2013 Strategic Plan. Among other things, UNFPA adopted the recommended health systems approach, as well as the corresponding focus on ensuring the provision of human and other resources to strengthen health systems in programme countries. The Strategic Plan also puts UNFPA’s partnership approach, i.e. in particular the role of the IHP+ and the steps of the “IHP+ work plan” in the context of health system strengthening. The recommendation to enhance UNFPA’s support of commodity security in programme countries might have facilitated the decision of the Fund to launch the Global Programme to Enhance Reproductive Health Commodity Security in 2006.
Findings from case study in <b>Ethiopia</b>	UNFPA is the lead on Maternal Mortality and Child Health and Data Collection and M&E outcome areas within UNDAF (+4 other OC areas in which it is a member) and co-chair of the M&E sector working group. UNFPA Ghana, like all other UNFPA offices, does not directly implement programmes in the field. However, UNFPA has its own monitoring and evaluation tools and systems which are aligned with government tools and systems for effective monitoring. Nevertheless, there are several independent evaluations in the integration of reproductive health/maternal health and EmONC that play a large part in evidence creation

#### Judgment criterion 8.2: Consideration and integration of relevant maternal health / SRH evidence and results data during development of country strategies

Findings from <b>desk study</b>	At country level, UNFPA country offices are only rarely making explicit use of lessons from evaluations of previous support or are using external evidence to customize UNFPA’s maternal health strategy in their respective countries. Only 5 out of 18 examined Country Programme Action Plans (CPAP) specifically referenced previous evaluations and only 6 out of 18 documents drew specific lessons from the maternal health components of the previous programme, albeit often without citing the evidence base supporting that decision. Only two documents <sup>781</sup> provided some concrete information on the operational implications from the lessons <sup>782</sup> . Less than half of the situational analyses in CCAs <sup>783</sup> explicitly identified gaps in national capacities as a basis for formulating specific responses or recommendations for UNFPA support or attempted some kind of “root cause analysis” for maternal health challenges <sup>784</sup> . Most documents merely covered the health sectors in general and disregarded specific maternal health/reproductive health issues.
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<sup>781</sup> From the Lao PDR country office and the Nepal country office.

<sup>782</sup> The authors of these documents attempted to link the lessons to specific elements of the past programme, during the description of the programme. This also means that the lessons in these documents were more specific and concrete; and provide more information on operational implications for the future.

<sup>783</sup> UNFPA is formally responsible for ensuring the inclusion of maternal health and SRH issues in the Common Country Assessments of the UNDAF process.

<sup>784</sup> I.e., by identifying the structural causes of persisting problems (such as “lack of resources”).

<p>Findings from case study in <b>Burkina Faso</b></p>	<p><i>L'UNFPA contribue a générer des données qui informent la planification et la programmation des différentes actions que ce soit par des analyse situationnelles, des enquêtes nationales ou l'évaluation de ses programmes. Par contre le manque de données quant aux résultats obtenus ne permet pas de tirer suffisamment d'enseignements pour les programmes futurs.</i></p> <p>Certaines informations obtenues lors de l'évaluation de certaines composantes, l'évaluation des programmes pays, ainsi que l'analyse des données du SNIS, des EDS et des recensements sont prises en compte lors de la planification. Au niveau du bureau pays certaines recommandations de l'évaluation du 5<sup>ème</sup> programme ont été prises en compte dans le 6<sup>ème</sup> programme, par exemple: l'appui au district sanitaire (DS) dans sa globalité pour plus d'impact et un financement direct des plans d'actions des DS pour une meilleure gestion et taux d'exécution<sup>785</sup>. Toutefois les évaluations, aussi bien à mi-parcours que finales, sont de qualité inégale et étant donné que les résultats des interventions ne sont pas mesurés de façon systématique l'analyse des enseignements tirés des programmes précédents est limitée et n'informe que peu la planification (cf. ci-dessous).</p> <p>Comme mentionné ci-dessus les analyses situationnelles réalisées avec le support de l'UNFPA concernent différents aspects de la Santé de la Reproduction (services et perception des populations) et les données obtenues ont permis d'informer la programmation aussi bien des partenaires gouvernementaux que celle de l'UNFPA<sup>786</sup>.</p>
<p>Findings from case study in <b>Cambodia</b></p>	<p><i>Both UNFPA country office and Government partners consider the monitoring arrangements of CCA and HSSP II (2006-10) to be appropriate. They also agree that progress to move from a project-based approach to a programme-based approach had been slow, but that there has been steady change in performance monitoring within HSSP II engagement.</i></p> <p>UNFPA programming undergoes regular monitoring and evaluation to produce evidence for better programming. The Internal Monitoring System of UNFPA relies on indicators listed in the CPD as a baseline and uses the CPAP Monitoring Tool for programme tracking and the Results and Resource Framework as a basis for financial reporting. The National Programme Officers (NPO) tracks the CPAP outputs and the Finance Officer provides the absorption and implementation rate on a month-by-month basis. Both meet regularly under the aegis of the Assistant Representative who is the authority on M&amp;E<sup>787</sup>. Annual reviews are performed for all IPs, including MoH, and the performance indicators are reviewed for all provinces. Secondly, as a member, UNFPA is subject to the External and Joint Monitoring System by peers of the Annual Operation Plan (AOP)<sup>788</sup>. This system analyzes supply and demand, insurance schemes,</p>

<sup>785</sup> Entretiens avec le personnel de l'UNFPA.

<sup>786</sup> Analyses situationnelles réalisées avec le support de l'UNFPA:

Evaluation des Besoins Complémentaires en Maternité à Moindre Risque (dans les régions du Sahel, Est et Centre Est) Burkina Faso (2004)

Analyse de la prise en charge des fistules urogénitales au niveau des services de santé de référence du Burkina 2001-2003.

Analyse situationnelle sur la sécurité de produits contraceptifs au Burkina Faso (2005)

Analyse situationnelle des services de santé de la reproduction (2006);

Evaluation de base des sites et prestataires formés en SONU dans les régions de l'Est, Centre est et sahel (2007) ;

Analyse des perceptions en SR des populations (2007).

Étude socio comportementale SR (2007).

Étude medias et communication (2007).

Analyse situationnelle de la profession sage femme/maïeuticien (SF/ME) du Burkina Faso (2009).

Evaluation des soins obstétricaux et néonataux d'urgence (2010).

<sup>787</sup> UNFPA Cambodia.

<sup>788</sup> UNFPA Cambodia, AWP 2007-10.

	<p>gender review and human resources. Once this evaluation is complete, the Annual Health Sector Review is conducted. In addition, the Joint Annual Performance Review for HSSP II reports on progress of achievements. Annual Operational Plans are prepared by all IPs and compiled as one under HSSP II to minimize chance of duplication. The NMNCH Centre performs a supervisory role, but is limited by the size of their team<sup>789</sup>. The Ministry of Planning leads the <u>annual monitoring of the National Strategic Development Plan and Health Sector Programme 2</u> linked to the MDGs, and UNFPA participates closely.</p> <p>UNFPA did not evaluate the second Country Programme, because it was part of the monitoring arrangements for the joint health sector programme. However, an evaluation of the third Country Programme was conducted due to requests from UNFPA headquarters. In addition, there have been many ad hoc evaluations of UNFPA Cambodia. This raised concerns from the Government that too many evaluations were being carried out that were parallel to the joint exercises associated with the sector programmes<sup>790</sup>, which put unnecessary additional strain on the Government capacity<sup>791</sup>. Internal and external monitoring systems are in place for HSSP II, but it is still questionable whether they provide real assessment of UNFPA interventions, and if the recommendations they proposed were appropriate<sup>792</sup>.</p>
Findings from case study in <b>DR Congo</b>	<p>On prend note des deux études/analyses entreprises par l'UNFPA/ RDC, basées sur lesquelles (ainsi que les conclusions du son Représentant) l'UNFPA a réorganisé ses bureaux nationaux, passant de onze bureaux provinciaux à trois bureaux décentralisés. Ceci a eu pour but de focaliser ses efforts sur le renforcement des services de santé maternelle en zones de santé bien ciblées.</p> <p>Les principaux facteurs qui ont contribué au faible contrôle des bureaux nationaux et de leur incapacité à apprendre de leurs efforts, ont été l'immensité du pays, le mauvais état des systèmes routiers et de communication, et surtout le manque d'une base de données fiable sur presque tous les aspects des besoins sanitaires et des prestations des services disponibles. La préparation d'une cartographie de la Santé Maternelle et Néonatale (SMN) a été une réponse à cette lacune, et le recensement national préparé par l'UNFPA maintenant prévu pour 2012, en sera une autre (Voir Judgment criteria 8.2 and 8.3 dans l'Annexe 6.3 pour une discussion plus détaillé de ces sujets).</p>
Findings from case study in <b>Ethiopia</b>	<p><i>UNFPA utilizes global, regional and national evidence, and creates evidence to feed into the annual work plans, which are developed in a consultative process. The country programme incorporates the national priorities within its mandate. UNFPA is participating in the MDG fund which is jointly planned and monitored by its members.</i></p> <p>The planning of the country programme is a consultative process within the country office for a year in advance and based on existing data, surveys and assessments, including census and DHS data. For the 6th country programme for example, a Collective Baseline Survey was done, even though only at half way. UNFPA is embedded in the national and UNDAF planning, which is part of the process. UNFPA is participating in the annual joint review meetings (JRM) of development and governmental partners, which address a different topic every year, such as health system development or supervision, etc. UNFPA contributed in 2009 to the design of the JRM to adapt the health system approach under the aspect of maternal and newborn health and presented the findings to the broad audience of development and national partners<sup>793</sup>. These review missions are a means of joint sector-wide monitoring, which provides evidence and</p>

<sup>789</sup> Government Partner.

<sup>790</sup>“The Government asks us why donors are having so many evaluations when the sector and strategic evaluations are happening every year” (UNFPA Cambodia)

<sup>791</sup>“The system works well and too many evaluations burdens the Government especially given the limited capacity of Government” (Government Partner).

<sup>792</sup>In particular the CBD evaluation was alluded to as a case in point (NGO Partner and External Development Partner).

<sup>793</sup> COAR 2009.

	<p>recommendations for further action. The CP 2007-2011 for example mentions: 'Lessons learned include the need to focus programme interventions thematically so that resources are made available where needs are greatest;' which has led UNFPA to reduce the number of regions: following the discussion with the government partners reduced midway in the 6<sup>th</sup> Country programme to 47 regions in order to finance a comprehensive combination of activities in these areas. Nevertheless, it uses 'flexible modalities such as sector-wide approaches to leverage resources and support programme implementation'<sup>794</sup>; the MDG fund can be considered an outcome of this increased focus on leveraging funds. The MDG fund is not only a step forward to joint planning but also to monitoring, and thus complies with the new aid environment. Else, development partners monitor their individual programmes, albeit usually with other partners and at least one participant from the FMOH-if they have time.</p>
<p>Findings from case study in <b>Ghana</b></p>	<p><i>The Ghana Country Assessment (also known as the Common Country Assessment) is based on a sum total of evidence gathered from several evaluations over the five-year period including the mid-term evaluations and the utilization by all IPs of the Annual CPAP monitoring tool and the Annual Programme Review Meeting. Trend analysis of Ghana DHS and census information which is disaggregated by regions and districts provides the macro and micro level evidence.</i></p> <p>In 2008 there was a mid-term review of 5 year programme of support by all UN agencies, the UNDAF, and the M&amp;E section of that framework was found as not having been implemented well. That led to UNFPA setting up itself to push M&amp;E forward, leading to the creation of M&amp;E sector working group. In the government led Sector Working Group UNFPA is the co-lead with National Development Planning Commission (NDPC) on M&amp;E and the lead UN agency in the UNDAF outcome area (OC12 – M&amp;E). This SWG with NDPC looks at the entire national M&amp;E strategy, not just for the health sector, which allows UNFPA to be an integral part of a multi-sectoral approach.</p> <p>UNFPA is involved in data collection such as DHS and Census and has remobilized the M&amp;E Sector Working Group as part of its strategy to build government's M&amp;E capacity and provide highly disaggregated data for planning, designing and tracking results in its three mandate areas<sup>795</sup>. UNFPA is the co-UN agency on UNDAF Outcome Areas for Maternal Mortality and Child Health (with the WHO lead) and HIV AIDS (with UNAIDS lead). It is a member of Outcome Areas such as Disaster Management, Political Governance and Economic Governance in which it is a member). It is not a member of the Social Protection and Education Sector Working Groups which is considered by many as a missing link<sup>796</sup>.</p> <p>UNFPA has its own monitoring and evaluation tools and systems which are aligned with government tools and systems for effective monitoring which is both advantageous (effective co-ordination) and disadvantageous (lack of rigor)<sup>797</sup>. Nevertheless, there are several independent evaluations in the integration of reproductive health/maternal health and EmONC Assessment will play a large part in evidence creation. UNFPA has been part of national baseline studies and is seeing measurable changes in government performance<sup>798</sup>. For example, with UNFPA, the NDPC is now able to produce annual maternal health/reproductive health progress reports in a more timely fashion The country office was also able to push and support development of Ghana Statistics Development Plan to include reproductive health/maternal health and gender data production without gaps as it is important to UNFPA's mandate areas<sup>799</sup>. UNFPA</p>

<sup>794</sup> CP 2007-2011.

<sup>795</sup> Interview with Government Partner.

<sup>796</sup> Interview with UNFPA and CSOs.

<sup>797</sup> Interview with External Development Partner.

<sup>798</sup> Interview with Government Partner.

<sup>799</sup> Interview with UNFPA.

	<p>directly supported the establishment of the Ghana M&amp;E Forum. It is also directly engaged in quarterly meetings led by National Population Council with Programme Component Management for reproductive health, gender, and population and development.</p> <p>M&amp;E calendars are developed every five years as part of CP planning. Furthermore, the M&amp;E system of Ghana Health Service includes national, regional and district M&amp;E teams that are directly funded by UNFPA through budget support to GHS.</p>
Findings from case study in <b>Kenya</b>	<p><i>UNFPA provides evidence on global, regional and country level which is utilized in the planning process of country strategies and the country programme of UNFPA. The country programme incorporates national priorities within its mandate and was reported to have little margin in promoting its own agenda or selection of partners.</i></p> <p>Country strategies have been developed with the support of UNFPA and other development partners (see also evaluation question 1 and evaluation question 2), based on political priorities of the GoK and health assessments. The GoK was reported to be in the 'driving seat', strongly directing the agenda, the location of implementation and the choice of implementing partners<sup>800</sup>. This does not seem to pose a problem, as currently the interests overlap with UNFPAs mandate<sup>801</sup>.</p> <p>The planning of the Country Programme is a consultative process which is programmatically embedded in the national and UNDAF frameworks. Annual planning workshops with Implementing Partners allow for a close exchange and a direct integration of needs of the country into the programming process. Ongoing assessments with the support of UNFPA in the sector of reproductive health and national surveys are providing the data basis for evidence based programming. The KCO also conducts assessments jointly with the DRH (Department of Reproductive Health in the MOH) to provide a framework of SMART indicators in its target districts.</p> <p>The M&amp;E frameworks of UNFPA, UNDAF and national Health Management Information Systems reporting differ substantially. Whereas UNFPA operates within the Government system, its own requirements for reporting and the development of reporting tools are contributing to work overload for Implementing Partners and probably a duplication of efforts.</p>
Findings from case study in <b>Lao PDR</b>	<p><i>UNFPA has supported a number of studies that allowed basing programming upon evidence up to a certain extent i.e. within the limits of the capacity to analyze the evidence available. But monitoring and evaluation of the programme cycles is usually weak and does not provide proper analysis and lessons that could be used for future programming.</i></p> <p>The development of the 4<sup>th</sup> Country Programme (CP4) benefited from evidence from a number of studies that had been carried out with UNFPA support such as the Census 2005, the Lao Reproductive Health Survey (LRHS) done in 2005<sup>802</sup>, the SBA assessment in 2008, the PEER Study in 2008 (see above), the Assessment of Condom Programming in 2008 and the annual stock availability surveys. Data generated were used for programming. For example the findings of the SBA assessment highlighted that there was a need to broaden partnership within MOH therefore UNFPA started working with Department of Organization and Personnel (DOP), the MOH Cabinet and the Medical Product Supply Centre (MPSC).</p> <p>However there are a lot of gaps regarding information availability on the achievement of the past programmes. Most of the indicators of</p>

<sup>800</sup> The NCAPD has been involved in the selection of the Implementing Partners for UNFPA who may be retained for a number of years and UNFPA is having only limited control over them or the choice.

The NCAPD has been involved in the selection of the Implementing Partners for UNFPA who may be retained for a number of years and UNFPA is having only limited control over them or the choice.)

<sup>801</sup> Information from KCO and Government partners.

<sup>802</sup> Particularly the analysis of provincial data

	<p>the CP4 logical framework matrix could not be measured as they were not appropriate. Although they were revised by the country office team they are often not reported against and therefore do not offer proper evidence-base to inform future planning<sup>803</sup>. It was reported that most of the time annual programming is done based on budgets allocated to the country office. Often it is not strategic enough because of lack of monitoring and evaluation results but also because the actual country office staff capacity does not allow systematic analysis for long term programming<sup>804</sup>. There was no end of cycle evaluation done for CP3 although data were collected but were never analyzed. The evaluation of CP4 undertaken in 2010 has been used for CP5 programming, but presented gaps.</p>
<p>Findings from case study in <b>Madagascar</b></p>	<p><i>UNFPA develops in annual planning meetings work plans with its national and international partners which are usually jointly monitored. Evidence creation is part of the process. UNFPA conducts regular training on results based management for new implementing partners and addresses specific capacity gaps (due to the current political situation) of the government partners.</i></p> <p>UNFPA with its partners (IP, DP, and GP) conduct regular programme evaluations, prepared by the UNFPA M&amp;E officer and the relevant advisor. M&amp;E mission are frequently conducted programme-wide and usually with local partners.<sup>805</sup> This approach of joint M&amp;E missions was initiated by the CoM with the aim to strengthen the integrated approach and to utilize resources efficiently. Nevertheless, the M&amp;E implementation on national, regional and district level in Madagascar lacks stamina, tools and resources.<sup>806</sup></p> <p>The H4 group in Madagascar represents a step forward to joint planning, implementing and monitoring within the framework of the 'new aid environment'. The impact of this recent cooperation on integration of new evidence is too early to assess, but the processes already are being 'institutionalized': monthly meetings address critical issues (gaps, shortfalls, overlaps) and develop solutions. As mentioned above (Judgment criteria 1.2, 1.3) external evidence for planning and programming of the CoM and its partners is derived from a variety of surveys and assessments, M&amp;E follow up, and external technical support. During the annual planning meeting, stakeholders decide on required additional data, which may then be included into the next DHS (as for example data on gender-based violence) or initiate an assessment or a survey.</p> <p>UNFPA internally conducts annual planning sessions with inclusion of lessons learnt from previous years. These annual revue meetings are reported<sup>807</sup> to be effectively solving issues on technical level, as they are in the control of the CoM, but less effective on solving financial and administrative issues, as they are based on formats and processes directed by headquarters. Additionally the current political situation is abnormal and implementation is cumbersome at present as UNFPA cannot give money to the government and has to pay for each input or activity directly.<sup>808</sup> UNFPA conducts regular training on RBM for all its IPs to ensure a common understanding and reporting.</p>
<p>Findings from case</p>	<p><i>With its UNFPA largely having limited itself to responding to small-scale funding requests from the Zambian Government, there is little</i></p>

<sup>803</sup> Assessment of development results supported by UNFPA CP4 for Lao PDR: Report and recommendations, Vientiane, Lao PDR, April, 2011

<sup>804</sup> UNFPA interviews

<sup>805</sup> These missions are prepared by the M&E officer with support of the relevant advisor, and frequently implemented covering two or more programmes; for example, if the humanitarian officer conducts a mission for her programme, she will at the same time monitor the family planning and/or reproductive health or other programme components, according to a jointly developed plan.

<sup>806</sup> The regional and district level health administration was reported (GP, DP) as being weak, and thus unable to provide an effective M&E with feed-back loops and accountability for non-performance.

<sup>807</sup> Information from UNFPA staff.

<sup>808</sup> Such a direct payment mechanism generates a huge burden of micro-management both at UNFPA country office level and at GoM and IP level. These implementing modalities impact on the focal points that have to spend a significant part of his time on micro-management.



<p>study in <b>Zambia</b></p>	<p><i>evidence to suggest that UNFPA has used lessons from its past support to help shape the policy priorities of the Zambian Government in the health sector or with regard to maternal health<sup>809</sup>, that UNFPA has adequately monitored the interventions it has financed or that it has supported its implementing partners in strengthening their own M&amp;E capacity. Neither implementing partners nor the country office were able to provide examples of evidence- and results-based management of UNFPA-funded projects.</i></p> <p>During the development of the current UNFPA country programmes, UNFPA's efforts to develop and use lessons-learned from its previous programmes have been closely tied to efforts of Zambia's Government and other development partners (including UNDAF partners) to draw lessons from previous years. UNFPA participated in sessions of the Sector Advisory Group that accompanied the preparation of Zambia's health sector plans that set health sector priorities for the 5<sup>th</sup> and 6<sup>th</sup> National Development Plans (NDPs). In accordance with the UNDAF planning process, UNFPA subsequently took the main priorities for its country programme from the common UNDAF that the UN negotiated with the Government on the basis of these NDPs<sup>810</sup>. Therefore, to increase the coherence between its own programming and the strategy development of the Government, UNFPA aligned its programming cycle with the planning cycle of the Government, starting with UNFPA's 6<sup>th</sup> Country Programme (2007 – 2010).</p> <p>Beyond that, there have been a number of factors that have limited UNFPA's ability to draw and apply "lessons learned" from past programming to its future work. Firstly, UNFPA has carried out a relatively small number of studies and evaluations to analyze lessons and experiences from its past programming. Most of the reporting activities and monitoring have focused on reporting on activities and outputs, but much less on the analysis of outcomes of UNFPA support<sup>811</sup>. Secondly, findings of existing studies have not been disseminated broadly enough among Government and development partners. Thirdly, the fact that most studies have been implemented under the population and development component of the country programme, and that there have been relatively weak linkages between population and development and the Reproductive Health component in UNFPA's country office have at times prevented the reproductive health staff from fully becoming aware of relevant findings and from integrating them into reproductive health programming.</p> <p>With only an M&amp;E focal point in the country office since 2009, but no budget at country office level for monitoring, and no real monitoring plan, there was nobody to "push" monitoring of implementing partners. The Population and Development Officer was assigned this responsibility for M&amp;E in 2009/ 2010. However, even after his nomination, there has been virtually no support in training the new M&amp;E Focal Point on M&amp;E<sup>812</sup> or to provide guidance on the responsibilities of an M&amp;E Focal Point in UNFPA. UNFPA has also not provided any specific support or guidance to implementing partners on monitoring and evaluation, nor has it provided specific tools for implementing partner to use for monitoring of UNFPA financed interventions<sup>813</sup>.</p>
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**Judgment criterion 8.3: Results- and evidence based management of individual projects throughout project life**

<sup>809</sup> Instead, UNFPA stressed that the Government was setting the priorities, and that it was UNFPA's role to support the Government in implementing these priorities.

<sup>810</sup> According to UNFPA information, the country office had established a team to "tease out priorities for the Country Programme from the UNDAF".

<sup>811</sup> Based on review of monitoring reports and feedback from implementing partners.

<sup>812</sup> Apart from his participation in one workshop on evidence-based programming which had been organized by headquarters.

<sup>813</sup> Interviews with implementing partners.

Findings from <b>desk study</b>	<p>At the project level, a significant number of country offices have not made use of the relatively complex system of monitoring reports and templates that formally is in place, including in particular the annual work plan Monitoring Tools and the Standard Progress Reports<sup>814</sup>. 7 out of 14 reviewed country programme evaluation reports found that monitoring at country level had been very weak, in that either no regular monitoring had been taking place, reports had been of extremely varying quality and data were generally not used by country offices to make corrections to project implementation<sup>815</sup>. Two additional reports found at least slight deficiencies<sup>816</sup>. Where project-monitoring tools remained unused, their absence created a significant gap in the UNFPA monitoring system. None of the other standard reporting tools would have provided project and activity level monitoring data. The commonly used country office Annual Reports were not intended to follow the implementation of individual activities. Instead they were very much macro-level reporting tools to allow country offices to show their contribution to the global outcomes of the Strategic Plan (or the MYFFs, for the period prior to 2008)<sup>817</sup>.</p> <p>Although UNFPA country offices implemented a large number of mid-term evaluations of country programmes, thematic evaluations or project level evaluations<sup>818</sup>, the quality of evaluation reports in UNFPA has been relatively low. Over 50% of reviewed evaluations for the years 2007 and 2008 were thought to be methodologically so weak that the weakness called into question the validity of any findings, conclusions and recommendations. Also over 50% of evaluations failed support their findings and results by the data. The suitability of these studies for evidence- and results-based management of UNFPA projects was therefore low. Without current progress data on activities and outputs, the opportunities for evidence-based management of UNFPA maternal health interventions must have been limited.</p>
Findings from case study in <b>Burkina Faso</b>	<p><i>Le système de suivi des programmes de l'UNFPA est insuffisant pour une gestion des différents projets sur la base de résultats concrets. Ceci est du à une définition inappropriée des indicateurs de suivi et à l'absence de stratégie cohérente de suivi qui ne permettent pas de démontrer la contribution de l'UNFPA.</i></p> <p>Le Système National d' Information Sanitaire (SNIS) est utilisé principalement comme outil de suivi mais ce système a des limites pour un suivi plus spécifique des actions de l'UNFPA et la mise en place d'outils pertinents qui permettent de réellement mesurer les résultats des activités de SR dans les zones du projet n'a pas été possible. Certains mécanismes sont mis en place pour analyser les résultats</p>

<sup>814</sup> According to the formal system, progress of maternal health activities and the achievement of maternal health outputs are meant to be monitored by UNFPA's implementing partners, using the so-called AWP Monitoring Tool. The Programme Component Manager is supposed to consolidate these reports into annual Standard Progress Reports (SPRs) and is also responsible for periodic Field Monitoring Visits (FMVs). The UNFPA country office is supposed to merely validate the reported achievements through its own Field Monitoring Visits and to forward the annual Standard Progress Reports to UNFPA HQ. The PPM notes that the note on CPAP monitoring and evaluation has to be updated substantially; however, without a new version yet in place, it is presumed that the corresponding guidance is still relevant.

