



THEMATIC EVALUATION
**UNFPA SUPPORT
TO MATERNAL
HEALTH**

2000 - 2011

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UNFPA SUPPORT TO MATERNAL HEALTH

Thematic Evaluation

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Foreword

Maternal mortality represents the greatest health inequity in the world. No other health indicator as starkly illustrates global disparities in human development. The recent United Nations (UN) report *Trends in mortality: 1990 to 2010* indicates that during the past decade maternal deaths fell from 543,000 to 287,000; yet this decline of 47 per cent has been uneven and marked by persistent disparities among – and within – countries. In 2010, an analysis published by *The Lancet* suggested that an annual decrease in maternal deaths of roughly 5.5 per cent worldwide would be necessary to achieve by 2015 the Millennium Development Goal for maternal mortality (MDG 5 - a reduction by three quarters from the 1990 level). While a handful of developing countries have now attained MDG 5 - including Nepal, Vietnam, Iran and Maldives - globally, the rate of reduction is currently under 1 per cent and a mere 0.1 per cent in Sub-Saharan Africa.

Improving maternal health is a key priority for the United Nations Population Fund (UNFPA). To achieve this end, the Fund has developed a broad scope of programmatic interventions – at global and regional levels as well as in about 150 countries – and has ensured critical linkages between the Fund’s three core areas: reproductive health and rights, gender equality, and population and development. In particular, in its position alongside United Nations agencies, governments, civil society and other development partners, UNFPA has adopted a three-pronged strategy aimed at ensuring that: all women have access to contraception to avoid unintended pregnancies; all pregnant women have access to skilled care at the time of birth; all those with complications have timely access to quality emergency obstetric care. More specifically, UNFPA interventions in the field of reproductive health and rights are meant to address maternal mortality, gender-based violence, harmful practices against women, sexually transmitted infections including HIV, adolescent reproductive health, as well as improve family planning.



In 2008, in response to the slow and uneven progress towards MDG 5, UNFPA launched the Maternal Health Thematic Fund (MHTF). The MHTF was designed as a rapid and flexible funding mechanism complementing UNFPA core resources in those programme countries that present the greatest maternal health needs. The MHTF now operates in 30 countries and has been conceived as a country-owned and country-driven initiative to support the capacity of national health systems to achieve results in reducing maternal mortality and morbidity.

This evaluation analyses the support of UNFPA in maternal health and assesses its contribution to the objectives as set out in the Multi-Year Funding Frameworks (from 2000 to 2007) as well as the Sexual and Reproductive Health framework under the UNFPA Strategic Plan (2008-2013). The evaluation also looks into the specific contribution of the MHTF, and therefore provides comprehensive and detailed insight into the thematic area of maternal and reproductive health at UNFPA. The scope of this thematic evaluation covers programmatic interventions supported by

all sources of funding – core resources, co-financing and a number of thematic funds. It specifically focuses on the three sets of interventions most effective in reducing maternal mortality and morbidity: universal access to family planning; skilled birth attendance; and emergency obstetric and newborn care. The evaluation also presents a comparative analysis of those countries which, in recent years, have benefited from the MHTF and those which have not. A detailed analysis of the contribution and performance of the MHTF – including its internal coordination and management processes – may be found in a separate volume.

The evaluation concludes that UNFPA has made significant, sustained and, at times, innovative contributions to improve maternal health by acting as a knowledge broker able to promote use of data as well as surveys and research-generated evidence into sexual and reproductive healthcare policies and practices. As an active advocate for maternal health issues, UNFPA has positioned itself at the interface between development partners and governments. This has helped to align donor assistance more closely with national structures while harmonizing maternal health support from a wide array of partners. In particular, UNFPA has helped programme countries to anchor family planning more firmly within their policy frameworks as well as to scale-up access to emergency obstetric and newborn care in their national health services. The evaluation shows that UNFPA has been a driving force to raise awareness of, and build capacity to address shortcomings and barriers in national health systems which prevent beneficiaries from accessing maternal health services.

However, the evaluation also identifies a number of challenges which have affected the ability of UNFPA to contribute to results. In particular, the report points at the insufficient guidance available to country offices for planning and targeting maternal health support strategies for the medium to long-term. Similarly, the evaluation shows that programmatic interventions should be complemented by a rigorous monitoring system for measuring results rather than tracking inputs and activities. In an area where the causes of poor maternal health are numerous and complex, the evaluation finds that the role of knowledge broker requires significant time as well as a shift in the use of financial and human resources by country offices to make use of UNFPA comparative advantage and create partnerships, notably with those organizations normally outside of the sphere of reproductive health.

To conduct this evaluation of an area and themes central to the mandate of UNFPA, the Evaluation Branch collaborated closely with the Sexual and Reproductive Health Branch from the UNFPA Technical Division. This partnership generated valuable insights to help identify a number of critical issues, thus optimizing the focus and utility of the evaluation. The Evaluation Branch also relied on independent consultants from AGEG Consultants eG, led by Martin Steinmeyer whose professionalism was pivotal in guiding the evaluation team through the design, data collection and analysis and reporting phases. I am most grateful to him for his commitment and dedication. I also would like to thank Isabelle Cazottes whose work was more specifically focused on the contribution of the Maternal Health Thematic Fund and who authored the specific report on the MHTF. Their work, together with the whole team of consultants (including local consultants for the field phase), enabled the complex scope of the evaluation to be addressed despite problems with availability of information.

To accompany the whole evaluation process, the Evaluation Branch also established a reference group consisting of UNFPA staff with expertise in sexual and reproductive health issues or in evaluation methodology. The evaluation benefited greatly from their insightful contributions and the reports produced at the different stages of the evaluation were revised on the basis of their comments, feedback and suggestions. I would like to express my gratitude to all the colleagues who participated in the reference group for their valuable time and active collaboration. Within the Evaluation Branch, quality enhancement is indeed a cornerstone of our approach to all evaluations, and I would especially like to thank Valeria Carou-Jones whose careful review and valuable support have contributed to improve the quality of the present report.

Without the involvement of a wide range of stakeholders, the Evaluation Branch could not have completed this evaluation. I am grateful to all UNFPA staff in headquarters, regional and country offices who took part in this exercise. In particular, my sincere gratitude goes to colleagues in Burkina Faso, Cambodia, the Democratic Republic of Congo, Ethiopia, Ghana, Kenya, Lao PDR, Madagascar, Sudan, and Zambia who generously shared their time and knowledge with the evaluation team. They played a key role in facilitating the evaluation fieldwork and its extensive data collection process that involved interviews, site visits, and focus group discussions in order to obtain the perspective of all key stakeholders as well as the views of the beneficiaries.

I hope that this evaluation will help UNFPA to strengthen the impact of its programmes, to achieve more sustainable results, and to further leverage strategic partnerships in order to become an ever more relevant, effective and valuable actor in the progression towards MDG 5.

Louis Charpentier
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List of Acronyms

AMDD	Averting Maternal Death and Disability
AWP	Annual work plan
BCC	Behavior change communication
CARMMA	Campaign on Accelerated Reduction of Maternal, Newborn and Child Mortality
CAPPD	Cambodian Association of Parliamentarians for Population and Development
CCA	Common country assessment
CHW	Community health workers
CMA	Country midwife advisor
COAR	Country office annual reports
CPAP	Country programme action plan
CPD	Country programme document
DAC	Development Assistance Committee
DFID	Department for International Development, United Kingdom
DHS	Demographic health survey
DOS	Division for Oversight Services
DPHPES	Directorate of Public Hygiene and Health Education
DRC	Democratic Republic of Congo
DSF	Directorate for Family Health (<i>Direction de la Santé de la Famille</i>), Ministry of Health Burkina Faso
EmONC	Emergency obstetric and newborn care
GHS	Ghana Health Service
GNI	Gross national income
GPRHCS	Global Programme to Enhance Reproductive Health Commodity Security
H4+	UNFPA, UNICEF, the World Bank, WHO and UNAIDS
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HRH	Human resources for health
HSSP	Health Sector Support Programme
IASC	Inter-Agency Standing Committee
ICM	International Confederation of Midwives
ICMA	International country midwife advisor
ICPD	International Conference on Population and Development
IEC	Information, education and communication
IFC	Individual, family, community

KAP	Knowledge, attitudes, and practices
Lao PDR	Lao People’s Democratic Republic
MDG	Millennium Development Goal
M&E	Monitoring and evaluation
MH	Maternal health
MHTF	Maternal Health Thematic Fund
MISP	Minimum Initial Service Packages
MMR	Maternal mortality ratio
MoH	Ministry of Health
MYFF	Multi-Year Funding Framework
NCDM	National Committee for Disaster Management
NGO	Non-governmental organization
P&D	Population and Development
PFSA	Pharmaceutical Fund Supply Agency
PPP	Peer education/Service provision/Parents programme
RHCS	Reproductive health commodity security systems
SMAG	Safe motherhood action groups
SRH	Sexual and reproductive health
SWAp	Sector-wide approach
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/ AIDS
UNDAF	United Nations Development Assistance Framework
UNDMT	United Nations Disaster Management Team
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
US\$	US-dollar
USAID	United States Agency for International Development

Executive Summary

Purpose and scope of the evaluation

The present evaluation assesses the extent to which UNFPA support has been relevant, effective, efficient and sustainable in contributing to the improvement of maternal health.

The evaluation covers all programmatic interventions that have been directly relevant to maternal mortality and morbidity within the UNFPA mandate, including all activities financed from core and non-core resources such as UNFPA reproductive health thematic funds (the Maternal Health Thematic Fund (MHTF), the Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS) and the joint UNFPA-UNICEF Female Genital Mutilation/Cutting Programme). Across these interventions and instruments, the maternal health thematic evaluation focuses on key elements of reproductive health including family planning, skilled birth attendance and emergency obstetric and newborn care (EmONC) - the “three pillars” of reducing maternal mortality (*thematic scope*). Following the terms of reference, the evaluation covers the period from 2000 until 2010, and also includes information related to a number of interventions implemented in 2011.

Background of the evaluation

In 1987, UNFPA was one of three UN agencies that launched the Global Campaign to Reduce Maternal Mortality at the first international Safe Motherhood Conference in Nairobi. The current mandate of UNFPA to support maternal health builds on the International Conference on Population and Development (ICPD, 1995) and the Millennium Summit (2000), and the adoption of the Millennium Development Goals (MDGs) by UNFPA, including MDG 5 to improve maternal health.

UNFPA has developed a broad range of programmatic interventions to support the improvement of maternal

health at global, regional and country level within its three programmatic core areas of reproductive health, gender equality and population and development. UNFPA resources support integrated reproductive health services, including interventions to address maternal mortality, gender-based violence, harmful traditional practices, and sexually transmitted infections including HIV, adolescent reproductive health, as well as family planning. Between 2000 and 2011, UNFPA provided support to 155 countries, areas and territories.

In 2008, UNFPA launched the Maternal Health Thematic Fund (MHTF) to help accelerate progress towards the achievement of MDG 5. The MHTF represents a focused effort in some of the poorest countries in the world with the greatest maternal health needs. It was intended to be a quick and flexible funding mechanism and a tool to make available additional technical expertise to UNFPA programme countries. The Campaign to End Fistula and the UNFPA-International Confederation of Midwives (ICM) Midwifery Programme were integrated into this umbrella fund in 2009. In addition, UNFPA has used the GPRHCS to provide technical assistance, commodities and financial support to programme countries.

Methodology

The scope of the evaluation is defined by twelve evaluation questions examining key components of the maternal health approach of UNFPA. For each evaluation question, a small number of judgment criteria specify which aspects of UNFPA-financed activities form the basis for the evaluators’ assessment and stand at the centre of the answer to each of the evaluation questions.

The evaluation used a staged sampling process to select the countries to be included in the evaluation. From a list of 55 programme countries with a maternal mortality ratio (MMR) higher than 300 deaths per 100,000 live births in the year 2000, 22 countries were selected for a desk study. From this sample, 10 countries were selected for more in-depth country case studies, of which, eight were recipients

of MHTF support: Burkina Faso, Cambodia, Ethiopia, Ghana, Lao PDR, Madagascar, Sudan, and Zambia. Another two countries do not receive MHTF funding: DRC and Kenya.

The evaluation draws on information from a desk review of UNFPA documents compiled from headquarters and country offices, individual interviews with UNFPA staff in headquarters, regional offices and country offices and additional interviews with partner governments and development partners. An online survey that was disseminated to UNFPA country offices in 55 programme countries provided information on country office capacity and availability of technical support from headquarters and regional offices. In addition, 10 country case studies provided an in-depth view of UNFPA operations at country level. Data collection for the case studies included the desk analysis of additional documents, key informant interviews with UNFPA partners, site visits and focus groups with beneficiaries. The combination of different types of information, data collection methods and data sources (triangulation) maximized the validity of the findings.

Findings

Neither has UNFPA sufficiently focused maternal health support on the countries with the greatest needs nor on the most vulnerable groups within countries.

Headquarters and regional offices based the distribution of resources for maternal health support on criteria such as “degree of political support to the agenda of the International Conference on Population and Development”, “absorptive capacity” or the “humanitarian response, transition and recovery situation in each country”. This allowed some leeway to consider aspects other than the scale of maternal health needs in these decisions. Furthermore, UNFPA has not developed clear, operational definitions of “maternal health vulnerability”. Only country offices that made use of data from surveys and socio-economic studies for needs-oriented targeting of specific groups were able to address existing socio-

economic service barriers, such as cost, distance or lack of means of transportation.

UNFPA has contributed to an improved harmonization of maternal health support, in particular through UNFPA participation in strategic and multi-sectoral partnerships.

UNFPA has utilized research and data collection, evidence-based advocacy and technical assistance to improve the harmonization of maternal health support in programme countries. Successful interventions were part of long-term working partnerships with development partners and governments. In these circumstances, country offices were able to generate momentum for the government-led development and review of maternal health policies. Revised policies helped to align donor assistance more closely with government structures and simultaneously harmonize maternal health support from development partners. However, it should be noted that global and regional aid harmonization campaigns, such as the H4+ Campaign, the Campaign on Accelerated Reduction of Maternal, New Born and Child Mortality (CARMMA) or the Maputo Road Map have so far had little effect on aid harmonization at country level.

UNFPA has contributed to a stronger involvement of communities and increased demand for reproductive health services.

UNFPA-supported initiatives have helped to raise maternal health awareness in targeted communities. However, not all approaches aiming at sensitizing communities were equally successful in increasing demand for maternal health services. Successful approaches coupled awareness raising and community empowerment efforts with national strategies to address financial barriers to access maternal health services in national health systems.

UNFPA partnerships with non-governmental organizations have historically been an important part of UNFPA community outreach and mobilization campaigns. However, country offices have begun to shift resources

and attention away from civil society in favour of channelling their support through government mechanisms.

UNFPA has contributed to an increased availability of human resources for maternal health although these efforts remain insufficiently linked to the wider health system framework.

UNFPA has helped to develop reproductive health-specific human resource regulatory frameworks and tools and to train technical reproductive health staff in key areas. However, UNFPA country offices encountered challenges in linking these efforts appropriately to mechanisms and agencies in the wider health system beyond reproductive health. Furthermore, system-wide challenges to human resources for health, such as low staff retention or inappropriate deployment have reduced the impact of UNFPA technical trainings on the availability of skilled reproductive health service providers.

The MHTF has helped UNFPA to contribute to human resource-related policy revisions for midwifery, emergency obstetric and newborn care and family planning, curriculum reviews and the strengthening of midwifery training facilities. These are important reproductive health components of the larger human resources for health systems in programme countries. However, as a thematic fund with limited scope, the MHTF was not able to help country offices to better address the inappropriate deployment or low retention of staff (particularly midwives) which undermine the beneficial effects of UNFPA skill-building activities.

UNFPA has showed a good response capacity to reproductive health threats in the context of humanitarian emergencies.

UNFPA has reacted to the need to anticipate and respond to reproductive health threats in humanitarian situations globally and at country level. At global level, UNFPA has provided guidance on reproductive health programming and maternal health support in the context of humanitarian emergencies, especially between 2005 and 2010. Country offices have responded by way of: a) joining international humanitarian campaigns; b) working with countries to include sexual and reproductive health and maternal health components in national emergency preparedness plans; and c) developing the capacities of national

counterparts to dispense Minimum Initial Service Packages (MISP) for reproductive health during emergencies.

UNFPA country offices have faced a number of operational challenges when working on humanitarian issues and have struggled to adequately integrate and link assistance in humanitarian situations to UNFPA support in more stable circumstances.

UNFPA has contributed to the scaling up and the increased utilization of and demand for family planning commodities.

UNFPA has helped to anchor family planning more firmly in policy frameworks of programme countries and to develop national capacities to manage commodity procurement and distribution. Country offices that combined the procurement of contraceptives with initiatives to strengthen reproductive health commodity security systems have contributed to increase access to family planning commodities. UNFPA support for community-based distribution helped to open alternative channels for the delivery of commodities to beneficiaries in areas where people have limited access to public health systems.

Prerequisites for scaling-up access to EmONC services have been put in place, although health system-wide bottlenecks remain insufficiently addressed.

By supporting the development of national emergency obstetric and newborn care (EmONC) plans, UNFPA has helped programme countries to put in place important prerequisites for scaling-up access to EmONC services. The MHTF contributed to accelerate the development of these plans by providing templates, tools and expertise that country offices used to contribute to the implementation of EmONC assessments. Despite these successes, UNFPA country offices struggle to define their roles and responsibilities for addressing health system-wide bottlenecks, including capacity gaps in line ministries, problems with staff retention, inadequate health management information systems or inadequate referral systems.

UNFPA has not been able to rely on its monitoring and evaluation system in order to inform strategy development, programming and programme implementation.

UNFPA has utilized evidence from macro-level surveys and other studies to design relevant maternal health interventions and to target its support in programme countries, albeit mostly geographically. However, UNFPA has not been able to use its monitoring and evaluation system to the same extent to generate information on the performance of its interventions. This weakness is partly linked to deficits in UNFPA planning processes and templates that inhibit the articulation of complete and coherent intervention strategies (also called intervention logic or theory of change). This shortcoming consequently often made it difficult to design quality indicators to help gauge the contribution of UNFPA to improved maternal health outcomes. Another factor has been the low technical capacity of country office staff for results-oriented monitoring.

Integration of maternal health into national development instruments and sector policy frameworks has been partially achieved.

UNFPA record of contributing to a stronger integration of maternal health into national policy frameworks has been mixed. UNFPA country offices were able to generate momentum for maternal health-related policy changes when they combined support for data generation, surveys and research with targeted advocacy campaigns and technical assistance. Partnerships with influential governmental and non-governmental stakeholders also contributed to the success of policy campaigns. However, UNFPA-supported policy initiatives that originated at regional level, such as CARMMA or the Maputo process, failed to affect the national maternal health policy agenda in the long-term.

The UNFPA contribution to an improved national capacity to monitor maternal health-related policies has been limited, as assistance in refining maternal health indicators neither addressed the larger, systemic weaknesses of national health management information systems, nor the shortcomings of other monitoring and evaluation systems.

There has been insufficient use of synergies between maternal health, gender and population and development focus areas.

Seeking and exploiting synergies between programming in gender and reproductive health has not been a firmly

established practice in UNFPA. Despite the availability of data on many gender-related reproductive and maternal health issues from standard macro-level assessments, such as censuses and demographic and health surveys, not all country offices have pursued opportunities to apply this information in specifically integrated reproductive health interventions. Country offices have generally taken advantage of external opportunities to finance integrated interventions. However, only country offices with appropriate internal planning or management mechanisms were able to create these kinds of opportunities themselves.

Country offices have not sufficiently benefited from technical support provided by regional offices and headquarters.

Inadequate staffing levels have created major bottlenecks in the capacity of country offices. These gaps have made it very challenging for country offices to adequately implement maternal health interventions and have reduced the visibility of UNFPA in programme countries. Since 2008, the MHTF has provided some additional resources to hire much needed human resources, particularly in areas like EmONC, midwifery and obstetric fistula. Regional offices and headquarters have provided technical support to country offices in family planning and reproductive health commodity security. However, they have not sufficiently focused on other areas, such as EmONC, midwifery and human resources for the overall health sector.

Good overall visibility of UNFPA in maternal health initiatives at global and national levels although to a lesser extent for country offices suffering from staffing shortages.

UNFPA has been a visible advocate for maternal health issues at global and at country level. The visibility of UNFPA was affected by the capacity of country offices to bring technical knowledge to bear in multilateral maternal health initiatives, such as the review of maternal health policies or the development of maternal health programmes. By supporting the development of maternal health policies and programmes, UNFPA also helped to leverage more funds for maternal health support from governments. Country offices that suffered from staffing shortages were less able to actively participate in maternal health coordination forums and technical working groups. In these cases, bigger and better-resourced

development partners overshadowed the role of UNFPA in maternal health.

Conclusions

C1 UNFPA maternal health support in programme countries has not been sufficiently based on country-specific medium or long-term strategies.

Neither the templates for country programme action plans (CPAP) nor the formats for annual work plans (AWP) required any kind of detailed multi-annual planning. Nonetheless, country offices that followed a multi-annual strategic vision to support maternal health made better use of the organizational resources of UNFPA. The longer-term visions led them to exploit synergies between their sub-programmes, for example, by combining data collection and dissemination with evidence-based policy advocacy over a period of several years. In the absence of a multi-annual perspective, country offices were more likely to manage individual interventions separately hence missing the opportunities for synergies.

C2 In its support to maternal health, UNFPA has not sufficiently focused on addressing the root causes of poor maternal health of the most vulnerable.

UNFPA has not yet defined the operational implications of the commitment to focus on the maternal health needs of the “most vulnerable”. Without this guidance, country offices have encountered difficulties in developing country-specific and detailed analyses of the important social, political, cultural and economic root causes of poor maternal health of vulnerable groups. As a result, country offices did not consistently tackle the systemic weaknesses of health systems and other social inequities that keep women from vulnerable groups from accessing maternal health services.

C3 UNFPA support to the provision of maternal health services at sub-national level has not consistently reflected the relative comparative strengths of UNFPA as a primarily knowledge- and evidence-based organization.

Working at sub-national level has committed a significant portion of the relatively small UNFPA budget for reproductive and maternal health support. In spite

of this, country offices have not consistently used their engagement at sub-national level to generate data and lessons to further the maternal health policy agenda at central level and to strengthen the capacity of UNFPA to generate and disseminate maternal health-related knowledge and expertise. Weaknesses in the UNFPA monitoring and evaluation system also limited opportunities to learn from these interventions.

C4 Insufficient staff capacity and gaps in the skills available in country offices have negatively affected the ability of UNFPA to act as brokers of maternal health-related expertise and to be a facilitator of national and international maternal health commitments and strategic partnerships.

The small numbers of reproductive health staff in country offices made it difficult or, at times, impossible for UNFPA to be present in relevant technical working group meetings or policy forums. Time constraints prevented reproductive health advisors from preparing technical inputs or to launch and pursue innovative approaches to support maternal health.

C5 Country offices have not yet received sufficient technical support from regional offices and headquarters to fulfill their central role in delivering maternal health support.

The availability of technical support from regional offices in areas such as human resources for health, EmONC and midwifery, but also on operational issues like strategic planning, results-based management or monitoring and evaluation was limited. These gaps in technical support affected the capacity of country offices to adequately plan, manage and evaluate their own maternal health portfolio.

C6 The variable capacity of country offices to establish and maintain long-term partnerships within, as well as outside of the reproductive health arena has influenced the ability of UNFPA to sustainably address service access barriers and other root causes of poor maternal health and to help strengthen the maternal health system in programme countries.

In some cases, long-term partnerships have allowed UNFPA to place specific maternal health-

related topics on the agenda of donor coordination meetings and other government-led policy forums. Partnerships also enabled UNFPA to ensure that initiatives spearheaded by UNFPA were subsequently implemented by government agencies, thus increasing the chances for their sustainability. However, not all country offices were able to engage in the long-term process of forging and maintaining partnerships that helped in the delivery of maternal health support.

C7 Weak monitoring and evaluation mechanisms have prevented UNFPA from assessing the results of maternal health support and from optimizing its corporate and country-level maternal health strategies over time.

Monitoring indicators focused primarily on activities or higher level societal changes in the maternal health situation in programme countries. The monitoring systems did not provide data on the direct effects of UNFPA-supported interventions on immediate target groups. This made it impossible to draw a link from monitoring data to intervention results and to gauge the contribution of these interventions to improvements in maternal health in programme countries.

C8 The Maternal Health Thematic Fund (MHTF) has helped to provide much needed financial and staff resources to UNFPA country offices and headquarters in the short and medium-term, in particular in EmONC, midwifery and obstetric fistula.

Staff positions financed by the MHTF bolstered the staff capacity of country offices and allowed them to intensify their engagement in these thematic areas. In addition, partnerships fostered by MHTF gave country offices access to additional technical support in key areas of the UNFPA maternal health portfolio. This has reinforced UNFPA support to improve maternal health and has increased the visibility of the Fund.

C9 The MHTF has not been sufficiently embedded into the organizational structure of UNFPA and the overall UNFPA planning process at country level to ensure sustainability of all of its results.

A majority of country offices have not systematically planned the mobilization of resources required to support the continuation of MHTF initiatives. In some instances, country offices have used MHTF funds to supplement core resources in a large number of different interventions, instead of intensifying their engagement in few specific areas such as EmONC or midwifery. This weakened the catalytic role of the MHTF.

Recommendations

R1 UNFPA should revise its internal procedures, tools and templates for strategic planning. The new process should require country offices to develop maternal health support strategies for the medium to long-term, and to detail how resources from the different sub-programmes will be used to implement these strategies.

The overall rationale and theory of change should be described in a comprehensive planning document. The programming documents should also include the presentation of detailed analysis of the specific political, administrative, cultural and socio-economic challenges related to maternal health that need to be addressed in the four to five years covered by the programme. Finally, the planning process should be multi-annual rather than based on annual work plans.

R2 UNFPA needs to better define the operational implications of targeting maternal health support towards the needs of the “most vulnerable”. The concept is a relevant part of the UNFPA maternal health strategy yet it is too vague in its current form to guide maternal health programming at country level.

The concrete ways in which characteristics of health systems, social support structures, and socio-economic conditions determine and shape the vulnerability of specific population groups to maternal health threats and risks should be assessed. UNFPA at corporate level should then provide programming and operational guidance to country offices on how to support the most vulnerable in their specific country programmes and interventions.

R3 UNFPA needs to increase the focus on knowledge generation, learning and evidence-based policy advocacy when supporting maternal health service delivery at sub-national level.

Country offices should provide the rationale for supporting maternal health service delivery at the sub-national level. Country offices should track progress, identify successes and failures and extract and use lessons from interventions implemented at sub-national level. In particular, they should collect, analyse and disseminate information from interventions, and notably pilot interventions, in support of maternal health service delivery on the ground.

R4 UNFPA needs to better align the capacity and skill mix of staff and managers to the work-related demands of country programmes with a view to fulfilling the role of country offices as knowledge brokers and facilitators of evidence-based approaches to improve maternal health.