<sup>815</sup> Bangladesh, Burkina Faso, Ghana, Lao PDR, Sierra Leone, Sudan, Zambia.

<sup>816</sup> The CPEs for Tanzania and Malawi.

<sup>817</sup> Shown by a review of the standard structure of the COARs.

<sup>818</sup> The evaluation team collected over 100 evaluations for the 22 countries included in the desk phase of this evaluation that were either directly concerned with or thematically closely related to SRH and maternal health. These evaluations had been conducted mostly in the period between 2006 and 2010; suggesting that the actual number of evaluations for the entire evaluation period (2000 – 2010) is far higher. The main types of evaluations conducted (apart from Final / End of Period Country Programme Evaluations) were: a) Country Programme Mid-Term Reviews; b) SRH Component Evaluations; Thematic Evaluation / Review of SRH specific topic; Programme / Project Evaluation of SRH interventions.

	<p>tels que les revues conjointes entreprises par le bureau pays, la DSF/ DSME et la Direction Générale de la Coopération mais elles sont axées sur l'aspect financier et les informations recueillies ne sont pas compilées pour permettre une vue d'ensemble<sup>819</sup>.</p> <p>Une autre limitation concerne la définition insuffisante des objectifs et des indicateurs clés, l'absence de plans de suivi et l'insuffisance des ressources financières nécessaires aux activités de suivi et évaluation<sup>820</sup>. Une documentation déficiente des activités a aussi entraîné une faible visibilité des réalisations du Programme. Durant le 5<sup>ème</sup> programme il n'y avait pas de personne responsable pour le suivi-évaluation, durant le 6<sup>ème</sup> programme un chargé de suivi-évaluation été recruté et une seconde personne n'est en train d'être recrutée pour le suivi évaluation de la SR avec des fonds RHTF<sup>821</sup>. La culture de suivi évaluation a évolué au fil des années et s'est améliorée mais reste insuffisante. Le 7<sup>ème</sup> programme met un accent particulier sur le suivi et l'évaluation, intègre le suivi/évaluation comme stratégie intégrale dans chaque produit.</p>
Findings from case study in <b>Cambodia</b>	<p><i>Both UNFPA country office and Government partners consider the monitoring arrangements of CCA and HSSP II (2006-10) to be appropriate. They also agree that progress to move from a project-based approach to a programme-based approach had been slow, but that there has been steady change in performance monitoring within HSSP II engagement.</i></p> <p>UNFPA programming undergoes regular monitoring and evaluation to produce evidence for better programming. The Internal Monitoring System of UNFPA relies on indicators listed in the CPD as a baseline and uses the CPAP Monitoring Tool for programme tracking and the Results and Resource Framework as a basis for financial reporting. The National Programme Officers (NPO) tracks the CPAP outputs and the Finance Officer provides the absorption and implementation rate on a month-by-month basis. Both meet regularly under the aegis of the Assistant Representative who is the authority on M&amp;E<sup>822</sup>. Annual reviews are performed for all IPs, including MoH, and the performance indicators are reviewed for all provinces. Secondly, as a member, UNFPA is subject to the External and Joint Monitoring System by peers of the Annual Operation Plan (AOP)<sup>823</sup>. This system analyzes supply and demand, insurance schemes, gender review and human resources. Once this evaluation is complete, the Annual Health Sector Review is conducted. In addition, the Joint Annual Performance Review for HSSP II reports on progress of achievements (). Annual Operational Plans are prepared by all IPs and compiled as one under HSSP II to minimize chance of duplication. The NMNCH Centre performs a supervisory role, but is limited by the size of their team<sup>824</sup>. The Ministry of Planning leads the <u>annual monitoring of the National Strategic Development Plan and Health Sector Programme 2</u> linked to the MDGs, and UNFPA participates closely.</p> <p>UNFPA did not evaluate the second Country Programme, because it was part of the monitoring arrangements for the joint health sector programme. However, an evaluation of the third Country Programme was conducted due to requests from UNFPA headquarters. In addition, there have been many ad hoc evaluations of UNFPA Cambodia. This raised concerns from the Government that too many evaluations were being carried out that were parallel to the joint exercises associated with the sector programmes<sup>825</sup>, which put unnecessary additional strain on the Government capacity<sup>826</sup> Internal and external monitoring systems are in place for HSSP II, but it is</p>

<sup>819</sup> Entretiens avec les partenaires d'exécution.

<sup>820</sup> Evaluation Finale du 6ème Programme de Coopération UNFPA-Burkina Faso 2006-2010.

<sup>821</sup> Entretiens avec l'équipe de l'UNFPA.

<sup>822</sup> UNFPA Cambodia.

<sup>823</sup> UNFPA Cambodia, AWP 2007-10.

<sup>824</sup> Government Partner.

<sup>825</sup> "The Government asks us why donors are having so many evaluations when the sector and strategic evaluations are happening every year" (UNFPA Cambodia).

<sup>826</sup> "The system works well and too many evaluations burdens the Government especially given the limited capacity of Government" (Government Partner).

	still questionable whether they provide real assessment of UNFPA interventions, and if the recommendations they proposed were appropriate <sup>827</sup> .
Findings from case study in <b>DR Congo</b>	See Judgment criterion 8.2
Findings from case study in <b>Ethiopia</b>	<p><i>The ECO collects results based data throughout the project lives which are analyzed in annual review meetings and lessons learnt and recommendation feed into the next annual work plans. Monitoring systems for implementing partners are in place. The supervisory mechanism for the task shifting project has yet to be developed.</i></p> <p>The results framework of the country programme is providing indicators for all levels and each implementing partner monitors the own programme according to predefined indicators and work plans. All IP receive training on results based management. The ECO has two M&amp;E officers. The ECO is in the process of aligning its results framework and improving coordination with and reporting of IPs<sup>828</sup>.</p> <p>Supervision through governmental partners was mentioned as a major problem in Ethiopia, lack of staff, funds and technical knowhow play a role. Quality assurance standards have not yet been developed, but seem to be of major importance for the supervision of the new cadres.</p>
Findings from case study in <b>Ghana</b>	See 8.2
Findings from case study in <b>Kenya</b>	<p><i>The KCO collects data throughout the project lives which are discussed in annual review meetings and decisions taken accordingly. Possible data and reporting overload may have been curbed with the 'One annual work plan per IP per CP Output', which has been followed as of 2010. Monitoring systems for implementing partners are in place and frequent reporting is required (quarterly).</i></p> <p>The results framework of UNFPA is providing good indicators for all levels; annual monitoring plans are elaborated and recently, the KCO has instituted a Country Programme Action Plan management tracking tool for recommendations from all involved stakeholders made during the monitoring missions. It is being used as "living" document and shall feed into the next programme cycle.</p> <p>The M&amp;E staff member works since 2007 in the KCO, but during her absence (maternity or other leave) tasks remain undone, as they constitute additional burden for other staff members, as consolidating all data from the various projects is quite a workload, even for a full time M&amp;E officer.</p> <p>The Implementing Partners have strict monitoring systems in place, with quarterly M&amp;E visits and training of by KCO staff or Government (NCAPD) staff. M&amp;E field visits, quarterly review meetings and the annual review meeting with all IPs and representatives from the health administration take place to enhance lessons learnt from previous or current programmes, such as the decision of the GoK together with the KCO to reduce midway in the 6<sup>th</sup> Country Programme UNFPAs support to four sites only in order to finance a comprehensive combination of activities. A further lesson learnt from the previous Country Programme review was to include and</p>

<sup>827</sup>In particular the CBD evaluation was alluded to as a case in point (NGO Partner and External Development Partner).

<sup>828</sup>Backstopping Mission to Addis Ababa, from 17<sup>th</sup> to 29<sup>th</sup>, June 2010, Mission Report.

	<p>upgrade the KCO humanitarian response capacity.</p> <p>Adjustment of implementation of individual projects as learning occurs was rated as good with its IPs and as weak with the MOPAN survey. (MOPAN Common Approach, November 2010)</p>
Findings from case study in <b>Lao PDR</b>	<p><i>Monitoring has relied mainly upon HMIS indicators that are not very accurate and not specific enough to capture the UNFPA contribution, i.e., the effects from the specific UNFPA interventions. The M&amp;E systems in place allow monitoring at activity level and even though information has been collected they have not been compiled further and does not capture progress at outcome level.</i></p> <p>As seen above the logical frameworks indicators are not appropriate and do not allow appropriate monitoring. UNFPA relies upon HMIS indicators and the HMIS in Lao PDR is weak although it is being strengthened by other partners such as WHO. A large number of indicators were defined in the MNCH package but they have to be refined and streamlined (which is an ongoing process)<sup>829</sup>. There are great expectations from all stakeholders on the Lao Social Indicator Survey that will produce results in 2012<sup>830</sup>. Yet HMIS indicators and other macro level indicators are not sufficient to capture the contribution of UNFPA supported interventions</p> <p>The annual working plan (AWP) monitoring tools are used quarterly mainly to release next budget tranches and are used by the project officer responsible for the particular annual work plan. In addition annual reviews take place with all the implementing partners and stakeholders and are the basis for planning the following year without real output/outcome or quality monitoring that would permit to develop a plan based on lessons learnt from the previous period<sup>831</sup>.</p>
Findings from case study in <b>Madagascar</b>	See Judgment criterion 8.2
Findings from case study in <b>Sudan</b>	<p><i>The lack of monitoring data on outcomes; and the lack of the systematic analysis of all monitoring data by the UNFPA country office in Sudan have severely limited any opportunity for the results-based and evidence-based management of UNFPA projects. Factors that have contributed to these shortcomings include the weak design of UNFPA's monitoring frameworks, the weak M&amp;E capacity of UNFPA's IPs and the insufficient analysis of existing monitoring data in the country office itself.</i></p> <p>The main factors that have contributed to weak monitoring in the Sudan country office are the largely low quality of the design of the current monitoring systems, including the design of indicators. Indicators used by UNFPA in Sudan have typically captured the activity level, but not the agreed "outputs" (i.e., outcomes) of UNFPA support. As a result, progress towards achieving these outputs is generally not monitored. In addition, both UNFPA IPs and to a lesser extent the UNFPA country office have demonstrated highly variable capacity to usefully analyze the available monitoring data for the purpose of drawing lessons for future programming, or managing lessons for continuation of an existing project. In particular, efforts to assess the existence of a logical link between the monitored activities and the higher level "output" results data have been insufficient<sup>832</sup>.</p>

<sup>829</sup> Government partners.

<sup>830</sup> UNFPA, government and development partners interviews.

<sup>831</sup> UNFPA staff interviews.

<sup>832</sup> Interview with UNFPA, review of protocols of quarterly review meetings, etc.

	<p>UNFPA has been conducting capacity assessments of their IPs as standard practice, but has been obtaining information on the M&amp;E capacities of their IPs primarily from the “way they are reporting”<sup>833</sup>. It is unclear to what extent UNFPA has then adjusted its M&amp;E requirements to the actual M&amp;E capacities of its IPs. IPs had the option to attend standardized courses on M&amp;E relevant topics, such as a course on results-based management that was offered by the regional office / headquarters, and appreciated by the IPs<sup>834</sup>. There is no information to suggest that IPs have received any customized technical support in matters of M&amp;E.</p>
<p>Findings from case study in <b>Zambia</b></p>	<p>See 8.2</p>

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<sup>833</sup> Interview with UNFPA.

<sup>834</sup> Interviews with IPs.

## 8.2.9 Evaluation question 9: To what extent has UNFPA helped to ensure that maternal health and sexual and reproductive health are appropriately integrated into national development instruments and sector policy frameworks in its programme countries?

### Judgment criterion 9.1: UNFPA support improved comprehensiveness of analysis of causes for poor maternal health and of effectiveness of past maternal health policies / strategies

Findings from <b>desk study</b>	UNFPA also supported skill-building and other technical support in data collection and analysis <sup>835</sup> through the Population and Development component of its country programmes. These had the potential to contribute to the improved availability of appropriately disaggregated data (disaggregated spatially, gender, socio-economically, ethnically, etc.). However, in a number of countries, important necessary conditions for lasting contributions to an improved availability and use of disaggregated data for maternal health policy-making and programming were not fulfilled. In these cases, the technical trainings and other skill-building activities supported by UNFPA were too narrowly focused to sufficiently address underlying capacity gaps in the beneficiary organization, which prevented trainees to use their newly acquired skills after the training. <sup>836</sup>
Findings from case study in <b>Burkina Faso</b>	<p><i>Le soutien de l'UNFPA a permis d'harmoniser et de définir plus avant les indicateurs de santé maternelle et d'obtenir des informations plus précises en ce qui concerne la santé maternelle.</i></p> <p>Les types de données recueillies (par le SNIS, les EDS et le recensement RGPH) sont révisés avec le support de l'UNFPA et des autres partenaires afin de répondre aux besoins de programmation et de suivi. Toutefois les besoins en informations désagrégées sont plus importants que ce qui peut être intégré dans ces différents outils et les négociations sont parfois ardues entre les différents acteurs pour inclure de nouveaux indicateurs répondant à leurs besoins. Par exemple le taux de mortalité maternelle était inclus dans l'EDS 1998 mais pas dans l'EDS 2003 par contre il est inclut dans l'EDS 2010 mais les résultats n'étaient pas encore disponibles au moment de l'évaluation.</p> <p>Les indicateurs de la Stratégie de Croissance Accélérée et de Développement Durable (SCADD) (2011-2015) sont les indicateurs des OMD similaires aux indicateurs du PNDS et de la feuille de route. La feuille de route contient des indicateurs plus précis mais leur suivi ne semble pas constant.</p>
Findings from case study in <b>Cambodia</b>	<i>Cambodia is a well-documented country when it comes to reproductive health/maternal health and this is due to no mean effort by UNFPA, which has supported policy development, assessments and upgrades of technical documents in support of removing barriers to maternal health and improving effectiveness of reproductive health/maternal health planning and programming.</i>

<sup>835</sup> Including the preparation and implementation of surveys (censuses, Demographic Health Surveys).

<sup>836</sup> In Burkina Faso, for example, technical trainings in data management systems had not been appropriately accompanied by an overall comprehensive analysis of overall organisational needs of the benefitting organisation; and had not been complemented by capacity development at sub-national level in addition to the national level to ensure that districts and provinces were able to generate data for the national level. In Ghana, technical trainings lacked follow-up and complementary support to ensure that trainees had access to the tools they had been trained in (in this case, access to the software required to run the new Management Information System (IMIS) at their workplaces in the districts). Improved evidence-based planning and policy making for maternal health was also hindered by the fact that increased awareness of the importance of data; and thus the demand for these data on the part of policy makers had not been established. The CP Evaluation for Tanzania also concluded that the capacity development approach, e.g. for census staff was too narrow by focusing on short-term courses and longer-term Masters Degree programmes.

The main analytical documents cited as evidence of effective support by UNFPA, perceived by interviewees as building blocks pioneered specifically for reproductive health/maternal health programming and effectively utilized by the Government were:

**Birth Spacing Policy** 1995 that legalized family planning services and its integration with MCH services.

**National Safe Motherhood Action Plan**, 2001-2005 whose aim was to promote the health of the woman and her newborn and was highly targeted to meet the needs of the poor and the disadvantaged.

**National Population Policy** 2003 for the first time envisioned rights based approach to SRH and promoted partnership between central and local Government in collaboration with civil society and private sector to remove barriers to reproductive health/maternal health.

**Health Workforce Plan** 2006 – 2015 which identified priority areas in reproductive health/maternal health (among others) that needed to be addressed so that MoH understands causes for poor maternal health from the perspective of the supplier and to guide, monitor, regulate the production and deployment of midwives through sound governance, training and quality management.

Sexual and Reproductive Health

**Health Strategic Plan**, 2003-2007, 2008-2015 (both have defined and elaborated on the Minimum and Complementary Packages of Activities for reproductive health/maternal health/family planning)

**Midwifery Report 2006** that highlighted MoH weaknesses because of low capacity of its health force and the poor state of emergency care in health centers and district hospitals and instigated the far-reaching Midwifery Programming.

**Midwifery Action Plan** 2007-2010 is the first centerpiece document, which focuses on increased coverage by competent midwives, increases in midwives education and training capacities, improvement of deployment and retention of midwives in remote and rural areas and increases the attractiveness of midwifery as a profession.

**National Strategy for Reproductive and Sexual Health in Cambodia**, 2006-10 (and current review) is the cornerstone for maternal health programming in Cambodia, which has through HSSP II sought to improve policy and resource environment, increase availability of skilled personnel and strengthen delivery of services, include communities and expand evidence base to inform policy.

**Strategic Plan for HIV/AIDS and STI prevention and Care** (2001-2005) for the first time identified the most at risk population (MARP) and prescribed various partnerships for prevention of mother child transmission (PMCT)

Draft **National Strategic Plan for Adolescent – Friendly RSH Services** (2005-10) was the first multi-sectoral document of its kind to analyze barriers faced by youth in accessing SRH services, prevention of teenage pregnancy and contraceptive education.

**National Assessment – EmONC** (2009) is the second centerpiece document, which determined the availability, functioning, quality and utilization of EmONC services, identified barriers there in and established a baseline for the first time to monitor progress.

**EmONC Improvement Plan** (2010 – 15) is the third centerpiece document, which seeks to improve the readiness of reproductive health/maternal health outlets especially Health Centers and District Referral Hospitals to provide quality service to the poor and disadvantaged.

Population and Development

Cambodia Population and Household Census 1998, 2008\* Cambodia Inter-censual Population Survey (2004)

**Cambodian Demographic Health Survey** (2000, 2005 and 2010) is the milestone monitoring document that provides trends and up-to date information on all the relevant indicators for reproductive health/maternal health as noted in the **National Population Policy Indicators** which feeds into the Cambodian MDGs

Gender

Cambodia Gender Assessment 2004, 2008

Findings from case | L'UNFPA a cherché à renforcer la prise en compte de la santé reproductive dans le développement des stratégies de planification au



study in <b>DR Congo</b>	niveau national. Il a, par exemple, organisé un atelier et un colloque scientifiques en 2010, destinés à renforcer les compétences en planification dans ce domaine. Par ailleurs, la cartographie entreprise avec le soutien de l'UNFPA et de l'USAID montre les efforts mis en œuvre pour atteindre une certaine cohérence dans le cadre des politiques de santé reproductive.
Findings from case study in <b>Ghana</b>	<p><i>UNFPA provides technical, financial and logistical support in the gathering and analysis of data. UNFPA Ghana has developed a three-pronged approach to support policy, programme and public advocacy.</i></p> <p>Decision makers in National Development Planning Commission (NDPC), National Population Council (NPC) and Ghana Statistical Survey are made aware of the importance of relevant maternal health/reproductive health disaggregated data and hence there is strong support among them for the national system of data collection and analysis which has increasingly become indispensable to MoH/GHS as service is decentralizing and rapidly expanding<sup>837</sup>.</p> <p>UNFPA has a highly positive relationship with the government (GHS) as its IP<sup>838</sup>; the country office with WHO acts as the bridge to GHS for Maternal Mortality issues within UNDAF and is fully represented in meetings and monitoring the achievement of all 3 Road Maps (Abuja/Maputo, CARMMA and Re-positioning family planning).</p> <p>UNFPA has Civil Society Organizations involved in awareness raising, sensitization and services and these CSOs are often linked directly to community initiatives by the public health system and through the respective Programme Component Managers<sup>839</sup>.</p>
Findings from case study in <b>Lao PDR</b>	<p><i>UNFPA has supported the generation of maternal health related disaggregated data that were included in the existing maternal health related strategies and other government policies. Nevertheless this is a building up process and the upcoming Lao Social Indicator Survey (LSIS) will provide data allowing further disaggregation.</i></p> <p>Policy documents such as the National Socio Economic Development Plan NSEDP (2006-2010), Health Sector Strategic Plan (HSSP), and even the MNCH package refer to the Census 2005, the LRHS 2005, both supported by UNFPA and the Lao MICS III 2006<sup>840</sup>. A certain degree of disaggregation has been achieved in the LRHS e.g. per province, urban/rural with road and without road but there is still a need to further disaggregate information such as ethnic groups, vulnerable groups, wealth quintile, etc. in order to refine maternal health needs assessment.</p> <p>The Lao Social Indicator Survey (LSIS), which is being undertaken with UNFPA support, is the largest survey undertaken in Lao PDR to measure progress on social development. The indicators and data to be collected (including maternal health related information) were discussed at length. An in depth analysis will allow to obtain a lot of disaggregated data<sup>841</sup>.</p>
Findings from case study in <b>Madagascar</b>	<p><i>UNFPA supports evidence creation of disaggregated data for maternal health through technical support and thus enables more focused interventions. Nevertheless, many data from other sources remain unused as they are dispersed and not linked or harmonized on national level. An analysis on effectiveness of past maternal health policies has as such not been performed, but the existing DHS data suggest at least a lack of effective implementation.</i></p> <p>Whilst no dedicated training on the importance of disaggregated data were conducted by UNFPA (other than the RBM trainings), it nevertheless aims to influence policy development through its initiation of and /or participation in technical working groups, surveys and</p>

<sup>837</sup> Interview with Government.

<sup>838</sup> Interview with External Development Partner.

<sup>839</sup> Interview with CSOs.

<sup>840</sup> Supported by UNICEF.

<sup>841</sup> Government partners and UNFPA staff interviews.

	needs assessments. These are jointly conducted with national counterparts and frequently based on requests from the MoH in the annual planning meetings (atelier d'estimation de besoin), and designed with the help of the UNFPA M&E officer <sup>842</sup> . As mentioned in evaluation question 1 and above, UNFPA supports in addition to the DHS a variety of studies <sup>843</sup> to evaluate causes for poor maternal health, which then feed into the planning of national programmes and policies. The household surveys and demographic health surveys include MDG and ICPD indicators. UNFPA lobbied successfully to include additionally gender, HIV and maternal health, reproductive health commodity security indicators into the 2008/2009 DHS. <sup>844</sup>
Findings from case study in <b>Sudan</b>	<p><i>UNFPA in Sudan has improved the comprehensiveness of the analysis of causes for poor maternal health and maternal deaths. No specific analyses have been supported to gauge the effectiveness of past maternal health policies or strategies.</i></p> <p>Most of the relevant policy frameworks (reproductive health policy, MNR road map, midwifery up-scaling strategy) have been drafted with UNFPA support. These policies are making reference to the evidence created by the various studies and reports that have been produced with UNFPA support over the recent years, such as the Census (2008), reproductive health situation analyses (2009) and other relevant assessments. However, the significance of policy level commitments for bringing about corresponding action of the Sudanese Government has been shown to be low in the past (see evaluation question 2).</p>

**Judgment criterion 9.2: Maternal health and SRH integration into policy frameworks and development instruments based on (UNFPA supported) transparent and participatory consultative process**

Findings from <b>desk study</b>	Beyond this, information on the underlying process for the development of maternal health and SRH policies; and the integration of maternal health into health sector policies and frameworks is limited <sup>845</sup> . The UNFPA-supported “participatory policy events” and technical working groups are cited as a contributing factor in the development of SRH and maternal health-relevant policies <sup>846</sup> . At least in some cases, the same events are thought to have lacked adequate follow-up to have effectively increased acceptance, support and legitimacy of maternal health policies and frameworks. <sup>847</sup>
Findings from case study in <b>Burkina Faso</b>	<p><i>Grâce à un plaidoyer soutenu à plusieurs niveaux ainsi qu'aux efforts de l'UNFPA, en collaboration avec les partenaires techniques et financiers, pour appuyer la planification sanitaire ainsi que la traduction opérationnelle du plan d'accélération de la réduction de la mortalité maternelle la santé maternelle est inscrite dans les stratégies de développement du Burkina Faso et fait partie des axes prioritaires du gouvernement.</i></p> <p>L'UNFPA a effectué un plaidoyer et a appuyé financièrement et techniquement des ateliers lors de l'élaboration de la loi SR qui a été</p>

<sup>842</sup> To this aim she participated in the EMoNC assessment in Benin, prior to the one conducted in Madagascar.

<sup>843</sup> As for example the: « Étude sur la disponibilité et l'accessibilité des Services de SR et de PF », 2008.

<sup>844</sup> Information from CoM.

<sup>845</sup> Evaluations for a number of UNFPA country programmes cite that relevant sectoral policies have been developed; and that their development is connected to UNFPA advocacy and technical support. However, the evaluations do not provide sufficient details on the specific role that UNFPA has played to support an assessment of UNFPA's contribution.

<sup>846</sup> Examples are midwifery forums in Cambodia; or informational forums with parliamentarians on MNCH services and SBA in Lao PDR.

<sup>847</sup> E.g., in Lao PDR, where sensitisation workshops with parliamentarians and other decision makers had raised awareness of maternal health challenges (according to interviews held with the participants), but where UNFPA and GoL had failed to agree on adequate follow-up actions to the initial events that would have helped to facilitate the translation of the raised awareness into policy initiatives or programmes of UNFPA in Kenya seems to have encountered a related, but different situation of “symbolic policy making”. The “Adolescent Reproductive Health and Development Policy” was eventually not implemented / translated into programmes, “largely because of the sensitivity of adolescent matters in the country” (UNFPA Kenya, 2008).

	<p>adoptée en 2005 ainsi que sa diffusion. Elle a été traduite dans certaines langues nationales du pays grâce à un financement de l'UNFPA. Il a également pris une part importante en soutenant la DSF/DSME lors de l'opérationnalisation du plan d'accélération de la réduction de la mortalité maternelle. En 2004-2005, le coût des services ayant été reconnu comme un frein à l'accès aux services une assistance technique auprès de la DSF et un plaidoyer auprès des parlementaires a permis que le gouvernement vote des lois de finances permettant l'application de la subvention des SONU. En même temps un plaidoyer à différents niveaux s'est traduit par une priorité donnée à la santé maternelle par le gouvernement et un engagement budgétaire avec la création de plusieurs lignes budgétaires: les produits SR, la subvention des SONU, la gratuité des soins préventifs pour les enfants et les femmes, les intrants PTME, la prise en compte des personnes vulnérables. Le plaidoyer sur la problématique de la santé maternelle implique aussi des journalistes et des membres des organisations de la société civile.</p> <p>Ces actions de plaidoyer à différents niveaux ainsi que les discussions liées aux OMDs ont entraîné l'inclusion de la santé maternelle dans la Stratégie de Croissance Accélérée et de Développement Durable (SCADD). Plus récemment l'UNFPA a contribué à l'évaluation du PNDS 2001-2010, à l'analyse de la situation sanitaire, à la relecture de la Politique Sanitaire, à l'élaboration de la stratégie nationale de financement basé sur la performance, à la participation aux États Généraux de la santé, à la revue du secteur de la santé dont un des thèmes spécifiques était l'état des lieux en matière de santé maternelle et infantile et à l'élaboration d'un document de plaidoyer et présentation de ce document en conseil des ministres pour la gratuité des services de santé maternelle et la planification familiale.</p>
<p>Findings from case study in <b>Cambodia</b></p>	<p><i>Overall, UNFPA contribution to policy and regulatory initiatives has been focused on a combination of high-profile political advocacy and public relations. UNFPA's logistical, financial and communication support to the National Committee on Population and Development (NCPD) within the Council of Ministers, the Cambodian Association of Parliamentarians for Population and Development (CAPPD) and the High Level Midwifery Forum has translated into a coordinated and coherent push to strengthen the integration of maternal health into Cambodia's health policy framework. It is too early to gauge the effect of the H4+ event around the Secretary General's Action Plan on Maternal Health.</i></p> <p>Through NCPD, UNFPA has consistently engaged in evidence-based advocacy with high-level politicians and national policy level decision-makers like the Prime Minister, the Council of Administration Reform (CAR) and the Ministry of Economy and Finance. When there was a need for midwives and additional political commitment was required, UNFPA and MoH approached NCPD to conduct a small campaign on Midwifery for All (2004), which culminated in a Midwifery Forum (2005), the two campaigns "Giving Birth with Skilled Attendants" and "No One Should Die Giving Birth" (2009). MoH has supported these forums every 4 years. In 2010, MoH was provided a 13% increase in health funding, and a large part of this funding is to be allocated to reproductive health/maternal health<sup>848</sup>.</p> <p>The Cambodian Midwife Council (CMC) has a Code of Ethics that was the product of intensive consultations with a broad range of stakeholders. The Council is seeking to make the code a decree/law. The Council has already received the support of Council of Administrative Reform for this initiative. These results are facilitated by the trusted relationship UNFPA has with the Government.<sup>849</sup></p> <p>Within CAPPD, UNFPA's contributing role has been well recognized. In the last fifteen years of "co-operation between UNFPA, UN and relevant ministries, Parliament has helped to pass important laws relevant to expanding maternal health activities".<sup>850</sup> Key Parliamentarians who are members of the Health, Women and Children Committees have participated in developing strategies and</p>

<sup>848</sup> Government Partner.

<sup>849</sup> External Development Partner.

<sup>850</sup> Government Partner.

	<p>policies that have been presented in various co-ordination meetings, NGO Forums and public gatherings. The First Lady signed up with CAPPD in 2010 after attending the Women Deliver Conference and was recognized as a Champion for maternal health. When Government halted new recruitment into the civil service in 2007, CAPPD helped increase trainings and recruitment of midwives and nurses. Currently, each Health Centre has at least one midwife. However, as the decree calls for a minimum two midwives per center, parliamentarians have increased the salaries of midwives and helped add prestige to their positions to attract additional staff members. CAPPD's advocacy has also resulted in a 10% increase in health budgets annually from 2011. UNFPA took part in the dialogue regarding policies such as Incentive to Providers for Delivery and the Health Equity Fund.<sup>851</sup> In addition to the above advocacy initiatives, UNFPA supports the Population and Development Annual Meeting (five meetings in each region) by NCPD with Governors, Provincial, District and Commune Councilors. In the last five years, the selected topics have been policy briefs, fact sheets and policy tools on the integration of midwifery services, the EmONC Assessment and the EmONC Improvement Plan. Reproductive health/maternal health Dialogue with Parliamentarians Forum occurs two times a year at the national level and includes policy review and dialogue. UNFPA also helps organize maternal health workshops for parliamentarians and Public Health Directorates, communes, primary beneficiaries (community men and women) and NGOs. The Annual Commune Council Forums are considered an important avenue, especially as the Ministry of Women's Affairs (MoWA), MoI and MoH are jointly promoting messages on utilization of Health Centers, the importance of assisted birth, ANC and Post Natal Care (PNC) and increasing staff such as midwives. High Level Policy Makers Round table discussions on population and health (2008) and three debates on increasing utilization of health facilities (2009) were facilitated by UNFPA and the Cambodian Health Education and Media Services (CHEMS)<sup>852</sup>.</p>
<p>Findings from case study in <b>DR Congo</b></p>	<p>Comme nous l'avons déjà noté, l'UNFPA a pris les devants dans le processus de planification pour le prochain recensement. En outre, il a fortement encouragé l'inclusion des indicateurs de la santé reproductive dans l'analyse des besoins et dans la définition des priorités et a participé avec d'autres partenaires à des efforts visant à améliorer la production de statistiques fiables, par exemple dans le cadre de la publication ministérielle de l'Enquête MICS en mai 2011. L'engagement du gouvernement reste toutefois faible.</p> <p>L'UNFPA a également contribué dans le domaine de la communication. Cette démarche s'appuie sur la mise en place de mécanismes tels qu'une collaboration avec des associations de journalistes, des agences de presse, des associations participant à la société civile et des représentants des milieux politiques aussi bien que la publication et distribution de supports de communication (affiches, bandes dessinées, boîte à images). Malheureusement, des moyens financiers suffisants pour la mise en œuvre ne sont pas disponibles.</p>
<p>Findings from case study in <b>Ethiopia</b></p>	<p><i>The ECO has supported through financial, technical and logistical assistance the formulation of policies and strategies, maternal health and SRH are prominently represented in the relevant documents. Regional initiatives as the CARMMA were equally supported together with other partners and integrated in the frameworks.</i></p>

<sup>851</sup> Government Partner.

<sup>852</sup> With regard to public relations, UNFPA performs the following:

- The development of television and radio spots on the important role of men in maternal care, migration and informed choice, lessons learned, the critical role of the Health Equity Fund (both for beneficiary and policy), and seminars on positive views of midwifery, in partnership with UNESCO, UNDP HRD and Alliance Française. Criteria on how to advocate for services for the poor has been developed between MoH, RAC and UNFPA.

- Campaigns and public events with the Khmer Youth Association (poor and migrant youth), NCPD (high-level policy makers), such as the State of the World Population Day, whose focus for the last 3 years has been on improving maternal health, SG's Plan of Action on maternal health and International Midwives Day.

- Hear Beneficiaries Talk, with photo clips and a voice forum.

	<p>UNFPA influenced and supported policy making through its participation in technical working groups, surveys and research. Amongst others, UNFPA lobbied successfully to include gender, HIV, maternal health and reproductive health commodity security indicators in the Demographic Health Survey in 2011. Also, it and supported the recognition of adolescent girls and young women's vulnerability on sexual and reproductive health, HIV and harmful traditional practices, gender based violence, including child marriage and female genital mutilation/cutting. The country office supported the launching of the National Adolescent and Youth Reproductive Health Strategy (AYRHS, 2007-2015) that aimed at tackling problems of early marriages and pregnancies, female circumcision, abduction, rape and poor access to care with persistent and active participation of UNFPA, the reproductive health road map, etc. It contributed to a standardization of health care through development of protocols (i.e. on management of major obstetric complications jointly with FMoH, WHO, UNICEF and national partners) and guidelines for "Repositioning Family Planning in Ethiopia," which is used for family planning programming.</p> <p>Ethiopia's commitment and engagement to improving performance with respect to MDG5 was fostered through initiatives such as the Campaign on Accelerated Reduction of Maternal Mortality in Africa. CARMMA was launched and adapted to the local context and all UN support the activities as part of the overall support, not as a special activity, as all activities are anyway within the H4 plan<sup>853</sup>.</p>
<p>Findings from case study in <b>Ghana</b></p>	<p><i>UNFPA Ghana has several publications that publicize the efforts of different initiatives for maternal health policy making and policy dialogue. Some of these publications have been catalytic to expanding programmes and partnerships. There are delays in important publication, some as long as six months.</i></p> <p>UNFPA's bi-annual policy digest is an evidence based tool for advocacy that is sent to key government and planning institutions. It has influenced the Re-positioning of family planning and drawn attention to gender-based violence and the effect of water and sanitation on family health, which has as a result been flagged for national attention. The private sector and media are utilizing policy digests increasingly<sup>854</sup>. UNFPA has provided strong support to the national Census, through production of Census fact sheets and publication of a special Census edition of the quarterly Springboard magazine, published originally by UNFPA and now by its CSO IP Curious Minds. UNFPA has also supported the State of Ghana Population Report (NPC) and the State of Ghana Population Report on Young People. There have however been publication delays with both from the government side hence beyond the control of UNFPA Ghana. UNFPA further supported the development of the EmONC needs assessments and related fact sheets as well as Culture Sensitivity Programming to influence policy in a multi-sectoral manner.</p> <p>Using media, UNFPA engages youth in policy and programme deliberations through its IP Curious Minds and high level journalists through MCAN (Media Communication and Advocacy Network). MCAN is a network that was created by UNFPA under the Africa Youth Alliance project (it is not a registered association). This network has seasoned journalists as members and engages opinion leaders and politicians to advocate on maternal health issues on radio, TV and in newspapers. MCAN has won awards for national maternal health related media coverage. Largely due to this influence, national media participation is increasing for population and development and is making the census not just an issue of citizenship but where the young have helped mobilize resources and promoted community engagement.</p>
<p>Findings from case</p>	<p><i>The KCO has supported through technical, financial and logistical assistance its line ministries in evidence creation for reproductive</i></p>

<sup>853</sup> Information from development partners.

<sup>854</sup> Interview with Government.

<p>study in <b>Kenya</b></p>	<p><i>health indicators; maternal health and SRH are prominently represented in policy frameworks. The engagement of the KCO in policy framework formulation has been reported since the 5<sup>th</sup> Country Programme<sup>855</sup>. Regional initiatives, such as CARMMA were equally supported jointly with other partners and under the guidance of the respective national partners.</i></p> <p>UNFPA is supporting policy making through its participation in Technical Working Groups, surveys and research. For example, UNFPA has lobbied successfully to include maternal mortality indicators in the 2009 Kenyan Population and Housing Census (KPHC). Within its population and development component, heads of district level departments have been trained to recognize the importance of data availability concerning adolescent girls and young women's vulnerability to Sexual Reproductive Health, HIV issues, gender-based violence, including child marriage and Female Genital Mutilation and Cutting for the District Development Planning. This has been reported to have increased willingness to include Reproductive Health indicators in respective planning processes. The participation of the KCO in the elaboration of the KPHC has ensured that relevant Maternal Health indicators are included<sup>856</sup>. According to the 2008-09 KDHS the maternal mortality ratio appears to be higher than the level of 414 from the 2003 KDHS, but the 95 percent confidence intervals range from 328 to 501 for the 2003 figure and from 333 to 643 for the 2008-09 figure. Consequently, the two estimates are not significantly different. This implies that it is impossible to say with confidence that maternal mortality has increased or decreased. It seems important to assess the maternal health indicators in the four focus regions to be able to define which interventions contributed most to increasing maternal health for the possible national roll-out of the centers of excellence initiative.</p> <p>Initiatives such as the Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA) have contributed to the current MDG 5 engagement in Kenya. Its launch was supported by the KCO, but was not considered as an initiative that would need to be followed up, as relevant activities are anyway taking place<sup>857</sup>. The KCO funds consultants/technical officers for up to five years in the MOYAS and in the ministry of Gender and Children Affairs with the aim to raise awareness and to contribute to the integration of Youth and gender issues into national policies. Positions are to be created by the ministries for these UNFPA funded officers, but relevant steps have yet to be taken.</p>
<p>Findings from case study in <b>Lao PDR</b></p>	<p><i>The MNCH package is a good model of integration of some key reproductive health elements with a strong focus upon maternal health. UNFPA contributed to its wider acceptance through providing evidence, advocating for maternal health and disseminating the strategy at sub national level. Nevertheless its operationalization still requires coordination efforts.</i></p> <p>The Reproductive Health Policy was developed in 2005 but was set aside after the MNCH package was developed. The MNCH package integrates various aspects of reproductive health including the SBA plan although its family planning component is not very strong and there are gaps such as ASRH particularly adolescent pregnancy, gender-based violence, and uterus cancer<sup>858</sup>. The MNCH package has been largely disseminated at provincial level with the support of UNFPA and the other development partners. Even though the document is relevant and coherent efforts for increased coordination between various MoH departments and between development partners are still necessary in order to define all the practicalities at implementation level. For instance the role of the Village Health Workers has</p>

<sup>855</sup> No earlier country programme documents have been available.

<sup>856</sup> 2008-09 KDHS: A strategy essential to reducing the high maternal mortality rates is to ensure that all births are managed by skilled health professionals. Currently the proportion of births managed by health professionals and the proportion delivered in a health facility are 44 percent and 43 percent, respectively. However, the use of health professionals at birth varies, and hence differences in the risk of maternal mortality in the country cannot be measured through the survey.

<sup>857</sup> Information from the KCO.

<sup>858</sup> Review of the implementation of the reproductive health policy and maternal, neonatal and child health package - October 2011.

	<p>been debated for a long time and is being reviewed under the concerned Technical Group.</p> <p>Several factors/events contributed to an increased the awareness of the government on the importance to address maternal health issue and to develop the MNCH strategy. A number of these events were supported by UNFPA such as the participation of MOH officials in various international events, a national level workshop where it was decided to conduct a SBA assessment and to develop a MNCH strategy, the SBA assessment as well as advocacy and capacity development of media and parliamentarians and the Celebration of the International Midwife day. The latter helped in raising the commitment of MoH and the national Assembly towards midwifery. Due to the long involvement of UNFPA with the parliamentarians, they are very committed to reproductive health. The review of MDGs achievements and the 2007 UN estimates showed that maternal health was 660 (worse than the 2005 Census estimate at 405/100,000 live births) was an important trigger as well.</p>
Findings from case study in <b>Madagascar</b>	<p><i>UNFPA can demonstrate some good examples of maternal health and SRH integration into national strategies (see also evaluation question 6) whilst overall the policy development is hampered by the lack of high level political engagement.</i></p> <p>Madagascar adheres to the MGD and ICPD frameworks; certain initiatives such as CARMMA have not been taken up, as the required higher political level for support of such initiatives is not accessible. The recent (CP 6) sensibilization and mobilization campaign for obstetric fistula demonstrates a good example of UNFPA efforts to promote its mandate: based on the results of a follow –up survey on the advocacy campaign, the MoH has integrated the requirement to support obstetric fistula patients countrywide into the national plan.<sup>859</sup> Whilst the outcome that hundred patients were operated may not be regarded as a big impact, the fact that obstetric fistula is now also integrated in the H4+ and the national plan, may already be regarded as a success.</p>
Findings from case study in <b>Sudan</b>	<p><i>Especially considering the difficult context of Sudan for advocacy and awareness rising on maternal health, UNFPA has established working relationships to a relatively diverse group of stakeholders, including a number of Government Ministries and other bodies. In spite of this, awareness rising on maternal health has remained a difficult and contentious endeavor in Sudan, and UNFPA has needed to tread lightly, and advocate for issues like family planning very carefully. A transparent and participatory consultative process of the kind that UNFPA might have initiated in other countries would therefore neither have been possible nor productive in Sudan.</i></p> <p>UNFPA has worked on affecting in particular the issues of gender-based violence, Female Genital Mutilation (FGM) and early marriage by means of advocacy awareness raising campaigns. Among the mechanisms to affect policy or legal changes have been awareness raising campaigns directed at parliamentarians. In addition, UNFPA has established close relationships with a number of policy-relevant organizations, such as the National Population Council, the Ministry of Social Welfare and Gender or the Ministry of Guidance (in addition to its relationship with the Ministry of Health). These relationships have also been used to discuss policy-relevant issues and to work on policy changes on the above topics<sup>860</sup>.</p>
Findings from case study in <b>Zambia</b>	<p><i>Overall, UNFPA’s contribution to policy and regulatory initiatives has been focused on logistical and financial support of planning and policy dissemination workshops. The mostly logistical and financial support provided by UNFPA to the launching of CARMMA and the development and revision of Zambia’s Maternal and Newborn Health Road Map did not translate into a coordinated and coherent push</i></p>

<sup>859</sup> Initially UNFPA supported a sensibilisation and mobilization campaign through the media, house visits, community involvement in the region of Atsimo Andrefana, followed by a survey which indicated that about 70.000 women suffer from obstetric fistula in Madagascar. Over a 100 were operated through the support of UNFPA.

<sup>860</sup> Based on information from UNFPA, the country office has advocated in particular on the issues of female genital mutilation, e.g., with the Ministry of Guidance

*to strengthen the integration of maternal health into Zambia's health policy framework.*

UNFPA support to the development of policies and frameworks for maternal health focused on providing financing for logistics (printing) or workshops for planning and dissemination. UNFPA often had to be absent from relevant policy level forums<sup>861</sup> and has even been perceived at times to shy away from addressing sensitive policy issues with the Government<sup>862</sup>. On the other hand, UNFPA's advocacy for the Safe Motherhood Action Groups (SMAGs) that had started during UNFPA's 5<sup>th</sup> Country Programme is seen as a positive contribution that has helped to establish the SMAGs in the Government strategies and policies; and in the approaches of development partners<sup>863</sup>.

CARMMA and the revision of Zambia's Maternal and Newborn Health Road Map are coherent at the level of objectives and have fed into each other. For example, the Road Map was used in the launching of CARMMA and informed the focus of the campaign. However, UNFPA has not successfully established coherence between these UN-driven initiatives and the maternal health support of other donors, i.e. those represented in the SWAp fora<sup>864</sup>. Although formally introduced into these fora, neither of these initiatives has been adopted by other partners. In the case of CARMMA, no concrete information on the operational follow-up to the CARMMA launch was readily available to partners or to the interested public in general, which deterred at least some development partners from following up on the initiative<sup>865</sup>.

The low level of follow up to the CARMMA launch is also exemplified by the fact that the Ministry of Health has no designated staff member to help maintain the momentum that had been created; and that the Ministry itself does not have an operational plan for following up on the launch. The status of the MNH Road Map is somewhat unclear: the majority of UNFPA's development partners were not familiar with the document, suggesting that the document has not yet had a significant effect on shaping the maternal health agenda of Zambia's development partners in maternal health (e.g. in relation to Zambia's health SWAp). At the same time, the Ministry of Health used the MNH Road Map to underscore the Government's commitment to reducing maternal mortality during the negotiations between the United States Government and Zambia for an increased US-engagement in maternal health in Zambia<sup>866</sup>. The Government also maintained that the amended version of the Road Map<sup>867</sup> had been integrated into the latest National Health Strategic Plan<sup>868</sup>.

### **Judgment criterion 9.3: Monitoring and evaluation of implementation of SRH / maternal health components of national policy framework and development instruments**

<sup>861</sup> Feedback from UNFPA (with reference to the low staffing levels at the country office) and from the majority of development partners.

<sup>862</sup> An example given was the initiative of the GRZ to procure a number of mobile health units / hospitals for use in rural areas. The majority of development partners opposed this effort because they doubted the sustainability of this approach. UNFPA was perceived to "attempt to avoid bringing this issue up in the first place".

<sup>863</sup> To illustrate: the 2011 work plan of the MoH foresees support to SMAGs from GRZ budget resources (e.g., the "scale-up of SMAGs to 10 districts"; supported with approx. 89 million Kwacha (approx. US\$ 18,000); other SMAG related activities are to be financed with donor funds); DfID, USAID are utilizing the SMAGs in their maternal health-related interventions in Zambia –see also Evaluation questions 3 on "Community involvement / demand orientation and CSO partnerships".

<sup>864</sup> The majority of donors were not familiar with the maternal health road map.

<sup>865</sup> For example, no website exists to make available information on the CARMMA initiatives as such; or on the follow up to the launch, e.g., with regard to the fulfilment of financial pledges; or with regard to other programmes to improve maternal health in Zambia.

<sup>866</sup> Mentioned in interview with MoH / GRZ.

<sup>867</sup> An amended version of the maternal health Road Map was published in 2011, to reflect implications from new data from the most recent ZDHS.

<sup>868</sup> The evaluators did not obtain a copy of this plan.



Findings from <b>desk study</b>	<p>Technical support to strengthen M&amp;E mechanisms and tools was also mostly delivered as part of the population and development component of country programmes. The assistance targeted the development of national M&amp;E strategies (e.g. in Ivory Coast); the development of “Monitoring and Evaluation Frameworks for Population and Development Programmes” (Kenya); or support to update and develop M&amp;E related management information systems (e.g., the Malawi Social Economic Database (MASEDA) in Malawi). Country evaluations have not provided a lot of information on the extent to which important conditions for the success of this of support had been fulfilled; i.e. in particular the leadership and ownership of the M&amp;E initiatives by the beneficiary Governments; the clear assignment of responsibilities for the use and maintenance of new tools; and the actual use of the provided tools. In Cote D’Ivoire, newly developed M&amp;E templates that UNFPA had financed under its population and development sub-programme had not been adopted for the national M&amp;E system, even though they had been developed for that purpose. In Malawi, the new national database whose development UNFPA had supported<sup>869</sup> had yet to be established. No information was available to assess the extent to which the M&amp;E tools were appropriate for capturing maternal health related information.</p>
Findings from case study in <b>Burkina Faso</b>	<p><i>Le processus en cours pour réviser les indicateurs en santé maternelle du SNIS permettra une mesure plus précise de ces indicateurs, toutefois l'amélioration du système d'information est une condition essentielle pour obtenir des données fiables quant aux progrès réalisés.</i></p> <p>La Direction générale de l'information sanitaire et de la statistique (DGISS) (nouvellement créée) est en train de redéfinir/réviser les indicateurs du SNIS car certains indicateurs ne sont pas définis de façon assez précise. Les données collectées par le biais du SNIS toutefois sont à considérer avec précaution sachant que le système n'est pas encore totalement performant bien que les PTFs (dont l'UNFPA) apportent un soutien pour l'améliorer.</p>
Findings from case study in <b>Cambodia</b>	<p><i>Apart from supporting the implementation of long-term national health surveys, UNFPA has not supported the development of any maternal-health specific monitoring and evaluation tools linked to the Midwifery Action Plan or the EmONC Improvement Plan. It has relied mostly on the UNFPA / MHTF internal monitoring system and the HSSP II external monitoring system. The effectiveness and efficiency of the various political and public advocacy initiatives have not been independently assessed.</i></p> <p>UNFPA has had success in the areas of policy change for family planning, midwives programming (incentives, salaries and placement/deployment), with the conduct of a NA-EmONC and the rapid implementation of the EmONC Improvement Plan<sup>870</sup>. Less has been accomplished in the areas of legislation and resource mobilization related to domestic violence, trafficking, safe abortion, PMCT and Reproductive Health Equity Fund<sup>871</sup>.</p> <p>The process leading to the current update of the National Strategy on Reproductive and Sexual Health was largely participatory. However, one interviewee commented, “<i>the strategy development mandate is now with an NGO that has outsourced it to another consultant and UNFPA is only back stopping</i>”<sup>872</sup>. On the other hand, UNFPA Cambodia is aware of the risks entailed in the process. The</p>

<sup>869</sup> The Malawi Social Economic Database (MASEDA).