Country offices should develop a resource plan as part of the country programme action plan to explain the allocation of staff time to the different components of the strategy. This, in turn, may require a stronger focus of country offices staff on health care issues specifically related to policy and management. Such a plan should also identify the additional resources which may be required to implement the strategy, and how these shall be mobilized.

R5 UNFPA needs to better integrate the planning process for technical support from regional level with the proposed long-term strategic and operational planning for maternal health support at country level. Regional offices need to support the current country-level programming and must also be able to anticipate the future support requirements of country offices.

R6 UNFPA needs to anchor the concept of partnerships more firmly in strategic documents, operational guidelines and job descriptions of management staff.

Strategic documents need to explain the importance of developing partnerships as a means to: increase the sustainability of results; ensure the appropriate positioning of UNFPA in the national and regional space; and to add value and identify opportunities for further cooperation in maternal health. Operational guidelines need to explain how country offices can foster partnerships and UNFPA senior managers need to be responsible for setting up such partnerships at country, regional and global level.

R7 UNFPA needs to strengthen results-oriented monitoring systems in country offices to measure results and not only activities and inputs.

In addition, country offices need to strengthen support to implementing partners to put in place appropriate monitoring mechanisms for UNFPA-funded interventions.

UNFPA must develop operational guidance for results-oriented monitoring. Detailed guidelines on results-oriented monitoring should be produced so that country offices can develop specific monitoring mechanisms for their maternal health portfolio.

R8 UNFPA should strengthen the capacity of the MHTF as a catalytic UNFPA tool that facilitates the implementation of evidence-based maternal health interventions in programme countries.

The MHTF Business Plan needs to emphasize that the MHTF is not only responsible for launching initiatives (like those in EmONC and midwifery), but also to mobilize required technical and financial resources to support country offices and programme countries in following through with these initiatives until their completion.

Introduction

1.1 Purpose of the evaluation

The objectives of the maternal health thematic evaluation are to assess to what extent UNFPA support to maternal health has been relevant, effective, efficient and sustainable in contributing to the improvement of maternal health. The evaluation covered all programmatic interventions that have been directly relevant to mortality and morbidity within the UNFPA mandate, including all relevant activities financed from core and non-core resources and those financed through UNFPA reproductive health thematic funds.¹ Across these interventions and instruments, the evaluation focused on key elements of reproductive health including family planning, skilled birth attendance and emergency obstetric and newborn care (EmONC), the “three pillars” of reducing maternal mortality.

The thematic evaluation of the UNFPA support in maternal health was carried out in parallel to the mid-term evaluation of the Maternal Health Thematic Fund (MHTF) to make use of the potential for synergies in the evaluation portfolio of UNFPA. The findings of the MHTF mid-term evaluation are presented in a separate report that is available on the web page of the Evaluation Branch.²

1.2 Mandate and strategy of UNFPA in the field of maternal health

Since the first international conference on maternal mortality in 1987, the Safe Motherhood Conference sponsored by UNFPA, the World Bank and the World Health Organization (WHO), a wide range of interna-

tional development agencies have supported maternal health and reproductive health. Two frameworks serve to focus international efforts: the Programme of Action adopted at the International Conference on Population and Development (ICPD, 1995) and the Millennium Development Goals (MDGs, 2000).

The Secretary General’s Global Strategy for Women and Children Health has been a key maternal health initiative. A range of global partners supported the Strategy and committed US\$ 40 billion for improved maternal and child health programmes and services. UNFPA, the World Health Organization (WHO), UNICEF and the World Bank (known as the H4 group) have joined forces to concentrate support in countries with the highest maternal mortality rates, starting with Afghanistan, Bangladesh, the Democratic Republic of Congo, Ethiopia, India and Nigeria. The H4 group (and with UNAIDS H4+) aims to help countries to strengthen their own health systems to reduce the maternal mortality ratio by 75 per cent and achieve universal access to reproductive health by 2015. Furthermore, Women Deliver, a global advocacy organization, and a wide range of non-governmental organizations work globally and locally to generate political and financial commitments to achieve MDG 5 to improve maternal health.

Globally, funding for maternal, newborn and child health activities have increased by 103 per cent between 2003 and 2008.³ Sixty eight high-needs countries that had been selected as priority countries by the *Countdown* initiative⁴ have received more than 70 per cent of those funds. In

¹ The Maternal Health Thematic Fund; the Global Programme to Enhance Reproductive Health. Commodity Security, the Midwifery Programme and the joint UNFPA-UNICEF female genital mutilation programme).

² <http://www.unfpa.org/public/home/about/Evaluation/EBIER/TE/pid/10094>

³ See “Countdown to 2015: Tracking progress in maternal, newborn & child survival” at http://www.who.int/child_adolescent_health/documents/9789280642841/en/index.html

⁴ A collaboration of individuals and institutions, including UNFPA, to stimulate progress towards MDG5 and other Millennium Development Goals.

2006, over 50 per cent of donor assistance to maternal, newborn and child health came from bilateral agencies, 31 per cent from multilateral financiers (World Bank, UNFPA, UNICEF and the European Commission), and 15 per cent from the Global Fund and the GAVI Alliance (Global Alliance for Vaccines and Immunization).⁵

Between 2000 and 2011, UNFPA has provided support to 155 developing countries, areas and territories across the sub-Saharan African region (45), the Arab States (14), Eastern Europe (20) and Central Asia (20), Latin America and the Caribbean (40), and in Asia and the Pacific (36). In 2009, UNFPA offices worldwide carried out a total of 221 joint programmes with other UN organizations. These partnerships included initiatives to stop gender-based violence, increase demand for HIV-prevention services, advance gender equality and expanded access to maternal health services. Recent UNFPA initiatives include the Maternal Health Thematic Fund (see below) and the Campaign to End Fistula.

The mandate of UNFPA to support maternal health builds on the International Conference on Population and Development (ICPD, see above) and the Millennium Summit (2000) with its adoption of the Millennium Development Goals (MDGs), including MDG 5 (improve maternal health). UNFPA has developed a broad scope of programmatic interventions to help improve maternal health at global, regional and country level within its three core areas (reproductive health and rights, gender equality and population and development). Each of the core areas addresses critical factors for reproductive health and cross cutting issues, such as gender equality, fundamental human rights and women-specific strengths and vulnerabilities. UNFPA uses resources from these areas to support integrated reproductive health

services, including interventions to address maternal mortality, gender-based violence, harmful practices, and sexually transmitted infections including HIV, and adolescent reproductive health, as well as family planning. UNFPA supports all functions of a health system with relevance to reproductive health: leadership/governance, health workforce, information, service delivery, financing, medical, products, vaccines and technologies.

In 2008, UNFPA launched the Maternal Health Thematic Fund (MHTF) to help accelerate progress to the achievement of MDG 5. The MHTF represents a focused effort in some of the poorest countries in the world with the greatest maternal health needs. It was intended to be a quick and flexible funding mechanism and a tool to make additional technical expertise available to UNFPA programme countries. The work supported by the MHTF is meant to be country-owned and country-driven. The specific activities supported by the MHTF in each country are intended to be identified by the government through a consultative process with key partners and stakeholders and in close coordination with other UNFPA programmes. The Campaign to End Fistula and the UNFPA-International Confederation of Midwives (ICM) Midwifery Programme were integrated into the MHTF. In addition, the Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS), one of the UNFPA reproductive health thematic funds, has provided technical assistance, commodities and financial support to UNFPA programme countries. The following table presents an overview of the expenditures of UNFPA in the field of maternal health from 2008 to 2010.

In 2012, UNFPA, along with WHO, UNICEF and the World Bank, published an updated analysis of the *Trends in maternal mortality: 1990 to 2010*.⁶

In 2012, UNFPA launched a new 'Cluster Approach' to improve institutional delivery on the 2012-2013 Strategic Plan. Two clusters were created - women's reproductive health; adolescents and youth - to maximize results through coherent planning and implementation of capacity development activities and technical support from headquarters and regional offices to country offices. This evaluation covers the period from 2000 until 2011 and was already underway when the cluster approach was launched. The planning and operational implications of this new approach are therefore not addressed in this report.

⁵ See "Countdown to 2015: Tracking progress in maternal, newborn and child survival" at http://www.who.int/child_adolescent_health/documents/9789280642841/en/index.html

⁶ WHO, UNICEF, UNFPA, World Bank (2012): Trends in maternal mortality: 1990 to 2010, New York.

Table 1: Overview of UNFPA expenditures in the field of reproductive/maternal health

Item	2008	2009	2010	Total for the period 2008 -2010
Overall UNFPA expenditures (in US\$,000) ⁷	340,400	366,200	347,800	1,054,400
Overall UNFPA expenditures for reproductive health (including maternal health) (regular sources, in US\$,000) ⁸	165,200	170,100	174,000	509,300
Number of countries receiving support from UNFPA	158	155	123	—
Expenditures of MHTF (total in US\$,000) ⁹	1,000	14,200	21,000	36,200
Number of countries receiving funding from MHTF ¹⁰	11	15	30	—
Percentage of MHTF expenditures to UNFPA reproductive health expenditures	0.6%	8.3%	12.1%	—
Expenditures of the Global Programme on Reproductive Health Commodity Security (total in US\$,000) ¹¹	25,635 ¹²	87,100	93,550	206,285
Number of countries receiving funding from GPRHCS ¹³	54	73	45	—
Percentage of GPRHCS expenditures to UNFPA reproductive health expenditures	15.5%	51.2%	53.8%	—

⁷ UNFPA annual reports 2008, 2009, 2010.

⁸ UNFPA annual report 2008, 2009 and 2010.

⁹ MHTF mid-annual review 2010.

¹⁰ MHTF mid-annual review 2010.

¹¹ UNFPA GPRHCS annual report 2009.

¹² Estimation according to UNFPA GPRHCS annual report 2009.

¹³ UNFPA GPRHCS annual report 2009 and 2010.

Methodology

The following sections describe the overall evaluation process and the main components of the methodology used for the evaluation. They include the approach used to define its scope, the methodology and the tools selected to collect data and information, and the methods used to analyze this information. This chapter also describes how evidence was used as a basis for formulating answers to the evaluation questions.

2.1 Overview of the evaluation process

This evaluation was carried out in four phases:

- *An inception phase* - to finalize the evaluation design (see Section 2.2 for methods and tools used during this phase to finalize the evaluation design).
- *A desk phase* - to collect and analyze information from relevant existing evaluations and other documents, and to prepare the subsequent phases of this evaluation.
- *A field phase* - to implement the country case studies and to conduct interviews with key stakeholders at global and regional levels (see Sections 2.3.2 and 2.3.4 for information on the methods and data collection tools used during this phase).
- *An analysis and reporting phase* - to develop answers to the evaluation questions based on the evidence collected in the previous phases (see Section 2.4 for methods and tools used for data analysis previous to and during reporting).

2.2 Methods and tools used in evaluation design

The following sections provide information on the different tools and methods used in the design of this evaluation.

2.2.1 Analysis of UNFPA strategic framework

The specific scope of the evaluation was determined on the basis of the review of the UNFPA strategic frameworks in maternal health. The evaluators constructed a series of *effects diagrams* to help visualize the UNFPA results chains in maternal health. The diagrams, a type of logic model, showed the theory of change that UNFPA had intended to use to improve the maternal health situation in programme countries.

These effects diagrams helped the evaluators to:

- i. comprehensively analyze the main elements, overall logic and intervention theory underlying UNFPA support to maternal health; this helped the evaluators improve and deepen their understanding of the UNFPA approach to maternal health over the last 10 years;
- ii. compare changes in UNFPA maternal health approach support over time and establish the common characteristics of the different results frameworks, partly with a view to narrowing the focus of the thematic evaluation (see below);
- iii. compare and contrast the approach and strategy of the Maternal Health Thematic Fund (MHTF) with that of the overall strategy with regard to reproductive and maternal health, and also prepare the analysis of

the added value of the thematic fund *vis-à-vis* that of maternal health support from other sources;

The development of these diagrams occurred in two distinct phases:

- The drafting of a diagram that *depicts the elements and linkages* specifically mentioned in the UNFPA strategies;
- *The logical reconstruction of the intervention logic* of UNFPA by adding, where necessary, the elements (intermediate outcomes, etc.) and linkages needed to make the diagrams more logically coherent.
- The resulting diagrams can be found in Volume 2.

2.2.2 Evaluation questions and judgment criteria

Based on the effects diagrams (see above), the evaluators developed a set of twelve evaluation questions that:

- i. reflect on the topics raised in the terms of reference (ToR) for this evaluation; and
- ii. focus on key components of the UNFPA intervention logic as analyzed and mapped out in the effects diagrams;
- iii. analyze the UNFPA maternal health strategy in accordance with four of the five standard DAC evaluation criteria (relevance, effectiveness, efficiency and sustainability).

A corresponding set of judgment criteria were developed to ensure a transparent assessment of UNFPA performance for each evaluation question. The judgment criteria specified which aspects of UNFPA maternal health support the evaluators would focus on when answering the evaluation questions. Each judgment criterion was specified by a set of qualitative and quantitative indicators, to further increase the transparency of the assessment and to streamline the collection and analysis of data.

In many areas, the ToR suggested a correspondence between the key issues to be addressed in the MHTF mid-term evaluation, and those to be covered by the Maternal Health Thematic Evaluation (MHTE). In order to facilitate a comparison between the two assignments, the evaluators defined a set of evaluation questions that covered the same issues in both studies, but in ways that reflected the differences between the strategic orientation of the MHTF and overall UNFPA maternal health support.

2.2.3 The typology of UNFPA-funded activities

The UNFPA multi-year funding frameworks (MYFF),¹⁴ UNFPA Strategic Plan (2008-2013), the country programme documents (CPD) and action plans (CPAP) and annual work plans (AWP) did not provide sufficient information to comprehensively reconstruct the intended theory of change in maternal health. As a result, the initial set of judgment criteria and indicators developed on the basis of these strategic and planning documents were not specific enough to reliably guide data collection (see section 2.3). The evaluators therefore developed a typology of UNFPA-funded activities to refine the theory of change and to complement the initial judgment criteria and indicators for each of the evaluation questions with additional criteria. These additional criteria allowed the evaluators to collect information during the subsequent evaluation phases in a more focused manner. The typology was developed on the basis of a selection of approximately 120 annual work plans (AWPs) that were made available to the evaluators by country offices.

2.2.4 Staged sampling to define the geographical scope of the evaluation

The countries included in this evaluation were selected in a staged sampling process. The first sampling stage resulted in the selection of all 55 UNFPA programme countries with a maternal mortality ratio (MMR) higher than 300 deaths per 100,000 live births in the year 2000.¹⁵ In the second sampling stage, 22 countries out of the initial 55 were selected for inclusion in the extended desk phase. To ensure that different types of country context were included in

¹⁴ Multi-Year Funding Frameworks (MYFFs) 2000 – 2003 and 2004 – 2007.

¹⁵ The sampling criterion was selected so as to establish a close link to the MDG 5 indicators. The data were taken from the H4 report “Trends in Maternal Mortality: 1990-2008” in agreement with UNFPA.

Table 2: Criteria used to create a typology of desk phase countries

Selection Criteria
Relative success of programme countries in improving maternal health (to include “high-performing” and “low-performing” countries);
Average income level in the different programme countries (to include countries with different poverty levels as one determinant of maternal health);
Quality of the public administration (to include countries with different administrative capacities to develop and manage maternal health programmes); and
Relative prevalence of HIV (to include programme countries whose maternal health situation was interlinked with a high incidence of HIV).

this second-stage sample, the countries were grouped and selected according to the following criteria (see Table 2).

In the third sampling stage, 10 countries from the desk phase group of 22 were selected for in-depth case studies (field phase). Eight of these countries were recipients of the MHTF support: Burkina Faso, Cambodia, Ethiopia, Ghana, Lao PDR, Madagascar, Sudan, and Zambia. Another two countries did not receive MHTF funding: DRC and Kenya.

2.3 Methods and tools used for data collection

The following sections explain the methods and tools used for collecting data throughout this evaluation.

Data for the evaluation were then collected by means of:

- a desk-based review of existing evaluations, reviews and other documents;
- ten country case studies conducted in UNFPA programme countries: Burkina Faso, Cambodia, Ethiopia, Ghana, Lao PDR, Madagascar, Sudan (North) and Zambia (see Section 2.3.2);
- an online survey covering 55 country offices to collect quantifiable information on the technical support that country offices had received, and solicit feedback on

the organizational capacity of the country offices (see Section 2.2.4);

- a series of face-to-face and telephone interviews with UNFPA staff both at headquarters, in the regional and sub-regional offices¹⁶, in case study countries, with other external partners, such as the H4+¹⁷ group (see Annex 3).

2.3.1 Desk review

The first round of data collection consisted of a review of existing documents, in particular available country programme evaluations, and country office annual reports (COAR, see Volume 2). These documents provided the most comprehensive presentation and analysis of UNFPA activities in maternal health for the countries included in the desk phase. Where available other relevant evaluations, including evaluations of joint programmes, were also analyzed. Unfortunately, the quality of decentralized country programme evaluations was low, with findings often not sufficiently supported by data, and conclusions inadequately linked to findings. This made it impossible to compile a complete set of preliminary answers to the evaluation questions for the desk assessment (see Section 2.3.5) and to identify a list of *issues to be assessed during the field phase* (see Section 2.4 below).

In addition the evaluation team also reviewed internal procedures such as resource allocation and resource distribution processes, the envisaged approach to monitoring and evaluation, and the planning process for country programmes. The team also assessed a number of common country assessments (CCA) with a view to identifying the quality of the maternal health-related analysis included in these documents.

2.3.2 Country case studies

Ten country case studies were conducted in UNFPA programme countries (Burkina Faso, Cambodia, DRC, Ethiopia, Ghana, Kenya, Lao PDR, Madagascar, Sudan (North), Zambia). The case studies provided information on the most critical parts of the UNFPA maternal health strategy that were identified during the desk phase, the *issues to be assessed during the field phase* (see Section 2.4.2).

¹⁶ Technical Advisor, Regional Team Coordinator, and Senior Programme Advisor.

¹⁷ UNFPA, UNICEF, the World Bank, WHO and UNAIDS.

All case studies followed a common format. However, the overall list of issues to be assessed was adapted to the specific contexts of each country case study.¹⁸ During each country visit, the evaluation teams used a range of different tools to collect data and information from UNFPA, its partners and other stakeholders:

- Individual interviews and collection of documents from UNFPA country offices and UNFPA partners in 10 programme countries. The team focused on collecting qualitative and quantitative data that would help describe the specific role of UNFPA in the country and provide contextual information on the UNFPA portfolio, its contributions to reducing maternal health, and its role in partnerships;
- Field visits to ascertain how UNFPA contributions were translated into maternal health services on the ground;
- Focus groups with beneficiaries of UNFPA support, often carried out at project sites;
- Follow-up interviews with key partners including the implementing agencies in the capitals, and staff of other UN agencies, donors and non-governmental organizations.

2.3.3 Online survey

The evaluators also carried out an online survey that was disseminated to UNFPA country offices in all 55 countries included in the evaluation (see Volume 2). The survey focused on collecting quantifiable information on the technical support that country offices had received, and soliciting feedback on the organizational capacity of the country offices.¹⁹ The response rate of the survey was 100%.

2.3.4 Key-informant interviews at global and regional level

Evaluators conducted individual interviews with UNFPA staff in headquarters and in the regional and sub-regional offices, both face-to-face and by telephone. A second round of individual interviews was conducted with global representatives of key UNFPA partners, such as the World

Health Organization (WHO), UNICEF, and the World Bank.²⁰ The purpose of the interviews was to complement the insights gained from country-level interviews with the opinions and impressions of UNFPA partners at global and regional levels.

2.3.5 Limitations to data collection

Table 3 lists the main limitations relating to data collection.

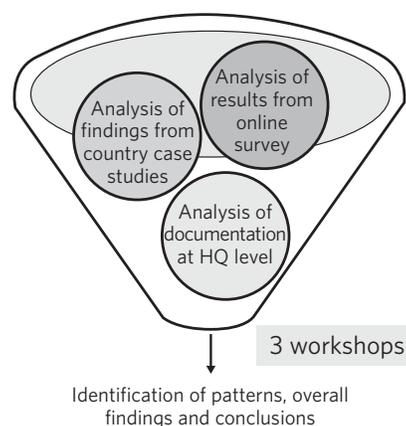
Table 4 lists the limitations related to data collection for the different data sources used for the evaluation. The table also discusses the implications for the validity of the evaluation findings.

As indicated above, the scarcity of data available at desk phase has entailed a shift in the data collection strategy. Evaluators had to approach the field phase with a view to filling the data gaps identified in the desk phase report. As a result, the interventions portfolio examined by the evaluators was – when relevant – extended to include a number of activities implemented in 2011. Thus, the evaluation *de facto* covers a broader period of time (2000-2011) than the one originally set in the terms of reference (2000-2010).

2.4 Methods and tools used for data analysis

The evaluation team analyzed the data and information obtained from the different sources in the following ways:

Figure 1: Analysis of data and information obtained



¹⁸ Therefore, issues addressed may vary from one country case study to the other. Those are shown in the annexes to each country note.

¹⁹ The details of the results of the survey are presented in Volume 2.

²⁰ A complete list of interviewees is included in Annex 3.

Table 3: Limitations related to data collection for the evaluation

Limitation regarding data collection	Evaluators' response/ Implication for the evaluation
<p>The MYFF, the Strategic Plan, CPD, CPAP, and the annual reports from country offices (COAR) provided an overview that was not specific enough on the types of activities funded. The portfolio of UNFPA activities and interventions by country could not be established on the basis of data from the ATLAS financial database. Unfortunately, ATLAS data do not provide sufficient details on UNFPA interventions such as full programming titles, description of activities, outputs and outcomes etc.. This situation, in combination with the absence of other suitable documentation, meant that at the end of the inception phase the evaluation team did not have a clear idea of what types of activity and interventions country offices had carried out in support of maternal health. This limited the extent to which the evaluators could develop a clear analysis of the theory of change underlying UNFPA maternal health interventions. It also meant that many of the judgment criteria and indicators proposed for assessing UNFPA performance and contributions remained relatively vague.</p>	<p>A <i>typology of activities</i> from individual <i>annual work plans (AWP)</i> was compiled during the desk phase. This typology was used to refine the analysis of UNFPA intervention logic and to develop a more concrete data collection strategy for the subsequent evaluation phases.</p>
<p>The available country programme evaluations, annual reports and other documents that would have provided an <i>ex post</i> review and analysis of UNFPA maternal health support were of very variable quality and often did not contain specific enough information to allow the evaluators to provide reasonably detailed preliminary answers to the evaluation questions.</p>	<p>The evaluators conducted a gap analysis based on the <i>typology of activities</i> (see above) and refined the data collection for the field phase and country visits. This information was identified in a list of <i>issues to be assessed during the field phase</i>, on the basis of which the evaluators developed the data collection strategy for each country case study.</p>
<p>UNFPA monitoring reports (CPAP and AWP monitoring tools) did not contain any information on the results of individual interventions. This made it impossible to track progress of results indicators at country level over time, or to make a firm link between UNFPA interventions and changes in maternal health outcomes.</p>	<p>The evaluators analyzed the quality and logical consistency of the strategies of UNFPA along the reconstructed chain of results or intervention logic. This helped the evaluators to construct logical arguments that supported or contradicted a presumed contribution of UNFPA to any observed changes in maternal health outcomes.</p>

An *evaluation matrix* guided the analysis of data and information during the desk phase. The evaluation matrix helped evaluators to compile relevant information for each of the indicators and judgment criteria for all 12 evaluation questions. Moreover, the matrix provided a template for evaluators to formulate their findings on the basis of the collected information at three different levels:

- At the level of the *indicators*, i.e., taking into account all information that had been collected for each indicator
- At the level of *judgment criteria*, across all indicators associated with the respective criterion

- At the level of the *evaluation question* itself.

Similar findings and evaluations matrices were also used during subsequent phases of the evaluation, i.e. for the analysis of country case studies and the analysis for the final report (see the following page).

Data from the country case studies were recorded and analyzed with the help of a *country level results matrix*. Each matrix listed the *issues to be assessed* for each evaluation question and guided the evaluators to formulate evidence-based findings at the level of each *issue*, and subsequently for each individual *judgment criterion*. The evaluators also used the results matrices to formulate

Table 4: Limitations associated with specific data sources

Data sources	Limitations associated with data source	Implications for validity of findings
Document analysis (desk phase)	The country evaluation reports for the 22 desk study countries within the evaluation period were of low quality. This made it difficult to compile a comprehensive picture of UNFPA maternal health support in these countries that should have helped to put the findings from the country case studies into the context of a larger sample of UNFPA programme countries. The limited availability of information from country programme evaluations also meant that the evaluators were not able to develop complete hypotheses, or preliminary answers to the evaluation questions that could be verified during the country case studies (see below).	The limited availability of quality evaluation reports made it more difficult to apply the findings from this evaluation to programme countries outside of the sample of case study countries. Nonetheless, the evaluation findings can be used to inform programming in countries other than those included in the field phase if staff members familiar with the country contexts confirm the applicability of the evaluation findings.
Country case studies	Without sufficiently detailed preliminary answers to the evaluation questions from the desk phase (see above), the evaluators had to collect a wider range of data during the country case studies than originally expected. This made it difficult to explore the contributions of UNFPA to progress in maternal health in the case study countries in the required depth.	The need to reduce the depth of the inquiry during country case studies made it more challenging to establish a well-documented link between UNFPA interventions and changes in maternal health in case study countries. This notwithstanding, the evaluators used information from complementary data sources in case study countries (e.g., donors, governments, civil society) to increase the credibility of claims of UNFPA contributions.

findings that were subsequently used to inform the comprehensive answers to each evaluation question in this final evaluation report. The country level results matrices are annexed to the 10 country reports and summarise the findings of each country case study.²¹

Data from the *online survey* were analyzed statistically. In a first round of analysis, the team prepared an overview of the data for each of the survey questions. A second round of analysis was then used to deepen the analysis arising from selected questions - for example to identify differences in responses between regions, between MHTF recipients and countries without MHTF, etc. (see Volume 2).

A series of *team workshops* allowed the evaluation team to compare and contrast the findings from the desk review,

the country case studies, the online survey and the individual interviews. The team used both internal workshops and collaborative sessions together with UNFPA staff and partners to formulate the overall findings and to reflect on conclusions and recommendations. Evaluators used the Metaplan™ visualization approach²² and mind maps²³ to identify patterns and draw conclusions on the basis of the entire body of evidence (see Figure 1).