<sup>870</sup> External Development Partner and Government Partner.

<sup>871</sup> Government Partner.

<sup>872</sup> NGO Partner.

	product <i>and</i> the consultant are closely managed by senior managers <sup>873</sup> . It has been noted that in the future the RSH Strategy will be become the Sexual and Reproductive Health Strategy. <sup>874</sup>
Findings from case study in <b>Ethiopia</b>	Whilst UNFPA has supported the development of a variety of policy documents, standards and guidelines, no specific tool is being utilized to monitor the uptake and implementation of such policies.
Findings from case study in <b>Ghana</b>	<p><i>UNFPA as the co-chair with National Development Planning Commission in M&amp;E government led Sector Working Group gives it tremendous influence in introducing tools and controlling systems that have been adopted to monitor national reproductive health/maternal health policies and programmes. However UNFPA's dependence on National Population Council (NPC) which has extensive monitoring role has its share of challenges.</i></p> <p>The Assistant Representative of UNFPA is writing the M&amp;E section for the National Health Plan. There is currently an ongoing effort to establish a system for a data collection, taking cognizance of all the other surveys that have been undertaken. Two tools were developed in 2010-11: Joint Monitoring Template and annual work plan Monitoring Tool (which is breakdown of the CPAP monitoring). These tools are used intermittently but the results are not always well utilized to inform government programme. In between times, these tools get lost and have to be re-discovered<sup>875</sup>.</p> <p>The NPC has been weak in reporting on UNFPA funded activities and there has not been effective feed-back from them to other ministries but especially Ministry of Finance and Economic Planning (MoFEP). The link between NPC and ministries use to be stronger with previous governments, rather than the current one. Under the current arrangement of monitoring, NPC is the technical coordinator whilst the MoFEP plays the financial management role and UNFPA support has encountered some challenges in this relationship. The MoFEP is following a results-based financial management system and so must be informed on outcomes of support from development partners which has suffered due to the fact that the position of UNFPA Country Representative was not filled for two years.<sup>876</sup></p> <p>The MoFEP has taken advantage of the preparation of the CP6 to re-visit the need for proper coordination and feedback on UNFPA activities and this is receiving attention from the current Country Representative. The UNFPA Representative is considered proactive and is likely to ensure more efficient coordination among public IPs and the ministry. UNFPA involved the MoFEP in workshops and seminars and collaboration seem to be getting back on track and there is some re-emergence of proper coordination from UNFPA. In August 2011, UNFPA conducted for the first time joint UNFPA/government/CSO partners monitoring missions to all five regions simultaneously to look at progress of programme implementation for the past half year. These findings have informed the development of the new "Deliver As one five-year plan for 2012 to 2016 (UNDAF). The Ghanaian President's Office has constituted its own data collecting system for some key indicators including health rather than using the ones provided by GSS<sup>877</sup> which is disconcerting<sup>878</sup>.</p>
Findings from case study in <b>Kenya</b>	<i>National frameworks frequently lack detailed implementation plans providing guidance on the day-to-day management of programmes defined by the policy frameworks. The UNFPA is considered by partners as key player to initiate the development of reproductive health</i>

<sup>873</sup> UNFPA Cambodia.

<sup>874</sup> UNFPA Cambodia.

<sup>875</sup> Interview with Government Partner.

<sup>876</sup> Interview with Government Partner (national).

<sup>877</sup> Interview with UNFPA.

<sup>878</sup> Interview with CSOs.

	<p><i>related business plans for the current and future policies.</i></p> <p>Whilst UNFPA has supported the development of a variety of policy documents, standards and guidelines<sup>879</sup>, no specific tool is being utilized to monitor the uptake and implementation of such policies. Some of these documents have not been officially launched and/or disseminated for public use and for some a separate M&amp;E framework exists (gender mainstreaming, HIV/AIDS, population and development, Reproductive Health 2001-2005). The delay in publication/dissemination of such documents was explained by lack of absorption capacity in the MoH and the division of the former MoH into two Ministries of Health; since March 2007 two separate Ministries, one of Public Health and Sanitation and one of Medical Services exist<sup>880</sup>.</p> <p>But also, in spite of the existing strategies and annual work plans, there is still a lack of business plans, which clearly operationalizing the plans and define measures and actions to be taken for implementation of the strategies. Several donors, such as DFID, GIZ, DANIDA and UNICEF have embarked on supporting the Department of Reproductive Health in developing a business plan for the Reproductive Health Policy to fill this gap. DFID would like to see UNFPA play a key role in this process, as it has the means to leverage a broad range of partners.</p>
Findings from case study in <b>Lao PDR</b>	A list of indicators has been defined as part of the MNCH package, at impact and outcome level. UNFPA has been part of the discussions regarding the definition of these indicators and more recently of the discussions concerning their revision. Although their definition needs refinement they are in line with international maternal health indicators.
Findings from case study in <b>Madagascar</b>	<i>National policies and development instruments are monitored according to the targets of its operational plans and not by UNFPA (or others) developed maternal health specific monitoring and evaluation tools.</i>
Findings from case study in <b>Sudan</b>	<p><i>UNFPA has ensured that the policies it helped to develop contain appropriate sets of indicators to capture progress towards the fulfillment of the strategic objectives. However, although the policies include appropriate indicators, it is not clear, and has not been clarified by UNFPA, how Sudan will manage to collect information on these measures. This is especially significant as the weaknesses of the Sudanese M&amp;E system in health will likely also affect the data collection for these new strategies.</i></p> <p>MNH specific indicators were included in Sudan's recently expired Health Five-Year Strategy (2007 – 2011); however, there is no indication to suggest that UNFPA has been involved in drafting the strategy or in ensuring that appropriate indicators were included<sup>881</sup>. The relatively recent MNH Road Map that has been developed with significant technical and financial support from UNFPA also included a comprehensive set of MNH indicators that consider maternal (and newborn) health from different perspectives<sup>882</sup>. The Road Map states that most of these indicators are also included in the SHHS and the HMIS; however, beyond that the Road Map does not present an assessment of the feasibility of collecting data on these numerous indicators, nor has it assigned responsibilities for data collection to specific stakeholders.</p> <p>As previously discussed, it is questionable how likely it is that the presence of maternal health in national policies will be enough for</p>

<sup>879</sup> Reproductive Health Policy, National Family Planning Policy, Kenya National AIDS Communication Strategy for Youth, Kenya National HIV/AIDS Strategic Plan and Plan of Action, National Sex Work Situational Analysis (Mapping), National Family Planning Guidelines, National Condom Policy and Strategy, National Guidelines for post Rape Management, National Guidelines for Prevention With Positives.

<sup>880</sup> Information from KCO, Development Partners.

<sup>881</sup> I.e., the Strategy is neither mentioned in COARs or in the relevant UNFPA programme evaluation; nor is UNFPA acknowledged in the Five Year Strategy itself.

<sup>882</sup> E.g., the community perspective, different aspects of maternal health, such as family planning, political will in the Government, etc.

	convincing the Government to intensify its maternal health support.
Findings from case study in <b>Zambia</b>	Apart from supporting the implementation of long-term national health surveys (e.g. the <b>Zambian Demographic and Health Survey (ZDHS)</b> ), UNFPA has not supported the development of any maternal health specific monitoring and evaluation tools.

## 8.2.10 Evaluation question 10: To what extent have UNFPA maternal health programming and implementation adequately used synergies between UNFPA’s sexual and reproductive health portfolio and its support in other programme areas?

### Judgment criterion 10.1: Linkages established between programmes (reproductive health with gender and population and development) established in intervention design

Findings from case study in <b>Burkina Faso</b>	<p><i>Au cours du 6<sup>ème</sup> programme l’UNFPA a permis une compréhension plus approfondie des contraintes liées au genre en matière de santé de la reproduction et a renforcé les actions de sensibilisation ciblées envers les hommes et les leaders d’opinion pour leur implication accrue. Par contre l’intégration de la SR dans les approches adoptées pour l’intervention genre n’a pas pu être clairement établie.</i></p> <p>Les analyses situationnelles ont identifié des contraintes spécifiques aux genres telles que la prise de décision en ce qui concerne l’utilisation de la PF et la recherche de soins qualifiés pendant la grossesse ou au moment de l’accouchement et aussi les pratiques de mutilations génitales féminines, les violences faites aux femmes et la discrimination des femmes souffrant de fistules obstétricales<sup>883</sup>. La composante communautaire de la feuille de route de même que le plan stratégique de communication en SR, cherchent à impliquer les hommes, ‘détenteurs de pouvoir dans les familles pour améliorer la prise en charge de la femme’. Des formations genre on été organisées pour leur personnels de santé mais ce type d’activité reste limité<sup>884</sup>.</p> <p>Au niveau local les outils tels que IFC sont reconnus par les partenaires comme permettant aux communautés et aux agents de santé de réaliser une analyse des contraintes liées au genre dans l’utilisation de la planification familiale et l’accès à la santé maternelle. Certaines actions de communication ont été axées sur les hommes et les leaders d’opinions. Les OBCs qui organisent les causeries et les séances de sensibilisations toutefois n’arrivent pas toujours à mobiliser les hommes et c’est souvent les femmes qui assistent à ces événements<sup>885</sup>. Les membres des cellules obstétricales d’urgence sont des personnes influentes qui sont un potentiel important pour mobiliser les hommes. Le programme de lutte contre les fistules obstétricales adopte une approche intégrée qui inclut les hommes que ce soit en matière de prévention mais aussi au moment de la réinsertion des femmes dans leur famille après leur traitement. Le plaidoyer implique des leaders religieux sur les droits des femmes, les mutilations génitales féminines, la planification familiale.</p> <p>Le 6ème plan a vu l’élaboration de la politique nationale genre qui a été adoptée en juillet 2009, ainsi que l’élaboration récente d’un programme de lutte contre les violences à l’égard des femmes et d’un programme pour accélérer le processus de l’élimination des Mutilations Génitales Féminines (MGF) et l’élaboration d’un plan de formation en genre. La promotion des droits en matière de santé sexuelle et de la reproduction en est un des axes. Cependant le lien entre les interventions en genre et la santé de la reproduction n’est pas apparu très clairement au moment de l’évaluation.</p>
Findings from case study in <b>Cambodia</b>	<p><i>Only a small number of interventions have more recently addressed gender-related challenges to maternal health. At national level, population and gender still operate separately because of funding flows, and the synergetic mechanisms are just evolving. At sub-national level UNFPA is more successful in integrating gender, population and development and reproductive health. Many initiatives at</i></p>

<sup>883</sup> En particulier l’Etude Socio-Comportementale sur l’Implication des Hommes et des Leaders d’Opinion dans les Activites de Santé de la Reproduction - dans les Regions du Sahel, du Centre-Est, de L’est et de la ville de Ouagadougou -2007.

<sup>884</sup> Le nombre de personnes formées n’étai pas disponible.

<sup>885</sup> Entretien avec les partenaires d’exécution.

	<p><i>that level are funded through a common pool that is managed by the Provincial Governor, who has wide authority on health and development.</i></p> <p>At policy and programme level, UNFPA Cambodia has lobbied with the Government on gender concerns, especially in poorly performing operational districts where traditional gender attitudes and relations continue to be reflected in the health practices of women and their families. These attitudes impede the utilization of Health Centers and District Referral Hospitals. UNFPA claims that its gender approach is practical and Health Equity Funds and EmONC Focal Point have helped to empower communities to increase the access to funds of poor women and to provide a “buddy system” when visiting health facilities<sup>886</sup>. UNFPA and the Ministry of Women’s Affairs (MoWA) have insisted that priority be given to girls and women in the Health Strategic Plan I and II through a multi-sectoral approach. The UNFPA-supported National Reproductive and Sexual Health Strategy (2006-10) is female-oriented, however there has been a realization that <i>“there has to be more balance in the ongoing review and update of the Strategy so there is greater male involvement in services and of youth especially adolescents”</i><sup>887</sup>.</p> <p>UNFPA supports a database in which information is increasingly disaggregated to improve gender analysis for health, as reflected in the more recent census and DHS<sup>888</sup>. The Cambodia Gender Assessments of 2004 and 2008, jointly funded by UNFPA, UNDP and several other donors, benefited from the availability of a number of UNFPA-supported surveys, including the Cambodian Inter-census Population Surveys (CIPs, NIS 2004) and the Cambodia DHS. The assessment included a review of the National Strategic Development Plan, and comments were received from the national CEDAW Committee. UNFPA supported two chapters of this assessment<sup>889</sup>. <sup>890</sup> <i>UNFPA plans to support gender NGOs who are involved in reproductive health issues, i.e., especially in gender-based violence and obstetric fistula in Country Programmes IV.</i><sup>891</sup> A Gender Team from the Ministry of Women’s Affairs works with the MoH Gender Team to develop (within MoH health strategy) a sub-strategy on gender mainstreaming. MoH, like other ministries and departments, has gender focal points and MoWA provided a curriculum on gender mainstreaming, technical tools for gender analysis, skills for integrating gender and health during programming, and for advocacy – <i>“talking points on the relationship between gender and health, how to lobby at sector level and multi-sectoral level”</i><sup>892</sup>.</p> <p>In the above process, UNFPA has assisted quarterly meetings of all the gender focal points in relevant line ministries. UNFPA has also provided a Master Trainer, who developed a manual, guidance notes and tools on gender analysis, and provided practical training on gender analysis of health budgeting. MoWA also has a gender focal person at provincial level. In the provinces and districts, the focal point is the chair of the Women and Child Health Committee (WCHC), which is part of the structure of the Department of Local Administration under the Ministry of the Interior. This is the very same department, which is responsible for the process of decentralization, de-concentration and the Commune Investment Plan. The WCHC Chair is the Gender Adviser to the Commune Council and a member of the Health Centre Management Committee and receives training from UNFPA.</p>
Findings from case	L’UNFPA a cherché à développer un programme cohérent qui lie l’ensemble de ses domaines d’activité. En particulier, il a mis l’accent

<sup>886</sup> UNFPA Cambodia.  
<sup>887</sup> NGO Partner.  
<sup>888</sup> UNFPA Cambodia.  
<sup>889</sup> Government Partner.  
<sup>890</sup> A Fair share for Women, Cambodian Gender Assessment 2008, MoWA 2008.  
<sup>891</sup> UNFPA Cambodia.  
<sup>892</sup> Government Partner.

study in <b>DR Congo</b>	sur la communication: relations avec la presse, travail avec des associations des femmes et des jeunes (par exemple ABEF-IPPF), développement et publication de supports pour les démarches de sensibilisation. Dans le cadre des démarches citées en objet, l'UNFPA a soutenu les activités du Ministère du Genre y compris dans les communications visant le changement des attitudes et la réhabilitation des centres de promotion de la femme (surtout au Bas Congo, à Kitanga et à Kinshasa). Ainsi, par exemple, l'UNFPA s'est associé au Ministère du Genre pour financer la réinsertion socio-économique des femmes guéries des fistules ou victimes de violences sexuelles ainsi que des filles-mères. Il s'est impliqué également dans la formation à la communication de l'Union Nationale des Femmes.
Findings from case study in <b>Ethiopia</b>	<p><i>UNFPA addresses in its gender, HIV/AIDS, youth work also community members, religious leaders, adolescent girls and youth clubs with information concerning, family planning, ANC, post natal care, HIV/AIDS. And vice –versa- in its reproductive health component the gender and population and development programme are being integrated at project level.</i></p> <p>The CPD 2007-2011 refers to 'The gender gap is significant in the social and economic spheres. Women and girls suffer from harmful practices such as early marriage and sexual and gender-based violence. Female genital cutting is practiced in 73 per cent of the country. School enrolment is 80.4 per cent for males and 67.6 per cent for females. The adult literacy rate is 33 per cent for men and 11 per cent for women. 'Gender issues affect every aspect of our work, (decision making power, information, financial support, travel restrictions)',<sup>893</sup></p> <p>The Ethiopia Gender Survey 2010 (UNFPA, Pop Council) identifies distinct health and education constraints for girls and women.</p> <p>With this in mind, whilst revising the Health Management Information System, UNFPA has thus pushed for gender disaggregated data at all levels. It also supported the adaptation of the community conversation guideline to include sexual and reproductive health and gender issues; all of this was incorporated into the health extension worker manual. The population and development programme developed maternal health, HIV/AIDS, and family planning indicators together with the reproductive health programme to be included in the DHS 2005.</p> <p>Interventions are designed based on evidence created by all the programmes (reproductive health, population and development, and gender) and integrated into the annual work plans of the country office. Within the country office, several mechanisms are in place for integration, such as the Project Appraisal Committee (PAC) i.e. an advisory committee where heads of all the units in the ECO are members and any project proposal submitted to the ECO has to be reviewed and endorsed by the PAC before it is approved by the Representative. This provides the opportunity to review the levels of integration between different components.</p> <p>On project level, the reproductive health team aims at joint implementation sites, support to same facilities or entry points, whilst mainstreaming of humanitarian and gender issues in training and advocacy material. The gender officer of the ECO participates in the reproductive health programming and 'mainstreams' gender into the proposals. Fewer implementation sites may facilitate a joint operational research to demonstrate the impact of best practices.</p> <p>The COAR report on each programme independently whilst each includes cross cutting issues, such as: 'Incorporation of Reproductive Health, HIV/AIDS and gender equality in the health sector policy/plan and budgeting (MTEP/F)' in the population and development programme, and 'gender equity and gender-based violence' in the reproductive health programme and 'Reproductive rights of women and adolescent girls incorporated in national human rights protection systems' in the gender programme.</p>
Findings from case study in <b>Ghana</b>	<i>UNFPA support to Ministry of Women and Children Affairs (MoWAC) has been on how to eradicate negative social practices affecting women and how to remove barriers to empowerment. Linkages between gender and population and development are clearer at the</i>

<sup>893</sup> Quote from NPO, ECO.

	<p><i>regional level in terms of monitoring whether girls and women are accessing services. The UNFPA senior management together with the reproductive health Specialist plays an integrationist role. Internally interest and practice in Coherence Programming is increasing</i></p> <p>UNFPA Ghana is part of Gender Sector Quality Forum and is participating in MDGs dialogue on gender but is not in the Sector Working Group on Social Protection. UNFPA Ghana assisted MoWAC during the last DHS study (2008) to review data collection instruments and ensure better integration of gender concerns as part of re-engineering strategic support. Since 2009 resources has been provided to the Department for Women for a three year Action Plan for gender-mainstreaming and capacity development for gender responsive budgeting. MoWAC has not benefited much on the maternal health side because of its co-ordination role <i>“we are the ones who ask of MoH why MMR is so high and what they are doing about it?”</i><sup>894</sup> UNFPA successfully advocated for and made possible the inclusion of a module to collect data related to Domestic Violence in the DHS 2008, the results of which led to the establishment of Domestic Violence Victim Support Unit (DOVVSU) by the Police Department (Ministry of Interior)<sup>895</sup>.</p> <p>UNFPA lead role in coordination around gender has not been so clear and remains a challenge with several agencies all of whom have gender as a cross-cutting issue<sup>896</sup>. It is not been apparent as too who is actually leading the interagency coordination on gender since UNIFEM was coordinating only as a project and UNDP was for some time playing a more leading role on the subject. UNFPA’s current mandate would require it to play a more leading and proactive in maternal health/reproductive health programming around gender. UNFPA has drafted a joint programme on gender which defines their position as the lead on gender which will be shared with UN Women for discussion.<sup>897</sup></p> <p>There is a UNFPA Coherence Programming being piloted in the Central Region, which started two years ago where implementing partners (IP) meet on a quarterly basis. The objective was to bring all IPs as part of programme together so they can share and limit duplication. There are detailed exercises to discuss programme activities. This has been done for HIV and SRH and gender using programming for young people as an entry point. There are plans to replicate the model in other programme regions.<sup>898</sup></p>
<p>Findings from case study in <b>Kenya</b></p>	<p><i>The country programmes are defined through a collaborative process within the country office, bringing the three components together; at programme level gender is integrated in all reproductive health trainings and youth activities; however the training manual on gender mainstreaming and the M&amp;E framework for gender mainstreaming is not specific on reproductive health. The KCO has identified that practices such as FGM/C has gender undertones that reflect gender barriers to the attainment of good health and consequently initiated law reforms.</i></p> <p>UNFPA has a multi-sectoral involvement through its International Conference on Population and Development (ICPD) mandate. This places UNFPA in a unique position of overseeing progress in the various sectors and identifying possible areas of synergy. UNFPA KCO has been trying to take advantage of this unique position, but a great challenge for UNFPA remains to coordinate its work on Youth. Three ministries are involved: Education, Gender, Youth and Health and each one of them may have conflicting approaches yet none of them has a clear leading role.</p> <p>Country Programmes have been closely linking the components of Reproductive Health, Gender and population and development which</p>

<sup>894</sup> Interview with Government Partner.

<sup>895</sup> Interview with Government Partner.

<sup>896</sup> Interview with External Development Partner.

<sup>897</sup> Interview with Development Partner.

<sup>898</sup> Interviews with UNFPA staff.



	<p>can also be seen in the overview table of the Annual Work Plans in the Annex.</p> <p>UNFPA spearheaded the inclusion of gender-based violence indicators into the KDHS, and it is only the second time in the history of the Demographic and Health Surveys in Kenya that questions on domestic violence have been included in the most recent one.</p> <p>The recognition of gender related constraints has led the Government to create the Ministry of Gender in 2003, which since then has been supported by UNFPA; inter alia by training of gender officers for all ministries and the funding of a Technical Assistant in the Ministry of Gender. At programme level, gender has been integrated in all Reproductive Health activities, youth training and other interventions. UNFPA advocates strongly for mainstreaming gender into its programmatic work. Implementing Partners see however still need for further integration of gender concerns into Reproductive Health programmes. One example is the consideration and specific targeting of husbands in family planning and fistula interventions.</p> <p>The KCO has considered gender-based violence as relevant to Maternal Health and has supported it via its joint programme with UNICEF. Gender-based violence (GBV) has further been addressed especially in the humanitarian context<sup>899</sup>, but since the last two years also in programming of reproductive health interventions. It has been requested by Implementing Partners to be further integrated into community dialogues as demand for GBV counseling is increasing with raised awareness about family planning. In five pilot health facilities an information management system for GBV has been established, as well as standard operating procedures for GBV prevention and response are being developed with the support of the KCO. Obstetric Fistula Campaign activities are included in the KCO advocacy campaigns for the elimination of culturally harmful practices.</p> <p>UNFPA has also been instrumental in the advocacy and working on Law reform on Female Genital Mutilation and Cutting in conjunction with the Federation of Women Lawyers (FIDA), Kenya Women Parliamentarians (KEWOPA) and the Ministries of Health and Education. From these efforts the national act against Female Genital Mutilation and Cutting has been passed into law; October 2011.</p>
<p>Findings from case study in <b>Lao PDR</b></p>	<p><i>UNFPA Lao PDR country office has worked with the Lao Women's Union in previous country programmes in order to promote reproductive health. A more recent shift aims at strengthening the Lao National Commission for the Advancement of Women (Lao NCAW) and ensuring that maternal health is part of the National Strategy for Advancement of Women. Through its support to the implementation of the MNCH package UNFPA strives to increasingly involve men in supporting maternal health. Gender has increasingly been integrated in programmes and policies but that a good understanding of the gender constraints affecting maternal health that could improve maternal health programming has still been missing.</i></p> <p>UNFPA has had a long standing relationship (from CP1) with the Lao Women's Union (LWU), that has an extensive network at central, provincial, district and village levels playing an active role in the socio-economic and cultural development of women. Until CP3 LWU was UNFPA implementing partner to promote reproductive health and reproductive rights, since CP4 direct support has been stopped to refocus support on MoH and these activities were discontinued<sup>900</sup>.</p> <p>In the 3<sup>rd</sup> and 4<sup>th</sup> Country Programme there was no separate gender component and gender equality was integrated into the 2 other components i.e. Population and Development and Reproductive Health. Under CP4 UNFPA has promoted dialogue at policy level on gender issues (including gender-based violence) through strengthening the Lao National Commission for the Advancement of Women (NCAW) and advocating for promoting gender equality in each line ministry. The National Strategy for Advancement of Women was</p>

<sup>899</sup> Coordination of gender-based violence Emergency Response and Transition Project Evaluation Report 2010.