2.5 Methods of judgment

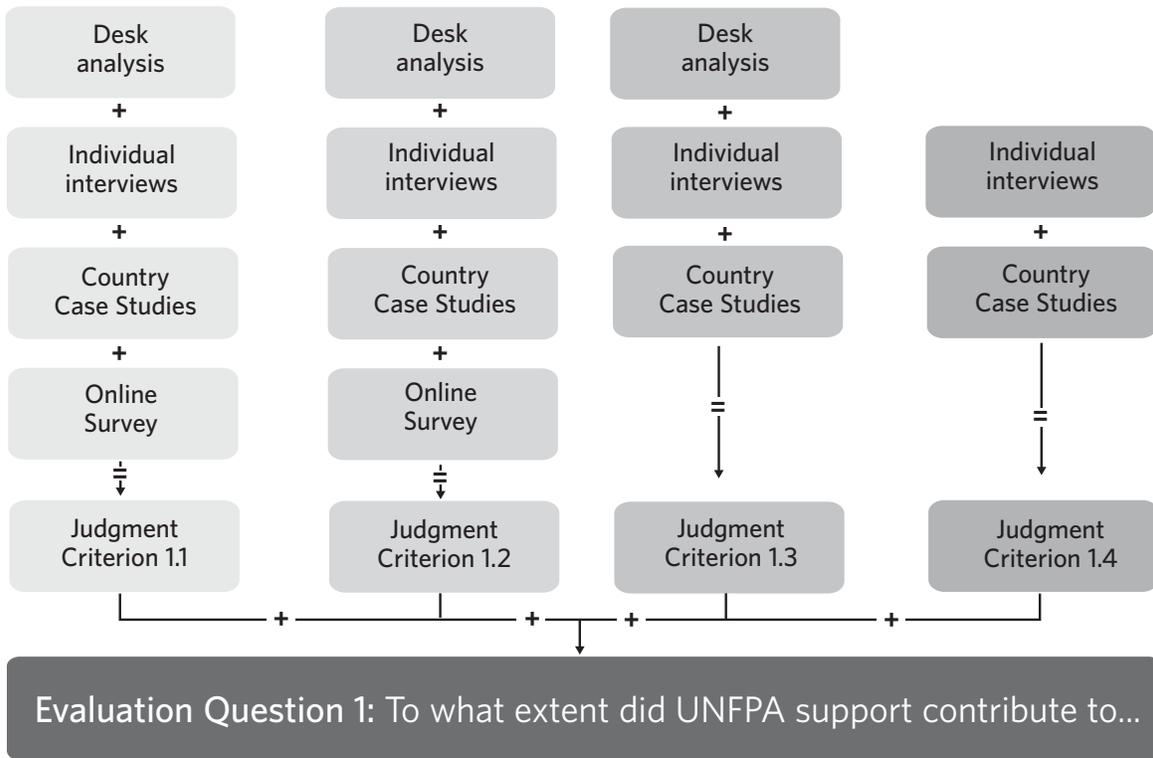
For each evaluation question, the answer was formulated based on the evidence collected for each of the judgment criteria and its corresponding specifications (see Section 2.2.2) for the different sources. The process is illustrated in Figure 2.

²¹ The country notes can be found at <http://www.unfpa.org/public/home/about/Evaluation/EBIER/TE/pid/10094>

²² The Metaplan™ moderation method is a proven and effective means of reaching a shared understanding in group discussion. Visualization makes all the important contributions to the discussion visible for the entire group. These contributions can be recorded and organized, and any relationships between them will emerge.

²³ A mind map is a diagram used to represent words, ideas, or other items linked to and arranged around a central key word or idea. The elements of a given mind map are arranged intuitively according to the importance of the concepts, and are classified into groupings, or areas, with the goal of representing connections between portions of information.

Figure 2: Summation of evidence from different sources within and across judgment criteria



The judgment criteria, which form the basis for the answer for the evaluation questions, are specified for each evaluation question in Chapter 4 and in Volume 2.

2.6 The approach to triangulation in this evaluation

The evaluation used different types of information, a range of sources and various data collection methods to increase the reliability of the data collected and to maximize the validity of the findings and conclusions derived from the data. Specifically, the evaluators ensured methodological and data triangulation in the following ways:

- Employing a mix of data collection methods for the evaluation process, including both qualitative and quantitative methods ranging from documentation

review to interviews, case studies and an online survey;

- Using a comparable mix of data collection methods during the country case studies (interviews, document review, focus groups, observation - see country reports);
- Ensuring the careful selection of a variety of sources of documented data (primary and secondary sources, from within UNFPA and from other donors or organizations at country, regional and global levels, etc.) during both the desk review and the in-depth documentation review for the country case studies (see Volume 2 and country case studies);

The following table provides an overview of the different data collection tools that were used to collect information for each of the evaluation questions.

Table 5: Collection of data for different evaluation questions by data collection tool/approach

Evaluation question	Desk review	Country case studies	Online survey	Individual inter-views HQ²⁴/RO²⁵	Individual interviews UNFPA partners
1. Relevance	XX	XX		XX	XX
2. Harmonization and coordination	XX	XX		X	
3. Community involvement and demand orientation	X	XX		X	
4. Human resources for health	X	XXX	X	XX	
5. Maternal health in humanitarian contexts	X		X	XX	
6. Family planning	X	XXX	X	XX	
7. EmONC	X	XXX	X	XX	XX
8. Evidence orientation of maternal health support	XX	XX			
9. Support of maternal health frameworks and policies	XX	XXX		XX	XX
10. Coherence of sexual and reproductive health, population and development and gender	X	XXX	X	XX	
11. Coherence between country, regional and global programme	X	XX	XXX	XX	XX
12. Visibility	X	XX		XX	XX

Legend: XXX: Provided extensive data for answering evaluation question

XX: Provided some data for answering evaluation question

X: Provided little data for answering evaluation question

²⁴ Headquarters.

²⁵ Regional offices.

Main findings and analysis

The following section presents the summary findings that emerged from the evaluation questions. The detailed findings are presented in the “*evaluation findings matrix*” and the “presentation of results from the online survey” in the volume 2 of this report. Where examples are drawn from specific case studies, these are indicated by listing the name of the country in brackets. The detailed findings include examples and descriptions from the desk review, 10 country case studies, the online survey and interviews, and can be used for further reading. Furthermore, the “analytical matrix” (Volume 2) presents an in-depth analysis for each of the evaluation questions.

3.1 Evaluation question 1 - Relevance

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 criteria

- 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

► Evaluation criteria covered

Relevance

Summary

UNFPA has not fully used the financial and technical resources at its disposal to focus maternal health support on the most vulnerable beneficiaries, neither

between countries, nor within programme countries. The organization did not consistently allocate its resources in proportion to the relative severity of national maternal health needs, because the resource allocation system did not consider the relative levels of the prevailing needs in each country. Headquarters and regional offices were allowed to base the distribution of resources on imprecise criteria such as “degree of political support to the agenda of the International Conference on Population and Development”, “absorptive capacity” or the “humanitarian response, transition and recovery situation in each country”. This resulted in aspects other than the severity of maternal health needs being considered in these resource decisions.

UNFPA has not developed clear, operational definitions of maternal health-related vulnerability to adequately direct maternal health programming toward the most vulnerable. In the absence of these definitions, UNFPA country offices have focused maternal health support geographically and have invested primarily in those regions within programme countries that had highest relative prevalence of maternal mortality. This helped to alleviate resource shortfalls in these areas, at least in the short- to medium term. Only country offices that made use of data from surveys and studies for needs-oriented targeting of specific socio-economic groups were able to address existing socio-economic service barriers, such as cost, distance or lack of transportation.

²⁶ UNFPA (2000): United Nations Population Fund – The Multi-Year Funding Framework, 2000 – 2003, New York; UNFPA (2004): United Nations Population Fund – The Multi-Year Funding Framework, 2004 – 2007, New York.

²⁷ UNFPA (2007): United Nations Population Fund – Strategic Plan 2008 – 2011: Accelerating progress and national ownership of the ICPD Programme of Action, New York.

The UNFPA Multi-Year Funding Frameworks²⁶ and the UNFPA Strategic Plan²⁷ all stated that universal access to reproductive health by 2015 needed to include the most vulnerable populations. In order to follow through on this commitment, UNFPA had intended to allocate the largest share of its support to the countries with the highest incidence of maternal mortality. In each country, UNFPA maternal health support was meant to benefit in particular the most excluded and marginalized population groups and address the issues that were at the root of their vulnerability to poor maternal health.²⁸ UNFPA-supported research and surveys that highlighted the situation of these most vulnerable group²⁹ were meant to provide governments and development partners with the data required to formulate interventions targeted at these parts of the population.³⁰

In practice, however, a number of factors reduced the focus of UNFPA on the maternal health-related needs of the most vulnerable countries and demographic groups. In particular, UNFPA was not able to allocate its funding so that the share of resources was in proportion to the severity of the maternal health crisis in each country. An internal UNFPA report³¹ found no correlation between the levels of UNFPA investments in reproductive health in its programme countries and key reproductive health indicators, such as lifetime risk of maternal death, contraceptive prevalence, or unmet needs for family planning or other services.³²

A number of characteristics of the combined UNFPA systems for resource allocation and resource distribution have contributed to this disconnect between needs and resources:

- The *resource allocation system* uses a set of eight maternal health/ reproductive health indicators to assign individual countries to different needs categories or groups: group A for countries with the highest maternal health challenges, and groups B and C for countries with relatively smaller needs. This includes indicators such as

the maternal mortality ratio (MMR), the proportion of births attended by skilled health personnel, contraceptive prevalence rate (modern methods), and the adolescent fertility rate. However, the resource allocation system does not fully consider the magnitude of any of these indicators. Instead, UNFPA has defined eight indicator thresholds that influence the categorization of a country. For example, the threshold for maternal mortality has been set to 100 deaths per 100,000 live births.³³ Countries are assigned to one of three respective need categories in accordance with the number of indicator thresholds they meet or fail to meet.³⁴ However, the allocation system does not consider the size of the ongoing needs in relation to these thresholds. It therefore does not distinguish if the countries in each group had failed to meet any of the indicator thresholds by a narrow or by a wide margin. As a result, the countries in the high needs category (group A) are allocated a fixed share of UNFPA programme resources³⁵ that does not vary with the severity of the individual maternal health challenges they face: the severity of maternal mortality, problems with access to contraceptives, and the inadequacy of access to skilled birth attendance, etc.

- Regional offices use the *resource distribution system* to determine budget ceilings for individual countries in each of the three needs categories. This system allows the regional offices to consider relatively vague qualitative criteria, such as “degree of political support to the ICPD³⁶ agenda”, “absorptive capacity” or the “humanitarian response, transition and recovery situation in each country” in determining the budget ceilings. This gives the regional offices and headquarters the option of basing resource distribution on criteria other than maternal health indicators and further weakens the systematic link between the severity of maternal health needs and UNFPA funding levels.

UNFPA has not developed clear, operational definitions of maternal health-related vulnerability that adequately

²⁸ See judgment criterion 1.1, Volume 2.

²⁹ See judgment criterion 1.2, Volume 2.

³⁰ See judgment criterion 1.3, Volume 2.

³¹ Report of the Director of the Division for Oversight Services on UNFPA Internal Audit and Oversight Activities in 2010, UNFPA, 2011.

³² See judgment criterion 1.1 in Sections 10.1 (analytical matrix) and 10.2 (findings matrix) in Volume 2.

³³ See UNFPA Resource Allocation and Distribution System 2008 – 2013 for the complete list of indicators and thresholds; or judgment criterion 1.2 in Volume 2.

³⁴ See judgment criterion 1.1, Volume 2.

³⁵ Between 71 per cent and 73 per cent of programming resources; see judgment criterion 1.1, Volume 2.

³⁶ International Conference on Population and Development.

direct maternal health programming to the countries with the greatest maternal health needs. None of the high-level strategic documents of UNFPA, such as the MYFF, the Strategic Plan or the Sexual and Reproductive Health Framework,³⁷ defined the vulnerability concept itself or explained how country offices were meant to translate vulnerability into adequately targeted programmes.³⁸ At country level, none of the 17 country programme action plans (CPAP) that were analyzed for this evaluation³⁹ offered clear operational definitions of maternal health vulnerability. Similarly, staff in all country offices visited during this evaluation cited only very broad definitions of the “most vulnerable” concept. The term was either meant to include all “women, girls, youth, extremely poor, disabled and elderly”, etc., or was interpreted according to geographical location, such as “remote, hard to reach or urban slums population” (Kenya, Madagascar, Sudan, and Zambia).⁴⁰

In the absence of clear operational guidance on the meaning of maternal health vulnerability, UNFPA country programmes have targeted the needs of specific socio-economic groups with varying success. One approach has been to use maternal health data from macro-level surveys to focus UNFPA investments in maternal health on geographic target areas (states or provinces) with particularly low maternal health indicators (geographic targeting). UNFPA programmes in eight of the 10 case study countries applied this approach to direct their investments into clinics, health centers, nursing schools and other facilities (Burkina Faso, Cambodia, DRC, Ghana, Kenya, Lao PDR, Sudan, and Zambia).⁴¹ These investments alleviated resource shortfalls in specific programme areas in the short- to medium-term.⁴² However, they did not target any of the more systemic barriers that often prevented health system access, such as service cost, distance or lack of transportation.⁴³

Case study country offices that performed better with regard to targeting used information from macro-level surveys and other studies, such as ‘situation analyses’ (in

areas such as skilled birth attendance, human resources for health or midwifery) to advocate for changes in national health policies or for the launch of national maternal health programmes (see Box 1 for examples of this type of socio-economic targeting). UNFPA supported initiatives to provide delivery incentives to midwives (Lao PDR) or to introduce a subsidy scheme for emergency obstetric and newborn care (Burkina Faso). These interventions complemented investments in specific states or provinces in these countries. Other than geographically targeted interventions, these national policies and programmes were specifically directed at removing the barriers to access of specific demographic groups, such as women below poverty level or women in remote areas.

Box 1: Examples of the use of socio-economic studies and research for socio-economic targeting of UNFPA support

In Lao PDR, the UNFPA country office participated in the development of the national maternal, newborn and child health package over a number of years and used this cooperation to contribute to a number of initiatives. UNFPA encouraged the Ministry of Health to carry out a skilled birth attendance assessment and also financed the implementation of the study. The results of this assessment subsequently helped to define the content of the Lao PDR national skilled birth attendance plan. This plan later became part of the national maternal, newborn and child health package. The country office also used findings from the skilled birth attendance assessment to advocate for the provision of delivery incentives for midwives in remote areas and to make available free assisted delivery to women in the lowest health quintile.

In Burkina Faso, the UNFPA country office has used a number of socio-economic studies and a socio-behavioural study to investigate the provision of services for reproductive health. UNFPA has used information from this study to maintain a steady policy dialogue with the national government. The dialogue enabled the country office to help promote the idea of an emergency obstetric and newborn care (EmONC) subsidy.

³⁷ UNFPA (2008): Making reproductive rights and sexual and reproductive health a reality for all – Reproductive Rights and Sexual and Reproductive Health Framework, New York.

³⁸ See judgment criterion 1.2, Volume 2.

³⁹ See judgment criterion 1.3, Volume 2.

⁴⁰ See judgment criterion 1.2, Volume 2.

⁴¹ See judgment criterion 1.3, Volume 2.

⁴² See evaluation questions 4 (human resources for health), 6 (family planning), and 7 (EmONC) for information on the UNFPA investments on implementation support.

⁴³ See judgment criterion 1.3, Volume 2.

Using the Maternal Health Thematic Fund (MHTF) to target a selection of maternal health priority countries has helped UNFPA channel more maternal health support to the programme countries with the greatest maternal health needs. The national assessments supported by the MHTF, particularly the emergency obstetric and newborn care assessments, also helped UNFPA and its partners identify bottlenecks in the provision of quality maternal health services for all women. However, the MHTF has not sufficiently addressed the full range of socio-economic barriers that have kept marginalized groups from accessing maternal health services.⁴⁴

3.2 Evaluation question 2 - Harmonization and coordination of maternal health support and partnerships

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 criteria⁴⁵

- 2.1. Harmonization in maternal health partnerships between UNFPA and United Nations (UN) organizations and World Bank (including H4+)⁴⁶ at global, regional and country level
- 2.2. Harmonization of maternal health support through partnerships at country and South-South/ regional levels

► Evaluation criteria covered

Effectiveness, Sustainability

Summary

UNFPA has been able to use research and data collection, evidence-based advocacy and technical assistance to improve the harmonization of maternal health support in programme countries. In order to be successful, these interventions had to be part of long-term working partnerships with development partners and governments. Under these circumstances, country offices were able to use the three programme areas to generate momentum for government-led reviews and amendments of maternal health policies. The resulting policies then functioned as focal points for development partners to align their assistance more closely with government structures and simultaneously harmonize their maternal health support.

Global and regional aid harmonization campaigns, such as the H4+ campaign or the Maputo Maternal and Newborn Health Road Maps have so far had minimal impact on aid harmonization at country level. H4+ has been launched in most of UNFPA programme countries, but partners have not yet begun to coordinate their support according to H4+ principles. Instead, they continue to use the existing coordination mechanisms to harmonize their approaches. The Maputo Road Maps entered national policy-making arenas without a clear view of how they should be integrated into existing policy frameworks and ongoing policy-making processes. Thus, the Maputo Road Maps did not gain sufficient traction as joint policy frameworks and therefore did not lead to an increase in harmonization in maternal health.

The notion and strategy of partnership has been an inherent part of the UNFPA approach in sexual and reproductive health for the entire evaluation period since 2000.⁴⁷ Partnerships with donors, implementing agencies and international and national civil society organizations were meant to enable UNFPA to advance a harmonized approach to support improvements of maternal health around the world. The UNFPA involvement in the H4+ partnership represented an intensified effort by UN organizations to avoid duplication and reduce the strain on scarce human and other resources provided by UNFPA and its partners.⁴⁸ Cooperative initiatives at regional level,

⁴⁴ See judgment criterion 1.1, Volume 2 and evaluation question 1 in the final report of the MHTF mid-term evaluation.

⁴⁵ Previously foreseen judgement criterion 2.3 was not considered for answering the evaluation question. No applicable UNFPA interventions were identified in case study countries. The relevance of the judgment criterion for answering the evaluation question was therefore assessed again.

⁴⁶ UNFPA, UNICEF, World Bank, World Health Organization (WHO), and UNAIDS.

⁴⁷ "Promoting, strengthening and coordinating partnerships" was already one of four key programme strategies of the Multi-Year Funding Framework (MYFF) 2000 - 2003.

⁴⁸ See judgment criterion 2.1.

‘south-south’ partnerships, were also meant to enable the sharing of experiences, development of capacity and the harmonization of maternal health approaches.⁴⁹

UNFPA partnerships with both development partners and governments played important roles in increasing harmonization of maternal health support at country level (Burkina Faso, Cambodia, and Lao PDR). UNFPA was able to use the dissemination of research findings and maternal health data to technical working groups and high-level policy forums to generate momentum for government-led policy reviews in maternal health (Burkina Faso, Cambodia, and Lao PDR).⁵⁰ Policy initiatives in country case studies that UNFPA supported in cooperation with partners, like the maternal, newborn and child health package (Lao PDR), the Health Equity Fund and the EmONC scale-up plan and the EmONC subsidy policy (Cambodia), were able to galvanize the support of other development partners (see Box 2). The increased alignment of donors with these government-owned reproductive health frameworks then led to advances in the harmonization of approaches between UNFPA and its development partners (Burkina Faso, Cambodia, and Lao PDR). UNFPA successes in advancing harmonization have therefore been closely linked to the success of its country offices in integrating of maternal health into policy frameworks in its programme countries (see evaluation question 9).

The membership and active participation of UNFPA country staff in technical working groups and other coordination bodies in reproductive health has been an important pre-requisite for the ability of UNFPA to increase harmonization (Burkina Faso, Cambodia, and Lao PDR). These coordination forums have provided country offices with the opportunity to advocate for required policy changes with partner governments and at the same time to work with development partners on elaborating a harmonized approach to support the implementation of the new or revised reproductive health frameworks.⁵¹ The country offices in Burkina Faso, Cambodia and Lao PDR have also participated in the respective coordination forums actively, consistently and regularly over a number

of years. This allowed UNFPA to earn credibility and trust among both government and development partners and strengthened the capacity of the country offices to further advance harmonized maternal health support.⁵²

Box 2: Advancing aid harmonization through evidence-based advocacy and partnerships

In Cambodia, UNFPA has utilized evidence-based policy advocacy to help increase aid harmonization in its long-term partnerships with the Government and development partners. At the time of evaluation, UNFPA also served as the Chair of the Health Sector Support Programme (HSSP) and had taken the lead on maternal health issues. This helped the country office to advocate and publicize its maternal health initiatives. It also illustrates that development partners had come to view UNFPA as a leader on maternal health.

The country office had used findings from the midwifery review of 2007⁵³ to advocate for increased funding, the extension of midwifery programming and to lobby for financial incentives for deliveries.

The MHTF-funded EmONC assessment played an important role in flagging deficits in the national EmONC situation. These initiatives caught the attention of development partners. For example, the EmONC improvement was taken up as a priority in the HSSP II of Cambodia. This allowed development partners to support EmONC in a coordinated manner.

In contrast, UNFPA has been less successful in helping to harmonize maternal health support when staffing shortages forced country offices to be absent from some of the key coordination bodies, both at technical and at policy level (Ethiopia, Kenya, Zambia). As a result of these shortages, UNFPA country offices played a less prominent role in aid coordination forums. This meant that UNFPA maintained a much lower profile in these groups and was not able to help launch major policy initiatives in maternal health (Ethiopia, Kenya, and Zambia).⁵⁴ Lower visibility of UNFPA in these bodies also meant

⁴⁹ See judgment criterion 2.2.

⁵⁰ See judgment criterion 2.1, Volume 2.

⁵¹ See judgment criterion 2.1, Volume 2.

⁵² See judgment criterion 2.1, Volume 2.

⁵³ Ministry of Health (2007): Final report of comprehensive midwifery review.

⁵⁴ See also evaluation question 9 on the integration of maternal health into policy frameworks.

that UNFPA enjoyed less support among its partners. This limited its capacity to promote joint maternal health initiatives. The contribution of UNFPA to aid harmonization was therefore also lower in these circumstances (Ethiopia, Kenya, and Zambia).⁵⁵

Internal financial and administrative procedures have made it challenging for UNFPA to remain a closely integrated member of the aid harmonization forums in some countries (Burkina Faso, Cambodia). In Burkina Faso, UNFPA-specific fiduciary and administrative procedures have regularly led to disbursement delays. At the time of evaluation, the UNFPA country office in Cambodia was considering abandoning the joint financing mechanism in place for the Health Sector Support Programme (HSSP) II that it had recently joined in 2010 because of internal procedural difficulties. This suggests that cumbersome internal fiduciary and administrative rules are one reason country offices continue to rely on parallel funding and why joint funding mechanisms have remained relatively underused.⁵⁶

Although H4+ had been launched in all of the case study countries at the time of the evaluation, the initiative had not changed how United Nations agencies cooperated at the level of programme countries. Partners continued to work the same way as before the launch of H4+ and used the previously existing mechanisms, such as the UNDAF subgroup for health (Zambia), to convene meetings (all 10 case study countries). The pilot initiative launched by the H4+ partners at global level was more successful. It led to the submission of a number of joint H4+ maternal health programmes for funding (Zambia, Burkina Faso). At the time of the evaluation, these programmes had just been approved and implementation had not yet started.⁵⁷ By the time of the evaluation, the H4+ had therefore not yet made a significant contribution to donor harmonization in maternal health support (all 10 case study countries). Together with development partners, UNFPA had intended to contribute to a more harmonized and intensified support to maternal health in African pro-

gramme countries by helping to translate the Maputo Plan of Action into national-level maternal health road maps. The intention had been to establish these road maps as focal points for harmonized donor support of maternal health. However, although many programme countries⁵⁸ had developed a road map, only a minority had created operational plans and mechanisms for their implementation and to integrate the road maps into their health sector policies.⁵⁹

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 challenging because the road maps were superimposed on already ongoing policy making processes (Ghana, Ethiopia, Kenya, Madagascar, and Zambia). In some instances, neither UNFPA nor its partners had detailed how these different policy frameworks, the Maputo

Box 3: Difficulties in using the Maputo Maternal and Newborn Health Road Maps to advance aid harmonization in maternal health

In Madagascar, the maternal health road map had already been developed in 2004/05. However, neither the government nor development partners established concrete interventions 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 five years later and also in the United Nations strategic vision – again, without specifying the operational implications of the road map for either UNFPA or its partners.

Similarly, the Maternal and Newborn Health Road Map in Zambia was 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 focus around, with the result that it was virtually unknown among development partners. It therefore had no effect on the extent of aid harmonization in the donor community.

⁵⁶ See judgment criterion 2.1, Volume 2.

⁵⁷ See Volume 2 for information from country case studies and interviews with H4+ partners.

⁵⁸ Based on a review of 35 countries; See de Bernis, L., Wolman, Y. (2009). Maternal and Newborn Health National Plans (Road Map) Assessments - African MNH Road Maps Assessment Report; New York: UNFPA Technical Division.

⁵⁹ Only 16 out of 35 countries assessed in a UNFPA study on the progress of implementing the road map had a plan for scaling-up or an operational plan at the district level. 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. See de Bernis, L., Wolman, Y. (2009).

Road Map and the existing maternal health policies, should be unified (Ghana, Kenya, Madagascar and Zambia). The ability to adopt and implement the road map was also affected by administrative and resource-related bottlenecks in the national health sectors (Ethiopia, Madagascar and Sudan). These problems either stemmed from a limited absorption capacity in the Ministry of Health (Ethiopia, Madagascar) or from a lack of financial resources in the health sector to fund the extensive maternal health strategy (Sudan).⁶⁰ The road maps were therefore integrated only in a very general and formulaic way and did not gain a sufficiently high status among development partners to drive aid harmonization (Ghana, Ethiopia, Kenya, Madagascar and Zambia; see also Box 3).

3.3 Evaluation question 3 – Community involvement/demand orientation and civil society organizations partnerships

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 criteria

- 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 involvement in sensitization on maternal health issues and facilitating community-based initiatives to address these issues supported by UNFPA

► Evaluation criteria covered

Effectiveness, Sustainability

Summary

UNFPA-supported initiatives have helped to increase maternal health awareness in targeted communities. However, not all approaches aiming at sensitizing communities were equally successful in increasing demand for maternal health services. Successful approaches

coupled awareness raising and community empowerment efforts with national strategies to address financial barriers to access maternal health services in national health systems.

UNFPA partnerships with non-governmental organizations have historically been an important part of UNFPA community outreach and mobilization campaigns. However, country offices have begun to shift resources and attention away from civil society in favour of channeling their support through government mechanisms.

UNFPA helped to shape the official strategies for community involvement in programme countries as part of the national maternal health strategies. Country offices contributed to operationalizing the community involvement components of the national maternal health strategies (Burkina Faso, Lao PDR, Ethiopia and Cambodia) and advanced specific individual concepts for community mobilization that subsequently were integrated into national maternal health strategies (Zambia) (see Box 4).⁶¹

Box 4: Examples of UNFPA advocacy for community empowerment and participation

In Burkina Faso, the concept of community involvement had been introduced by the Maputo Maternal and Newborn Health Road Map. The Road Map had been developed in Burkina Faso primarily by WHO. However, UNFPA had supported the Maputo process at regional level.

In Lao PDR, community mobilization was part of the national maternal, newborn and child health package. Strategic Objective 3 of the maternal, newborn and child health package calls for the mobilization of “individuals, families and communities for maternal, newborn and child health at different levels”. UNFPA had taken part in the coordination of community mobilization and awareness and demand creation interventions. It had also helped to develop the respective capacities at national level.

In Zambia, UNFPA introduced the concept of Safe Motherhood Action Groups (SMAGs) and helped to integrate them into the national maternal health policy frameworks. UNFPA also piloted the use of SMAGs in its own three focal provinces in Zambia.

⁶⁰ See judgment criterion 2.2, Volume 2.

⁶¹ Judgment criterion 3.1, Volume 2.

UNFPA country offices have utilized a variety of approaches to sensitize communities about maternal health issues. The range of concepts include community conversations (Ethiopia, Kenya), community health workers (CHW) or community midwives (Kenya, Sudan, Ethiopia, Madagascar), and the mobilization of traditional leaders, such as elders, chiefs, or traditional initiators (Kenya, Sudan, Zambia).⁶² Some other country offices have supported and promoted a range of approaches to facilitate increased involvement of communities in maternal health planning and management, which include community-based maternal health committees, such as Safe Motherhood Action Groups (SMAGs) (Zambia), obstetric emergency committees (Burkina Faso) or Women and Child Health Committees (Cambodia).

Country offices in case study countries have differed in their level of success in using community participation in maternal health interventions to create stronger links between beneficiaries and the national health systems. In Zambia, the rate of skilled attendance at birth in two of the focal provinces of UNFPA has declined, despite UNFPA support for SMAGs (see Box 5). Feedback from focus groups suggested that barriers such as lack of transport or the absence of lodging at health centers prevented women in these provinces from seeking out skilled birth attendance. Although the UNFPA-supported SMAGs had helped to increase awareness on the importance of professional care during pregnancies, the absence of complementary support to overcome access barriers reduced the effect of this support to increase skilled attendance at birth.⁶³

In Burkina Faso, Cambodia and Lao PDR, the UNFPA-supported community mobilization approaches coupled awareness-raising efforts with empowering individuals, families and communities (IFC) to take action to address maternal health issues such as establishing transportation schemes or emergency funds and to establish closer linkages with the respective health systems. In Cambodia, UNFPA has used the decentralized governance structures to support community mobilization. In Burkina Faso and Lao PDR, the country office piloted forms of the WHO IFC approach. These mechanisms have helped Burkina Faso and Cambodia to considerably increase the rates of facility-based deliveries between 2003 and 2007 (see Box 6).

⁶² Judgment criterion 3.1, Volume 2.

⁶³ Judgment criterion 3.1 and judgment criterion 3.1, Volume 2; see also evaluation question 7 (EmONC).

⁶⁴ See judgment criterion 3.2, Volume 2 for details

⁶⁵ The country notes are available at <http://www.unfpa.org/public/home/about/Evaluation/EBIER/TE/pid/10094>

Box 5: Example of a UNFPA initiative for community mobilization – the Safe Motherhood Action Groups (SMAGs) in Zambia

In Zambia, UNFPA helped to establish Safe Motherhood Action Groups (SMAGs) during the fifth country programme (2002 – 2006). Since then, SMAGs have been integrated in the national maternal health strategies of Zambia, and UNFPA continues to support them in its three focal provinces. The SMAGs allowed UNFPA and its implementing partners to reach communities, families and individuals with information, education and communication (IEC)/ behavioral change communication (BCC) campaigns. Nevertheless, the percentage of women who seek out professional services during delivery has decreased in two out of the three provinces that UNFPA has supported. In Luapula Province, the rate of births attended by skilled personnel fell from 36 per cent in 1997 to 34 per cent in 2007. In North-Western Province, the rate of assisted deliveries decreased from 50 per cent to 41 per cent in the same period (Zambian Demographic and Health Survey, 2007).

Box 6: Examples of integrated approaches for community mobilization and provision of complementary support⁶⁴

In Burkina Faso, UNFPA has helped to create *cellules villageoises de gestion des urgences obstétricales* to organize communities and to raise awareness of individuals and families. In addition, UNFPA advocacy and technical assistance has encouraged the government to put in place EmONC subsidies. Since 2007, these grants cover up to 80 per cent of the costs of childbirth and have considerably decreased financial risks of poor households. Facility-based deliveries have increased by 27.4 per cent overall, and even by 28.99 per cent in rural areas between 2005 and 2010 (country report Burkina Faso).

In Cambodia, the emerging decentralized governance structures have helped to link communities to the national health system. Village Health Support Groups help to organize communities. These groups are also represented in the Health Centre Management Committees, which are also supported by UNFPA. In addition, the Village Health Support Groups can also access resources from the Health Equity Fund of Cambodia. The money is used to provide transport costs to pregnant women who need to access health service. Between 2005 and 2010, facility-based deliveries have increased by 37.8 per cent overall, and even by 37.9 per cent in rural areas (Country Report: Cambodia).⁶⁵

UNFPA country offices have played an active role in setting up partnerships between non-governmental organizations (NGOs) and governments to enable civil society organizations to play a more active role in the promotion of maternal health. NGO partners were responsible for both maternal health outreach and advocacy and for service delivery and the management of community-based delivery of contraceptives (Burkina Faso, Cambodia, Ghana, Madagascar, and Zambia).

In two case study countries (Cambodia, Zambia), UNFPA country offices have started to shift resources away from civil society and have begun to promote community participation in partnerships with national government and local governance bodies. These changes helped to increase the government ownership of the respective programmes. However, they weakened the role of civil society as service providers and as independent advocates for maternal health concerns (see Box 7).⁶⁶

Box 7: Examples of resource shifts from civil society to government

In Cambodia, UNFPA has shifted resources away from non-governmental organizations (NGOs) to support the Government Community Investment Plan and the associated local governance bodies (Commune Councils, Village Health Support Group, Village Health Committees, Health Centre Management Committee). Between the second and the third country programme, non-core reproductive health funding to NGOs had been reduced from 62 per cent to 13 per cent. Core funding to NGOs had been cut from 16.2 per cent to 9 per cent.

In Zambia, UNFPA also shifted resources away from civil society. While during the fifth country programme (2002 – 2006) UNFPA had still assigned the role of “executive agency” for its PPP programme⁶⁷ to a Zambian NGO, the country office transferred the responsibilities for managing these interventions to the government at the beginning of the sixth country programme (2007 – 2010) and the NGO remained only responsible for implementation.

⁶⁶ See judgment criterion 3.2, Volume 2.

⁶⁷ A programme supporting peer education, service provision and supports the role of parents in maternal/sexual and reproductive health education.

3.4 Evaluation question 4 - Capacity development - human resources for health

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 criteria**

- 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

► **Evaluation criteria covered**

Effectiveness, Sustainability

Summary

UNFPA has helped develop reproductive health-specific human resource regulatory frameworks and tools and train technical reproductive health staff in key areas. However, UNFPA country offices encountered challenges linking these efforts appropriately to mechanisms and agencies in the larger human resources for health system. This has weakened the implementation of reproductive health human resource policies that country offices had helped to develop. Furthermore, system-wide challenges in human resources for health, such as low staff retention or inappropriate deployment, have reduced the effect of UNFPA technical trainings on the availability of skilled reproductive health service providers.

The Maternal Health Thematic Fund (MHTF) has helped improve UNFPA capacity to contribute to assessments of human resources for health policies for midwifery, EmONC and family planning, curriculum reviews and the strengthening of midwifery training facilities. These are important components of the larger human resources for health systems in programme countries that are specific to reproductive health. However, as a thematic fund with limited scope, the MHTF was not able to help country offices to address the larger challenges, particularly the inappropriate deployment or low retention of staff (particularly midwives), which undermine the beneficial effects of UNFPA skill-building activities.

Logistical and financial support of technical training of nurses, midwives and doctors in HIV/AIDS, family planning, obstetric fistula, skilled birth attendants and EmONC has been one of the major components of UNFPA maternal health-related support (all 10 case study countries) and has been provided by UNFPA country offices around the world.⁶⁸ However, these trainings have not been sufficiently aligned to the human resources for health of UNFPA programme countries, particularly in the period 2000-2005. Sustained results from these earlier trainings have therefore been rare.⁶⁹

During the latter half of the period covered by this evaluation (i.e., approximately the period between 2005 and 2010), UNFPA country offices shifted more of their resources from in-service trainings to the support of pre-service trainings (Burkina Faso, Cambodia, Ethiopia, Lao PDR, Zambia). For this purpose, country offices developed partnerships with the government agencies responsible for regulating and overseeing training of health cadres and used these partnerships to channel their maternal health contributions. These included the development and review of training curricula for nurses and midwives and assistance in the development of regulatory frameworks for the delivery of reproductive health services (Burkina Faso, Cambodia, DRC, Ethiopia, Ghana, Lao PDR, Sudan and Zambia). The UNFPA partnerships with national training institutions helped to closely align UNFPA assistance with the existing training systems (nursing schools, midwifery schools, etc.) in programme countries (Burkina Faso, Cambodia, Ethiopia, Lao PDR and Zambia). This increased the effectiveness and the sustainability of UNFPA support in this area although quality concerns remain in most case study countries.⁷⁰ The MHTF-financed staff members at country level, i.e. (international) country midwife advisors (CMA and ICMA) and further advisors in other disciplines, were able to raise UNFPA profile in these forums (Burkina Faso, Cambodia, Lao PDR, Madagascar and Zambia).⁷¹

However, despite these successes, UNFPA and its partners faced difficulties to make trained reproductive health staff

available in the most remote and vulnerable regions of their programme countries.⁷² Inappropriate staff deployment (Burkina Faso, Cambodia, DRC, Ethiopia, Lao PDR, Sudan and Zambia) and high turnover and mobility of staff (Burkina Faso, Sudan and Zambia) prevented reproductive health services from becoming available in many programme countries. These types of challenges had not been caused by deficits of the reproductive health system alone. Instead, they were linked to systemic weaknesses of the larger system for human resources for health in these countries (see above): inadequate planning capacities in national human resource departments; difficulties with coordination, communication and cooperation between national human resource departments and their counterparts in local administrations; or the lack of reliable data to track the availability of health workers across the country.⁷³

A number of the UNFPA country offices visited for this evaluation had found it difficult to approach these interrelated challenges with their sexual and reproductive health programmes (Burkina Faso, DRC, Ethiopia and Zambia). They struggled to position themselves to accommodate both (i) the need to remove these systemic bottlenecks to improve the availability of skilled reproductive health staff in health facilities across their programme countries and (ii) the necessity to keep UNFPA involvement in human resources for health reforms at a manageable level for the often over-burdened reproductive health teams. As a result, UNFPA was unable to help to address these systemic challenges in those countries. It also meant that inadequate deployment and retention continued to limit the effects of UNFPA training assistance (Burkina Faso, Ethiopia and Zambia) (see Box 8).⁷⁴

Among the case study countries, UNFPA offices in Cambodia, Lao PDR and Madagascar had attempted to address this challenge by investing time and effort to build strong working relations with the human resources for health departments of Ministries of Health in their countries. The UNFPA country offices were able to use these partnerships to place their support of reproductive

⁶⁸ Based on review of approximately 100 annual work plans from 22 UNFPA programme countries; for list of countries. and additional information on analysis, see judgment criterion 4.2, Volume 2.

⁶⁹ See judgment criterion 4.2, Volume 2.

⁷⁰ See judgment criterion 4.2, Volume 2 and separate report of MHTF mid-term evaluation.

⁷¹ See judgment criteria 4.1 and 4.2, Volume 2.

⁷² See judgment criterion 4.2, Volume 2.

⁷³ See judgment criteria 4.1 and 4.2, Volume 2.

⁷⁴ See judgment criterion 4.2, Volume 2.

Box 8: Insufficient integration of reproductive health trainings in human resources for health reforms

In Burkina Faso, where UNFPA had not established close working relations with the Human Resource Department of the Ministry of Health, mobility of trained reproductive health personnel was a problem throughout the period of the evaluation. Staff members are often transferred from their original posts to another area after just a few months. Effects from UNFPA trainings in Ethiopia are also limited by high staff turnover and the poor capacity of the health system to retain employees. In Zambia, UNFPA was involved in human resource issues at a technical level (namely in relation to curriculum review for midwifery trainings), but had not conducted complementary advocacy on human resources for health at policy level, despite the fact that UNFPA was formally a member of the SWAp-related technical working groups and policy-level coordination forums.

Box 9: UNFPA partnerships and their significance for promoting reforms of the human resources for health system

In Cambodia, UNFPA has been financing the full-time position of human resources for health adviser in the Human Resource Development Department of the Ministry of Health since 2002. This expert supported the country office as a focal point in the government and has helped to deepen the relationship between both organizations over time. UNFPA and its partners have been able to use the proximity to the Human Resource Department to successfully push for a number of salary increases for reproductive health staff since 2006, including a 20 per cent increase of base pay to midwives to limit dual practice⁷⁵ by health workers. The partnership with the Human Resource Department was also important to maintain the recruitment and transfer policy, which limits recruitment and transfers to Phnom Penh and is the basis for providing additional funds for health staff payroll in the Cambodian provinces.

health-specific skill-building interventions more firmly in the institutional context of the wider human resources for health policies. They facilitated the official endorsement of reproductive health human resource plans, involved the departments in implementing these plans (Cambodia, Lao PDR and Madagascar) or called for salary increases for reproductive health staff (Cambodia) (see Box 9).

In contrast, none of the country offices in Burkina Faso, Ghana, Kenya or Zambia had well-established relations with the human resources departments in the national Ministries of Health. This made it more difficult for UNFPA to link human resources for health advocacy for reproductive health to the overall human resources for health framework. Bottlenecks such as the lack of overall human resources for health plan to improve retention of nurses and midwives (Burkina Faso, Zambia) or insufficient budget allocations for reproductive health staff (Ghana) were not addressed.⁷⁶

3.5 Evaluation question 5 - Maternal health in humanitarian contexts (relief, emergency/crisis, post-emergency/-crisis) health

EVALUATION QUESTION 5

To what extent has UNFPA anticipated and responded to reproductive health threats in the context of humanitarian emergencies?

► Judgment criteria

- 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

► Evaluation criteria covered

Relevance, Effectiveness

Summary

UNFPA has anticipated and responded to reproductive health threats in humanitarian emergencies by providing guidance on reproductive health programming in emergencies at global level. Country offices have used this guidance to strengthen emergency preparedness

(continued)

⁷⁵ The term "dual practice" applies when clinicians combine salaried, and often public-sector clinical work with a fee-for-service private clientele.

⁷⁶ See judgment criteria 4.1, Volume 2.

SUMMARY (continued)

in sexual and reproductive health by: a) joining international humanitarian campaigns; b) working with countries to include sexual and reproductive health and maternal health components in national emergency preparedness plans; and c) developing the capacities of national counterparts to dispense Minimum Initial Service Packages (MISP) for reproductive health during emergencies. Operationally, UNFPA country offices have faced challenges in responding to the added responsibility of working on humanitarian issues in addition to providing development assistance. More importantly, country offices have also struggled to adequately integrate and link assistance in humanitarian situations to UNFPA support in more stable circumstances.

UNFPA has advocated for the institutionalization of reproductive and sexual health in emergency preparedness, humanitarian response and post-conflict recovery in its global reproductive health strategies. The Reproductive Rights and Sexual and Reproductive Health Framework 2008-2011⁷⁷ called for the sexual and reproductive health package to include the same services in emergencies and humanitarian crises as in other situations. The Framework also finds that the most effective and cost-efficient way to ensure that sexual and reproductive health issues are part of a humanitarian response is to incorporate them into emergency preparedness plans and to develop national capacities for preparedness.⁷⁸ The previous Multi-Year Funding Frameworks⁷⁹ had also referred to the integration of sexual and reproductive health into relief operations and emergency preparedness programmes as important components of UNFPA country programmes.⁸⁰

UNFPA produced a number of tools to advance the inclusion of sexual and reproductive health into emergency preparedness and response. These include:

- The Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings (2009)

- The Inter-Agency Standing Committee (IASC) guidelines on gender-based violence (2005)
- The Inter-Agency Standing Committee gender handbook in humanitarian action (2006)
- A distance-learning module on Minimum Initial Service Packages (MISP) for reproductive health in crisis situations (2007)⁸¹

UNFPA country offices in case study countries played a leading role in integrating sexual and reproductive health in emergency preparation. Country offices were involved in the preparation or amendment of emergency response plans with sexual and reproductive health components (Burkina Faso, Cambodia, Ethiopia, Lao PDR, Madagascar, and Sudan).⁸² They have also been members of the respective disaster management and coordination committees of the United Nations system and the international humanitarian community overall, such as the United Nations Disaster Management Teams (UNDMT) (Cambodia, Ethiopia), and the various clusters, sub-clusters and other committees to coordinate humanitarian responses in emergencies (DRC, Ethiopia, Ghana, Kenya, Madagascar, Sudan).⁸³

In order to help increase the capacity of governments and their partners to ensure the accessibility of emergency obstetric and newborn care (EmONC), family planning and other reproductive health-related services in emergencies, UNFPA country offices have financially and technically supported national emergency management agencies or other relevant national stakeholders to prepare for humanitarian disasters (Burkina Faso, Cambodia, DRC, Ethiopia, Ghana, Lao PDR, Madagascar, Sudan; see Box 10).⁸⁴

UNFPA offices in Ethiopia, Ghana and Kenya had intensified their efforts to make emergency preparedness a permanent component of their country programmes since

⁷⁷ UNFPA (2008); Making Reproductive Rights and Sexual and Reproductive Health a Reality for All - Reproductive Rights and Sexual and Reproductive Health Framework; New York City: UNFPA.

⁷⁸ See judgment criterion 5.1, Volume 2.

⁷⁹ UNFPA (2004) Multi-Year Funding Framework, 2004 - 2007; UNFPA (2000); Multi-Year Funding Framework, 2000 - 2003.

⁸⁰ See judgment criterion 5.1, Volume 2.

⁸¹ See judgment criterion 5.1, Volume 2.

⁸² Judgment criterion 5.1, Volume 2.

⁸³ Judgment criterion 5.1, Volume 2.

⁸⁴ Judgment criterion 5.2, Volume 2.

Box 10: Examples of UNFPA support to prepare for humanitarian disasters

In Cambodia, UNFPA provided seed funding to the Secretariat for National Committee for Disaster Management (NCDM). This support was used by NCDM and the Ministry of Health to develop a joint plan of action for emergencies. In Madagascar, UNFPA supported the *Bureau de Gestion Risqué de Catastrophe* with production and dissemination of relevant data for emergency management. In Ethiopia, UNFPA conducted or supported several assessments and baseline surveys on reproductive health, HIV and gender-based violence in humanitarian settings. UNFPA country offices in Burkina Faso, Cambodia, DRC, Ethiopia, Ghana, Lao PDR, Madagascar and Sudan also 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.

2007/08. In Kenya, this increase in emergency-related support was a reaction to the humanitarian impact of the post-election violence in 2008 (see Box 11).

Among the case study countries, country offices in DRC, Ethiopia, Ghana, Kenya and Sudan have integrated humanitarian issues into their core programming. Case study

Box 11: Increases in country office involvement in emergency preparedness

In Ethiopia, the UNFPA country office had started to incorporate humanitarian issues in its country office advocacy strategy in 2007 and had also integrated its staff group for humanitarian issues (one national programme officer, two UN Volunteers) into its reproductive health sub-programme. In Kenya, the UNFPA office was unprepared for the humanitarian impact of the 2008 post-election violence. Nevertheless, the country office was able to provide family planning commodities and emergency kits to the affected population at very short notice. After the situation had calmed, the country office contracted a humanitarian focal point, who now works towards mainstreaming humanitarian issues, gender, and gender-based violence at all levels of service provision.

countries with lower prevalence of recurring or persistent emergencies had instead chosen to adopt internal contingency plans for disasters (Lao PDR, Burkina Faso). This was viewed as a more cost-effective approach to respond to the UNFPA mandate for emergency preparedness.⁸⁵

Country offices have provided a range of medical products and reproductive health commodities in emergencies (Burkina Faso, DRC, Ghana, Kenya, Lao PDR, Sudan), both as part of international humanitarian response mechanisms and their regular maternal health programming, including emergency preparedness support. Supplies include delivery and hygiene kits, contraceptives and other reproductive health commodities, including those required for the delivery of the MISP. UNFPA has also supported the availability of MISP by training service providers and emergency coordination agencies (see Box 12).⁸⁶

Box 12: Supply of commodities in emergencies

In Ghana, UNFPA has assisted the Government to mobilize delivery kits in emergency situations. The country office has also supported capacity development of the National Disaster Coordination Agency on the prepositioning of supplies for MISP.

In Lao PDR, UNFPA has helped to distribute delivery kits in regions affected by emergencies, using funds from the country office emergency contingency plan.

In Ethiopia, UNFPA helped the national Government to establish a stock of emergency reproductive health kits in 2007.

In Sudan, UNFPA has helped the Ministries of Health in its five focal states to preposition basic supplies, such as reproductive health kits and personal hygiene kits, to prepare for the provision of MISP.

In Ethiopia and Kenya, the involvement in emergency preparedness has increased demands on country office staff.⁸⁷ The country office in Ethiopia has joined more than 10 additional coordination forums since it increased its engagement in emergency preparation.⁸⁸ In Sudan,

⁸⁵ See judgment criterion 5.2, Volume 2.

⁸⁶ See judgment criterion 5.3, Volume 2.

⁸⁷ See judgment criterion 5.2, Volume 2.

⁸⁸ These included the Health and Protection Cluster, the Strategic Disaster Management Team, the UN Technical Officers Group, the Emergency Health and Nutrition Task Force, the HIV/AIDS Emergency Task Force, the Early Warning Working Group, the UN/NGO coordination meeting, the Humanitarian Response Fund Review Board and the UN Communication Officers Group; see judgment criterion 5.1, Volume 2.

humanitarian emergencies have existed alongside more stable situations throughout much of the last decade, not just in Darfur,⁸⁹ but also in the Eastern States of the country. The experiences of the Sudan country office have shown that UNFPA global standard procedures for maternal health support in development frameworks are not appropriate for this kind of context. Logistical and financial infrastructure and other prerequisites for project management and financing are often not in place, and the social, political and security situation is often in flux.⁹⁰ UNFPA financial accountability requirements foresee quarterly advances and limit the possibility of rolling-over funds from one quarter to the next. However, where financial transfers from UNFPA to implementing partners can take up to two quarters, it is difficult for the country office to comply with UNFPA finance requirements (Sudan).⁹¹

3.6 Evaluation question 6 - Sexual and reproductive health services - family planning

EVALUATION QUESTION 6

To what extent has the UNFPA contributed to the scaling up and increased utilization of and demand for family planning?

► Judgment criteria

- 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 programme countries, particularly among vulnerable groups
- 6.3. Improved access to contraceptives (commodity security)

► Evaluation criteria covered

Effectiveness, Sustainability

Summary

UNFPA has helped to anchor family planning more firmly in policy frameworks of programme countries and to develop national capacities to manage commodity procurement and distribution. In particular, country offices that were able to combine long-term policy support on family planning, communication campaigns and the procurement of contraceptives (three of UNFPA well-established types of family planning support) with focused initiatives to strengthen key stakeholders of reproductive health commodity security systems have helped to increase access to family planning commodities. UNFPA use of community-based distribution helped to open alternative channels for the delivery of commodities to beneficiaries in remote areas where there is limited access to public health systems.

Family planning has been one of three pillars of UNFPA support for reducing maternal mortality and morbidity. The UNFPA approach was to help develop the capacity of health systems in programme countries to provide quality family planning services. Support in case study countries was designed to include trainings for managers and service providers in family planning, as well assistance in the establishment of appropriate regulatory frameworks and quality assurance systems.⁹² UNFPA also had pledged to help develop the capacity of national reproductive health commodity security systems (RHCS) to ensure access to family planning commodities in health centers, particularly in remote areas.⁹³ Research on socio-economic barriers to family planning utilization and support of communication and community mobilization campaigns were meant to help increase demand for family planning services and the use of contraceptives among beneficiaries. UNFPA also aimed to support community-based distribution of commodities for this purpose.⁹⁴

UNFPA has provided technical and financial support to help develop the family planning policy frameworks of programme countries.⁹⁵ Country offices in case study countries have helped to develop a broad range of national policies, service protocols and other frameworks for family planning

⁸⁹ The UNFPA engagement in the humanitarian effort in Darfur is not covered by this evaluation.

⁹⁰ Judgment criterion 5.2, Volume 2.

⁹¹ Judgment criterion 5.2, Volume 2.

⁹² Judgment criterion 6.1.

⁹³ Judgment criterion 6.3.

⁹⁴ Judgment criterion 6.2.

⁹⁵ Based on review of 120 annual work plans from 22 programme countries and the findings from ten country case studies.

and contraceptive security (Burkina Faso, Cambodia, DRC, Ethiopia, Ghana, Kenya, Madagascar, Zambia). In some of these countries, UNFPA was also able to ensure that family planning was included in national health plans and national development plans (Burkina Faso, Madagascar).

UNFPA has helped to train health staff (nurses, midwives and doctors) to improve the delivery of family planning services in health facilities (all 10 case study countries).⁹⁶ However, the training has been not been planned strategically enough to improve the quality of family planning services overall.

UNFPA has contributed to the development of capacities in its programme countries for the management of health commodities, in particular in the forecasting, financing, procurement and also the distribution of contraceptives and related logistics. Here, the Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS)⁹⁷ also has intensified UNFPA efforts⁹⁸ (especially in its “Stream one countries”).⁹⁹ UNFPA helped to strengthen the national commodities agencies as important nodal points of the national reproductive health commodity security systems (Ethiopia, Lao PDR and Madagascar). This allowed the country offices to align their support to existing national health commodity management systems. UNFPA was also better able to harmonize its support of reproductive health commodities with the assistance of other donors that worked in this area (Ethiopia, Lao PDR and Madagascar) (see Box 13). In other case study countries, the continued existence of several commodity management systems made harmonized support of commodity management difficult (Burkina Faso, Cambodia, DRC and Sudan).¹⁰⁰

UNFPA has also successfully used joint government-development partner steering committees to help harmonize donor support to reproductive health commodity security (Burkina Faso, Cambodia, Ghana and Zambia). UNFPA country offices have initiated the creation of reproductive

Box 13: Supporting national commodities agencies to improve integrated commodities management

In Ethiopia, the Government created the Pharmaceutical Fund Supply Agency (PFSA) in 2009 in response to a UNFPA-supported review of commodity procurement and distribution. The 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. UNFPA has since supported PFSA with technical assistance and equipment. This helped to improve the management of reproductive health commodities, and also benefited the commodity management system overall. For example, UNFPA funds were used to provide computers for health commodity warehouses and to support the national logistics management information system.