<sup>900</sup> Implementing partners interview.

	<p>recently revised and reproductive health and HIV/AIDS were put as a priority in the new version.</p> <p>Besides a study conducted in 2005 on gender and ethnic issues<sup>901</sup> in reproductive health, the PEER study and the Gender Profile of World Bank and ADB, there is little information on how gender constraints affect maternal health. Gender based violence is an issue that is acknowledged in CP4 CPAP but has not been specifically addressed in the various interventions.</p> <p>The 3<sup>rd</sup> Country Programme spells out that the IEC/BCC interventions would be oriented towards male involvement. All aspects of the demand creation (RH3) programme are targeted to both women and men<sup>902</sup>. Both 'Empowering Communities' and 'Working with Individuals, Families and Communities' projects <i>are based on the analysis of local situations and</i> have the potential to involve men, for example community motivators talk to men during maternal health promotion sessions and quota were established for the membership of women in the Village Health Committees. But it is unclear whether this potential is fully utilized mainly since staff in charge of reproductive health and gender does not systematically analyze the information generated through these approaches.</p>
<p>Findings from case study in <b>Madagascar</b></p>	<p><i>Linkages between the D&amp;P, the gender and the reproductive health programmes in the COM are well established, certainly also through good interpersonal relationships and the team approach during field missions and joint planning sessions. Reproductive health and gender indicators are included by the D&amp;P into the DHS and household surveys to enable focused programme planning. The gender related barriers to health services and the high rate of teenage pregnancies with low utilization of youth friendly centers by girls needs to be addressed more efficiently.</i></p> <p>Gender constraints, affecting and impeding reproductive health programmes, have already been identified in 2004 by UNFPA, when it supported the development of the National Action Plan on Gender and Development, which due to lack of commitment and funding by the GoM was not implemented. UNFPA conducted in 2009 sensitization campaigns directed to church leaders and men – as head of families and thus decision makers – with focus on family planning<sup>903</sup>. In June 2011, the increasing recognition of gender based barriers to services and gender-based violence led to a stakeholder meeting (including UNFPA) with the aim to developing a framework for action.</p> <p>The protocol for treatment of victims of gender-based violence in health care services, eight counseling centers and Centers Amis de Jeunes in selected health facilities are being developed with the support of UNFPA.<sup>904</sup> Visitors are predominantly male adolescents and rarely young women or girls, which should be the main target group, as the teenage pregnancy rate was reported to be between 30 and 50 percent in the sites visited<sup>905</sup>. To address this, UNFPA supported a campaign to increase awareness of the importance of SRA which started during the mission, and a qualitative survey on youth will be conducted in the near future to define the SRA programme, which then should be targeting the teenage girls.</p> <p>UNFPA has a multi-sectoral involvement through its ICPD mandate and these places UNFPA in a unique position of overseeing progresses in the various sectors and identifying possible areas of synergy. UNFPA has utilized its position to an advantage through</p>

<sup>901</sup> Study on Gender and Ethnic Issues that Affect the Knowledge and Use of Reproductive Health Services in Six Ethnic Villages of Lao PDR - conducted in August 2005 - Committee for Planning & Investment - Department of General Planning National University of Lao PDR - Population Studies Center - Supported by UNFPA Lao PDR - April, 2007.

<sup>902</sup> RH3 evaluation – draft – UNFPA – 2011.

<sup>903</sup> The IP reported it was a very useful initiative and it was not clear why it had not continued. (Also, the responsible UNFPA staff has not been employed at that time).

<sup>904</sup> The youth friendly services provide psycho-social counseling, STI treatment and family planning.

<sup>905</sup> Information from IP and GP.

	<p>supporting increasing disaggregation of gender related data in the DHS; the next DHS will include even more questions on gender issues.</p>
<p>Findings from case study in <b>Sudan</b></p>	<p><i>Despite the awareness in UNFPA of the linkages between gender and maternal health and despite the fact that UNFPA has on a small scale created opportunities for IPs to address maternal health in this integrated way, UNFPA has not established a clear organizational culture and structure that promotes gender-integrated maternal health programming. The few programmatic linkages between sub-programmes have depended more on the pull from committed IPs than on a clear push from UNFPA's sexual and reproductive health sub-programme<sup>906</sup>.</i></p> <p>At least on a small scale, UNFPA in Sudan has created new opportunities for a stronger integration of medical concerns about maternal health with social considerations regarding the role and position of women in Sudanese society. It has established partnerships with important stakeholders in the Sudanese Government, such as, for example, the Ministry of Social Welfare that is responsible for setting policies, plans and programmes on social insurance, population, maternity and childhood, social consolidation and development<sup>907</sup>. UNFPA has also been involved in awareness rising on FGM and early marriage and credits itself with helping to kick-start a review of corresponding legislation that proposes to rise the age of marriage from 10 years to 15 or 16 years.</p> <p>UNFPA staff acknowledges that cultural and religious attitudes towards women have been as much a cause for poor maternal health as purely medical issues, and maybe even more so<sup>908</sup>. UNFPA considers these factors to directly affect the health of women and mothers; and also to constrict their access to maternal health services. At the time of the evaluation, there was an ongoing debate in the country office as to whether UNFPA programming has been sufficiently addressing these cultural barriers to maternal health or was still approaching maternal health too exclusively as a medical issue.</p> <p>However, only a small share of UNFPA annual work plans had in fact specifically integrated reproductive health and gender into one project. The majority of annual work plans, including the more recent ones (i.e., from 2009 and 2010) often showed little explicit integration of gender into reproductive health annual work plans. Although the way these projects were formulated would in principle allow the integrated treatment of medical and cultural barriers to maternal health, the annual work plans did not formulate a clear requirement for addressing maternal health from a medical as well as a gender perspective. The extent to which a gender perspective was actually integrated into these projects therefore would have depended on the capacity and commitment of the Implementing Partners to do so<sup>909</sup>.</p>

<sup>906</sup> It should be noted that a number of UNFPA staff members from outside the SRH subprogramme have emphasized the importance of a stronger integration of sexual and reproductive health issues and gender issues in UNFPA's response.

<sup>907</sup> According to UNFPA information, the Ministry had not been aware of the issues of maternal mortality prior to UNFPA's engagement, but had not begun to do independent research into the issue that had already generated information on the social determinants for women's and mothers' health status from different States (Interview with UNFPA).

<sup>908</sup> Main issues that were mentioned were Gender-Based Violence (GBV) including rape and female genital mutilation (FGM), attitudes toward family planning that limits women's access to contraceptives, early marriage, the persisting pressure to have multiple children against any medical indications of risks for the women, as well as the low social status of women and the resulting low self-esteem of women overall (Interview with UNFPA).

<sup>909</sup> The extent of integration between maternal health and gender seemed to have been stronger in UNFPA's humanitarian programme in Darfur, for a variety of reasons. For example, the concentration of beneficiaries in camps, and the more regular presence of humanitarian personnel allowed UNFPA and its partners to roll out more closely knit communication efforts on gender and maternal health.

	<p>The examples of annual work plans that had explicitly integrated reproductive health and gender issues had been drafted and implemented by IPs with a widely known prior commitment to an integrated approach to improving maternal health<sup>910</sup>.</p> <p>UNFPA annual work plan's and UNFPA's planning and administrative structure have provided relatively few "push" factors to ensure that gender and reproductive health are addressed in this integrated way; this integration seems to have occurred primarily when IPs that had experience in working in an integrated way used this experience as a "pull" factor to design and implement an integrated project with UNFPA funding. Also, the current vertical differentiation of the gender and reproductive health sub-programme has presented an obstacle for implementing partners that want to implement these types of integrated projects, in that these partners at times had to work with three different UNFPA officers to implement one integrated project.</p> <p>The main challenge for integrating gender, population and development and reproductive health therefore has been as much organizational as it has been conceptual. The country office had experienced a number of internal challenges ( i.e., in UNFPA procedures and processes) to do integrated programming, but also external challenges that have to do with finding appropriate implementing partners and other partners to carry out integrated programmes and projects. Solutions to these challenges would not be "one size fits all", but would need to be adapted to the specific challenges in each country; one important factor that had constrained the ability of UNFPA to work in an integrated way had been the lack of time to devise procedures <i>and</i> projects that could facilitate an integrated approach in Sudan. Another detracting factor in this regard had been that UNFPA as an organization had of necessity become too focused on financial accountability<sup>911</sup> in a country where managing money flow and accountability through quarterly reporting is particularly difficult, which took away their time to do conceptual work, i.e. to put the concept of integrated programming into practice in actual projects.</p>
Findings from case study in <b>Zambia</b>	<p><i>The country office has not established deliberate and systematic programmatic linkages between the reproductive health component and the population and development and gender component of the country programme. Only a small number of interventions addressed gender-related challenges to maternal health.</i></p> <p>UNFPA's maternal health support has addressed a number of gender-related issues over the years<sup>912</sup>. This has included working directly with communities, by supporting the creation of <i>Safe Motherhood Action Groups (SMAGs)</i>. With UNFPA support, SMAGs have become a model for creating awareness and demand for maternal health services; and for addressing cultural and other barriers that keep women from accessing the appropriate services in time<sup>913</sup>.</p> <p>Beyond that, synergies at country office level between the gender component and the reproductive health/ maternal health programme component are less apparent. After the previous gender officer resigned, the position remained vacant for 8 months; and was only filled</p>

<sup>910</sup> One of these projects was designed to specifically contribute to the population and development sub-programme of the UNFPA CP, as well as the reproductive health sub-programme (Note: gender was not a separate sub-programme in UNFPA's country programme when this project was carried out), and addressed the social and economic position of women, e.g., through income-generating activities, as well as the awareness of gender and reproductive health issues among communities and leaders. Another project had used UNFPA funding to conduct awareness raising campaigns against female genital mutilation, for which they organized workshops and open forums for men and women together and approached doctors, religious and community leaders. The IP for this project also had an already established profile outside of the medical field.

<sup>911</sup> "UNFPA staff members here in Sudan have become 'compliance officers'" (UNFPA interview).

<sup>912</sup> Also shown by a review of past reproductive health component Annual Work Plans.

<sup>913</sup> See Evaluation questions 3 on community involvement and demand creation for more details.

	<p>in July 2011. UNFPA has supported Zambia's <i>Gender in Development Division (GIDD)</i>. However, the supported interventions consisted of generic gender awareness-raising and training workshops with gender focal points of different line ministries<sup>914</sup>. The events were not used to discuss and operationalizing specific maternal-health related gender issues<sup>915</sup>.</p> <p>Deliberate programmatic synergies between UNFPA's population &amp; development programme component and the maternal health component have been rare. The UNFPA population and development advisor has made some relevant contributions to the development of Zambia's Fifth National Development Plan (FNDP), e.g., by suggesting the replacement of the indicator for "institutional deliveries" with the more meaningful indicator of "percentage of births attended by skilled personnel". In many ways, however, the population and development component of UNFPA's country office has been perceived to operate without strong linkages to other programme components, including that of sexual and reproductive health<sup>916</sup>.</p>
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### Judgment criterion 10.2: Integration of Monitoring and Reporting of UNFPA operations

Findings from <b>desk study</b>	<p>In 2009, 42% of COs worked with emerging populations and issues, this increased to 46% in 2010<sup>917</sup>. UNFPA monitoring, evaluation and reporting system were meant to capture the maternal health related situation of the poorest of the poor<sup>918</sup>. One of the supportive roles of the population and development components of country programmes was to facilitate the improvement of the technical capacity of reproductive health and gender programmes, i.e. their implementers, to improve their evidence-based policymaking, programming, implementation and reporting and to facilitate the integration of maternal health issues into national policies, plans, programme and budgets. Assistance offered by the population and development sub-programmes at country level in this area has evolved from mere data collection to a greater emphasis on the UNFPA-assisted development of integrated M&amp;E systems. Cross-fertilization among programmes is better in countries that have achieved greater improvements in the maternal health situation, such as Ghana, Bangladesh, Cambodia and Nepal. Coherence is lower in low performing countries (e.g., Sudan).</p>
Findings from case study in <b>Burkina Faso</b>	<p><i>Les enquêtes nationales réalisées avec le support de l'UNFPA sont les références pour le suivi des principaux indicateurs de SR par les différents partenaires.</i></p> <p>Comme décrit ci-dessus les informations incluses dans les Enquêtes Démographiques et de Santé (EDS) sont alignées avec la feuille de route. La SR a une place importante dans les données collectées dans les EDS surtout en ce qui concerne la PF. Ces données sont utilisées comme référence par les institutions nationales (dont les capacités à utiliser les données de population sont renforcées par la composante Population et Développement) et les partenaires financiers pour le suivi des indicateurs de santé maternelle, par exemple les accouchements assistés ou la prévalence contraceptive Le recensement permet d'établir des estimations de population plus précises qui sont utilisées pour des prévisions budgétaires plus justes.</p>
Findings from case	<p><i>There is close coordination between UNFPA staff and Ministry of Planning, National Institute of Statistics, MoH, Ministry of Women's</i></p>

<sup>914</sup> Including the gender focal point of the Ministry of Health.

<sup>915</sup> Interviews with UNFPA, GIDD.

<sup>916</sup> Feedback from UNFPA partners involved in research / data collection (see Evaluation questions 8 on evidence-orientation of UNFPA's work for details).

<sup>917</sup> Based on an analysis of UNFPA 2009-10 COARS.

<sup>918</sup> Especially disadvantaged adolescents and youth, women and survivors/victims of violence and abuse, out-of-school youth, women living with HIV, women engaged in sex work, minorities and indigenous people, women living with disabilities, refugees and internally displaced persons, women living under occupation and ageing populations.

study in <b>Cambodia</b>	<p><i>Affairs, Parliamentarians Forum, National Committee on Population and Development, National Committee for Decentralization and Deconcentration, the Department of Local Administration (that oversees communes) in formulating and harmonizing indicators in Health Strategic Plan, population policies and National Strategy for Reproductive and Sexual Health.</i></p> <p>Population and development provides an overarching framework in UNFPA's push for better reproductive health outcomes. Population and development supports the Government closely to create an enabling environment. UNFPA's reproductive health component provided budget support to the C-DHS, as population and development did not have sufficient funds.<sup>919</sup> With regard to gender, population and development works with gender statistics and helps Ministry of Planning to formulate their gender sub-strategy, with the assistance of MoWA. Together they formulated gender indicators for health.<sup>920</sup> Population and development helps MoH analyze C-DHS and to compare results with MoH data. (MoH has its own system of indicator tracking for each year, including trend analysis and review of the reliability of data collected through the system). In other regards, population and development technical support in M&amp;E relates to reproductive health and gender programming, data processing, analysis, policy implications, and integration of results in performance monitoring and midterm review of HSSP II.</p> <p>UNFPA, public health authorities at district level and the Department of Local Administration have created a demand for maternal health service but response from the supply side (especially the Health Centre) still has major delivery gaps. The biggest gap for UNFPA is that reproductive health/maternal health data at community and CBD level is missing.</p>
Findings from case study in <b>DR Congo</b>	L'UNFPA a effectué un travail important de plaidoyer en faveur d'un recensement national de la population ainsi que dans la production régulière de l'Enquête MICS. (Voir Judgment criterion 10.2 dans la Matrice des Résultats, Annexe 6.3, pour les détails.)
Findings from case study in <b>Ghana</b>	<p><i>UNFPA supports Ghana Statistical Service in collecting, processing, analyzing, writing and disseminating reports. UNFPA population and development trains government institutions that make decisions on how to use data once it is available, including Ghana Health Service, National Development Planning Commission, National Population Council, Ghana AIDS Commission, ministries, departments, agencies, metropolitan municipalities, district assemblies, local development and health authorities as well as CSOs.</i></p> <p>UNFPA Ghana through its support to Ghana Statistical Service (GSS) makes gender disaggregated data available to the GoG for evidence based decision making at all stages of policy development, planning, programming, and budgeting. NDPC provides guidelines that are followed closely by UNFPA and GSS. Civil Society tends to go directly to GHS and NPC for data but is aware of UNFPAs contributions to the collection of this data.<sup>921</sup></p> <p>At the joint programme level, UNFPA works closely with government to ensure adequate and accurate information on cultural context and human rights approaches and to address harmful cultural practices (e.g., gender-based violence and female genital cutting) and also works with the Federation of Women Lawyers (FIDA) on male involvement to improve gender relations and advocacy for women who experience domestic violence. In terms of joint engagement for advocacy, UNFPA supported the passing of the Domestic Violence Act in 2007, formulation of the National Domestic Violence Policy 2009 to 2019 and Action Plan, and the Re-Engineering Action Plan for MoWAC.</p> <p>The synergy between UNFPA's mandate area of reproductive health, population and development and gender exists in the quarterly</p>

<sup>919</sup> UNFPA Cambodia.

<sup>920</sup> Government Partner.

<sup>921</sup> Interview with Government.

	<p>monitoring meeting of the Programme Component Managers under the aegis of the National Population Council (NPC) where gender related implementing partners involved in reproductive health/maternal health interact with reproductive health/maternal health implementing partners involved in gender. UNFPA works with NPC to share results of gender and health based data. Both entities realize the importance of being able to share reliable data bi-annually with traditional leaders and community leaders who form part of the District Health Management Team about monitoring what is happening both within their regions and districts. There were complaints that gender mainstreaming trainings provided by UNFPA are theoretical and do not provide sufficient practical examples in integrating with maternal health/reproductive health<sup>922</sup>.</p>
Findings from case study in <b>Lao PDR</b>	<p><i>UNFPA supported national surveys under the Population and Development Component have contributed to inform maternal health programming and to measure progress in this area. However it is unclear whether the tools for joint monitoring have been used.</i></p> <p>UNFPA has closely worked with the Ministry of Planning and Investment (MPI) to develop the National Population Development Policy in 2006. This policy lays the foundation for collecting disaggregated data for development, doing analysis and population projections under Lao Info that was initiated by UNFPA. These provided useful inputs into the 7th 5 year National Socio-Economic Development Plan (NSED)<sup>923</sup>.</p> <p>The Census 2005 and Lao Reproductive Health Survey (2005) provided key reproductive health related indicators that have been extensively used by the government and the development partners. Following discussions it was agreed that instead of repeating the LRHS in 2011-2012, the next survey LSIS (supported by different partners) would combine data that are usually collected under Demographic Health Survey (DHS) and under Multiple Indicators Cluster Survey (MICS).</p> <p>Besides the national surveys the CPAP Planning and Tracking tools could allow to monitor the integration of different mandate areas (in particular reproductive health and gender) but the evaluation team could not find evidence of actual use of this tool<sup>924</sup>.</p>
Findings from case study in <b>Madagascar</b>	<p><i>The CoM integrates monitoring missions office-wide<sup>925</sup>, but reporting requirements still remain linked to the respective programme.</i></p>
Findings from case study in <b>Zambia</b>	<p>Monitoring and reporting on past UNFPA support is weak. Although the population and development advisor has been named as M&amp;E focal point, he has not received any significant support or training to help him perform this function. No specific monitoring of attempts to create inter-programme synergies has occurred.</p>

<sup>922</sup> Interview with Regional Health Directorate.

<sup>923</sup> Government partners interviews.

<sup>924</sup> The CPAP Planning and Tracking Tools – Lao PDR.

<sup>925</sup> See also findings of evaluation questions 6 and 8

## 8.2.11 Evaluation question 11: To what extent has UNFPA been able to complement maternal health programming and implementation at country level with related interventions, initiatives and resources from the regional and global level to maximize its contribution to maternal health?

### Judgment criterion 11.1: Clarity of division of labor and delineation of responsibilities between UNFPA’s global, regional and country offices

Findings from <b>desk study</b>	<p>The existing operational rules for the delineation of responsibilities and division of labor between the GRP and the country programmes are relatively broad. The Global and Regional Programme Guidelines of the PPM broadly state that the GRP is meant to “complement country programmes” and to “contribute towards implementing the UNFPA Strategic Plan” (i.e., 2008-2011). GRP programming is meant to be based on a situation analysis that determines needs and gaps at the global level; and identifies the required complementarity of the GRP with country programmes. Regional offices are called to consult with country offices concerned in the approval and implementation of regional activities to ensure synergies between regional and country programmes.</p> <p>The complementarity that is called for in the Global and Regional Programme Guidelines is only partly reflected in the corresponding Programme Action Plans (i.e. programme action plans at global, regional and country level). The intended outputs of the UNFPA’s Global Programme<sup>926</sup> are broadly complementary to the maternal health outputs of Country Programmes: The Global Programme focuses on mobilizing support from “global actors” and on developing programming tools &amp; guidelines to be applied by country offices and their partners at country level. For example, the GP had committed itself to making available “programming tools &amp; guidelines to facilitate integration of SRH into national policies” and to provide “models” for up-scaling of SRH packages at the national level. Similar outputs are mentioned for commodity security and demand creation for maternal health and SRH services. At this point there is not sufficient information to assess the actual coherence<sup>927</sup> between efforts at the global and the national level, e.g., the extent to which the developed tools suitably facilitated programme implementation at country level.</p> <p>The complementarity between programming at the regional and country level<sup>928</sup> is less evident, at least based on a comparison of the regional outputs of the African Regional Programme; and the maternal health outputs at country level<sup>929</sup>. For example, the ARP pledged to build maternal health-relevant capacity not only among regional and sub-regional stakeholders, but also among UNFPA partners and stakeholders at national level. The programme does not clearly state, however, how the ARP capacity development efforts are meant to complement the UNFPA efforts at country level. This observation applies to different subject areas, including the up-scaling of the essential SRH package, i.e. in commodity security, reproductive health demand creation and “health system strengthening”.</p>
Findings from case study in <b>Cambodia</b>	<p><i>UNFPA country office, headquarters and the Asia and Pacific regional office (APRO) know what to expect of each other. There is a mutual respect for each other’s roles and responsibilities.</i></p> <p>The regional office (RO) provides technical and programmatic assistance at two levels: to improve aid effectiveness through CCA/UNDAF and to support UNFPA country office in the development of CP/CPD/CPAP. Additionally, regional office (RO) has provided</p>

<sup>926</sup> For the period 2008 – 2013.

<sup>927</sup> Coherence, in the sense of the absence of conflicts or contradictions between activities, procedures and outputs at global and national level.

<sup>928</sup> Exemplified here by the African Regional Programme (2008 – 2013) and the African countries among the desk phase sample (18 out of 22 of the desk phase countries are African countries).

<sup>929</sup> I.e. from the African Regional Programme (ARP)) and at all African countries in the desk phase sample.



	<p>technical support on special initiatives, such as Midwives Programming and EmONC Assessment, and sourced long- and short-term consultants for various evaluations related to CCA. The UNFPA headquarters has greater involvement during special events such as the State of the World Population campaign (an annual event), the Women Deliver Conference and Sag's Joint Action Plan. HQ-provided tools for Midwifery Review 2006 and EmONC Assessment 2009, and Briefing Materials/Kit such as Talking Points have been helpful<sup>930</sup>. Both regional office and headquarters are sometimes involved in operational trainings related to administration, finance and security<sup>931</sup>.</p>
Findings from case study in <b>DR Congo</b>	<p>Le budget consacré à la santé maternelle et à la planification familiale en RDC semble très insuffisant comparé à l'amplitude des problèmes connus par la population, au budget de l'UNFPA dans d'autres pays africains, et au budget des autres structures des Nations Unies en RDC.</p> <p>Il est toutefois important de mentionner que la communication, et les échanges d'idées et de ressources entre le Bureau de Pays (BP)/ RDC et les bureaux régionaux, sont rendus difficiles par le fait que le BP/ RDC appartient à la région sud, dont les autres membres utilisent l'anglais comme langue de travail; ce qui limite les contacts. L'équipe a observé que des plaintes avaient été exprimées chez le BP à ce sujet, car ils se sentent marginalisés lors des réunions et conférences régionaux.</p> <p>Néanmoins, malgré le manque évident de communication et partage des ressources entre le BP et les autres bureaux régionaux, il n'apparaît pas que ce soit une lacune importante dans le travail de l'équipe de l'UNFPA en RDC. C'est une équipe assez forte. Il a bien sûr quelques lacunes dans ses capacités, et en particulier dans les techniques de suivi formatif, mais les limitations budgétaires actuelles signifient qu'il ne sera pas possible de les combler pour le moment. Le personnel en place et sa direction sont tout à fait capable de faire le nécessaire pour faire avancer le programme de santé maternelle (Judgment criteria 11.1, 11.2, 11.3).</p>
Findings from case study in <b>Ghana</b>	<p><i>UNFPA country office gets technical support from the RO (e.g., the Tanzanian Deputy Representative's visit to Ghana to help with preparation of CP6), while the sub-regional office (SRO) in Dakar facilitates knowledge sharing.</i></p> <p>Since last year (2010), response from sub-regional office (SRO) has become more efficient. The SRO has recently developed software that handles all requests from country offices for technical support in a streamlined manner. There is now an online form at country level to request technical support from regional office/sub-regional office and a regular weekly programme meeting takes place where requests are made. The Assistant Representative acts on behalf of the Ghana country office for these requests. SRO files the request to regional office if and when clarification is needed and country office can also go directly to headquarters for technical support. As long as there is adequate time between notification and response, the requests are duly fulfilled by sub-regional office, regional office and HQ<sup>932</sup>.</p> <p>UNFPA country office Staff would generally prefer to see sub-regional office being more proactive with country office to provide technical support on programme and financing issues as well as ensuring appropriate linkages between CPAP. For example, sub-regional office could check the quarterly reports than just waiting for requests for assistance. Sub-regional office does not have funds for visiting and country office has to pay for all requests filled. However, staff would like sub-regional office to pick up an annual work programme document and see if it speaks to the Country Programme/Action Plan and track results reported in the Annual Report and provide an</p>

<sup>930</sup> UNFPA Cambodia.