In Lao PDR, family planning logistics used to be managed through the National Maternal and Child Health Centre. When the Centre faced difficulties to ensure the regular supply of contraceptives, UNFPA helped forge a partnership with the national Medical Product Supply Centre. This improved the supply situation and also helped harmonize UNFPA support of reproductive health commodities with the support of other development partners of one single commodities management system. The Government, development partners and UNFPA agreed that this new system held promise for a more unified approach.

health commodity security committees in some of the case study countries (Burkina Faso, Cambodia and Zambia). However, the success of these initiatives varied. In Burkina Faso and Cambodia, the creation of these committees was part of a long-term strategy to improve commodity security. The country offices used their staff resources to support the committees with technical assistance and to mobilize support among the governments and development partners. By the time of the evaluation, the committees in both countries were well-established. In Zambia, staffing shortages made it difficult for UNFPA to maintain its presence

⁹⁶ Based on review of 120 AWP from 22 programme countries; in addition, all programme countries included in the field phase had received this type of support.

⁹⁷ The GPRHCS was designed to foster the emergence of more predictable, planned and sustainable country driven approaches for securing and using essential reproductive health supplies. The Programme is intended to galvanise, institutionalise and facilitate coordination of national efforts to enhance RHCS. For details on the GPRHCS, please see the GPRHCS mid-term review (Chattoe-Brown, Weil, & Braddock, 2011).

⁹⁸ See GPRHCS mid-term review for details (Chattoe-Brown, Weil, & Braddock, 2011).

⁹⁹ Burkina Faso, Ethiopia, Haiti, Madagascar, Mali, Mongolia, Mozambique, Nicaragua, Niger, Lao PDR, Sierra Leone.

¹⁰⁰ Judgment criterion 6.3, Volume 2.

in coordination bodies. This reduced its ability to sustain sufficient support for the commodity security committee from among the Government and development partners to ensure its continued operation (see Box 14).¹⁰¹

Box 14: Examples of joint government-development partner steering committees to harmonize donor support to reproductive health commodity security

In Burkina Faso, the country office helped 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 continues to operate.

In Zambia, UNFPA also attempted to launch a “Reproductive Health Commodity Security Committee”. The country office provided technical input to communicate the concept of the Committee. However, staffing constraints prevented UNFPA from following-up with targeted and persistent advocacy among the Government and development partners. The Committee ceased to function after four meetings.

To ensure the availability of commodities in remote areas, UNFPA country offices have embraced the support of community-based distribution of contraceptives, particularly since 2005 (Burkina Faso, Cambodia, Ethiopia, Kenya, Lao PDR) (see Box 15). The earlier programmes have periodically achieved significant increases in the prevalence of contraceptives and are seen as candidates for scale-up in other regions (Lao PDR, Cambodia). In Lao PDR, UNFPA has supported community-based distribution in very remote and underprivileged areas of the country. The use of contraceptives has increased from 17.5 per cent at the beginning of the intervention to 43.1 per cent in 2010.¹⁰² In Cambodia, contraceptive prevalence rate in rural areas (any modern method) has increased from 26.5 per cent to 35.8 per cent between 2005 and 2010.¹⁰³

Box 15: Community-based distribution of contraceptives

In Cambodia, UNFPA introduced the concept of community-based distribution of contraceptives, and initiated a corresponding programme that started implementation in 2004, targeting areas that were far from health centers (approximately 10 kilometers or more). After initially providing only basic training to the community-based distribution in 2004 and 2005, UNFPA developed a training manual for community-based distribution, in conjunction with the National Health Promotion Centre. The training consists of a five-day accredited package that all implementers must follow. Non-governmental organizations now use the community-based distribution manual, and the National Maternal Newborn Child Health Centre is responsible for all community-based distribution programming. UNFPA and USAID updated the community-based distribution guidelines in 2008.

Financial, logistical and technical support to IEC/BCC interventions on family planning has been a standard component of UNFPA country programmes (in all 10 country case studies).¹⁰⁴ Country offices in Burkina Faso, Cambodia Ethiopia and Lao PDR utilized research to inform the design of individual communication campaigns and to decide on the kinds of messages to be communicated. IEC/BCC campaigns were also rarely monitored or evaluated (see Box 16). Among the countries visited, only the CO in Cambodia had monitored the results of its communication campaigns, using KAP (knowledge, attitudes, and practices) baseline and end-line surveys.¹⁰⁵

The financial sustainability of commodity security systems and commodity procurement is uncertain. In case study countries, financing for reproductive health commodity security has become almost exclusively dependent on external support from development partners (Cambodia, DRC, Ethiopia, Ghana, Lao PDR, Madagascar, Sudan, and Zambia). In a number of case study countries, UNFPA has been one of relatively few providers of contraceptives (Cambodia, Ghana, Lao PDR, DRC, Madagascar, and Sudan).¹⁰⁶ In Madagascar and Sudan, contraceptives for family planning have been

¹⁰¹ Judgment criterion 6.3, Volume 2.

¹⁰² Data from internal monitoring reports (2010), UNPA; see judgment criterion 6.3, Volume 2.

¹⁰³ Data compiled from www.measuredhs.com/Data in 04/2012

¹⁰⁴ Based on a review of 120 annual work plans from 22 programme countries; also, all UNFPA country offices in case study countries had offered this kind of support. For details, see judgment criterion 6.2, Volume 2.

¹⁰⁵ Judgment criterion 6.2, Volume 2.

Box 16: Using research to develop messages for IEC/BCC campaigns

In Burkina Faso, the country office had supported the Directorate of Public Hygiene and Health Education (DPHPES) to develop a strategic communications plan for reproductive health (2007 - 2010), including family planning. Studies provided information that suggested targeting communications and other strategies toward a greater involvement of men and opinion leaders.

nearly exclusively supplied by UNFPA. The GPRHCS has provided the majority of funds for the provision of family planning commodities since 2007, and between 2007 and 2010, the GPRHCS contributed over US\$101.9 million for commodities in UNFPA programme countries. The GPRHCS has also intensified UNFPA involvement in strengthening national systems for commodity management,¹⁰⁷ particularly in its Stream One countries (included in this evaluation are Burkina Faso, Ethiopia, Lao PDR and Madagascar).

In crisis or post-crisis countries (Sudan, DRC and Madagascar), this situation is acceptable and even inevitable. However, even in more stable situations (Cambodia,

Box 17: Reliance on external funding for reproductive health commodities

In Ghana, now considered a middle-income country, UNFPA, DFID and USAID together provide approximately US\$4 million for contraceptive security. This leaves a national annual funding gap of approximately US\$8.5 million. Despite past efforts of UNFPA and other development partners, the Government has so far refused to take on greater financial responsibility for family planning commodities. A past government pledge to provide almost US\$1 million per annum towards the funding gap has not been fulfilled. After the maiden launch of family planning week in September 2011, the Minister pledged approximately US\$3 million to support contraceptive procurement. "UNFPA and partners are following up on this pledge to ensure that it is implemented." (Interview with UNFPA.)

Ghana, Lao PDR), UNFPA and its partners have neither managed to convince governments to take on a greater share of the financial responsibility for reproductive health commodities, nor implemented a phase-in strategy to obtain greater financial contributions from government in the future (see Box 17). The only case study countries that had assumed more financial responsibility for reproductive health commodities were Burkina Faso and Kenya.¹⁰⁸

3.7 Evaluation question 7 - Sexual and reproductive health services - EmONC

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 criteria

- 7.1. Increased access to EmONC services
- 7.2. Increased utilization of EmONC services

► Evaluation criteria covered

Effectiveness, Sustainability

Summary

UNFPA has been able to help its programme countries implement important prerequisites for scaling-up skilled attendance during pregnancy and access to emergency obstetric and newborn care (EmONC) services. Although UNFPA country offices had already supported the scale-up of EmONC in the years prior to the launch of the Maternal Health Thematic Fund (MHTF), the MHTF did help to accelerate the development of national EmONC plans. The MHTF provided useful templates, tools and know-how that country offices used to contribute to the implementation of EmONC assessments and to support

(continued)

¹⁰⁶ Judgment criterion 6.3, Volume 2.

¹⁰⁷ See Chattoe-Brown, A., Weil, O., & Braddock, M. (2011): UNFPA Global Programme to Enhance Reproductive Health Commodity Security Mid Term Review; HLSP.

¹⁰⁸ Judgment criterion 6.3, Volume 2.

SUMMARY (continued)

the evidence-based development of EmONC plans. Despite these successes, UNFPA country offices have not yet adequately defined their roles and responsibilities for addressing health system-wide bottlenecks, including capacity gaps in line ministries, problems with staff retention, identification of barriers and addressing them, inadequate health management information systems or inadequate referral systems. Unless these bottlenecks are addressed, the chances that EmONC plans can be implemented to their fullest potential will decrease.

UNFPA aimed to increase access to emergency obstetric and newborn care (EmONC) services by assisting in the development of health system capacity in programme countries to deliver such services. Evidence from needs assessments and other surveys were meant to help in the development of customized national and sub-national EmONC strategies. The UNFPA strategy had also included support in the development of appropriate referral systems.¹⁰⁹ In addition, UNFPA worked to increase demand for EmONC services among beneficiaries. Interventions aimed at sensitizing communities on the importance of emergency obstetric care and empowering them to demand and access affordable quality EmONC services.¹¹⁰

UNFPA efforts to anchor EmONC on the sexual and reproductive health agenda pre-dated the launch of the Maternal Health Thematic Fund (MHTF) (Burkina Faso, Cambodia, Ethiopia, Ghana, Lao PDR, Madagascar, and Sudan). Country offices have used information from situational analyses, needs assessments and EmONC surveys to increase commitment of partner governments to scale-up EmONC over time (Cambodia, Ghana and Sudan) (see Box 18).

From 2008 onwards, the human resources and the financial means provided by the MHTF helped to speed up the planning of national EmONC needs assessments (Burkina Faso, Cambodia, Ethiopia, Lao PDR and Madagascar). UNFPA country offices used data from these surveys on the existing EmONC service gaps to advocate for the development of national EmONC scale-up plans (Burkina Faso, Cambodia, Ghana, Lao PDR and Madagascar). The

Box 18: Needs assessment and advocacy campaigns for improved emergency obstetric care programming and scale up

Advocacy for the needs-based improvement of access to EmONC services has benefited from a series of consecutive advocacy attempts before and after launching the MHTF. 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 supported by MHTF) to target several stakeholders (parliamentarians, other government agencies) with their policy dialogue. In Ghana, UNFPA had funded an EmONC assessment in 2007, in one region of the country only (Upper East Region, in cooperation with Ghana Health Service (GHS)). Three 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). In Sudan, UNFPA had supported an EmONC survey in 2005. This survey had had a significant effect on bringing more Government attention to the poor state of emergency maternal health services. The country office followed up with an assessment in 2008 to further influence strategy development and EmONC-related planning in its focal states.

tools made available through the UNFPA partnership with the Averting Maternal Death and Disability (AMDD) allowed countries to apply clear and well-established procedures to implement their EmONC assessments.¹¹¹ This helped to effectively contribute to the implementation of EmONC assessments and to support the evidence-based development of EmONC plans. As a result, UNFPA was able to help anchor emergency obstetric and newborn care 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.

Administrative gaps in health ministries, inadequate health management information systems, inadequate referral systems (see Box 19) and problems with staff retention have negatively affected the availability of and access to EmONC services (Burkina Faso, Cambodia, DRC, Ethiopia, Ghana, Kenya, Lao PDR, Madagascar, Sudan and Zambia). Unless these bottlenecks are addressed, they will also hinder the implementation of UNFPA-supported EmONC scale-

¹⁰⁹ See judgment criterion 7.1.

¹¹⁰ See judgment criterion 7.2.

¹¹¹ See judgment criterion 7.1, Volume 2.

Box 19: Examples of the limited UNFPA support to national referral systems

In all case study countries, UNFPA had provided ambulances to hospitals, health centers or local authorities. In some countries, this was all the support provided by UNFPA for the improvement of referral systems (Burkina Faso, Ethiopia or Zambia). However, in all cases, the ambulances only served as partial and temporary fixes to the inadequate referral systems. Basic prerequisites for the sustained operation of the ambulances (maintenance, operating budgets) were not put in place.¹¹⁵ Moreover, the ambulances alone were not suited to address the more systemic and far-reaching shortcomings of the referral systems in these countries, such as lack of referral guidelines, or a coherent and comprehensive strategies for referrals.¹¹⁶

up plans.¹¹² However, UNFPA offices in several countries (Burkina Faso, Ethiopia, DRC, Kenya, Sudan, and Zambia) have found it challenging to adequately define their roles and responsibilities for addressing these types of health system-wide, capacity-related, bottlenecks. In some country offices, UNFPA staff were not sure if these types of larger, health system-wide issues were covered by the UNFPA mandate (Ethiopia, Kenya and Zambia). As a result, the country offices had not established sufficiently strong partnerships with organizations outside of the immediate sphere of reproductive health to approach these larger, health system-wide issues (Ethiopia, Kenya and Zambia).¹¹³ In Sudan, the country office had recognized the negative implications of these kinds of bottlenecks, but was challenged to address them in the absence of viable candidates for corresponding partnerships.¹¹⁴

Country offices in Zambia and Ethiopia have supported the scaling-up of EmONC by financing EmONC scale-up activities in specific geographic areas (Zambia, Ethiopia). UNFPA offices in Burkina Faso, Cambodia and Lao PDR have taken a further step by identifying

economic, cultural and social barriers that have prevented women from accessing EmONC services (e.g., costs of services, distance, and lack of transportation other than referral). The country offices analyzed the challenges women from particular socio-economic groups faced in accessing EmONC services and advocated to address economic barriers at the policy level.¹¹⁷ The three offices used findings to inform the policy dialogue on EmONC with the national ministries of health, parliamentary associations and other stakeholders.¹¹⁸ In Burkina Faso, these efforts helped to convince the Government to put in place the EmONC subsidy (2009) that subsidizes 80 per cent of the costs of EmONC services. The subsidy has considerably reduced the financial burden of poor EmONC patients in Burkina Faso (see Box 20).¹¹⁹

Box 20: UNFPA contribution to the development of the EmONC subsidy

Since 2009, the EmONC subsidy in Burkina Faso ensures that patients and their families pay only 20 per cent of EmONC costs. The law evolved out of a series of policy initiatives that had been supported by UNFPA. It was recognized that cost presented a barrier to many mothers to access EmONC services, so in 2004/5 the UNFPA country office provided technical assistance to the *Direction de la Famille* (DSF) in the Ministry of Health and advocated with parliamentarians. This helped convince the government to pass laws to finance the implementation of an EmONC subsidy for patients. At the same time, requests to different stakeholders resulted in the prioritization of maternal health by the government and a budget commitment with the creation of several related budget lines, including one to fund the EmONC subsidy.

UNFPA in Burkina Faso and Cambodia also helped raise awareness in communities on the warning signs of complications during pregnancies and birth.¹²⁰ In addition, the country offices in Burkina Faso and Lao PDR piloted the IFC approach to empower individuals, families and

¹¹² See judgment criterion 7.1, Volume 2.

¹¹³ See judgment criterion 7.1, Volume 2; See also the discussion on partnerships in evaluation question 4 on UNFPA support for human resources for health.

¹¹⁴ See Judgment criterion 7.1, Volume 2.

¹¹⁵ See Judgment criterion 7.1, Volume 2.

¹¹⁶ See judgment criterion 7.1, Volume 2.

¹¹⁷ See the discussion on socio-economic targeting in evaluation question 1.

¹¹⁸ Judgment criterion 7.2, Volume 2.

¹¹⁹ Ridde, V., Kouanda, S., Bado, A., Bado, N., & Haddad, S. (2012). Reducing the Medical Cost of Deliveries in Burkina Faso is good for Everyone, Including the Poor. *PLoS ONE* 7(3).

¹²⁰ See judgment criterion 7.2, Volume 2.

communities (IFC) and to strengthen their links with the national health systems. In Cambodia, UNFPA took advantage of the well-developed local governance system to support maternal health with the same integrating effect.¹²¹ Both Burkina Faso and Cambodia have been able to increase the share of facility-based deliveries concomitant to the introduction of these policies. In Burkina Faso, facility-based deliveries have increased by 27.4 per cent overall, between 2003 and 2010.¹²² Facility-based deliveries in Cambodia have even increased by 37.8 per cent overall, between 2005 and 2010.¹²³ The increase has been the largest in rural areas in both countries, where the above-mentioned cultural, social and economic barriers typically are the most severe.¹²⁴

3.8 Evaluation question 8 - Results/ evidence orientation of UNFPA maternal health support

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 criteria

- 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

► Evaluation criteria covered

Efficiency, Coherence

Summary

Use of evidence by UNFPA from macro-level surveys and other studies has helped its country offices as well as the organization as a whole to design relevant maternal health interventions and to target its support in countries, albeit mostly geographically. However, the organization has not been able to adequately assess the performance of its programmes and interventions by means of monitoring and evaluation to optimize maternal health support over time. The root causes for this weakness are ultimately linked to deficits in UNFPA processes and templates for intervention planning and to problems with the design of quality indicators and the low technical capacity of country office staff for results-oriented monitoring.

Evidence from surveys and studies, such as the demographic and health surveys (DHS), censuses, skilled birth attendance or EmONC assessments have played a prominent role in the development of country programmes and in the design of individual interventions (all 10 country case studies). Data from these sources were used to target UNFPA support geographically, namely to select specific states or provinces as geographic focal areas for UNFPA financed maternal health support. Only a few of the country offices (Burkina Faso, Cambodia, Lao PDR) used data from specific qualitative studies to identify systemic service barriers of particular socio-economic groups (e.g., rural poor in remote communities, etc) and to advocate for changes in national health policies that would help to remove these barriers.¹²⁵

UNFPA has neither adequately monitored nor evaluated the performance of its past maternal health programmes. Weaknesses in their monitoring systems have prevented country offices from collecting information on the results of their programmes, namely on the effects of UNFPA interventions on the immediate target groups.¹²⁶ This has also been the case for interventions that UNFPA has initiated to pilot new approaches in

¹²¹ See evaluation question 3 on community participation.

¹²² Data compiled from <http://www.measuredhs.com/Data/> on 4/14/2012

¹²³ Data compiled from <http://www.measuredhs.com/Data/> on 4/14/2012

¹²⁴ See judgment criterion 7.2, Volume 2.

¹²⁵ Judgment criteria 8.2, 8.3, Volume 2; See also evaluation question 1 on the difference between geographic targeting and socio-economic targeting.

¹²⁶ Often also called "expected accomplishments" or "outcomes" in the logical framework language.

Box 21: Problems in the selection of results indicators

A maternal health intervention in Sudan (“Increased awareness of reproductive health information and improved knowledge or preventing HIV/ AIDS, especially among out-of-school youths”; 2010) was meant to contribute to Output 3 of the Sudan country programme. Neither the country programme action plan nor the annual work plan described which theory of change would allow the intervention to alter the reproductive health awareness of the target group. This omission is reflected in the design of the monitoring system. The selected indicators were aimed at information on activities or their tangible products (“number of sessions conducted”, “established radio/TV broadcasting network with monthly public session”) or captured higher-level behavioral changes without a direct logical link to the intervention (“percentage of pregnant women with regular antenatal care visits”; or “percentage of pregnant women immunized”). None of the indicators measured changes in the behaviour of the direct beneficiaries of the intervention (e.g. condom use among out-of-school youths).

maternal health. Consequently, UNFPA has not been able to gauge which contributions maternal health programmes have made to higher level maternal health outcomes and to systematically use lessons from pilot interventions for future maternal health support (all 10 country case studies).¹²⁷

The weakness of the UNFPA monitoring system is linked to deficits in UNFPA processes and templates for strategic planning, such as the annual work plans (AWP) and the country programme action plans (CPAP) monitoring framework. The templates used to develop the CPAP and AWP have not allowed elaboration of consistent and complete theories of change for individual interventions that explain how the

interventions should contribute to specific country programme outputs and the higher-level country programme outcomes (all 10 country case studies).¹²⁸ This has made it difficult to define appropriate indicators to measure achievements along the expected chain of intervention effects. As a result, country offices defined indicators or selected measures from the country programme action plan monitoring framework without considering their logical relationship to the outputs of the annual work plan in question¹²⁹ (see Box 21) (all 10 case study countries).¹³⁰

The weaknesses of the UNFPA monitoring system were exacerbated by the insufficient staff resources of country offices to appropriately analyze and use the data that were available (Burkina Faso, Ghana, Lao PDR, Sierra Leone, Sudan, Zambia).¹³¹ UNFPA internal guidelines had assigned the responsibility for monitoring primarily to UNFPA implementing partners. The Programme Component Manager, typically a government agency, was responsible for consolidation of these reports into annual standard progress reports (SPR), conducting periodic field monitoring visits and forwarding the results to the country offices.¹³² The UNFPA country office has only been responsible for validating the reported achievements through its own field monitoring visits and forwarding the annual standard progress reports to UNFPA headquarters.¹³³

This system has proven to be problematic at least in three ways (all 10 country case studies):

- UNFPA implementing partners have not had the capacity to develop appropriate monitoring mechanisms for their interventions, to develop relevant indicators and to design appropriate procedures to collect information on the indicators.

¹²⁷ Judgment criteria 8.2, 8.3, Volume 2.

¹²⁸ Based on review of 120 annual work plans from UNFPA programme countries and from findings of the ten country case studies.

¹²⁹ It has to be noted that the UNFPA interpretation of outputs in CPAPs and CPDs is not in line with the commonly accepted definition of the Development Assistance Committee (DAC) of the OECD that defines outputs to be the (direct and tangible) “products, capital goods and services which result from a development intervention” (OECD/DAC (2002): Glossary of key terms in evaluation and results-based management, Paris).

¹³⁰ See judgment criterion 8.2, Volume 2.

¹³¹ Based on a review of 14 country programme evaluations and findings from the ten country case studies (judgment criterion 7.3, Volume 2).

¹³² UNFPA Policies and Procedures: Programme Country Programme Monitoring and Evaluation (UNFPA, 2004). The policies and procedures manual 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.

¹³³ See judgment criterion 8.2, 8.3, Volume 2.

- Internally, country offices did not build sufficient staff capacity to compensate for the weaknesses of the implementing partners, namely to redact reports of insufficient quality and to build monitoring capacity in implementing partners over time.
- 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 office and to draw corresponding lessons for individual interventions and the country programme overall.¹³⁴

Although UNFPA country offices commissioned a large number of mid-term evaluations of country programmes, thematic evaluations or intervention level evaluations, the quality of evaluation reports in UNFPA has been low. An evaluation quality assessment carried out by UNFPA¹³⁵ found that 20 out of the 37 reviewed evaluations (54 per cent) for the years 2007 and 2008 had methodological weaknesses that called into question the validity of their findings, conclusions and recommendations. Nineteen out of the 37 reviewed evaluations (51 per cent) failed to support their findings and results with data. The suitability of these studies for evidence- and results-based management of UNFPA interventions was therefore low. Without progress data on activities and outputs, the opportunities for evidence-based management of UNFPA maternal health interventions have been limited.¹³⁶

These weaknesses at country level have negatively affected the ability of UNFPA to use lessons from past maternal health support to develop future support strategies at global level. UNFPA did integrate some key lessons on maternal health/ sexual and reproductive health from an independent review of the Second Multi-Year Funding Framework (MYFF) when developing the 2008 – 2013 Strategic Plan. However, the limitations of the UNFPA monitoring system detrimentally affected the quality and validity of these lessons.¹³⁷

3.9 Evaluation question 9 - Integrating maternal health into national policies and development frameworks

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 criteria

- 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

► Evaluation criteria covered

Effectiveness, Sustainability

Summary

The UNFPA record of contributing to a stronger integration of maternal health into national policy frameworks has been mixed. UNFPA country offices were able to generate momentum for maternal health-related policy changes when they combined support for data generation, surveys and research with targeted advocacy campaigns and technical assistance. Strong partnerships between UNFPA offices and governmental and non-governmental stakeholders also contributed to the success of policy campaigns. Country offices without the staff capacity required to build and maintain partnerships and to follow-up maternal health research with targeted policy advocacy were not able to influence the policy agenda in programme countries. UNFPA-supported policy initiatives that originated at regional level, such as Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA) or the Maputo

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¹³⁴ Judgment criteria 8.2, 8.3, Volume 2.

¹³⁵ UNFPA - Division for Oversight Services (2010). Evaluation Quality Assessment: 2007 - 2008, Report No. UNFPA104. New York City: UNFPA.

¹³⁶ Judgment criteria 8.2, 8.3, Volume 2.

¹³⁷ Judgment criterion 8.3, Volume 2.

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process, did not affect the national maternal health policy agenda in the long-term. The UNFPA contribution to an improved national capacity to monitor maternal health-related policies has been small, as assistance in refining maternal health indicators did not address the larger, systemic weaknesses of national health management information systems or other monitoring and evaluation systems.

Furthering the integration of maternal health in national health and sexual and reproductive health frameworks on the basis of: (i) evidence and research, (ii) targeted advocacy campaigns and (iii) technical assistance has been one of the core elements of UNFPA maternal health strategy. UNFPA country offices have provided support on a range of related issues, such as technical and financial assistance to national demographic and health surveys (DHS) and other macro-level surveys and studies, maternal health-related advocacy with decisions makers and IEC/ BCC campaigns (all 10 country case studies). In particular assistance for surveys and research has helped make disaggregated data on maternal health more available to governmental and non-governmental partners.¹³⁸

Country offices were able to use maternal health data to generate momentum for maternal health-related policy changes when they combined support for surveys and research with targeted advocacy campaigns and technical assistance (Burkina Faso, Cambodia, Lao PDR, and Madagascar). Each of these components played a particular role in the policy campaigns: i) advocacy with government, parliamentarians and civil society made stakeholders aware that policy changes were required to improve maternal health; ii) demographic and other data on maternal health helped identify which issues needed to be addressed on the policy level and formed the evidence-base for new policies and programmes; iii) technical assistance from UNFPA helped programme countries to implement the surveys and studies (Burkina Faso, Cambodia, Lao PDR). This process is illustrated by an example from Lao PDR in Box 22.

Well-established and long-term working relationships with governmental and non-governmental stakeholders

Box 22: Example of a successful approach to achieve maternal health-related policy changes

The integrated maternal, newborn and child health package (2009) in Lao PDR was the result of a multi-year campaign that involved a number of different development partners. The UNFPA country office in Lao PDR had provided this campaign with data and research, evidence-based advocacy and technical assistance between 2006 and 2009.

UNFPA initially financed the participation of a number of officials from the national Ministry of Health (MoH) in a series of international maternal health conferences and workshops, to bring the issue and the possible policy responses to their attention (advocacy with MoH). Subsequently, UNFPA built on the motivation of the MoH staff members it had financed to organize a national level maternal health workshop in 2007. This resulted in the decision of the MoH to conduct a skilled birth attendance assessment to evaluate the extent of skilled birth attendance deficits in the country (advocacy with MoH; other national stakeholders).

In 2008, the UNFPA programme provided follow-up by financing the skilled birth attendance assessment and technically supported its implementation (data collection; technical assistance). UNFPA complemented these activities by conducting related advocacy and capacity development directed at the media and parliamentarians to build support for a stronger national response to maternal health deficits among lawmakers and society overall (advocacy, technical assistance with media, lawmakers, general public).

in programme countries helped UNFPA to advocate for changes in maternal health policies and frameworks. Parliamentary associations, national population committees and other influential stakeholders that had become partners of UNFPA were able to act as “maternal health champions” during policy campaigns. As governments agencies, these partners were able to advocate for budget increases for maternal and reproductive health and could speak on other sensitive topics that UNFPA could not have addressed on its own (see Box 23) (Burkina Faso, Cambodia, Lao PDR, Madagascar).¹³⁹

¹³⁸ Judgment criterion 9.1, Volume 2.

¹³⁹ Judgment criterion 9.2, Volume 2.

Box 23: The use of maternal health champions for maternal health policy advocacy

The UNFPA country office in Cambodia has established partnerships with the “National Committee on Population and Development” and the “Cambodian Association of Parliamentarians for Population and Development” (CAPPD). UNFPA had provided technical and financial assistance to both organizations consistently for five to six years and has called on them to support specific advocacy efforts. 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, non-governmental organizations forums and public gatherings. When the Cambodian Government halted new recruitment into the civil service in 2007, interventions from CAPPD helped increase trainings and recruitment of midwives and nurses.

However, staffing shortages have made it difficult for country offices to establish and maintain these kinds of partnerships and to remain active in strategic, high-level policy advocacy and donor harmonization forums (Ethiopia, Kenya, and Zambia). This has reduced the ability of UNFPA offices to follow-up maternal health related studies or surveys with complementary advocacy and diminished the visibility of UNFPA in maternal health policy debates (Ethiopia, Kenya, and Zambia).¹⁴⁰

The lack of follow-up also limited the significance of the Maputo Road Maps for reproductive health and maternal health policy formulation in UNFPA programme countries. UNFPA and other UN organizations had supported the Maputo Plan of Action at regional level. UNFPA country offices, with other development partners, had assumed responsibility for translating the Plan of Action into national maternal health road maps (Burkina Faso, Ghana, Ethiopia, Madagascar, Sudan and Zambia). However, with the exception of Sudan and Madagascar, these road maps were neither costed, nor used to lobby for increased resources for maternal health support among development partners. Their influence

on the policy agenda of UNFPA partner governments in case study countries was therefore small.¹⁴¹ In the case of the African Union “Campaign for Accelerated Reduction of Maternal Mortality in Africa” (CARMMA), UNFPA country offices in African case study countries supported the launching of the campaign, but did not follow-up on its continuation (DRC, Ghana, Ethiopia and Zambia). In these cases, CARMMA remained a “one-off” campaign and did not influence subsequent maternal health programming.¹⁴²

Country offices utilized resources from their population and development sub-programmes to help define appropriate indicators for policies on reproductive health, maternal health and other areas (all 10 country case studies). However, only the country offices in Burkina Faso, Sudan and Kenya had offered more comprehensive support to develop the capacity of national monitoring and evaluation systems.¹⁴³

3.10 Evaluation question 10 - Coherence of sexual reproductive health/maternal health support with gender and population and development support¹⁴⁴

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 areas¹⁴⁵

▶ Judgment criteria

- 10.1. Linkages established between programmes (reproductive health with gender and population and development) in intervention design
- 10.2. Integration of monitoring and reporting of UNFPA operations

▶ Evaluation criteria covered

Efficiency, Coherence

¹⁴² Judgment criterion 9.2, Volume 2; see also evaluation question 2 on UNFPA contributions to aid harmonization in the field of maternal health.

¹⁴³ Judgment criterion 9.3, Volume 2.

¹⁴⁵ Gender (including female genital mutilation/ cutting, gender-based violence, HIV-PMTCT (prevention of mother-to-child HIV transmission)), population and development.

Summary

Seeking and exploiting synergies between programming in gender and reproductive health has not been a firmly established practice in UNFPA. In spite of the availability of data on many gender-related reproductive and maternal health issues from standard macro-level assessments, such as censuses and demographic and health surveys, country offices have typically not pursued opportunities to apply this information in specifically integrated reproductive health interventions. Country offices have generally taken advantage of opportunities to finance integrated interventions (pull factors for integrated programming). However, country offices commonly lacked appropriate planning or management mechanisms to create these kinds of opportunities themselves (push factors for integrated programming).

UNFPA country programmes have helped to increase the availability of data on sexual and reproductive health including gender-related maternal health challenges, such as gender-based violence.¹⁴⁶ All country offices visited during the field phase of the evaluation have helped to include gender-specific data in censuses and demographic and health surveys (DHS) (all 10 country case studies) (see Box 24).¹⁴⁷ However, only the offices in Ethiopia and Madagascar had supported additional studies to analyze the gender-specific constraints women experienced when accessing maternal health services.¹⁴⁸

Box 24: Examples of UNFPA support to gender-disaggregated data collection

The country offices in Kenya and Ghana spearheaded the inclusion of gender-based violence indicators in the respective country demographic and health surveys (DHS). The UNFPA office in Ethiopia helped to develop maternal health, HIV/AIDS and family planning indicators for the 2005 DHS. The UNFPA country office in Cambodia facilitated gender-specific data collection and compilation through several surveys (Cambodia gender assessments (2004, 2008)). In Cambodia, UNDP and several other donors benefited from the availability of a number of UNFPA-supported surveys, including the Cambodian Inter-census Population Surveys (2004) and the Cambodia DHS. UNFPA also supported a central database for storing gender-disaggregated data.

Ethiopia was also the only case study country office to establish internal organizational mechanisms to promote integrated planning and programming between the three sub-programmes. The country office in Ethiopia has been using an internal, country-level Project Appraisal Committee. The Committee allowed heads of the thematic units to review and endorse project proposals prior to their approval by the UNFPA country representative. Country office procedures also encouraged the selection of joint implementation sites for reproductive health and gender sub-programmes. In Madagascar, UNFPA has been holding joint planning sessions for staff from the three sub-programmes. These mechanisms have helped to achieve a closer integration between reproductive health interventions and gender support than in the other case study country offices.¹⁴⁹

Box 25: Examples of pull factors for integrated programming in UNFPA

UNFPA staff in Sudan were aware of the importance to integrate reproductive health and gender programming in the country. However, at the time of the evaluation, the country office had not yet developed internal mechanisms to facilitate integrated planning on a regular basis. This situation notwithstanding, the country office succeeded in financing a number of interventions that consciously integrated gender and reproductive health. The country office did so in partnership with implementing partners with long-term experiences in integrated programming and the corresponding internal management mechanisms.

In Cambodia, the UNFPA country office took advantage of the well-integrated governance structures at sub-national level to support integrated programming. UNFPA had trained a number of gender focal persons that represented the Ministry of Women Affairs at provincial level. These focal persons were part of the local structures of the Department of Local Administration (the department responsible for the process of decentralization, de-concentration and the commune investment plans). In addition, the gender focal points served as gender advisers to the commune councils. In this capacity, they were also members of the management committees for health centers that UNFPA has been supporting to develop EmONC capacities.

¹⁴⁶ Judgment criterion 10.1, Volume 2.

¹⁴⁷ Judgment criterion 10.1, Volume 2.

¹⁴⁸ Judgment criterion 10.1, Volume 2.

¹⁴⁹ Based on a review of annual work plans from Madagascar and Ethiopia, see judgment criterion 10.1, Volume 2.

Other country offices also financed integrated reproductive health and gender interventions, albeit on a smaller scale (Burkina Faso, Cambodia, DRC, Ghana, Kenya, Sudan and Zambia). In the absence of well-established internal mechanisms for integrated programming, these country offices depended on opportunities from outside of the country office to promote integrated programming (pull factors) (see Box 25).¹⁵⁰

Without sufficient human resources or technical support for monitoring, country offices were not able to establish systems to monitor their sub-programmes in gender, reproductive health and population and development in an integrated way. The monitoring function remained attached to individual annual work plans in the respective sub-programmes (Burkina Faso, Cambodia, DRC, Ghana, Kenya, Lao PDR, Sudan and Zambia).¹⁵¹

3.11 Evaluation question 11 - Coherence between country, regional, global programmes

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 criteria

- 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

► Evaluation criteria covered

Efficiency, Coherence

¹⁵⁰ Judgment criterion 10.1, Volume 2.

¹⁵¹ Judgment criterion 10.2, Volume 2.

Summary

Inadequate staffing levels have created major bottlenecks in the capacity of country offices. Staffing gaps have made the adequate implementation of maternal health interventions very challenging and have reduced the profile of UNFPA in programme countries. The Maternal Health Thematic Fund (MHTF) has provided resources to hire required additional staff members, in particular in areas like EmONC, midwifery and obstetric fistula.

Technical support from regional offices and headquarters has been skewed towards family planning and reproductive health commodity security. EmONC, midwifery (and human resources for health overall) and the prevention and treatment of obstetric fistula were neglected, although they have been important focus areas of the UNFPA reproductive health strategy.

Numbers of technical and management staff have been too low to allow country offices to respond to their maternal health programming requirements. Country offices reported various types of problems with fulfilling their programming responsibilities due to insufficient staffing levels. These included the inability to attend important meetings of development partners, to prepare technical contributions to multi-lateral meetings and to follow-up on information from monitoring reports (Cambodia, Ethiopia, Kenya, Lao PDR, and Zambia). A majority of the 55 country offices that had participated in the online survey considered their staffing levels to be insufficient to respond to all responsibilities linked to the implementation of their sexual and reproductive health sub-programme (see Box 26).

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 United Nations and government technical working groups as well as other coordination forums with programme countries. It also prevented country offices from consistently providing sound technical contributions to their partners (Ethiopia, Kenya and Zambia), which contributed to low profiles and visibility of UNFPA in maternal health in some countries (Kenya, Zambia).

Box 26: Findings from online survey – adequacy of staffing level in country offices

Of the 55 country offices that responded in the online survey, 49 per cent 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 maternal health component of the country programme”, 47.2 per cent agreed with the statement and 3.6 per cent found the statement “not applicable”. Thirty six per cent of country offices questioned in the online survey considered their staffing capacity for technical contributions in maternal health to be insufficient, 38 per cent of country offices saw gaps in their staffing capacity for high-level policy advocacy.

Staffing gaps at management level, such as long-term vacancies of the positions of country representatives and deputy country representatives also lowered the UNFPA profile in policy dialogue and affected the overall capacity of the respective offices (see Box 26 above) (Ethiopia, Kenya and Zambia).¹⁵²

Vacancies of existing positions have been a significant cause for the insufficient staffing capacities of UNFPA country offices. Nineteen out of the 55 UNFPA country offices (36 per cent) responding to the online survey of countries with high maternal mortality ratios¹⁵³ reported 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. On average, positions of national programme officers for reproductive health had been vacant for approximately one and one-half years. Management positions, such as those of deputy representative or country representative had been vacant for nearly 16 months. The longest reported vacancy for a national programme officer position in reproductive health has been four years.¹⁵⁴

The MHTF has made a noticeable contribution to improve the skill mix in country offices. Approximately 88 per cent of country offices that had received MHTF assistance since 2008¹⁵⁵ reported that they have seen at least

“limited improvements” in the technical skills available in their office. Among the MHTF recipients, 72.5 per cent of country offices thought the MHTF had led to “considerable improvements” in the skill-mix available for maternal health programming. The country case studies confirmed that the availability of resources from the MHTF to hire additional technical expertise was an important asset for UNFPA country offices (Cambodia, Ethiopia, Lao PDR, Madagascar and Zambia) (see Box 27). In a number of countries, the recruitment of MHTF-funded country midwifery advisers or other advisers represented the only increase of staff capacity that country offices had recently experienced (Cambodia, Ethiopia and Zambia). MHTF resources also have been used to compensate for losses in staff positions funded with core funds (Ethiopia; see Box 27).¹⁵⁶

The responsibilities between the global and regional programme and individual country programmes have not been delineated clearly. According to the global and regional programme guidelines,¹⁵⁷ the global and regional programme is meant to “complement country

Box 27: Effects of MHTF funding on country office staffing

The country office in Cambodia initially used MHTF resources to hire an international midwifery expert. After launching the EmONC assessment in 2009 (also MHTF funded), the office re-dedicated the resources to hire a full-time EmONC adviser to manage and supervise the future EmONC support of UNFPA.

The country office in Lao PDR used MHTF resources to continue hiring a full-time skilled birth attendance coordinator to support its intensified involvement in this subject area.

In Ethiopia, overall staff numbers have been reduced in the last three years from approximately 65 to 55 in 2011. One of the positions that had not been filled again was the International Reproductive Health Adviser. The country office used MHTF resources to hire two midwifery advisers, who now cover the midwifery, nurse anesthetist and obstetric fistula programmes.

¹⁵² Based on findings from the online survey and the country case studies; see judgment criterion 11.2, Volume 2.

¹⁵³ Maternal mortality rate (MMR) above 300 deaths in 100,000 live births, according to estimates of the MMR in the year 2000 (WHO, UNICEF, UNFPA, World Bank, 2010).

¹⁵⁴ Judgment criterion 10.2, and online survey, Volume 2.

¹⁵⁵ 40 country offices of the 55 country offices that had participated in the online survey had received MHTF assistance in either 2008, 2009 or 2010.

¹⁵⁶ See judgment criterion 11.2 in Volume 2 for more detailed information on the different aspects of staff capacity.

¹⁵⁷ UNFPA (2010): Global and Regional Programme Guidelines; Policies and Procedures Manual, New York.

programmes” and to “contribute towards implementing the UNFPA Strategic Plan”. Regional offices are asked to consult with the country offices concerned in the approval and implementation of regional activities to ensure synergies between regional and country programmes. Country offices have not received clear guidance on their responsibilities in the implementation of the UNFPA maternal health approach.¹⁵⁸

Regional offices have focused on supporting country offices in family planning and reproductive health commodity security and have not addressed other important subjects to the same extent, such as the prevention and treatment of obstetric fistula, EmONC, midwifery and human resources for health overall. Between 50 and 60 per cent of country offices in countries with high maternal mortality ratios responded in the online survey that they had not received technical support from regional offices in these areas (see Box 28). The results from the online survey also indicated that integration of gender, population and development with maternal health was rarely addressed in technical support from regional offices. These gaps have limited the ability of the regional programme to adequately support the implementation of sexual and reproductive health sub-programmes in programme countries, particularly because EmONC, midwifery and human resources for health are focus areas in the UNFPA reproductive health strategy.¹⁵⁹ The quality of support from regional offices, as opposed to support coverage, has been adequate overall, with little differences in levels of satisfaction between the different technical areas reported in the survey.¹⁶⁰

One of the causes for the insufficient coverage of technical support has been low staffing levels at regional and sub-regional level.¹⁶¹ Regional offices stated that they consequently felt the need to select a small set of priority country offices from the larger pool of UNFPA offices in order to be able to focus their support in a manageable number of cases.¹⁶²

Box 28: Findings from online survey -support of country offices from UNFPA regional offices

Eighty two per cent of the 55 country offices responding to the online survey had received support in family planning and reproductive health commodity security from their regional office in the recent past. Only slightly more than half of country offices had received technical support from regional offices in EmONC and obstetric fistula, 58 per cent in the case of obstetric fistula and 53 per cent in the case of EmONC. 75 per cent of country offices that had received support in these areas had found the support useful. Forty seven per cent of country offices had received support in midwifery and just 42 per cent had received support in human resources for health overall. Less than 50 per cent had received support on the integration of gender, population and development with maternal health.

Overall, across different thematic areas and types of support, 66 per cent of country offices have been “rather satisfied” (53 per cent) or “very satisfied” (13 per cent) with technical support from regional offices. 31 per cent have been dissatisfied (22 per cent “rather dissatisfied”; 9 per cent “very dissatisfied”).

Findings from the survey show that this approach has left those country offices not on the priority list without the assistance they required.¹⁶³

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 assistance over phone, Skype or e-mail.¹⁶⁴ More customized forms of assistance, such as in-country technical assistance (other than workshops) by regional office staff or by external consultants or on-demand workshops have been less common (see Box 29).¹⁶⁵

¹⁵⁸ Judgment criterion 11.1, Volume 2.

¹⁵⁹ Judgment criterion 11.3, Volume 2.

¹⁶⁰ Judgment criterion 11.3 and online survey, Volume 2.

¹⁶¹ Based on feedback from interviews with regional and sub-regional offices; see judgment criterion 11.3, Volume 2.

¹⁶² Interviews with regional office staff; see judgment criterion 11.3, Volume 2.

¹⁶³ Judgment criterion 11.3, Volume 2.

¹⁶⁴ See Volume 2 for the results of the online survey of country offices. 48 out of 55 country offices surveyed (87 per cent) had received assistance from regional offices through standardized workshops and through guidance documents; 45 out of 55 country offices (82 per cent) had received assistance via phone, e-mail or Skype.

¹⁶⁵ Judgment criterion 11.3, Volume 2.

Box 29: Findings from online survey – types of support received from regional offices

Only 37 out of 55 country offices (67 per cent) had received in-country technical assistance (other than workshops) by regional office staff; 31 country offices out of 55 (56 per cent) had received in-country technical assistance by external consultants. Finally, only 36 per cent of country offices (20 out of 55) had received technical assistance in the form of customized workshops on a topic of their choosing.

UNFPA headquarters has been at least as active in providing technical support as UNFPA regional offices, and in some areas even more active. Country offices have not just benefited from technical guidance documents, but have also sought assistance from headquarters staff by means of direct phone calls, Skype, or e-mail messages. In areas like obstetric fistula, emergency obstetric and newborn care (EmONC), family planning & reproductive health commodity security and midwifery, country offices rated technical support from headquarters as more “useful” than the technical support from regional offices (see Box 30). These are also the areas in which country offices have seen the greatest improvements in technical support since the launch of the MHTF,¹⁶⁶ with most of the MHTF-related technical support provided directly from the Technical Division at UNFPA headquarters (see Box 30).¹⁶⁷ The high rating (see Box 30) of country office support from headquarters in these four technical areas are therefore linked to the additional staff resources the MHTF had provided for the Technical Division.

In 2008, UNFPA moved the geographical divisions that had technically supported country office operations from UNFPA headquarters to their respective regions. This process is often referred to as the regionalization of technical support. UNFPA strengthened already existing offices in the regions and established additional regional and sub-regional offices. The main aim of this reform was to strengthen the capacity of UNFPA country offices to provide integrated technical, programmatic and management support to programme countries. However, this regionalization so far has failed to improve the technical support to country offices in the majority of countries evaluated (see Box 31).¹⁶⁸

¹⁶⁶ See judgment criterion 11.3, Volume 2.

¹⁶⁷ See final report of the MHTF mid-term evaluation.

¹⁶⁸ See judgment criterion 11.3, Volume 2.

Box 30: Findings from online survey – support of country offices from UNFPA headquarters

Eighty nine per cent of country offices (49 out of the 55 surveyed) had received assistance from headquarters through e-mails, phone or Skype, in comparison to 82 per cent of country offices (45 out of 55) that had received the same kind of support from regional offices. Roughly 54 per cent thought that support from headquarters on obstetric fistula had been useful or very useful, in contrast to only 44 per cent that thought the same about obstetric fistula support from regional offices. Twenty seven out of 55 country offices thought that headquarters support on EmONC had been useful, compared to only 24 offices that thought the same for support in this area from regional offices.

Box 31: Findings from online survey – effect of regionalization on quality of technical support

Only 13 per cent of country offices that have experienced technical support under both models (from headquarters and regional) think that the regionalization of technical support has led to improved technical support. In the Johannesburg sub-region, 40 per cent of the countries found that the technical support has worsened; overall, 27 per cent of country offices think that the quality of technical support has declined. Twenty four per cent of country offices think quality of technical support has remained unchanged.

3.12 Evaluation question 12 - Visibility

EVALUATION QUESTION 12

To what extent has UNFPA maternal health support contributed to the visibility of UNFPA in global, regional and national maternal health initiatives and helped the organization to increase financial commitments to maternal health at national level?

► **Judgment criteria**

- 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

► **Evaluation criteria covered**

Visibility

Summary

UNFPA has been a visible advocate for maternal health issues at global and at country level. At the level of programme countries, the reputation of UNFPA was determined by the capacity of country offices to bring technical knowledge to bear in multilateral maternal health initiatives, such as the review of maternal health policies or the development of maternal health programmes. By supporting the development of maternal health policies and programmes, UNFPA also helped to leverage additional funds for maternal health support from governments in programme countries. Country offices that suffered from staffing shortages were less able to actively participate in maternal health coordination forums and technical working groups. In these cases, bigger and better-resourced development partners overshadowed the role of UNFPA in maternal health.

UNFPA has been a visible and well-recognized partner and leader of maternal health campaigns at global level and in its programme countries. Partners from government, civil society and the development community have overwhelmingly acknowledged the leadership role of UNFPA in Burkina Faso, Ethiopia, Ghana and Lao PDR. In other countries, UNFPA has been almost the sole provider of maternal health support, and in some instances continued, when other development partners discontinued their support (Madagascar, Sudan).¹⁶⁹

UNFPA has been able to establish itself as a maternal health leader and a respected partner in case study coun-

tries through the pro-active involvement of country office staff in technical working groups and other similar forums (Burkina Faso, Cambodia, Ethiopia and Lao PDR). Country offices have used their membership in these groups to provide data and other technical inputs to help in the drafting of maternal health-related strategies and in the planning and management of maternal health services (Burkina Faso, Cambodia, Ethiopia, Lao PDR and Madagascar).¹⁷⁰ The MHTF has helped increase UNFPA visibility in midwifery/ skilled birth attendance and EmONC (Burkina Faso, Cambodia, Ethiopia, Ghana, Madagascar and Zambia).¹⁷¹

Maternal health-specific advocacy campaigns, such as the Campaign on Accelerated Reduction of Maternal, Newborn and Child Mortality (CARMMA) or the International Day of the Midwife have added to the visibility of UNFPA. However, UNFPA partners criticized the low level of follow-up to the highly publicized CARMMA launches (Burkina Faso, Ethiopia, Ghana, Kenya, Madagascar and Zambia).¹⁷²

In two case study countries (Kenya, Zambia), UNFPA was overshadowed by larger and better-funded agencies, even in family planning which is a traditional core area of UNFPA. Staffing shortages had made it difficult for these country offices to actively contribute to donor coordination and policy dialogue forums. This had limited their opportunities to make technical contributions that could help launch maternal health-related policy initiatives. Partners in both countries regretted that UNFPA had not been playing a more pro-active role in maternal health.¹⁷³

Helping to draft and cost comprehensive maternal health strategies has allowed UNFPA country offices to help leverage resources from partner governments to improve maternal health (Burkina Faso, Lao PDR).¹⁷⁴ The development of high-profile maternal health strategies created political and social momentum in programme countries to expand maternal health support. This also motivated national governments to increase maternal health budget allocations (Burkina Faso, Lao PDR and Cambodia).¹⁷⁵

¹⁶⁹ See judgment criterion 12.2, Volume 2.

¹⁷⁰ See judgment criterion 12.2, Volume 2.

¹⁷¹ See judgment criterion 12.2, Volume 2; also see MHTF mid-term evaluation, final report ¹⁷² Judgment criterion 12.1, Volume 2.

¹⁷³ Feedback from development partners; see judgment criterion 12.2, Volume 2.

¹⁷⁴ Judgment criterion 12.3.

¹⁷⁵ Judgment criterion 12.3.

Conclusions

The maternal health situation in a given country is the outcome of complex interactions between a large number of stakeholders, policies and resources that reach beyond the immediate sphere of maternal and reproductive health.

Stakeholders, such as health ministries, local authorities and civil society organizations influence directly the availability of health services for women in need. Numerous other organizations and individuals, such as community and religious leaders, as well as government ministries in sectors other than health (e.g., transport, social affairs) also affect the possibility for women from different population groups to access maternal health services. Likewise, a *wide range of policies* and other strategic frameworks in a diversity of public policies and sectors influence both the availability of maternal health services and the possibility for women to access and use sexual and reproductive health services.

In fact, the availability and accessibility of quality reproductive health services is also determined *by numerous factors relating to issues which are outside of the reproductive health arena* (e.g.; transport, social security, gender relations etc.). *UNFPA country offices need to play an active role in navigating this complex environment.* To this aim, in UNFPA country offices, the staff participates in policy forums and donor coordination meetings with a view to ensuring that maternal health is anchored on the national policy agenda for health as well as for other sectors. Acknowledging the complex interplay of maternal health determinants, UNFPA staff also builds alliances with relevant partners within, as well as outside of, the sphere of reproductive health.

This evaluation has found that country offices are often struggling to fulfill this important and central role. This

is largely the consequence of insufficient human resources in country offices (*see Conclusion C4*) and gaps with regard to technical support (*see Conclusion C5*). This shortcoming is further aggravated by UNFPA weaknesses in terms of strategic planning (*see Conclusion C1*).

A – Facing a complex policy, institutional and stakeholder context with a weak multi-annual strategy

In country offices, short-term and “project-by-project” planning prevails over comprehensive, long-term strategic planning in the area of maternal health. Inadequate templates and procedures for project and strategic planning at country level make it challenging for country offices to develop multi-annual strategies (*see Conclusion C1*). Neither the *templates for country programme action plans (CPAP)* nor the *formats for annual work plans (AWP)* require a detailed multi-annual planning. The CPAP often list the objectives for the country programme period without exploring the details and logical coherence of the strategy to achieve them. As a result, none of the 10 country offices visited over the course of this evaluation had developed a detailed and explicitly documented multi-annual support strategy for maternal health focusing on the needs of the groups most vulnerable to poor maternal health (*see Conclusion C2*). Instead, *planning occurred exclusively on the basis of AWP*, whose format and limited scope make it difficult to develop comprehensive, long-term plans to guide maternal health support.¹⁷⁶

Confined to the reproductive health sphere. In the absence of appropriate strategic direction, many country offices focus their engagement and support of maternal health on the immediate national policy arena for reproductive health. UNFPA reproductive health

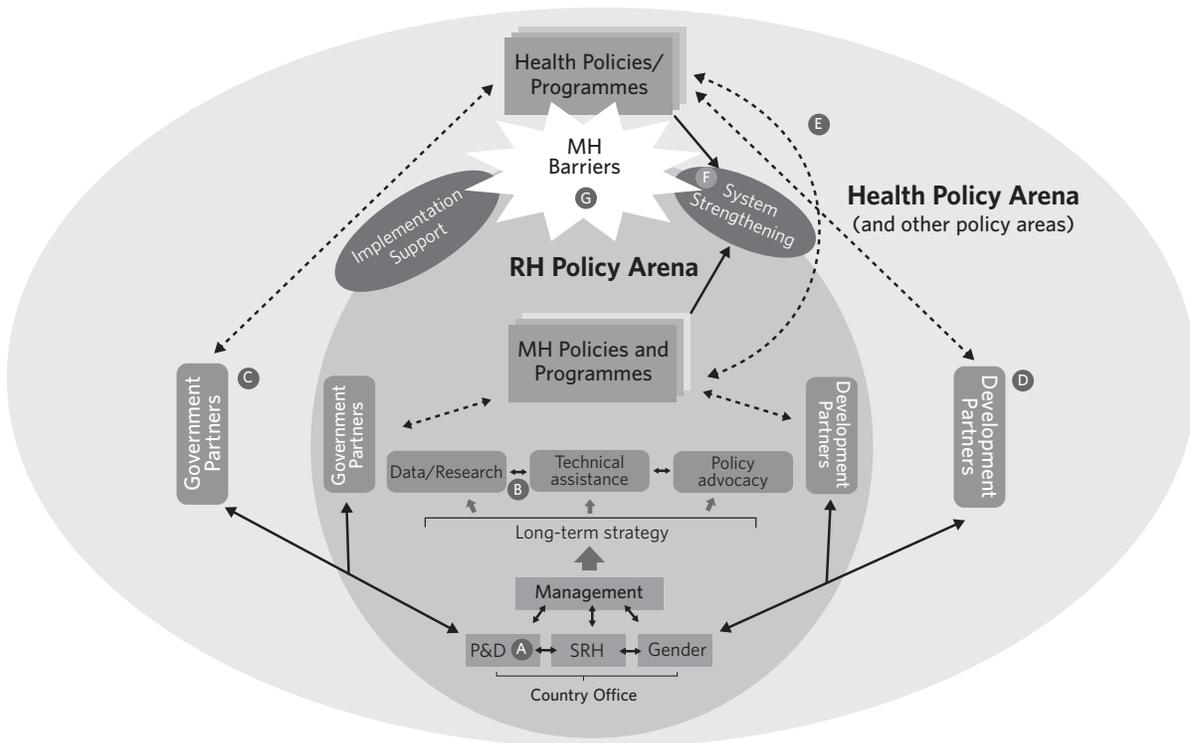
¹⁷⁶ See evaluation question 8 (evidence orientation).