<sup>931</sup> "HQ, through regional office, can also request country evaluations as they did with CP III, or as in 2004 ordered UNFPA to co-ordinate with SWAP/SWiM or as in 2011 make it improbable for the country office to stay in the HSSP II pool" (UNFPA Cambodia, Government partner and EDP).

<sup>932</sup> Interview with UNFPA.

	<p>independent view on the country office's achievements. UNFPA country office believes that sub-regional office should then be funded for doing these tasks<sup>933</sup>.</p> <p>Both regional and sub-regional offices play a hand off role and respond only to country office requests. This system works well according to some country office staff because UNFPA country office has to pay for technical support, requests tend to be made more efficiently and effectively.</p>
Findings from case study in <b>Sudan</b>	<p><i>At least in Sudan, the division of labor between the global, regional and country offices had not been communicated clearly enough to the country office, which had hindered the extent to which the country office could request targeted assistance from the regional level.</i></p> <p>Staff and also implementing partners feel that they have not had enough information on the role of the regional office to use it as a source of support for their work. Cooperation between the country office and the regional office has also been prevented by difficulties to contact UNFPA staff in regional offices, and to get feedback from them on specific topics. IPs who have had contact with the Country Support Team prior to the set-up of the regional offices find that the quality and intensity of support has decreased and deteriorated since the reform, to the extent that there had been no more support from the regional level since the regional offices had been set up.</p>

**Judgment criterion 11.2: Alignment of UNFPA's organizational capacities at country level and the (intended) division of labor and delineation of responsibilities**

Findings from <b>desk study</b>	<p>It is difficult to assess at this point, if and to what extent the intended division of labor is adequately reflected in the resource and staff allocation in particular to country offices; and vice versa; to what extent the UNFPA, with its resources at regional and global level has been able to complement and support the available technical maternal health capacity in country offices with additional know how and appropriate guidance. Information on this issue in country evaluations is limited<sup>934</sup>. Out of the six CPEs that did provide information, only two (Lao PDR (CP4; 2007 – 2011) and Malawi (CP6; 2008 - 2011) found that the country offices had sufficient organizational and staff capacity to manage their overall programmes. The country office Lao PDR was considered to be “punching above its weight” in sexual and reproductive health, in part due to the “skillful use of high quality technical support”<sup>935</sup>. In Malawi, where staff allocation corresponded “reasonably well” with the programme budget, the capacity of the country office was still going to be strengthened by recruiting an international reproductive health expert<sup>936</sup>.</p> <p>Four evaluations found minor or even severe imbalances between operational requirements and staff allocations. In Tanzania (CP6, 2007 – 2010), the dual responsibilities of country office staff for managing the UNFPA country programme as well as the acting as lead agency for a “One UN Joint Programme” overstretched the staff capacity of the office. At the same time, efforts to recruiting additional staff in reproductive health to the UN Zanzibar office were unsuccessful, despite repeat advertisements of the position, so that in the end, UNFPA on the mainland had to deploy one of its reproductive health NPOs to the office. The Zambia country office (CP6, 2007 – 2010) experienced delays in recruiting staff for its sub-offices; and also was found to require more technical staff to be able to strengthen its “programme implementation, management and monitoring &amp; evaluation”. Country offices in Sierra Leone (CP4, 2008 – 2010) and</p>
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<sup>933</sup> Interview with UNFPA.

<sup>934</sup> 8 out of the 14 Country Programme Evaluations analysed did not provide sufficient information on the adequacy of country office staffing levels, in particular with regard to reproductive health.

<sup>935</sup> Unfortunately, the evaluation did not provide any additional information on the kinds of technical support or the sources of this support.

<sup>936</sup> The evaluation did not provide any information on the source of the fund for this staff position.

	Burkina Faso (CP6; 2006 – 2010) were thought to be significantly under resourced. Programme officers in Sierra Leone were thought to be overloaded; while various vacancies existed, in particular among “middle management” <sup>937</sup> . In particular the SRH / HIV sector was found to be “too large for a lone Programme Associate” (recommendation to employ SRH / HIV National Programme Officer).
Findings from case study in <b>Cambodia</b>	<p><i>UNFPA Cambodia has gone through major changes in its human resources that have affected its capacity to lead and make interventions in a timely and consistent manner.</i></p> <p>Like any agency, UNFPA Cambodia, is highly dependent on experienced and credible professionals. There have been major delays in replacement of senior management posts including that of Representative. The country office also has suffered recent losses of key long-time senior programmatic staff related to reproductive health, population and development and the NPO for gender. Under the previous representative, the management was active in terms of coordination and strengthening of systems during HSSP I and HSSP II. “UNFPA was the first chair of HSSP2 with a strong leadership technical as well as astutely political in the process of harmonization and alignment”<sup>938</sup>. UNFPA was contributing only 2 to 3% to the pool fund, but it had significant influence, due to a very strong combination of country office Representative, reproductive health Manager and international Midwife expert, who were participating actively in the debates and influencing outcomes for UNFPA’s three mandate areas<sup>939</sup></p> <p>The recovery from the staffing problems has begun with a new country office Representative in place, who is also the chair of HSSP II<sup>940</sup>. When the Midwifery Programme began consolidation and the National EmONC Assessment started in 2009, the international Midwife, who had been operating since 2007, was replaced by an EmONC Officer. There has been successful recruitment of a new reproductive health Manager and population and development Manager. The gender post has been upgraded, and the recruitment process was ongoing at the time of the evaluation. In Cambodia, there are shortages of skilled laborers, and there are many agencies and NGOs competing for the same small skill pool.</p>
Findings from case study in <b>Ethiopia</b>	<p><i>The capacities at country level seem to be stretched to cover all aspects of the work already now, and the situation might worsen with the upcoming devolution in Ethiopia, whereby the regional health bureaus will require more technical input.</i></p> <p>‘They were assigned a broad mandate with difficult issues but not enough staff to cover all issues to the extent required’<sup>941</sup>. Capacities in the office seemed stretched, so that not all fora or TWG could be attended<sup>942</sup> and the guidelines on family planning were reported to have been written without the presence of UNFPA in the working group<sup>943</sup>. The FMoH wished for more seconding of technical staff to the ministry, as they had previously good experience with that<sup>944</sup>. In the last three years staff was reduced from about 65 to about 55, the international reproductive health advisor post was not filled and vacant positions had not been re-filled. The MHTF funds two midwifery</p>

<sup>937</sup> No additional information on type of vacancies were provided.

<sup>938</sup> External Development partner.

<sup>939</sup> “If the Representative and the reproductive health team are strong they can influence at policy level. This is what has suffered rather than the programme which had consolidated well under the past leadership” (Government Partner).

<sup>940</sup> “However, it was noted that UNFPA has no financial significance in HSSP II. “ There is now an institutional issue as withdrawing from the pool as it is not perceived well by the some partners” (External Development Partner).

<sup>941</sup> Quote from development partner.

<sup>942</sup> ‘Increase staff to provide stronger representation in regional health bureaus and to be able to attend all technical working groups, where UNFPA should be the lead’ (government partner).

<sup>943</sup> Information from development partner.

<sup>944</sup> The ECO though, reported mixed experience with seconding.

	<p>advisors, who cover the midwifery, nurse anesthetist and obstetric fistula programmes.</p> <p>National staff usually is employed on short term contracts with maximal 11 months, and then a proper recruitment has to take place, which takes 5-6 months. The position of the national professional officer for midwifery was filled for about 22 months (2009-2011).</p> <p>The regional office tended to complement the work, when requested to do so and provided advice towards the choice of consultants (i.e. for in case of the nurse anesthetist curricula development the regional office provided and found a consultant).</p>
<p>Findings from case study in <b>Ghana</b></p>	<p><i>The organogram of the UNFPA country office is tied to the country needs and the content of the country programme. UNFPA staff plays advisory roles and need to be equal to MoH counterparts and colleagues; however other UN agencies provide better starting levels and grades for similarly qualified and experienced professionals. The UNFPA salary and benefits package does not always attract the most appropriate higher level applicants or expatriates.</i></p> <p>Examples of recruitment challenges: There was no full-time UNFPA Country Representative for almost two years. The reasons provided for absence were contradictory based on who one spoke to - the government (which vehemently denied any responsibility for the delay) or UNFPA itself. There had been no Deputy Representative in place for six months and none had been identified at the time of this evaluation. Regardless of the reasons, the lack of two high level decision making staff was felt by all ministries and UN agencies as there was no one in UNFPA to drive the core mandate at policy, sector and budget level decision making<sup>945</sup>. UNFPA was represented by the UNDP Resident Coordinator who did her best but is never the same as having one own<sup>946</sup>.</p> <p>Monitoring &amp; Evaluation was under the remit of the Deputy Representative as an expert in the field. With his leaving in early 2011, a full-time M&amp;E position was created but it remains vacant after an unsuccessful recruitment process. Given UNFPA Ghana's role in M&amp;E system, the position is critically important and it was noted that it was difficult to find a person with the both appropriate caliber and status. The requirement as stated in the ToR for the Country Midwife Adviser's position has been technically fulfilled, as evidenced by three successful yearly performance appraisals. The position was supposed to have offices both at the GHS and UNFPA however GHS has indicated the unavailability of office space whilst UNFPA has an office for the position<sup>947</sup>.</p> <p>UNFPA recognizes that other UN agencies provide better starting levels and grades for similarly qualified and experienced professionals and this is de-motivating. There were queries about UNFPA not having an international Operations Manager<sup>948</sup>. Ghana Health Service remains keen to have a full time Country Midwife Adviser based in the Ministry rather than at UNFPA and for the country office to facilitate a closer co-operation with ICM Sub-regional Office based in Accra<sup>949</sup>. UNFPA processes and reputation at the Local Appointment Board and Compliance Review Panel have been praised and others are encouraged to emulate<sup>950</sup>. The Technical staff of UNFPA Ghana was well respected for their expertise and interventions so much so that at the programme/project level activities moved along reasonably well in the last two because it is a seasoned and well-honed programme but there are some critical gaps to do with policy planning, sector co-ordination and budgeting which the new Representative is expected to take on board<sup>951</sup></p>

<sup>945</sup> Interview with Development Partner.

<sup>946</sup> Interview with UNFPA.

<sup>947</sup> Interview with UNFPA.

<sup>948</sup> Interview with Development Partner.

<sup>949</sup> Interview with Government Partner.

<sup>950</sup> Interview with UNFPA staff.

<sup>951</sup> Interview with Government Partner.

Findings from case study in <b>Kenya</b>	UNFPA KCO with its current staff level seems not to be able to ensure adequate capacity for supporting its programmes and catalytic role in implementation of the 7 <sup>th</sup> Country Programme as well as other UN programmes in the country <sup>952</sup> . Additional high level technical expertise may be required to be available to participate in and follow up on current technical working groups. Staff recruitment has been taking a long time; often staff remains for years on Special Service Agreements, the recruitment of the humanitarian officer for example had not been finalized at the time of the mission.
Findings from case study in <b>Lao PDR</b>	<p><i>UNFPA has been providing a very intensive support in particular to the Ministry of Health what put a real load on the Reproductive Health team. Although it has been reinforced by the recruitment of an additional position the non-replacement of the other positions and the need to reinforce the capacities of the whole team has led to a real stress on the existing team members and some gaps in technical support provision.</i></p> <p>Following the development of the SBA plan a position of International SBA Coordinator was created. It was initially funded with Luxemburg funds and completed by MHTF funds in 2011. The Deputy Representative post had been vacant for more than a year at the time of the mission. The RHCS/MNCH Technical Advisor has not been replaced. The SBA International Coordinator has been replacing them. Recently a short term MNCH Advisor position was created to provide additional support to the reproductive health component. The structure is to be reviewed under the 5<sup>th</sup> Country Programme.</p> <p>Considering the many fronts where technical support has to be provided there is a gap in the provision of the necessary technical support because of the limited capacity of some the staff and the load of the SBA coordinator who has a large range of responsibilities. In addition staff is overwhelmed with a large number of IPs and annual work plans to manage and thus spend considerable time in managing funds rather than providing technical expertise. The management of GPRHCS funds is heavy and quite demanding on staff. It was expressed that the Lao country office misses expertise and development of its staff's capacities in order to provide appropriate assistance<sup>953</sup>.</p>
Findings from case study in <b>Madagascar</b>	<p><i>UNFPAs human resources at country level seem to enable sufficient effective engagement in current level activities. Implementing, development and government partners of UNFPA commended the increased availability of technical staff in the last two/three years.</i></p> <p>In 2010 UNFPA reported 62 staff, with just over 50% on SSA, and currently one position for a SRA expert is open and no problems with recruitment were mentioned. Additional staff has been recruited to cope with the direct payment mechanisms currently in place.</p>
Findings from case study in <b>Zambia</b>	<p><i>The UNFPA country office was not sufficiently staffed to adequately support the implementation of the past country programmes, specifically in the sexual and reproductive health programme component.</i></p> <p>The country office continues to be understaffed in the area of sexual and reproductive health. Prior to the launch of the MHTF in Zambia, the SRH adviser was the only staff member to manage the SRH/ maternal health portfolio. The recruitment of the Country Midwife Advisor (CMA) and Country Fistula Advisor (CFA) has improved the situation somewhat, as both the CMA and CFA have taken on some responsibilities for the overall maternal health portfolio beyond their main responsibility for midwifery and fistula programming (see also evaluation questions on MHTF below). Nonetheless, the number of staff members is still insufficient to be able to respond to all</p>

<sup>952</sup> Information from Government and Development partners.

<sup>953</sup> UNFPA staff interview.

	requirements of the maternal health programming, such as the attendance of all maternal health relevant technical working groups (SWAp structure) and other coordination meetings has not been possible, given the staffing bottlenecks in the country office <sup>954</sup> .
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**Judgment criterion 11.3: Enhancement / improvement of UNFPA country level programming and interventions through technical and programmatic support from global and regional level**

Findings from <b>desk study</b>	The extent to which existing capacity gaps in reproductive health were identified and filled in a timely manner will have to be assessed during the next phase of the evaluation, by means of a country office survey.
Findings from case study in <b>Burkina Faso</b>	<p><i>La capacité du bureau pays a été renforcée grâce aux postes additionnels financés fonds thématiques pour la SR mais il s'avère que les besoins des partenaires en appui technique ne sont pas totalement satisfaits.</i></p> <p>L'équipe du bureau pays du Burkina Faso considère qu'elle reçoit le soutien dont elle a besoin aussi bien de la part du siège que de la part du bureau régional. Les postes prévus au sein de l'équipe SR sont pourvus avec deux chargés de programme SR, une conseillère pays pour le projet de renforcement des capacités des sages femmes (financée par le MHTF), un administrateur national PF/SPSR (financé par le GPRHCS) et une Conseillère Technique pour le Projet Fistules Obstétricales. Malgré tout l'équipe en place n'est pas toujours en mesure d'apporter le soutien nécessaire à ses partenaires (par exemple appui aux districts sanitaires lors de la planification annuelle dans le cadre du panier commun), d'une part car son appui est très sollicité par les partenaires gouvernementaux et d'autre part car l'équipe est plus impliquée dans le suivi administratif que dans l'appui technique à cause de procédures lourdes. De plus la chargée de programme SR/ Maternité à Moindre Risque (MMR) a du assumer en 2010 la charge de deux positions pendant 6 mois lors de l'absence du représentant (due à un remplacement tardif). Il est prévu qu'un personnel de suivi-évaluation ainsi qu'une personne responsable pour les Fistules Obstétricales soient recrutés grâce au MHTF.</p>
Findings from case study in <b>Cambodia</b>	<p><i>The Asia and Pacific regional office has offered on-demand support and has provided country office staff with the opportunity to attend workshops on issues such as "results-based management and financial management". The information conveyed in these events is appreciated. The challenge of implementing any new concepts in the country office and country-level programming has been shared by the two offices.</i></p> <p>Regional office (RO) input is considered as supportive and timely. The Regional Adviser is generally available; when unavailable, he would identify a suitable substitute. The sub-regional office played a critical role during the introduction of the EmONC <i>assessment and improvement plan</i><sup>955</sup>.</p> <p>In 2008, the main support received by UNFPA country office for the Mid Term Review (MTR) was from the regional office. It cleared the process, provided technical inputs, and joined the high-level review meeting<sup>956</sup>. In 2009, the country office (CO) and APRO were involved in the formulation of the new UNDAF and Country Programme IV, with several facilitating and constraining factors. Overall, the process worked well as both the UNFPA RO/CO had a clear understanding of equity and knowledge of sectoral issues<sup>957</sup>.</p>

<sup>954</sup> Interviews with UNFPA staff and development partners.

<sup>955</sup> "If we compare to the days of Country Support Team we have to sometimes juggle for attention now but the quality of technical assistance has improved" (UNFPA Cambodia).

<sup>956</sup> "Support from GD was generally good with some gaps during transition to Regional Office, but full support was available again" (COARS, 2008).

<sup>957</sup> External Development Partner.

Findings from case study in <b>Kenya</b>	The Africa regional and sub-regional office is providing on-demand support and has also offered the opportunity to attend workshops on issues as leadership management for example. The sub-regional office participated in field M&E missions and provides on request feedback for the annual work plan. However, it seems that for example in the 7 <sup>th</sup> CPAP development the relevant line ministries have been more involved than the regional office.
Findings from case study in <b>Lao PDR</b>	<i>Country office receives some technical support from the regional office on specific tasks and issues what proved to be useful in some instances. This support however remains occasional Workshop or trainings are also arranged at regional level to increase the capacity of country office staff or to introduce particular tools.</i> Usually the country office has contacts rather with the regional office (RO) in Bangkok than with the UNFPA headquarters. At the beginning of the 4 <sup>th</sup> country programme the country office got support from the regional office e.g. technical back up during the MNCH package preparation in 2007. Support is provided through sharing of knowledge or experiences from other countries or through visits of the regional office reproductive health advisor to attend the TWGs meeting on specific issues requiring technical expertise <sup>958</sup> . Capacity building and planning meeting and seminars are organized at regional level for country office staff e.g. for introducing new GPRHCS tools and for media training. There are some exchanges between countries e.g. Lao PDR undertook the SBA assessment based on Cambodia example. More recently the regional office support was not always considered as very useful.
Findings from case study in <b>Madagascar</b>	The Africa regional and sub-regional office offers on-demand support and depending on the programme is more or less involved. Headquarters is the main counterpart for the MHTF.
Findings from case study in <b>Sudan</b>	Only little information is available. However, at least the “National Strategy Document for Scaling-up Midwifery in the Republic of Sudan” was developed by adapting a corresponding framework for scaling-up midwifery that had been developed during the First International Form on Scaling-Up Midwifery (held in Tunisia, in 2006). The Sudan scaling-up strategy contains many of the same issues and key topics that had also been laid out by the global framework for scaling up midwifery.
Findings from case study in <b>Zambia</b>	The Africa regional and sub-regional office has offered on-demand support and has also offered the opportunity to attend workshops on issues such as “results-based management”. Although the training opportunity is appreciated, the country office has found it challenging to implement the new concepts after only one such workshop. No follow-up support to accompany the longer-term process of adapting new concepts at country level has been made available by the regional or global offices <sup>959</sup> .

<sup>958</sup> UNFPA staff interview.

<sup>959</sup> Interviews with UNFPA staff.

## 8.2.12 Evaluation question 12: To what extent did UNFPA’s maternal health support contribute to UNFPA’s visibility in global, regional and national maternal health initiatives and help the organization to increase financial commitments to maternal health at national level?

### Judgment criterion 12.1: UNFPA presence in global and regional maternal health initiatives

Findings from desk study	UNFPA advocated appropriately at global and regional level to increase its visibility, as emphasized in its strategic documents. The UNFPA ICPD mandate and its advocacy and campaign work have been supported by statutory donors and governments and by an expanding alliance within inter-agency groups, individuals, NGOs, foundations and corporations. Networks and alliances of civil society organizations have become increasingly important since ICPD Cairo (1994) to overcome challenges to reproductive choice and freedom that UNFPA can face.
Findings from case study in DR Congo	<p>L'UNFPA s'est engagé dans un plaidoyer en direction du gouvernement, militant en faveur d'un recensement national de la population et pour la modification du cadre juridique lié à la santé maternelle et à la planification familiale (par exemple, l'UNFPA a soutenu avec d'autres partenaires le Ministère du Genre dans l'élaboration d'un nouveau Code de la Famille, et le Ministère de la Santé dans ses tentatives de réforme de la loi sur la contraception).</p> <p>La participation de l'UNFPA dans les activités H4+ souligne son rôle de leader dans les provinces cibles. En outre, le BP a pris la décision de se restructurer pour passer de onze bureaux à trois bureaux décentralisés (en plus du bureau central), action qui leur permettra de focaliser leurs interventions et de les rendre plus visibles. Cette démarche stratégique a été en partie motivée par les difficultés que connaît le BP du fait de l'insuffisance budgétaire par rapport aux besoins énormes du pays (Judgment criteria 12.1, 12.2).</p>
Findings from case study in Ghana	<p><i>The overall reaction to the question of UNFPA visibility was positive in that the organization was considered as visible where it mattered most. It was noted by partners that visibility had to be assessed within UNFPA's reality of limited funding, difficult and sensitive mandate areas, leadership of the government and the growing influence of UNDAF Deliver as One.</i></p> <p>The country office has been visible through its support for the heavily attended CARMMA launch in 2009 spearheaded by the First Lady and the well-attended launch of the National Plan of Action on Prevention of Domestic Violence by MoWAC which was attended by four ministers;<sup>960</sup> During the planning of events the difficult mandate areas is an important consideration and the positive work of UNFPA and the response by high level public officials speaks for itself.<sup>961</sup></p> <p>Generally, UNFPA is more visible in its target regions and districts, which stands to reason<sup>962</sup>. It is visible within UNDAF in the outcome areas where it is engaged as the lead or a member of SWGs but the two year absence of a fulltime Country Representative has had an effect especially in guiding UNFPA decision making.<sup>963</sup> It is visible to relevant sector Ministries: Ministry of Health/Ghana Health Services and Regional Directorates, Ministry of Women and Children Affairs, Ministry of Chieftaincy and Culture, Police Department and Ministry of Interior and to the National Population Council and Ghana Statistical Services. With MoWAC, UNFPA is especially visible</p>

<sup>960</sup> Interview with Government.

<sup>961</sup> Interview with UNFPA Staff.

<sup>962</sup> Interview with Government.

<sup>963</sup> Interview with Development Partner.



	<p>around its work in preventing domestic violence which has been a difficult area to get public health funding and to promote gender responsive budgeting and policy.</p> <p>Work with UNFPA in and of itself has value<sup>964</sup>. UNFPA is visible through its smaller IPs than the larger ones. Small IPs like Curious Minds' and SWAA have public media events and platforms, e.g. through the campaign to engage youth in national census activities; prevention of teenage pregnancy, safer sex initiatives for women porters and innovation around condom programming. In the Central Region UNFPA has generated visibility through its support for the public/private partnership with the Transport Union involved in tackling Delay One of the Three Delays model, delay in reaching a health centre<sup>965</sup>.</p> <p>With UNFPA, a little goes a long way; and given their working mechanism of supporting the government and not leading; they are where it counts.<sup>966</sup> UNFPA and WHO work very closely and "<i>we don't have the money but if we are visible they are too or vice versa</i>"<sup>967</sup> Some agencies did comment that UNFPA of recent was not seen in the high level regional meetings (outside fistula and EmONC assessment) nor in the health sector meetings but this could also mean the agencies do not work in the same geographical areas or the absence of senior staff for a long period of time.<sup>968</sup> The implementation of the Deliver as One could be the days of reckoning as further UNDAF harmonization with government priorities is the call of the day; it will affect visibility of most UN agencies including UNFPA.<sup>969</sup></p>
Findings from case study in <b>Madagascar</b>	<p><i>Regional maternal health initiatives, such as the CARMMA are in the current political situation not possible; UNFPA supports national counterparts in their participation in regional workshops and conferences.</i></p> <p>UNFPA participated along with other UN agencies on the initiative on HIV/ AIDS organized by the Commission of the Indian Ocean, an intergovernmental organization that joins the Comoros, La Reunion, Mauritius, the Seychelles and Madagascar to encourage mainly economic and commercial cooperation. Representation in other high level regional initiatives is lacking due to the non-recognition of the current Government. UNFPA funded during the last three years travel- and workshop costs for regional events (such as the Accra ICM workshop and the Durban midwifery conference).</p>

#### **Judgment criterion 12.2: UNFPA leadership of maternal health advocacy campaigns at national level**

Findings from <b>desk study</b>	<p>UNFPA's mandate has to be accepted and translated into concrete programmes on the ground by those countries that are signatories to ICPD PoA and have ratified this document. The joint CPAP, CPD RRF and annual work plan of each country elucidate UNFPA's responsibilities and government commitment. UNFPA has utilized a variety of mechanisms, such as aid instruments (SWAps, PRS), UNGASS conferences, World Summits, declarations such as universal access, inter-agency initiatives (Safe Motherhood) and regional co-operation like the Maputo Plan (African Union). However, evaluations have commented on the lack of UNFPA visibility in important stakeholder meetings.</p>
Findings from case	<p><i>Les efforts de l'UNFPA en matière de plaidoyer pour la santé de la reproduction et la santé maternelle à plusieurs niveaux et sa position</i></p>

<sup>964</sup> Interview with NGO.