B – A “multi-annual vision” to navigate the complex policy, institutional and stakeholder context

In a number of country offices, a “multi-annual vision” for maternal health support has been developed, albeit in a tacit and unwritten manner. Although such a vision cannot amount to a substitute for a clearly formulated multi-annual strategic plan for maternal health support, it has nonetheless allowed country offices to promote improvements and pursue reforms of the policy frameworks in EmONC, family planning or midwifery in a coherent and systematic manner over a number of years. This effort to adopt a more strategic approach has also led to an improved management of scarce internal resources and staff in country offices (see Conclusion C4) and helps in positioning the country office vis-à-vis its partners in maternal health and beyond.

Synergies. Adopting strategic foresight in planning maternal health support allows country offices to exploit synergies between the reproductive health sub-programme, the reproductive health thematic funds and the sub-programmes for gender and population and development (fig.4 – a). For example, having a longer-term perspective has encouraged reproductive health advisers and managers to plan the use of the resources from the population and development sub-programme to generate data on the maternal health situation. Country offices are then able to use this information to advocate for policy changes in EmONC, human resources for health and family planning, amongst other crucial areas. Those country offices also provided technical assistance to partner governments to implement corresponding studies, such as EmONC or midwifery assessments, thus linking these components strategically within a more

Figure 4: Guided by medium- to long-term strategy, country offices navigate the complex policy, institutional and stakeholder context of maternal health support



comprehensive and longer-term set of maternal health interventions (fig.4 – b).¹⁷⁷

Stable partnerships. The adoption of a “multi-annual” vision for supporting maternal health also leads to the establishment of stable partnerships with strategically important partner organizations. Country offices have built a certain amount of trust and credibility with important stakeholders in maternal health (maternal health centers, nursing councils, etc.) as well as with organizations in the wider health policy arena, both in government (such as HRH departments) and in the development community (fig.4 - c and d). These partnerships eventually proved to be important tools to link UNFPA maternal health support (such as the development of maternal health training policies and frameworks) to corresponding initiatives in the wider health policy arena (fig.4 - e). Those country offices which have developed these partnerships are more successful in affecting changes in policies for health-system-wide concerns, such as the deployment and retention of staff. They are also more effective in achieving the official endorsement of reproductive health policies in the context of a strengthened health system (fig.4 – f),¹⁷⁸ and, ultimately, can better address key maternal health barriers in the access to, and use of maternal health services (fig.4 - g).

Higher visibility. The synergetic use of scarce organizational resources coupled with the capacity to form stable partnerships with a wide range of organizations increases the visibility of UNFPA at country level. In particular, donors, non-governmental organizations and partner governments have acknowledged the contributions of country offices that used their ability to generate data and research to drive advocacy on EmONC or on the issue of pay and incentives for health workers.¹⁷⁹

The following sections present the conclusions of the evaluation.

4.1 Appropriateness of UNFPA maternal health strategy

CONCLUSION 1

UNFPA maternal health support in programme countries has not been sufficiently based on country-specific medium or long-term strategies

► **Origin:** Evaluation questions 1 (relevance); 3 (community & demand), 4 (HRH), 6 (family planning), 7 (EmONC), 8 (evidence), 9 (maternal health frameworks), 11 (headquarters, regional, country coherence)

► **Evaluation criteria:** Effectiveness, Sustainability

UNFPA support to maternal health has been more effective when country offices have based their interventions on a multi-annual strategic vision which served as a common framework for their individual interventions and annual work plans (AWP). However, current templates for strategic planning are not conducive to developing this kind of multi-annual vision. Neither the CPAP (nor the individual AWP) require country offices to develop and articulate a theory of change to achieve the higher level objectives. Furthermore, country offices are not required to elaborate a multi-annual operational plan for any of the interventions based upon the theory of change within the particular context of each programme country. This has weakened the long-term strategic orientation of maternal health support and has also affected the ability of UNFPA to adequately monitor and evaluate medium and long-term results of maternal health support (see Conclusion C7 for details).

Those country offices which have managed to develop their maternal health support within a medium- to long-term strategic vision have made more effective use of the organizational resources of UNFPA. The long-term vision allowed them to logically plan interventions such as data collection in one year, the dissemination of the collected information and associated policy advocacy in the following year and technical assistance for the

¹⁷⁷ See evaluation questions 4 (HRH), 6 (family planning), 7 (EmONC), 9 (policy frameworks).

¹⁷⁸ See in particular evaluation question 4 (HRH), but also evaluation questions 2 (harmonization) and 9 (policy frameworks).

¹⁷⁹ See evaluation questions 4 (HRH), 6 (family planning), 7 (EmONC), 9 (policy frameworks).

formulation of national maternal health initiatives in the subsequent years. On the contrary, those country offices which lacked a multi-annual perspective were more likely to manage individual interventions separately from each other. This silo approach provided fewer incentives for staff working on different interventions to coordinate their work and to pool financial and organizational resources from different funding sources, such as the different sub-programmes or the reproductive health thematic funds, such as the MHTF and the GPRHCS.

CONCLUSION 2

In its approach to support maternal health, UNFPA has not sufficiently responded to its mandate to focus on addressing the root causes of poor maternal health of the most vulnerable

► **Origin:** Evaluation questions 1 (relevance); 3 (community and demand), 4 (human resources for health), 6 (family planning), 7 (EmONC), 8 (evidence), 9 (maternal health frameworks), 11 (headquarters, regional, country coherence)

► **Evaluation criteria:** Relevance

UNFPA headquarters has not sufficiently defined the operational implications of focusing on the maternal health needs of the “most vulnerable”. As a result, country offices have had difficulties developing country-specific and detailed analyses of the important social, political, cultural and economic root causes of poor maternal health of vulnerable groups. Instead, country offices identified a list of vulnerable populations, such as the rural poor, migrant populations, youth. However, they did not sufficiently analyze and identify the particular risks and barriers that kept women and girls from these populations from accessing quality maternal health services.

Country offices commonly targeted geographical ‘pockets’ of high maternal mortality and large groups from the vulnerable populations. The systemic weaknesses of health systems, other social inequities responsible for lack of access, and other risk factors that made particular socio-economic groups in the country more vulnerable to poor maternal health were not adequately

addressed. Some country offices supported community empowerment to minimize some of these barriers. However, a more systematic approach requires a better understanding of the country-specific social, cultural and economic barriers faced by vulnerable populations. Studies to identify and examine access barriers were only rarely carried out.

CONCLUSION 3

UNFPA support to the provision of maternal health services at sub-national level has not consistently reflected the relative comparative strengths of UNFPA as a primarily knowledge- and evidence-based organization.

► **Origin:** Evaluation Questions 1 (relevance), 4 (HRH), 7 (EmONC), 8 (evidence), 12 (visibility)

► **Evaluation criteria:** Effectiveness, Efficiency

A significant portion of the relatively small budget of UNFPA for reproductive and maternal health support was allocated to interventions at sub-national level. UNFPA has worked directly with sub-national authorities to financially and technically support the delivery of maternal health services. In many countries, UNFPA established sub-national offices to support operations in provinces. At times, UNFPA was either the only, or one of very few organizations working on maternal health. In these cases, there was no alternative to the engagement of UNFPA in the provinces to secure the provision of maternal health services to beneficiaries.

In other countries, however, UNFPA was one of many organizations that offered support to maternal health. As an organization with a relatively small budget, but with a considerable access to maternal health know-how and technical expertise, UNFPA did not have a clear comparative advantage to engage in resource-intensive support of maternal health services at sub-national level in these situations.

Moreover, country offices have not consistently used their engagement at sub-national level to generate data and lessons to further the maternal health policy agenda at national level. While some country offices implemented

pilot interventions at sub-national level, weaknesses in the monitoring and evaluation system limited their opportunities to learn from these experiences. In other cases, country offices utilized UNFPA presence at sub-national level primarily as a means to support service delivery to beneficiaries without strengthening the capacity of UNFPA to generate and disseminate maternal health-related knowledge and expertise.

4.2 Role and capacity of UNFPA country offices

CONCLUSION 4

Insufficient staff capacity and gaps in the skills available in country offices have negatively affected the ability of UNFPA to act as brokers of maternal health-related expertise and to be a facilitator of national and international maternal health commitments and strategic partnerships.

► **Origin:** Evaluation questions 1 (relevance), 4 (human resources for health), 7 (EmONC), 8 (evidence), 9 (maternal health frameworks), 10 (reproductive health, population and development, gender), 11 (headquarters, regional, country coherence)

► **Evaluation criteria:** Efficiency, Effectiveness

The success of UNFPA maternal health interventions at country level depends to a large extent on the capacity of country offices to act as brokers of maternal health-related data and expertise and to mobilize resources from development partners and obtain financial commitments from governments. Managers and staff at country level are responsible for translating global UNFPA strategies into country-specific support strategies (see C1). They are called on to champion maternal health in national policy initiatives and in donor coordination forums. Reproductive health staff needs to be able to introduce novel approaches to support maternal health and also have to oversee the implementation of UNFPA-supported maternal health interventions. Finally, country offices also are required to pull together resources and technical support from a variety of different sources, such as core funds, reproductive health thematic funds and external sources.

Staffing constraints in country offices made it difficult for reproductive health teams to fulfill all the above tasks. Annual planning based on inadequate templates (AWP, CPAP; see C1), combined with limited experience and know-how in strategic planning prevented country offices from developing appropriate multi-annual strategies to support maternal health. The small number of reproductive health staff in country offices made it difficult for UNFPA to be present in relevant technical working group meetings or policy forums. Time constraints prevented reproductive health advisors from preparing technical inputs or from launching and pursuing innovative approaches to support maternal health.

CONCLUSION 5

Country offices have not received sufficient technical support from regional offices and headquarters to fulfill their central role delivering maternal health support

► **Origin:** Evaluation Questions 2 (harmonization), 8 (evidence), 11 (headquarters, regional, country coherence), 12 (visibility)

► **Evaluation criteria:** Effectiveness, Efficiency

For many of the themes and topics associated with maternal health, UNFPA country offices needed to rely on technical support from regional offices or from headquarters, either because the required expertise was not readily available at country level or because it would not have been cost-efficient to permanently employ the respective experts. In the areas of human resource development and training, country offices were faced with the challenge of linking the training of midwives and other health cadres to the resolution of related challenges, such as deficiencies in the deployment and retention of trained staff. As this is a relatively new field for UNFPA, staff at country level has relatively little experience in this regard.

However, for regional offices, the availability of technical support is limited in particular in technical fields like human resources for health, EmONC and midwifery, as well as for operational issues such as strategic planning, results-based management or monitoring and evalua-

tion. These gaps in technical support have affected the capacity of country offices to adequately plan, manage and monitor their own maternal health portfolio. They also negatively impacted on the role of UNFPA as broker of maternal health knowledge and expertise by reducing the opportunities to provide evidenced-based information to development and governmental partners.

In this context, the Maternal Health Thematic Fund has been a valuable instrument to make available additional resources for technical support on EmONC, midwifery and family planning (see C8 below).

4.3 Partnerships with donors, governments and other stakeholders

CONCLUSION 6

The varying capacity of country offices to establish and maintain partnerships with governmental organizations, donors and civil society in and outside of the reproductive health arena has influenced the ability of UNFPA to address service access barriers and other root causes of poor maternal health and to help strengthen the maternal health system in programme countries.

► **Origin:** Evaluation questions 1 (relevance), 4 (human resources for health), 7 (EmONC), 8 (evidence), 9 (maternal health frameworks), 10 (reproductive health, population and development, gender), 11 (headquarters, regional, country coherence)

► **Evaluation criteria:** Effectiveness, Sustainability

Well-established and long-term working partnerships at country, regional and global levels are an important asset for UNFPA. They allow the organization to extend its reach beyond the area of maternal health and to ensure the sustained improvement of maternal health outcomes. Such partnerships (e.g. with parliamentary associations and various departments in health ministries) have improved the capacity of country offices to advocate for policy initiatives (e.g., EmONC subsidies) with a view to removing or diminishing key access barriers preventing women from utilizing quality maternal health services.

Long-term partnerships with government organizations and donors also enable country offices to tie their support for developing national human resource capacity for maternal health to larger governmental efforts with a view to strengthening the national health systems. In particular, good relationships with HRH departments helped UNFPA to convince health ministries to address deficits in the deployment and retention of health staff.

Country offices have utilized the influence of their partners to solicit financial commitments for maternal health and to lobby for increases in the salaries of health and maternal health staff. Long-term partnerships have also allowed UNFPA to place specific maternal health-related topics (such as EmONC and midwifery) on the agenda of donor coordination meetings and other government-led policy forums. Finally, partnerships also enabled UNFPA to ensure that initiatives that had been spearheaded by UNFPA were subsequently implemented by government agencies, thus increasing the chances for their sustainability.

However, not all country offices were able to engage in the long-term process of forging and maintaining partnerships. To build strong partnerships, country offices need to repeatedly prove themselves over a number of years as reliable and valuable partners to gain the trust and collaboration of donors and government agencies. Successful partnerships also required the lead and consistent drive of country office representatives.

4.4 Use of Evidence and Monitoring and Evaluation

CONCLUSION 7

A lack of appropriate monitoring and evaluation mechanisms has affected the capacity of UNFPA to assess the results of maternal health support. The absence of a results-oriented monitoring, also negatively impact on the optimization of the corporate and country-level maternal health strategies over time.

- **Origin:** Evaluation questions 1 (relevance); 3 (community and demand), 4 (human resources for health), 6 (family planning), 7 (EmONC), 8 (evidence), 9 (maternal health frameworks), 11 (headquarters, regional, country coherence)
- Also see Mid-term Evaluation of the MHTF Conclusion 9
- **Evaluation criteria:** Efficiency, Effectiveness

UNFPA monitoring and evaluation system has not been effective at generating data on the results of maternal health support. Monitoring indicators focus primarily on UNFPA activities or outputs contained in country programme documents (CPD). However, these CPD outputs were typically formulated as outcomes and relate to higher level societal changes in the maternal health situation (such as “improve access to maternal health care”). This renders it impossible to draw a direct link from the CPD output indicators to the interventions supported by UNFPA.

As a result, country offices are largely unable to collect monitoring data on the progress of UNFPA-supported interventions. The information on the chain of effects linking UNFPA-supported activities to higher-level societal changes is therefore incomplete. As a result, monitoring data cannot provide information on the contribution of individual interventions (along the intended chain of effects) to improvements in maternal health in programme countries.

The weaknesses in the monitoring system mirror deficiencies in the system and procedures for strategic planning in country offices and in UNFPA overall (see Con-

clusion C1). As mentioned above, UNFPA annual work plans (AWP) merely present targets for individual activities which furthermore are loosely related to high level outputs from CPD. Indeed, neither the AWP, nor the Country Programme Action Plan (CPAP) and the CPD define a comprehensive *theory of change* for individual interventions (or groups of interventions) with a view to describing how these interventions are intended to affect change in the maternal health situation of the programme country. This leaves UNFPA staff without the necessary reference framework to develop a monitoring system that tracks changes along the presumed results chain. Consequently, UNFPA country offices lack the data to optimize and refine their approach to support maternal health over time. This shortcoming affected the work of UNFPA in EmONC, human resources for health, community empowerment, behaviour change communication, policy advocacy and family planning.

Finally, UNFPA implementing partners often do not have the required technical capacity and know-how to fulfill their monitoring-related responsibilities. Consequently, country offices have not been able to consistently support the development of M&E capacity among implementing partners.

4.5 Added value of UNFPA Maternal Health Thematic Fund

CONCLUSION 8

The Maternal Health Thematic Fund (MHTF) has helped to provide much needed financial and staff resources to UNFPA country offices and headquarters in the short and medium-term.

- **Origin:** Evaluation question 4 (human resources for health), 7 (EmONC), 11 (headquarters, regional, country coherence)
- Also see Mid-term Evaluation of the MHTF Conclusions 1, 2, 3 and 7
- **Evaluation criteria:** Efficiency and Sustainability

In important technical areas, such as EmONC, midwifery or obstetric fistula, the MHTF has provided

much needed funds, staff resources and technical guidance to country offices. The staff positions financed by the MHTF bolstered staff capacity in country offices and allowed them to intensify their engagement in areas like EmONC and midwifery. In addition, the MHTF partnerships with Averting Maternal Death and Disability (AMDD) and also with the International Confederation of Midwives (ICM) gave country offices access to additional technical support in key areas of the UNFPA maternal health portfolio. Overall, these additional resources have helped country offices and headquarters to launch a number of new initiatives in EmONC and midwifery and overall have contributed to reinforce interventions in maternal health. Finally, the MHTF has also helped raise the profile of UNFPA at country level and in global maternal health forums.

CONCLUSION 9

The MHTF has not been sufficiently integrated into the organizational structure of UNFPA and the overall planning process at country level to ensure sustainability of its interventions

- **Origin:** Evaluation Questions 1 (relevance), 2 (harmonization), 4 (HRH), 7 (EmONC), 11 (headquarters, regional, country coherence)
- Also see Mid-term Evaluation of the MHTF Conclusions 1, 2, 10, 11 and 12
- **Evaluation criteria:** Efficiency, Sustainability

The MHTF has helped country offices to provide a stronger support to EmONC and midwifery and to launch new initiatives in both areas. In particular it has proved instrumental in the conduct of EmONC assessments and midwifery needs assessments. Those assessments constitute the indispensable basis for governments to launch reforms of parts of their human resources for health (HRH) systems for nurses and midwives. Also, following the adoption of newly developed curricula, governments need to ensure the quality of trainings for nurses and midwives and also need to address other risk factors such as costs or other barriers that prevent women from using reproductive health services. Supporting these im-

portant reforms requires more resources and know-how which cannot be provided by the MHTF alone. Further support has to be supplied by UNFPA overall and by its development partners.

However, to date, the MHTF has not been sufficiently integrated into planning processes to ensure that country offices and regional offices mobilize the resources required to continue the initiatives that the MHTF has contributed to launching. For instance, the EmONC assessments are meant to trigger the development and implementation of national EmONC scale-up plans by governments. However, as MHTF support was provided outside of UNFPA technical support structures, regional offices have not yet provided the technical resources needed by country offices. Country offices also did not yet systematically plan for the mobilization of resources necessary for the continuation of MHTF initiatives.

Recommendations

The following sections present recommendations based on the conclusions developed above.

5.1 Reviewing UNFPA maternal health strategy and approach

RECOMMENDATION 1

UNFPA should revise its internal procedures, tools and templates for strategic planning. The new process should require country offices to develop maternal health support strategies for the medium to long-term, and to detail how resources from the different sub-programmes will be used to implement these strategies.

- ▶ **Priority:** Very High
- ▶ **Target level:** Programme Division
- ▶ **Based on conclusions:** C1, C7

OPERATIONAL IMPLICATIONS

- ▶ Revise country programme document (CPD) and country programme action plan (CPAP) templates to allow for the presentation of detailed analyses of the specific political, administrative, cultural and socio-economic challenges related to maternal health that need to be addressed in the four to five years covered by the programme.
- ▶ Require country offices to present in the CPAP a detailed description of the medium-term strategy and the human resources required to implement that strategy (see Recommendation R5)

- ▶ Replace intervention planning based on *annual work plans* with a system that requires multi-annual planning.
- ▶ The overall rationale and theory of change should be described in a comprehensive planning document that details the entire results chain for the intervention, following the results framework (inputs, activities, outputs, expected outcomes, and development results).
- ▶ In addition, the document will have to explain the risks and assumptions on which the intervention is based. The assumptions need to include a description of the support or cooperation the intervention will require from UNFPA partners.
- ▶ The planning document also needs to include a set of monitoring indicators for the different results levels that will become the basis for the monitoring system of the intervention. This information should be presented in a results framework.

RECOMMENDATION 2

UNFPA needs to better define the operational implications of the objective to target the needs of the “most vulnerable”. This concept is a relevant part of the UNFPA maternal health strategy, yet it is too vague in its current form to guide maternal health programming at country level.

- ▶ **Priority:** Very High
- ▶ **Target level:** Technical Division
- ▶ **Based on conclusions:** C2

OPERATIONAL IMPLICATIONS

- ▶ Conduct an internal assessment to analyze the concrete ways in which characteristics of health systems, social support structures, and socio-economic conditions determine and shape the vulnerability of specific population groups to maternal health threats and risks. The assessment needs to result in a concretely defined typology of barriers for different types of context and services that are common in UNFPA programme countries.
- ▶ Based on this assessment, prepare an operational and programming guide that explains how country offices need to translate the UNFPA mandate for working with the most vulnerable into specific country programmes and interventions. The guide needs to:
 - ▶ Offer a clear definition of maternal health vulnerability that explains: (a) what vulnerability is; (b) what types of risk factors create vulnerability to poor maternal health for different population groups; (c) what social, political and economic variables determine the level of risks these populations are exposed to and their ability to manage these risks;
 - ▶ Identify the policy sectors that are relevant to influencing the social, political and economic variables that determine the risk levels and risk management options of vulnerable populations (health policy, social policy, transport and infrastructure policy, economic policy);
 - ▶ Explain: (a) the main options for donors to influence the social, political and economic variables at the policy level and at community level; (b) the main options for UNFPA to contribute to a common response of development partners, based on its organizational comparative advantage (see Recommendation R3);
 - ▶ Discuss the use of partnerships with different organizations in the various policy sectors to address maternal health vulnerabilities.

RECOMMENDATION 3

When supporting maternal health service delivery at the national and sub-national levels, UNFPA needs to increase the focus on knowledge generation and learning, to ensure that the organization can make use of lessons from these interventions to inform evidence-based policy advocacy and other knowledge-based activities that are at the core of the UNFPA mandate.

- ▶ **Priority:** High
- ▶ **Target level:** Technical Division, Programme Division
- ▶ **Based on conclusions:** C3, C7

OPERATIONAL IMPLICATIONS

- ▶ Require country offices to specifically justify their intention to support maternal health service delivery at the sub-national level in country programme action plans (CPAP) and in the respective programme documents.
 - ▶ Country offices should be required to justify in both CPAP and planning documents why UNFPA should engage in the support of service delivery at sub-national level in each particular situation;
 - ▶ Country offices should demonstrate that no other development partners are able and/or available to provide the support of service delivery; or that UNFPA will use the experiences of work at sub-national level to generate lessons that can be used to shape the maternal health policy agenda at national level.
- ▶ Require country offices to present in planning documents (see above, Recommendation R1) on interventions implemented at sub-national level: (a) how these interventions will contribute to the body of knowledge and experience on maternal health in the programme country; (b) what activities the country office has foreseen to formulate and disseminate lessons learned on the basis of these interventions.

- ▶ Strengthen the UNFPA provisions for monitoring (see Recommendation R8 below) to ensure that country offices track progress, identify successes and failures and promote lessons from the interventions they support at sub-national level.
- ▶ Ensure that country offices collect, analyze and disseminate information from interventions, and notably pilot interventions, in support of maternal health service delivery on the ground. Responsibilities for ensuring appropriate knowledge management and utilization of lessons-learned from UNFPA activities should be reflected in the job descriptions of the relevant country office staff (including country representatives).

5.2 Improving the capacity of UNFPA country offices

RECOMMENDATION 4

UNFPA needs to better align the capacity and skill mix of staff and managers to ensure that country offices can fulfill their role as knowledge brokers and facilitators of evidence-based approaches to improve maternal health.

- ▶ **Priority:** Very High
- ▶ **Target level:** Division for Human Resources
- ▶ **Based on conclusions:** C1, C4, C7

OPERATIONAL IMPLICATIONS

- ▶ Require country offices to develop a resource plan as part of the country programme action plan (CPAP) (see Recommendation R1 above) to explain how staff time will be allocated to the different components of the strategy. The resource plans also should state which additional resources will be required to implement the strategy, and how these will be mobilized.
- ▶ Increase the focus of staff in country offices on health care issues related to policy and management. Emphasize professional development of staff in sexual

and reproductive health in disciplines like project management, strategic planning, monitoring and evaluation, public health, policy development, and policy advocacy.

- ▶ Ensure that job descriptions for country representatives appropriately emphasize their accountability for the strategic orientation and performance of country offices. In particular, the following responsibilities need to be stressed:
 - ▶ The development of multi-annual strategies in CPD and CPAP that reflect the organizational comparative advantages of UNFPA as a knowledge-based organization;
 - ▶ Positioning country offices to develop strategic partnerships with governments, development partners and civil society organizations to ensure sustainability of results.

- ▶ Offer seminars for professional exchanges between advisors in sexual and reproductive health.

RECOMMENDATION 5

The planning process for technical support elaborated at regional level needs to be better aligned with the long-term strategic and operational planning for maternal health support at country level (see Recommendation R1). Regional offices' planning processes need to address the current country-level programming needs and to anticipate the future support requirements of country offices.

- ▶ **Priority:** High
- ▶ **Target level:** Regional offices
- ▶ **Based on conclusions:** C4, C5

OPERATIONAL IMPLICATIONS

- ▶ As country offices develop more comprehensive and coherent long-term maternal health strategies (see

Recommendation R1), UNFPA needs to ensure that the corresponding requirements for technical support are well addressed by regional offices and become the basis for long-term strategic planning at regional level.