<sup>965</sup> Interview with Regional Health Authority.

<sup>966</sup> Interview with Government.

<sup>967</sup> Interview with Development Partner.

<sup>968</sup> Interview with Development Partner.

<sup>969</sup> Interview with UNFPA Staff.

<p>study in <b>Burkina Faso</b></p>	<p><i>proéminente dans ce domaine sont reconnus par les différents partenaires. Avec le soutien des partenaires techniques et financiers le gouvernement (en particulier le ministère de la santé/ DSME) s'est approprié la priorité placée sur la santé maternelle.</i></p> <p>L'UNFPA a participé à la diffusion sur le plan national d'initiatives régionales telles la feuille de route pour accélérer la réduction de la mortalité maternelle, le plan de Maputo, la CARMMA, ainsi qu'au plaidoyer auprès du gouvernement pour leur mise en œuvre effective, appui à la planification qui intègre les recommandations des initiatives, et appui financier à la mise en œuvre des actions planifiées.</p> <p>L'UNFPA a contribué avec le projet AWARE à l'élaboration du modèle 'Reduce' (santé maternelle et développement) pour le Burkina en 2005 et l'a utilisé comme instrument de plaidoyer auprès des décideurs. En 2010, UNFPA également travaillé avec le projet AWARE II pour élaborer le model RAPID (planification familiale et développement) qu'il utilise actuellement avec les leaders coutumiers et religieux pour le plaidoyer en faveur de la santé maternelle auprès des organisations religieuses influentes. Les guides de communication envoyés du siège sont consultés mais pas particulièrement utilisés car « la préférence est donnée à la stratégie nationale ». Le bureau pays n'a donc pas sa propre stratégie de plaidoyer mais soutien la stratégie nationale.</p> <p>Le gouvernement et tous les partenaires y compris ceux du système des NU reconnaissent le rôle de leader de l'UNFPA en matière de santé maternelle. Son rôle de leader dans le plaidoyer est positivement apprécié par le gouvernement qui dit se sentir motivé par l'appui des partenaires, l'incitant à s'engager de plus en plus dans la réduction de la mortalité maternelle et respecter ledit engagement.</p>
<p>Findings from case study in <b>Cambodia</b></p>	<p><i>UNFPA leadership of maternal health advocacy at national level takes a strategic place within the UN framework in terms of participating in other donor relationships and advocacy of their mandate areas. At sectoral level, UNFPA brings a broad-based understanding coming from long-term experience; Because of this, UNFPA advocates well on behalf of reproductive health/maternal health.</i></p> <p>UNFPA is deeply involved in the health sectoral framework and in the Technical Working Groups on Health and a sub-group on Maternal Health and as such remains a key player in maternal health advocacy and demand creation campaigns through Government and NGO channels. The Ministry of Planning is responsible for M&amp;E, supervised by the National Strategy Development Plan. UNFPA has remained a key player with both. It has ensured balanced reporting on C-MDG, census and C-DHS by Government in various aid and assistance forums and has supported national workshops to discuss “achievement and gaps and ensured dissemination of results”<sup>970</sup>.</p> <p>In providing quality data sets that are well maintained, “UNFPA funds resources critical to the country which means they are well positioned, have the reputation of involvement, provide proper evidence for their reproductive health/maternal health arguments and are a responsible partner”<sup>971</sup>. With regard to planning and programming, UNFPA Cambodia is grounded in its support to the National RSH Strategy, HSSP II Chairmanship, evidence documents and their mandate “so they negotiated toughly in UNDAF and HSP II; all the maternal health indicators in CMDGs are there due to UNFPA”<sup>972</sup>.</p>
<p>Findings from case study in <b>Ethiopia</b></p>	<p><i>UNFPA is partner to a broad range of maternal health related advocacy campaigns and the recognized leader in the subject of family planning commodity security, obstetric fistula repair and since the advent of the MHTF also midwifery and task shifting. Neonatal and postpartum health is an area that is not covered by development partners in Ethiopia and several government partners suggested UNFPA to take this up.</i></p> <p>UNFPA has been attested leadership in family planning commodity security and advocacy, obstetric fistula, midwifery training, master</p>

<sup>970</sup> Government Partner.

<sup>971</sup> External Development Partner.

<sup>972</sup> External Development Partner.

	<p>degree training and midwifery association support. It has been recognized as a collaborative partner, supporting the GoE with a flexible approach and channeling the funds mainly through Treasury. The main instruments in providing leadership have been general advocacy (speeches, etc. on issues of maternal health), support of high level advocacy campaigns and strategic documents, Safe Motherhood Month and many others. UNFPA is currently the co-chair of the Health Population and Nutrition group, which is the most important coordination group for health, led by the MoH, with the task to harmonize and agree on priorities. The H4 is led by WHO and there is no other functioning TWG to coordinate or harmonize reproductive health.</p> <p>In the last three years UNFPA supported financially, technically and logistically several South-South interventions, the launching of the Campaign on Accelerated Reduction of Maternal Mortality (CARMMA), the SMH month, the Midwifery Day and a regional conference on task shifting.</p> <p>It has been noted that neonatal health is not addressed by any development partner and UNFPA is well positioned to take this on. Government partners suggest that as family planning is addressed by donors with huge funds, UNFPA should shift to neonatal and postpartum health. The current capacity may not allow further extension and the additional workload due to the planned administrative devolution may be already challenging.</p>
<p>Findings from case study in <b>Kenya</b></p>	<p><i>Whilst UNFPA is recognized in two areas of reproductive health as taking the lead, the overall perception by its partners seems to be that it does not utilize its full potential in providing strategic and pro-active leadership. This may be further aggravated by the reduction to four pilot sites only for implementation on sub-national level. A communication strategy to highlight the potential outcome as research and evidence creation base for national centers of excellence has not been developed.</i></p> <p>On national level, the KCO has been attested strategic leadership by the government and development partners in the areas of obstetric fistula and reproductive health commodity security and similarly on project level, the implementing partners commended UNFPA for its leadership and responsiveness to its needs. The NCAPD regards UNFPA as catalyst to leverage funds (or partners with funds) as proven in marshaling partners for the KDHS and other surveys. Given UNFPA as a brand, if UNFPA is on board, others follow.</p> <p>Nevertheless, in most of its programmes UNFPA has been overshadowed by the well-funded agencies. This concerns also more and more traditional UNFPA fields of work such as family planning, which is currently in the focus of UNICEF Kenya. Government partners would like to see UNFPA provide a strong leadership in reproductive health; this is also the sentiment of development partners who observe that proactive leadership for UNFPA has not been felt in Kenya. Initiatives in reproductive health are usually taken by other agencies (i.e. the development of business plans for reproductive health strategies) and few partners report using the technical support during the current country programme, as locally higher qualified people are found. Also, the presence of technical officers in many meetings has been reported as limited due to lack of sufficient staff capacity and this will deteriorate further with devolution to county level, as each county will have to be served and demand for services<sup>973</sup>.</p> <p>The low level of funding that UNFPA has at its disposal relative to other donors and bilateral organizations seems not to have translated into initiation of joint initiatives with other development partners. The joint HIV/AIDS programme of UNFPA and UNICEF has been put in place due to the fact that DFID made joint programming and implementation conditional for provision of funds.</p> <p>Communication strategies are considered as being underdeveloped by the KCO itself, as sometimes UNFPA contribution is not even highlighted on national level in cases where its interventions have been commended for excellence. One example would be that UNFPA</p>

<sup>973</sup> As already expressed by government partners, development partners and the KCO.

	<p>frequently supports policy developments, but the final document may be printed by others and the logo of UNFPA might be forgotten/missed out<sup>974</sup>. Another example is that UNFPA has provided operational support to the CARMMA launch, but no further follow up to it, although the Ministry of Public Health has regarded this event as catalytic for Maternal Health. The UNDAF document contains a lot of information on breastfeeding<sup>975</sup> but nothing on Kenyan census, and all four proposals from UNFPA for the Consolidated Appeal Process 2011<sup>976</sup> were not included. Some of these issues may reflect a non-proactive leadership, an insufficient capacity within the KCO team to follow up efficiently on all areas, or a lack of recognition by partners based on insufficient demonstration of UNFPAs country work. The newly designed communications strategy may help to rectify the perception of a ‘not-felt’ UNFPA.</p>
Findings from case study in <b>Lao PDR</b>	<p><i>UNFPA leadership in terms of boosting maternal health in Lao PDR is highly recognized by all the partners in terms of advocacy but also due to its strong technical support to the Ministry of Health.</i></p> <p>UNFPA’s visibility in terms of maternal health is well recognized by the development partners and the government officials<sup>977</sup>. As seen above, UNFPA supported a number of channels and approaches to advocate for maternal health: participation of MOH officials in various international events, the development of the SBA assessment and plan, advocacy and capacity development of media and parliamentarians, Celebration of the International Midwife day. In addition its presence in many of the Technical Work Groups with a strong technical expertise has certainly influenced the government and the development partners.</p>
Findings from case study in <b>Madagascar</b>	<p><i>UNFPAs leadership in maternal health advocacy is currently facilitated by its unique position as being the only MOH donor in SHR; it has demonstrated that it utilized this position successfully for the obstetric fistula programme, but needs to ensure and increase the MoH stewardship capacities to absorb future influx of strong players.</i></p> <p>UNFPA has been near to being a synonym for family planning since the early years (1990s) and still is the strongest supporter and nearly sole provider of family planning<sup>978</sup>. Its convening power has been demonstrated in the initiation and the leadership position in the H4+ group. It has been equally successful in leveraging support for the recognition of obstetric fistula as a reproductive health need and - increasingly so since the MHTF - on MW training and MW empowerment. The mechanisms utilized by UNFPA include long-term and reliable commitment, continuous technical support, a collaborative approach and funds. Given its unique position as the only functional MoH donor in SRH at present, UNFPA can utilize this window of opportunity to scale up and enforce the coordination and planning mechanisms of the MoH.</p>
Findings from case study in <b>Sudan</b>	<p><i>UNFPA has supported a number of advocacy causes that were related to maternal health, but has done so while trying to keep a low profile as an organization.</i></p> <p>UNFPA has worked on affecting awareness on particular issues of gender-based violence, including Female Genital Mutilation and early marriage, SAFE motherhood, HIV and health. Among the mechanisms used in these campaigns have been joint programme with UNICEF on FGM, media campaigns / working in partnership with state level media, support of youth networks, and awareness raising campaigns directed at parliamentarians. Also, UNFPA has been working with and supporting a “Religious Leaders Platform on</p>

<sup>974</sup> The KDHS carries two logos, none of which belongs to the national institution: USAID and ‘Kenyan and Americans to fight HIV/AIDS’.

<sup>975</sup> Led by UNICEF.

<sup>976</sup> Led by OCHA; the health and protection sectors by WHO and UNHCR.

<sup>977</sup> Government and development partners interviews.

<sup>978</sup> UNFPA has been attested by several IPs, DPs and GPs strong and long standing leadership, especially in family planning.

	<p>Reproductive Health”. In addition, UNFPA has established close relationships with a number of policy-relevant organizations, such as the National Population Council, the Ministry of Social Welfare and Gender or the Ministry of Guidance (in addition to its relationship with the Ministry of Health). In addition, UNFPA has worked with local media and has supported the development and airing of programmes on maternal health-related topics.</p> <p>One more recent attribute of UNFPA’s approach to advocacy and awareness raising campaigns has been to keep a low profile as an organization in order not to hurt possible sensitivities towards the presence of an international organization, in particular when addressing sensitive cultural, religious or political issues.</p>
Findings from case study in <b>Zambia</b>	<p><i>UNFPA has limited its leadership of maternal health advocacy campaigns to logistical and financial support for the launch of large, government-driven campaigns (e.g., CARMMA) without working with the Government to put in place concrete follow-up activities.</i></p> <p>In Zambia, UNFPA’s maternal health support has increased its visibility primarily through its support of initiatives like CARMMA or the longer term support of issues like fistula, through the <i>Campaign to End Fistula</i>. Although UNFPA’s support of these initiatives has helped to generate a lot of national attention at the time of their launch, UNFPA has not sustained its leadership role in supporting the Government with these campaigns during the subsequent follow-up. The UNFPA-supported CARMMA launch has eventually not translated into any significant and concrete new commitments to maternal health. This weakness is also exemplified by lack of any designated staffing for CARMMA in the MoH. UNFPA has so far not worked with the Government to improve its weak follow-up to the official launch of CARMMA<sup>979</sup>.</p>

### Judgment criterion 12.3: Increased financial commitments of partner governments to SRH and maternal health

Findings from <b>desk study</b>	<p>UNFPA intended to assist in the mobilization of resources for SR and maternal health support in both developing and developed countries; and to use the tools at its disposal for this purpose. Improved and reliable socio- economic data, e.g., from UNFPA supported censuses and other surveys, are able to form the basis for countries to determine priorities, but also to allocate and monitor resources for maternal health, among others. In principle, UNFPA partner government can use this data to advocate with development partners for additional support, for maternal health or other issues, and to decide to allocate more of its own resources to SRH and maternal health. It is notable that by 2006, more countries allocated larger amounts of their national resources towards funding contraceptive purchases, expanding family planning services, improving maternal care and preventing HIV, especially among women and adolescents. However, at this point, it is not clear to what extent UNFPA maternal health data and surveys contributed to this trend; this will be further assessed during the field phase.</p> <p>Starting in 2001, UNFPA’s introduction of results-based management principles put the focus on increasing regular resources for country programmes to come primarily through governmental pledges. By 2005, more countries contributed to UNFPA than in any year since the Fund began operations in 1969, bringing the number of donor nations to 172. By 2006, the total number of donor nations had reached 180. SRH and maternal health have received the bulk of the resources in country.</p>
Findings from case study in <b>Burkina Faso</b>	<p><i>L’UNFPA a contribué à créer un environnement propice à un engagement accru du gouvernement pour financer la santé maternelle mais aussi celui d’autres partenaires qui souhaitent appuyer des projets dans ce domaine.</i></p>

<sup>979</sup> Interviews with UNFPA, development partners and MoH.

	<p>Les actions de plaidoyer mentionnées ci-dessus ont un lien direct avec l'augmentation progressive de la contribution du budget de l'État à la santé de la reproduction et de l'ajout au budget national de lignes budgétaires spécifiques pour la SR Cet engagement ferme du gouvernement favorise la mobilisation de fonds additionnels avec les bailleurs de fonds. De nouveaux projets d'appui sont en cours de finalisation avec l'Union Européenne (planification familiale et santé maternelle), la Banque Mondiale (planification familiale et santé maternelle), l'Agence Française pour le Développement AFD et l'Agence Canadienne pour le Développement International ACDI (santé maternelle et néonatale). L'UNFPA a été le chef de file pour la préparation de ce dernier projet.</p>
Findings from case study in <b>Cambodia</b>	<p><i>UNFPA Cambodia has been successful in leveraging funding and additional support with new ideas and concepts in maternal health/reproductive health through a programme-based and integrated approach to joint programming, especially through HSSPII.</i></p> <p>Prior to 2006, most of UNFPA funding was through the European Union for expanding its programme on adolescent health (RHIYA 2001-2005). In 2006, UNFPA joined HSSP II and became its chair. By 2010, 40% of the total pool fund (noted in 2010 at over \$100 million) was being allocated for reproductive health/maternal health and this was due to the evidence provided to the big donors “with the <i>Midwifery Review (2006), Midwifery programming (2007-10), its National Assessments on EmONC (2009) and the Improvement Plan (2010-2015)</i>”.<sup>980</sup> UNFPA Cambodia has received funding from both the German Government and AusAid for its Midwifery Programming and EmONC assessments successfully replacing MHTF resources, which in turn have been used for other maternal health activities.</p> <p>The MoH has put in additional resources for health of which 13% is earmarked for maternal health<sup>981</sup>. In 2010, the Parliament voted to commit an increase of 10% annually to the health budgets and agreed on a proportion for maternal health at sub-national level<sup>982</sup>. Full attribution is difficult, but MoH staff and Parliamentarians did allude to the advocacy role of UNFPA during the interviews<sup>983</sup>. UNFPA has been less successful in its advocacy with regard to Government funding of contraceptives, but due to its procurement expertise has received further support from AusAid.</p>
Findings from case study in <b>DR Congo</b>	<p>Le Plan National de Développement Sanitaire 2011/2015 (PNDS) démontre clairement la situation critique de la santé reproductive dans le pays. L'UNFPA utilise ces données pour mettre en évidence les besoins et pour sensibiliser le gouvernement à l'impérieuse nécessité d'un engagement plus soutenu de sa part. La part du gouvernement dans les activités de collecte de fonds complémentaires pour la santé reproductive est jusqu'à ce jour insignifiante.</p>
Findings from case study in <b>Ethiopia</b>	<p><i>Resource mobilization is one of the tasks of the ECO, which seems to be an add-on for the technical officers and not pursued by a dedicated staff member. UNFPAs engagement in maternal health has attracted extra-budgetary funds.</i></p> <p>The COARs have a section on local resource mobilization indicating the presence or absence of a resource mobilization plan (yes in 2006, no in 2008, no information in 2009) and listing the received amount, but the reports do usually not specify for which programme, unless it is UN joint programme (as for example in 2006 'pooled funding for the UN HIV/AIDS programme'). In 2006 the ECO mobilized</p>

<sup>980</sup> External Development Partner.

<sup>981</sup> Government partner.

<sup>982</sup> Government Partner.

<sup>983</sup> After the SG visit last year, UNFPA and Health Minister requested additional funds. NCPD had access to the Council of Ministers. The Minister asked the Deputy PM for a meeting, and as the chair of Council of Administrative Reform, the latter helped to push for a successful increase for the Initiative (according to information from Government Partners and external development partners).

	<p>over 1.4 million USD (Trust fund); in 2008 it was the holder of the Census Pooled Fund (over 16 million USD) and, also in 2008, it successfully coordinated the preparation of the gender window of the Spanish MDG Achievement Fund<sup>984</sup>. In 2009 no additional funds were mobilized<sup>985</sup>.</p> <p>SIDA funds (3 million USD) were raised on country level, based on convincing advocacy and the Swedish interest in UNFPAs midwifery programme.</p> <p>The ECO has some experience with pooled funding in Ethiopia. Currently UNFPA supports the MDG fund through the MHTF with annually one million USD and leveraged further three million USD for family planning and maternal health. (see MHTF for further detail) Following the example of the UNFPA also the WHO joined the fund and the World Bank is planning to do so.</p> <p>Whilst the 2015 deadline to achieve the MDGs seems to be the main push for the GoE to engage in maternal health, the UNFPA has contributed through its technical and financial commitment to greater investment of the GoE, which invests meanwhile considerably more on salaries of the midwives, the new cadres of the task shifting programme and on the provision of relevant equipment to selected health facilities.</p>
<p>Findings from case study in <b>Ghana</b></p>	<p><i>UNFPA Ghana has found Road Maps and the launch of CARMMA as useful tools/events to leverage additional commitment and resources to support maternal health but commitment does not always lead to budget allocations in all areas of maternal health and when they are committed they can easily be re-allocated as often happens with family planning funds.</i></p> <p>Since 2008 government funds to maternal health has gone up fourfold and this was based on Maternal Health Survey 2007 which UNFPA and other agencies pushed for. Government managed to raise more than money for 2010 census from the private sector after it was challenged by two UNFPA Implementing Partners – Curious Mind and MCAN and Ghanaian youth rallied in support of the census with their own social and health issues which also included a maternal mortality module and domestic violence. Curious Mind is now attached to the National Population Council Programme Component Manager as an important advocate for youth and reproductive health/maternal health.</p> <p>The CARMMA Initiative has been gathering momentum since 2009, and the launching of the ten region campaign and national family planning week as an annual event has definitely put UNFPA Ghana firmly on the map. UNFPA’s promotion of a broader national Reproductive Health Commodities Security Policy has in all likelihood influenced the recent GoG commitment of US\$3million for family planning commodities, the largest annual commitment made for family planning. It was however noted that commitment does not necessarily translate to annual budget allocation and when there is allocation it does not easily translate to expenditure. It was noted that family planning budget is the one that gets nibbled away to cover shortages in any other part of the health budget.<sup>986</sup></p>
<p>Findings from case study in <b>Kenya</b></p>	<p>The Ministry of Planning has identified family planning for budgetary support as priority area of development; UNFPA contributed to this rather recent development directly with purchase of contraceptives over many years and indirectly with support to reproductive health strategy development.</p>

<sup>984</sup> COAR 2008.

<sup>985</sup> COAR 2009: ‘Mid-way through the programme cycle, UNFPA Ethiopia was able to surpass its mid-point resource mobilization target by mobilizing over US\$40.7. As a result, much more focus was given in 2009 in effectively and efficiently using the already mobilized resources by setting up new internal mechanisms and strengthening programme management and monitoring mechanisms rather than mobilizing additional funds’.

<sup>986</sup> Interview with a Development Partner.

	UNFPA funded assessments and surveys have contributed to attract funds (e.g. SIDA funds for the census). The Annual Report 2010 mentioned also resource mobilization from DFID for the joint HIV/AIDS programme with UNICEF.
Findings from case study in <b>Lao PDR</b>	<p><i>The strategies developed with UNFPA support were endorsed by the government and budgets were shared between the government and the development partners. However despite advocacy and ongoing discussions the government has been slow in committing itself for funding contraceptives, one of the explanations being the low absorption capacity of the Ministry of Health.</i></p> <p>The MNCH package was costed and the MoH is doing a resource mapping for the coming 5 years in order to achieve it. The government bears infrastructures, salary costs but still relies on external assistance for the other components<sup>987</sup>.</p> <p>It can be noticed that the government is gradually allocating funds for MNCH particularly for the immunization programme and to procure vaccines. Recently it allocated little funds for contraceptives. But there are still no specific lines for MNCH. The government has approved the production of community midwives including direct entries and committed to fill up the vacant positions as well as to provide incentives for staff in remote areas and free assisted delivery services for women in the lowest wealth quintile although its contribution is not clear<sup>988</sup>.</p> <p>The slow progress in this aspect can be explained by the fact that the Ministry of Finance is reluctant to increase the health budget because of the low absorption capacity of the MOH despite a strong awareness of the high level government officials and parliamentarians<sup>989</sup>. However some stakeholders expressed that UNFPA could have even more leverage with the government and to be more involved in affecting policies, budgets, and ensuring that its mandate areas are progressively getting funded by the government<sup>990</sup>.</p>
Findings from case study in <b>Madagascar</b>	<p><i>UNFPA has leveraged internationally but not nationally funds for its work in Madagascar.</i></p> <p>UNFPA has been able to leverage reproductive health funds from Monaco<sup>991</sup> for a joint programme with WFP and recently it launched a PPP with TELMA<sup>992</sup>, a telecommunication provider. Funds from bi-lateral donors are currently not available (political situation) and the MoH has a diminishing budget, hence is not able to co-finance joint activities. The previous government had acknowledged maternal health as priority and increased the health expenditure to 9% of the GDP, but because of lack of absorption capacity it was reduced to 6% in 2011.</p>
Findings from case study in <b>Sudan</b>	<p><i>UNFPA supported advocacy campaigns have not translated into the commitment of additional money to improve maternal health in Sudan.</i></p> <p>In principle, the MNH Road Map that was developed largely by means of UNFPA technical support is now meant to be used as tool to leverage additional funding for improving maternal and newborn health in Sudan. However, so far, neither the Government, nor UNFPA itself has been able to raise any of the required money for its implementation. As mentioned above, “the projected costs to implement this road map exceed the estimated amount that is currently spent on reproductive health by the Sudanese Government by a factor of approximately 165. This means that funds from external sources, development partners and others, will have to fill an annual funding</p>

<sup>987</sup> Government partners interviews.

<sup>988</sup> UNFPA staff interview.

<sup>989</sup> Development partners interviews.

<sup>990</sup> Idem.

<sup>991</sup> COAR 2010.

<sup>992</sup> UNFPA Technical Advisor maternal health.



	<p>gap of approximately US\$ 39.8 million to allow for the implementation of the road map overall; and the family planning support in particular”.</p> <p>Moreover, there has not been a direct link between public awareness of maternal health, formal Government commitments to maternal health, and increased funding for maternal health. Maternal health as an issue is actually relatively visible issue in Sudan, as evidence by the fact that some public events (e.g., on midwifery) are attended by the President. However, this symbolic support has not translated into increased levels of funding for maternal health support. Even though staff in the Ministry of Health is generally committed, their options for ensuring increased funding for health overall and maternal health in particular are limited by the nontransparent budgeting process in Sudan<sup>993</sup>.</p>
<p>Findings from case study in <b>Zambia</b></p>	<p><i>UNFPA and the Zambian Government have found it difficult to use the launch of CARMMA or the revision and official launch of the MNH Road Map to leverage additional commitment and resources to support maternal health in Zambia.</i></p> <p>By supporting the development of the MNH Road Map, UNFPA helped to develop a useful tool for increasing national attention both on maternal and newborn health and on its own role in supporting these causes. However, the Road Map has not been circulated widely enough to attract support from UNFPA’s development partners<sup>994</sup> or to encourage increased resource allocations to maternal health by the majority of these partners. This notwithstanding, the Government has used the MNH Road Map to document its commitment to maternal health with the Government of the United States, in preparation of the US pledge to commit significant resources to reducing maternal mortality in Zambia (see evaluation question 9 for details).</p>

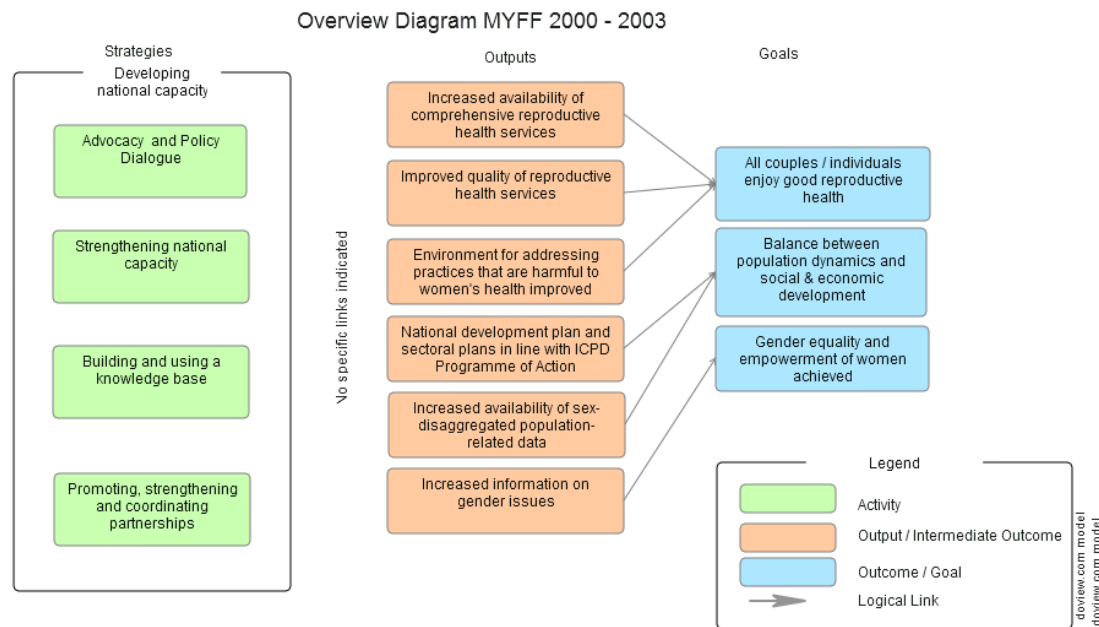
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<sup>993</sup> Interview with UNFPA.

<sup>994</sup> Interviews with Development Partners (DPs) showed that the road map was hardly known among development partners.

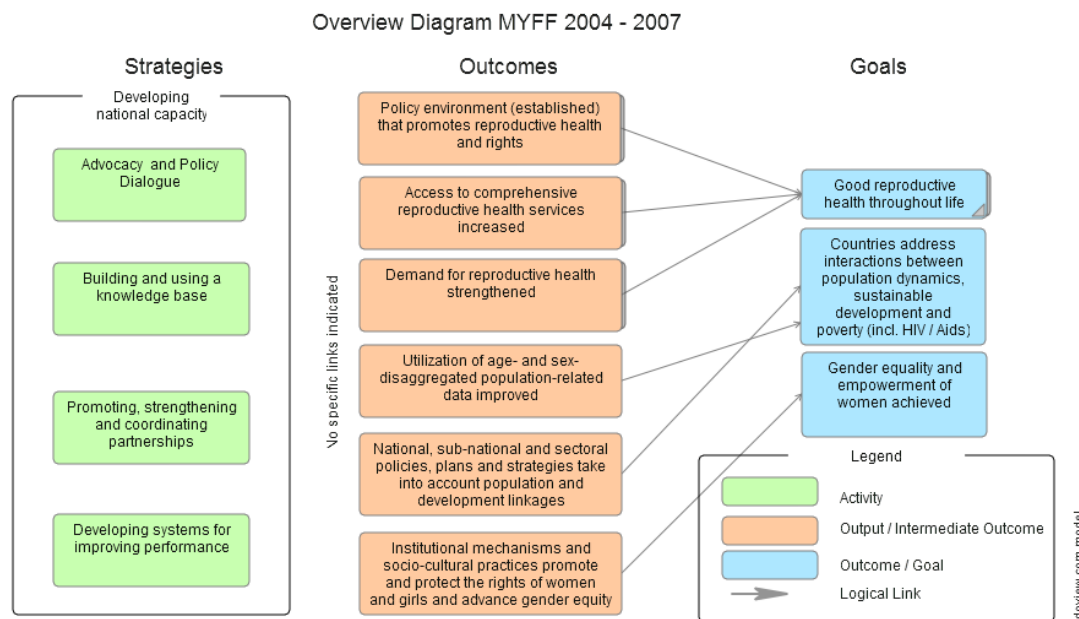
## 9. Diagrams of intervention logic of UNFPA strategic frameworks

Figure 3: Overview of UNFPA Multi-Year Funding Framework (MYFF) 2000 – 2003 (faithful)<sup>995</sup>



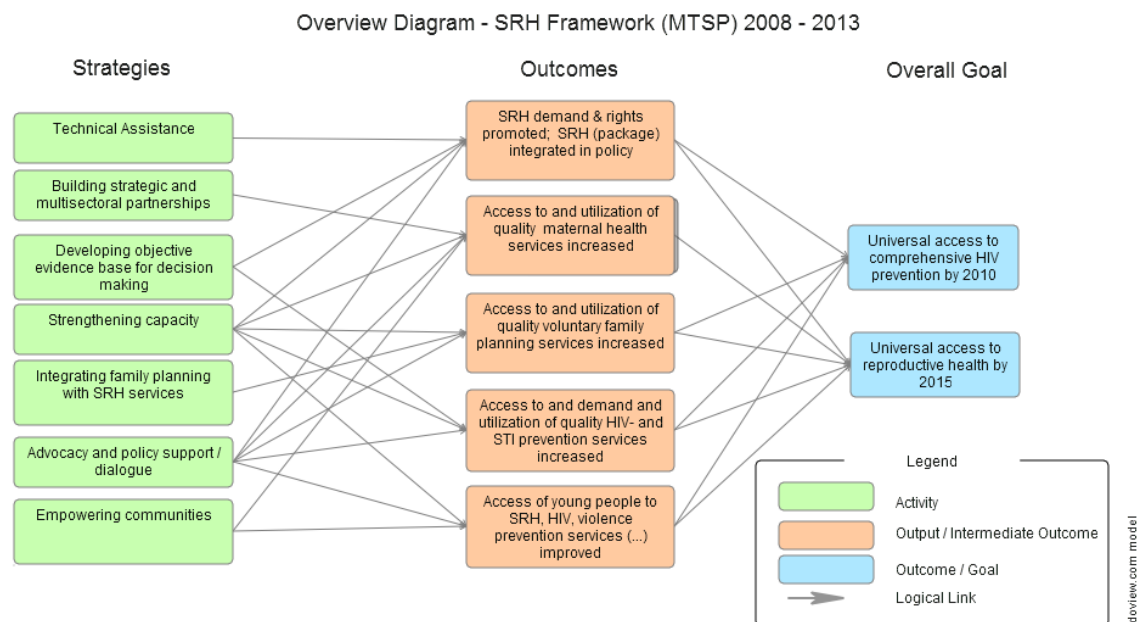
<sup>995</sup> Figure developed on the basis of "The Multi-Year Funding Framework 2000 – 2003" (DP/FPA/2000/6).

Figure 4: Overview of UNFPA Multi-Year Funding Framework (MYFF) 2004 – 2007 (faithful)<sup>996</sup>



<sup>996</sup> Figure developed on the basis of the *Multi-Year Funding Framework 2004 – 2007* (DP/FPA/2004/4).

**Figure 5: Overview of UNFPA sexual and reproductive health framework under the Strategic Plan (2008 – 2013) (faithful)997**



<sup>997</sup> UNFPA (2008): Making Reproductive Rights and Sexual and Reproductive Health a Reality for All – Reproductive Rights and Sexual and Reproductive Health Framework, May 2008.

Figure 6: Overview MHTF Business Plan (faithful)

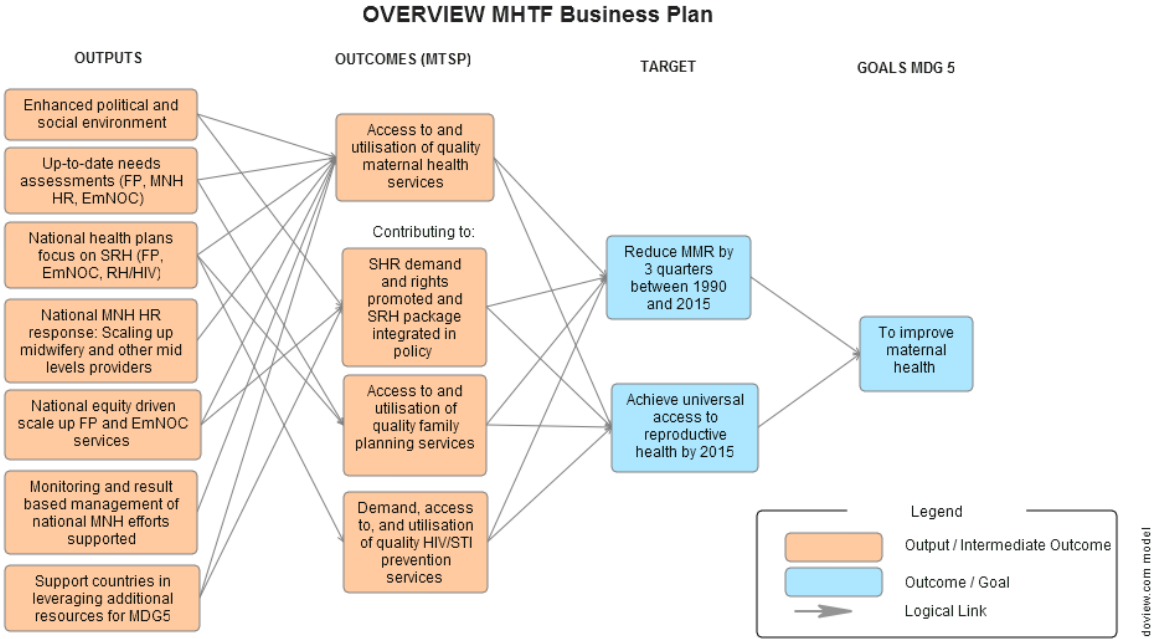
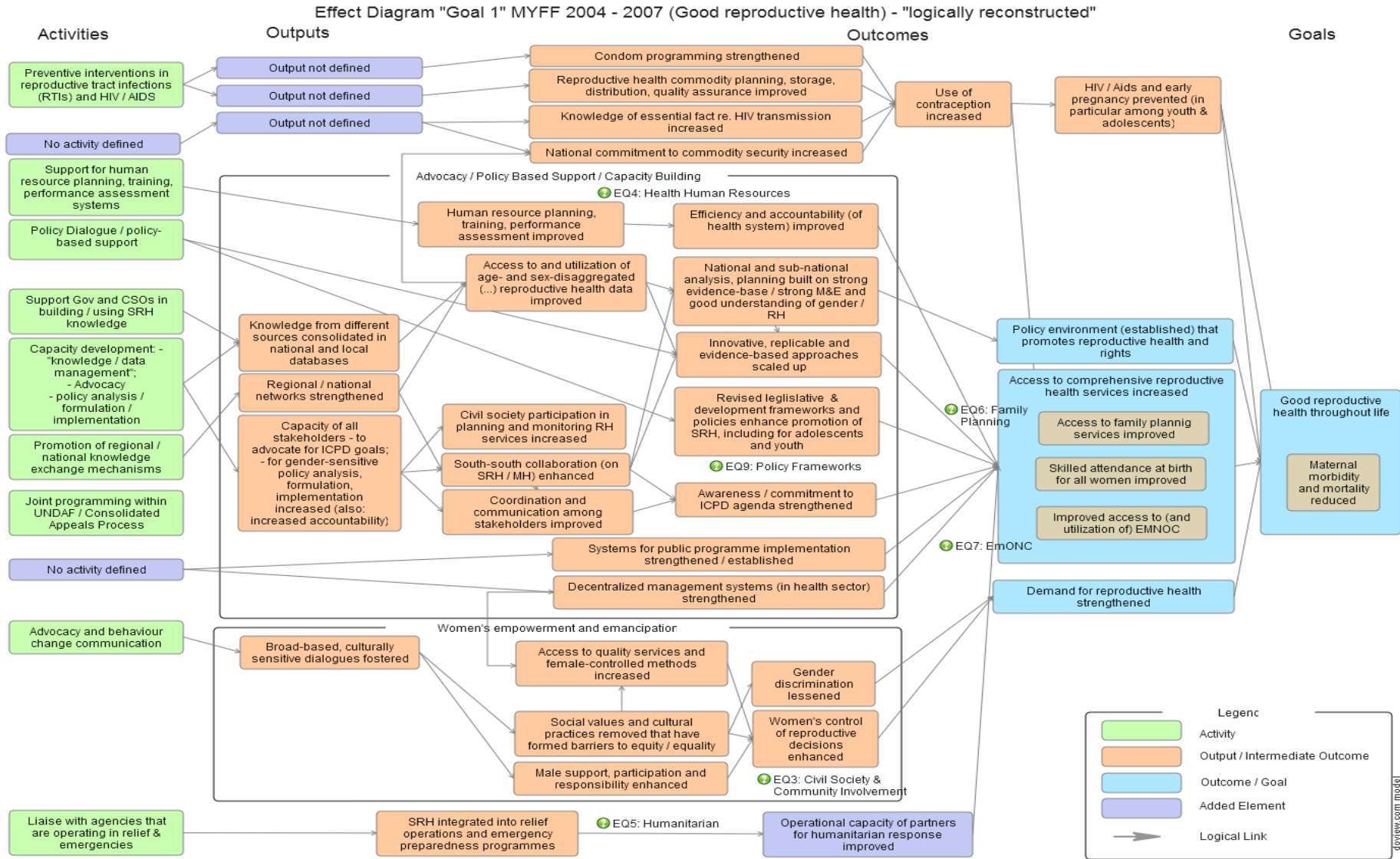
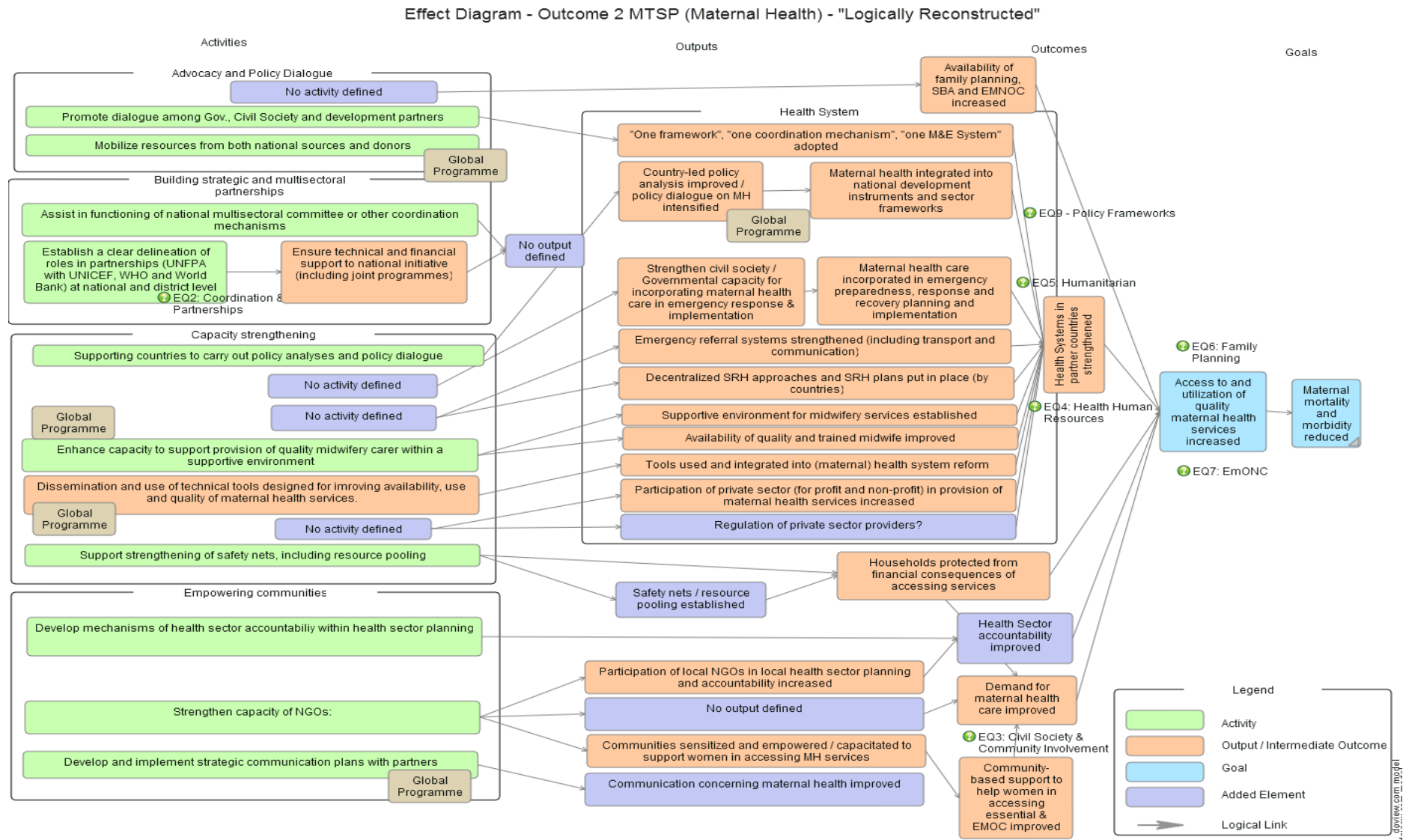


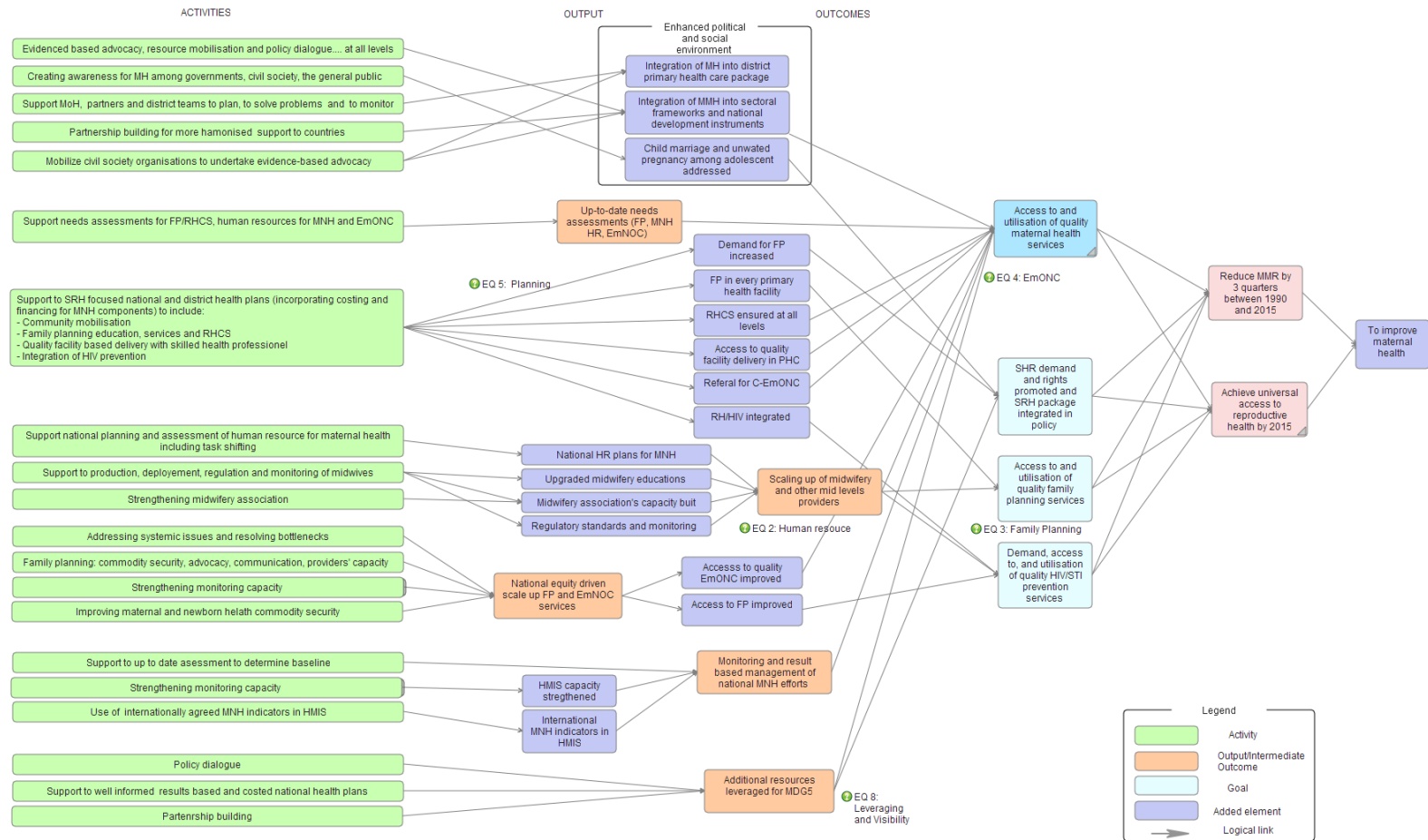
Figure 7: Effect diagram for Goal 1 (Good Reproductive Health) of UNFPA MYFF 2004 – 2007 (logically reconstructed)



**Figure 8: Effect diagram for Outcome 2 (Maternal Health) of UNFPA sexual and reproductive health framework (under Strategic Plan) 2008 – 2013 (logically reconstructed)**



**Figure 9: Effect diagram for MHTF Business Plan 2008 – 2011 (logically reconstructed)**



©view.com model



## 10. Team of external consultants

The evaluation was conducted by the Evaluation Branch (DOS) in collaboration with a team of independent experts from AGEG Consultants eG.

Core team	
Team leader mid-term evaluation MHTF, field team leader Burkina Faso, Lao PDR	Ms. Isabelle Cazottes
Team leader Maternal Health Thematic Evaluation, field team leader Sudan, Zambia	Mr. Martin Steinmeyer
Core team member, field team leader Ethiopia, Kenya, Madagascar	Dr. Corinna Reinicke
Core team member, field team leader Ghana, Cambodia	Ms. Poonam Thapa
Field team members	
Field team member Zambia	Ms. Paula Boogaart
Field team leader DRC	Mr. Eliot Putnam
Field team member Madagascar	Ms. Gisele Maynard-Tucker
Field team member Ethiopia, Ghana, Sudan	Ms. Deborah McSmith
Field team member Burkina Faso	Mr. Matias K. Yameogo
Field team member Kenya	Ms. Joyce Olenja
Field team member DRC	Ms. Christine Thayer
Field team member Zambia	Ms. Geneviève Mwale
Field team member Burkina Faso	Mr. Simplicie Zio
Field team member DRC	Mr. Nzanzu Kikuhe
Field team member Cambodia	Mr. Virak Prum
Field team member Lao PDR	Ms. Douangchanh Sihalathavong
Field team member Ghana	Ms. Patience Agyare-Kwabi
Field team member Ethiopia	Mr. Mesganaw Afework
Field team member Kenya	Ms. Mumbi Wanjiku Mwakio
Field team member Madagascar	Mr. Julio Rakotonirina
Coordination	
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Evaluation coordinator, junior expert, field team member Sudan	Ms. Miriam Amine
Desk research	Ms. Rosa Izquierdo
Desk research	Ms. Evelyn Wong
Research assistant	Mr. Michael Jedelhauser
Research assistant	Ms. Andrey Viegas Romano
Research assistant	Ms. Sara-Lisa Elholm
Peer review	Mr. Max Hennion