- ▶ Regional programme documents (RPD) and regional programme action plans (RPAP) need to be developed in joint planning sessions that bring together participants from country offices, headquarters (including from the reproductive health thematic funds, such as MHTE, GPRHCS) and regional office staff.
- ▶ In addition to the RPAP, regional offices need to develop a plan in coordination with UNFPA thematic funds and headquarters (Technical Division, Programme Division) to estimate the resources required to deliver the needed technical support, identify likely resource gaps and develop strategies (such as partnerships, raising of external funds) to close these gaps.
- ▶ Technical support priorities and related resource allocations as well as resource mobilization strategies should be reassessed annually (or bi-annually) as part of the periodic review of the RPAP. This assessment should be jointly conducted by the Technical Division (including MHTE, GPRHCS and other reproductive health thematic funds), the Programme Division, and selected country offices and regional offices.

5.3 Improving the guidance on UNFPA partnerships

RECOMMENDATION 6

UNFPA needs to anchor the concept of partnerships more firmly in strategic documents, operational guidelines and terms of references/job descriptions of management staff. Strategic documents need to explain why partnerships are an important operational and strategic component to ensure sustainable results for UNFPA maternal health support. Operational guidelines need to explain how country offices can foster different types of partnerships. UNFPA managers need to be responsible for setting up the required partnerships at country, regional and global levels.

- ▶ **Priority:** High
- ▶ **Target level:** Technical Division, Programme Division
- ▶ **Based on conclusions:** C1, C6

OPERATIONAL IMPLICATIONS

- ▶ Identify the significance of partnerships for implementing UNFPA programmes at country, regional and global levels, and how partnerships can help make programme effects sustainable.
- ▶ Prepare an assessment for the different technical areas (EmONC, human resources for health, midwifery) to analyze the inter-dependencies of poor maternal health outcomes and systemic weaknesses in national health systems and deficiencies in social support structures.
- ▶ Use the assessment to develop a typology of stakeholders who can help UNFPA address the identified deficits and root causes of poor maternal health in the context of the wider health system (e.g., human resources for health systems, local governance system, resource allocation systems, etc.).
- ▶ Strengthen the capacity of regional offices to support country offices in establishing partnerships.
 - ▶ Encourage regional offices to produce short-lists of organizations at regional level that are good candidates for UNFPA partnerships in different technical areas.
 - ▶ Develop training resources that regional offices can use to train staff in country offices in developing partnerships for EmONC, human resources for health and midwifery
- ▶ Ensure that the job descriptions of UNFPA country representatives, directors of regional offices and managers at headquarters emphasize their responsibility for developing partnerships. Consider “development of partnerships” as a criterion for staff performance assessment.

5.4 Improving UNFPA provisions for monitoring

RECOMMENDATION 7

UNFPA needs to strengthen result-oriented monitoring for country offices to measure results and not only activities and inputs. UNFPA also needs to assign greater responsibilities and offer more guidance to country offices for supporting the set-up of appropriate monitoring mechanisms with implementing partners.

- ▶ **Priority:** Very High
- ▶ **Target level:** Programme Division
- ▶ **Based on conclusions:** C1, C4, C5, C7

OPERATIONAL IMPLICATIONS

- ▶ Provide operational guidance for *results-oriented* monitoring to clarify that monitoring at output level is primarily tasked to collect data that can gauge the *contribution* of UNFPA support to higher level health outcomes (those outcomes identified in the CPD/CPAP).
- ▶ Develop a set of guidelines on results-oriented monitoring and related training resources that country offices can access and use in the development of monitoring mechanisms for their maternal health portfolio.
- ▶ Strengthen the responsibilities and capacities of country offices to support the set-up of appropriate monitoring mechanisms with implementing partners.
 - ▶ Ensure that monitoring staff at country offices receive formal training in monitoring;
 - ▶ Develop guidelines for M&E officers in country offices to communicate UNFPA monitoring requirements to implementing partners and to offer some technical guidance on monitoring.

5.5 Revise role and integration of the Maternal Health Thematic Fund in UNFPA

RECOMMENDATION 8

Strengthen the capacity of the MHTF as a catalytic tool to facilitate the implementation of evidence-based maternal health interventions in programme countries. Clarify in the MHTF Business Plan that the MHTF is not only responsible for launching initiatives (like those in EmONC and midwifery), but also for mobilizing required technical and financial resources (UNFPA-internal and from external sources) to support country offices and programme countries in following-through with these initiatives until their completion.

- ▶ **Priority:** Very High
- ▶ **Target level:** Technical Division
- ▶ **Based on conclusions:** C8, C9 of the MHTF mid-term evaluation

OPERATIONAL IMPLICATIONS

- ▶ Clarify the purpose of the MHTF (e.g., as described in the Business Plan). Stress that the MHTF is a tool that:
 - ▶ Helps the organization to launch and support evidence-based maternal health interventions in selected thematic areas (currently EmONC, midwifery);
 - ▶ Helps country offices to mobilize the technical support needed to assist partner governments to implement these initiatives at national level;
 - ▶ Is responsible for assessing the technical support needs of UNFPA to implement these initiatives.

- ▶ Update the guidance to country offices on the purpose and role of the MHTF to clarify:
 - ▶ What type of resources and support country offices can expect from the MHTF if they access MHTF funds and what type of support they cannot expect;
 - ▶ What are the responsibilities of country offices when working with MHTF funds, in particular: stress the catalytic nature of the MHTF and spell out the resulting responsibilities of the country office. Also highlight the shared responsibilities to mobilize resources with a view to ensuring that MHTF-funded initiatives (such as EmONC up-scaling) are pursued until completion.
- ▶ Harmonize MHTF planning with the (proposed) multi-annual planning approach for core funds (see Recommendation R1 above).
 - ▶ MHTF-financed interventions need to be reflected in the CPAP and also need to be based on multi-annual planning documents detailing: results chains, risks, assumptions.
 - ▶ Planning documents for MHTF interventions should also include a resource plan explaining what staff resources and technical support will be required to implement the MHTF-funded interventions.

RECOMMENDATION 9

UNFPA should use MHTF funds to carry out pilot interventions in programme countries on selected core maternal health issues, such as the development of appropriate support strategies to better target populations with high vulnerability to poor maternal health (also see Recommendation 2 above)

- ▶ **Priority:** Medium
- ▶ **Target level:** Technical Division
- ▶ **Based on conclusions:** C3, C8, C9

OPERATIONAL IMPLICATIONS

- ▶ Conduct an inventory of maternal health issues and topics that require pilot-testing (including in particular EmONC and midwifery);
- ▶ Prioritize issues and topics and invite country offices to submit proposals for pilot interventions;
- ▶ Ensure that country offices have access to the required resources and skills to appropriately monitor and evaluate the pilot interventions throughout their lifetime;
- ▶ Prepare activities to analyze and disseminate results from the pilot interventions.

Terms of Reference

1. About UNFPA

UNFPA, the United Nations Population Fund,¹⁸⁰ is one of the world's largest international sources of funding for population and reproductive health programmes. Since the Fund began operations in 1969, it has provided nearly USD 6 billion in assistance to developing countries. UNFPA is an international development agency that promotes the right of every woman, man and child to enjoy a life of health and equal opportunity. UNFPA supports countries in using population data for policies and programmes to reduce poverty and to ensure that every pregnancy is wanted, every birth is safe, every young person is free of HIV, and every girl and woman is treated with dignity and respect.

UNFPA works in partnership with governments, as well as with other agencies and civil society broadly, to advance its mission. Two frameworks serve to focus its efforts: The Programme of Action adopted at the International Conference on Population (ICPD) and Development and the Millennium Development Goals (MDG) which the international development community committed itself to six years later. Since the dates for achievement of these interconnected sets of goals and related targets are fast approaching, considerable work is being undertaken to analyze what has worked, as well as to galvanize support and a redoubling of efforts.

Under its second Goal ("Universal access to reproductive health by 2015 and universal access to comprehensive HIV prevention by 2010 for improved quality of life"), the *Strategic Plan (2008-11)* aims at strengthening

partner countries' health systems to meet sexual and reproductive health goals, especially with respect to lowering maternal mortality and morbidity rates. In 2008, UNFPA adopted the *Sexual and Reproductive Health Framework* which serves as the Fund's framework of action for the Strategic Plan. The SRH Framework advocates for the support of an integrated package of interventions in the area of reproductive health which includes maternal health. Acknowledging the inter-related needs that women experience throughout their life cycle, the Framework promotes the support of reproductive health services as a way to foster empowerment of women, gender equality, protection of human rights, health and well-being. This includes reduction of maternal mortality and morbidities, prevention of HIV and other sexually-transmitted diseases and the promotion of adolescent reproductive health.

The three core areas of work of UNFPA are reproductive health, gender equality and population and development strategies. These are inextricably related. Population dynamics, including growth rates, age structure, fertility and mortality, migration etc. influence every aspect of human, social and economic development. Reproductive health and women's empowerment powerfully affect, and are, in turn, affected by, population trends.

UNFPA supports programmes aiming at helping women, men and young people to:

- promote their reproductive rights
- plan their families and avoid unwanted pregnancies

¹⁸⁰ See <http://www.unfpa.org/public/home/about>

* The complete set of annexes to this reports are available in Volume 2.

- undergo pregnancy and childbirth safely
- avoid sexually transmitted infections - including HIV/AIDS
- combat violence against women.

Together, these elements protect reproductive rights understood as the right of all couples and individuals to decide freely about the number, spacing and timing of their children and to have the information and the means to do so. Reproductive health designates a state of complete physical, mental and social well being in all matters related to the reproductive system. It is recognized as a human right, as part of the right to health.

UNFPA also provides support to governments in the world's poorest countries, and in other countries in need, to formulate population policies and strategies in support of sustainable development. All UNFPA-funded programmes promote gender equality and the empowerment of women.

2. Mandate

Systematic and timely evaluation of expenditure programmes is a comprehensive function which incorporates accountability for, and oversight of the management of allocated funds. It is also an important tool to promote a lesson-learning culture throughout the organization.

The 2009 Evaluation Policy of UNFPA supports the organization's efforts to strengthen results-based management, as reinforced by the Strategic Plan (2008-2011). In this context, an evaluation to appraise the support of UNFPA and interventions in maternal health comes as an independent assessment of an area of crucial importance to UNFPA.

This evaluation was included in the 2010 Business Plan approved by the Executive Director on 22 January 2010. The planning of annual activities at the Division for Oversight Services (DOS) is based upon an internal risk assessment aiming at to identifying high risk areas/oper-

tions in the organization. The decision to undertake a maternal health thematic evaluation is based upon the results of DOS oversight engagements which, in the course of the past years, have repeatedly shown that, in many *high MMR countries*, Reproductive Health programming is insufficiently evidence-based. DOS evaluations have repetitively shown that COs RH portfolios tend to indicate an orientation towards a wide spectrum of activities rather than a focus on a limited set of proven interventions that have the potential to efficiently and effectively contribute to improve maternal health (reduction of maternal mortality and morbidity). As a result, this thematic evaluation shall be mainly focused on key elements of reproductive health including family planning, skilled birth attendance and emergency obstetric and newborn care (EmONC), within the context of the Sexual and reproductive Health Framework (2008) of UNFPA.

Concurrently, a mid-term evaluation of the Maternal Health Thematic Fund had also been planned by the Technical Division of UNFPA in view of assessing the design and implementation of the Fund. Given the potential complementarities and positive interconnections as well as risks of possible overlaps between the Maternal Health Thematic Fund mid-term evaluation and the thematic evaluation of the support of UNFPA in the area of maternal health, the Technical Division (TD) and the Division for Oversight Services have agreed to put in place single process in order to build upon the synergies of both exercises and make an optimal use of available resources. However, in order to reflect the evaluations' specificities (notably in terms of audience) the evaluations have clearly delineated scopes and shall lead to separate final reports (see sections 4 and 9 below)

3. Background

Maternal mortality represents the greatest health inequity in the world. No other health indicator as starkly illustrates global disparities in human development. Each year more than 350,000 women die during pregnancy or childbirth.¹⁸¹ Half of the maternal deaths that occur each year are in Africa – a continent which represents 11 per cent of the world's population and six countries (India, Nigeria,

¹⁸¹ The most recent assessment of maternal mortality, which was jointly sponsored by WHO, UNICEF, UNFPA, and the World Bank, reported 573,300 maternal deaths globally in 1990, and 535,000 in 2005 (a 0.48% yearly rate of decline).

Pakistan, Afghanistan, Ethiopia and the Democratic Republic of Congo) account for over half of maternal deaths.

The reduction of maternal mortality¹⁸² is a key feature in human, social and economic development. It is linked to improvements in health – including of the newborns, to the reduction of the gender divide and it also contributes towards poverty reduction. The improvement of maternal health was adopted as one of the eight Millennium Development Goals back in 2000.

Goal 5: Improve maternal health:

Target 5a: Reduce by three quarters the maternal mortality ratio

- 5.1 Maternal mortality ratio
- 5.2 Proportion of births attended by skilled health personnel

Target 5b: Achieve, by 2015, universal access to reproductive health

- 5.3 Contraceptive prevalence rate
- 5.4 Adolescent birth rate
- 5.5 Antenatal care coverage (at least one visit and at least four visits)
- 5.6 Unmet need for family planning

Though maternal mortality and morbidity continue to be a major health problem in many parts of the world, notable progress has been achieved in over 100 countries. Furthermore, recent analyses provide new and encouraging estimates indicating that in 2008 maternal deaths had fallen to 358,900. The vast majority of maternal and newborn deaths can be prevented with proven and highly cost-effective interventions. Progress in the countries that have managed to reduce maternal mortality by half in less than 10 years has led indeed to a growing consensus in the global health community on three sets of interventions most effective in reducing maternal mortality and morbidity: (1) universal access to family planning; (2) a skilled health professional present at every delivery; and (3) access to emergency obstetric and newborn care, when needed; recent research also shows the connection with HIV and maternal deaths.¹⁸³ Reducing maternal

mortality also calls on interventions in other areas than the health sector, in particular in view of eliminating child marriage, retaining girls in school and providing comprehensive sexuality education.

To this date, the two MDG 5 targets of: reducing maternal mortality by 75% and achieving universal access to reproductive health by 2015 have shown limited progress and have been unequal. Between 1990 and 2005, Asia experienced a 20 per cent reduction in MMR. During the same time period, MMR in sub-Saharan Africa decreased by a mere two per cent. Globally, the rate of death from pregnancy and childbirth declined between 1990 and 2005 by only 1% per year. In order to get back on track toward achieving MDG 5, it is estimated that a 5.5% annual rate of decline is needed from 2005 to 2015. Increase in proportion of births attended by skilled health personnel has been slow. Globally, the proportion of births attended by skilled health personnel has increased from 62% during the 1990s to 66% during 2000–2008, with virtually no progress over the last decade in Africa (WHO); caesarean section rates have also remained low. Furthermore, access to and utilization of family planning services have remained insufficient as illustrated by the high adolescent birth rate and low contraceptive prevalence rates (CPR) in many countries of the continent especially West and Central Africa. The adolescent fertility rate¹⁸⁴ is highest in the Africa (118 per 1000) and particularly in low-income countries (110 per 1000) as compared with a global average of 47 per 1000 over the period 2000–2008. Furthermore, it must be noted that the average CPR is less than 24% in Africa over 2000-2008).¹⁸⁵

In 2008, UNFPA also launched the *Maternal Health Thematic Fund (MHTF)*. This new initiative was meant to provide support to countries with a high burden of maternal mortality in order to scale up the *proven interventions needed* to save women and newborns as well as promoting reproductive health. In synergy with the Global Programme on Reproductive Health Commodity Security (GPRHCS), MHTF provides support to strengthen national health systems through technical expertise and financial resources to address bottlenecks of progress in maternal health.

¹⁸² Maternal mortality is defined as the death of women during pregnancy, childbirth, or in the 42 days after the end of pregnancy.

¹⁸³ Indicating that in the absence of HIV, there would have been 281000 maternal deaths worldwide in 2008, *ibidem*.

¹⁸⁴ Births per 1000 women aged 15-19 years.

¹⁸⁵ Given the numerous indicators associated with the improvement of maternal health, it will be an important task for the evaluation team to collect and analyze process indicators that can be used directly to answer the evaluation questions; in particular the process of data collection (Desk and Field phases - see section 5 below) shall be focused on the evaluation questions retained for the evaluation (see section 6 below).

The MHTF is intended to:

- 1) Be strategic in the sense that it should address priority bottlenecks that are hampering progress in maternal health and health systems strengthening at the country level;
- 2) Be catalytic in the sense of boosting ongoing country office efforts aimed at strengthening national capacity to advance towards universal access to adequate and quality maternal health care in the context of reproductive health and the integrated package of services;
- 3) Be catalytic in the sense of leveraging global, regional and national awareness/ focus/resources on the subject and foster further commitment and action;
- 4) Make additional financial resources available to priority countries, (i.e., those showing the least progress on Millennium Development Goal 5) to facilitate and accelerate points 1 and 2.

The priority areas of the Maternal Health Thematic Fund are:

- **Family Planning**

Ensuring that all pregnancies are wanted: complementarily with the GPRHCS, to address policies for access and uptake of family planning (service delivery), supply-side interventions (commodities), capacity building related to logistics and procurement, and demand generation interventions.

- **Human resources for maternal and newborn health**

Skilled care during pregnancy, at delivery, and in the post-partum period—particularly through strengthening of midwifery (including family planning and HIV prevention).

- **Access and uptake of Emergency Obstetric and Newborn Care**

In partnership with UNICEF and AMDD, support through the emergency obstetric and newborn care needs assessments the availability of strategic information to governments and partners for advocacy, planning, scaling up of EmONC services, and monitoring of progress.

- **Addressing Maternal Morbidity – The Campaign to End Fistula**

Scale up of prevention, treatment and social reintegration of fistula patients

4. Purpose and Scope of the Evaluation

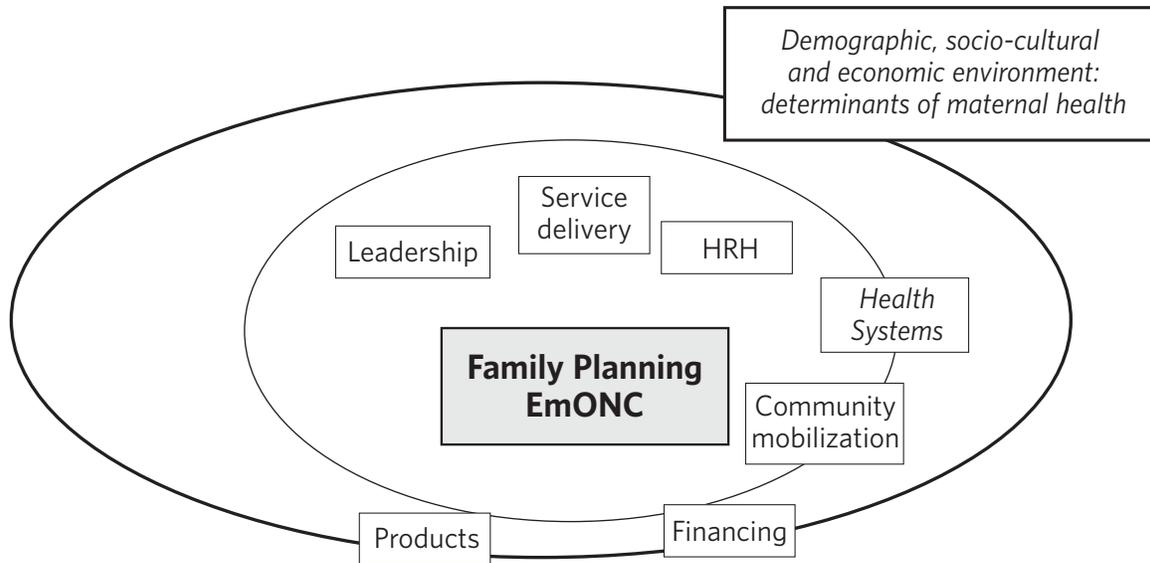
The purpose of the evaluation is twofold:

A. The maternal health thematic evaluation will assess to what extent the overall assistance of UNFPA— i.e.; the support of UNFPA 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 *in the last 10 years*.

Improving of maternal health is at the confluence of many determinants belonging to both national health systems as well as the overall demographic, socio-cultural as well as economic environment (population and economic growth, girls and women status, literacy and education, good governance etc.)

The scope of the maternal health thematic evaluation covers all programmatic interventions directly relevant to mortality and morbidity within the mandate of UNFPA, and covers all relevant activities financed from core and non-core resources as well as resources provided through the reproductive health thematic funds of UNFPA (Maternal Health Thematic Fund, the Global Programme to enhance Reproductive Health Commodity Security, the joint UNFPA-UNICEF FGM Programme) as well as other funds provided by the Global and Regional Programme - GRP). As a result, the maternal health thematic evaluation shall be inclusive of the following initiatives and instruments of UNFPA:

- The core funding and other co-financing mechanisms contribute to all 3 pillars to reduce maternal mortality and morbidity. In the 145 UNFPA programme countries, the core resources represent the large majority of country programme funding.
- The Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS) which (i) provides RH commodities (procurements, product



and technologies for family planning, condom programming and obstetric care); (ii) strengthens health information management system (HIMS for forecasting and logistics); and (iii) builds governments' capacities. Therefore, the GPRHCS improves access and uptake of family planning (considered as the first pillar of reducing maternal mortality and morbidity). It must be noted that a mid-term evaluation of the *Global Programme to Enhance Reproductive Health Commodity Security* is currently on-going. The present evaluation will foster synergies with the GPRHCS evaluation so as not to duplicate effort.

- The MHTF addresses mainly EmONC, fistula and human resources for health – in particular: midwifery (as the other two pillars for reducing maternal mortality and morbidity).
- The Joint UNICEF-UNFPA Programme on Female Genital Mutilation/Cutting (FGM/C) addresses mainly social change, legal aspects and community mobilization.
- The core funding and other co-financing mechanisms contribute to all 3 pillars to reduce maternal mortality and morbidity

B. The evaluation will also review the design, coordination, and added value of the Maternal Health The-

matic Fund as a targeted effort to improve maternal health since the start of its country support in the fall of 2008.

The scope of the MHTF mid-term evaluation covers the programmatic directions including the assumptions, design and early choices (as per the MHTF Business Plan) at national, regional and global levels. The scope also covers the internal coordination and management mechanisms (including technical capacities at the three above-mentioned levels), the effectiveness (performance of the contribution), efficiency and sustainability of the technical and financial support. The evaluation will assess the complementarities internally with the other reproductive health thematic fund (the Global Programme to Enhance Reproductive Health Commodity Security within UNFPA) as well as externally in the context of H4+ (UNFPA, UNICEF, WHO, the World Bank and UNAIDS) support to priority countries. The evaluation will thus help improve the management of the thematic fund at the Technical Division, Internal and External Relations Division (IERD) levels, and UNFPA country and regional offices levels.

More specifically, the objectives of the mid-term evaluation of the MHTF are:

√ to assess the strategic, synergistic and catalytic nature of the interventions supported by the fund, specifically

how effectively countries and regions integrate the MHTF-supported programmes within regular country and regional programmes;

- ✓ to assess the programmatic and geographic focus (priority countries);
- ✓ to assess the effectiveness (performance) of MHTF contributions and achievements towards maternal health in supported countries;
- ✓ to assess the effectiveness in increasing UNFPA and country capacity to effectively support the delivery of interventions in the area of maternal health;
- ✓ to assess the efficiency and sustainability of the support;
- ✓ to assess the internal coordination and management mechanisms (identify strengths and weaknesses in the structure, coordination mechanisms and the management of the MHTF);
- ✓ to suggest evidence-based informed amendments to the MHTF outputs and results framework that can be implemented for the remaining duration of the MHTF.

The evaluation should also assess the coordination and complementarity of interventions with other donors and agencies, notably in view of the 2008 *Joint Statement on Accelerating Efforts to save the life of women and Newborns and Joint Country Support for accelerated implementation of maternal and newborn continuum of care* (WHO, UNICEF, UNFPA, World Bank and, since 2010, UNAIDS). The five agencies (referred to as “the Health 4+”) aim at enhancing their support to the 25 countries with the highest maternal mortality rates.¹⁸⁶

The contribution of UNFPA to the Campaign to End Fistula having been recently the subject of an in-depth evaluation¹⁸⁷, the obstetric fistula components of the

MHTF will not be studied in details in the course of the present evaluation.

The evaluation’s findings and recommendations should inform policy decision-making and project management purposes as well as how to strengthen existing partnerships. The main users of the evaluation should be UNFPA country and regional offices, UNFPA Programme and Technical Divisions, including the Maternal Health Thematic Fund staff. The evaluation should also generate results of interest to a broader audience, including governments of partner countries, UNFPA member states including donors, civil society and others.

The evaluation will include a comprehensive desk phase followed by country case studies to be carried out in a *maximum of 12* different partner countries. Country case studies will be identified during the desk phase. The evaluators shall identify and formulate in-depth questions and test hypotheses for country case studies, allowing addressing the issues of relevance, effectiveness, efficiency, results and sustainability of UNFPA support to maternal health.

The evaluation shall cover aid implementation during the Period 2006-2010. The specific mid-term evaluation of the Maternal Health Thematic Trust Fund (MHTF) will cover the period 2008-2010.

The evaluation should come to country-specific as well as to general overall judgments of the extent to which the strategies of UNFPA as programmed by and implemented under the management of country offices, have contributed towards the achievements of the objectives and intended impacts in terms of improving maternal health, based on the answers to the agreed evaluation questions.

The evaluation shall lead to conclusions based on objectives, credible, reliable and valid findings and provide UNFPA with a set of operational and useful recommendations.

¹⁸⁶ The evaluators shall take note of the fact that in September 2010, the UN Secretary General launched an Initiative on women’s and children’s health.

¹⁸⁷ Two volumes available at: http://www.endfistula.org/UNFPA_Fistula_Evaluation_VOL%20I.pdf and http://www.endfistula.org/UNFPA_Fistula_Evaluation_VOL_II.pdf

5. Methodology and Approach

Sampling Approach

The Thematic evaluation will focus on a sample of 12 (maximum) countries. The criteria for the selection of the countries will be proposed by evaluators, presented to and validated by the Reference Group.

The sample should include both countries that substantially reduced their MMR as well as countries that have not significantly progressed on their MMR (>300 per 100,000 is considered high MMR) in the course of the past 20 years and are recipients of core and thematic funds. This combination could provide interesting insights into bottlenecks and main constraints as well as the identification of lessons learned and evidences to improve maternal health. The selection of countries should also be based on their comparability in terms of population size, poverty level, education level, economy, political stability, other funding mechanism (and in particular that of GPRHCS) and other relevant drivers in terms of maternal health/mortality. The sample should also be inclusive of countries that have benefited from the MHTF and some that have not. Finally, the countries retained should also be reflective of the geographical distribution of the support of UNFPA and the relative acuity of maternal health in those regions (ARO, APRO, ASRO, LACRO).

The evaluation approach should encompass the following fundamental tasks:

(i) Identify and explain the selected CO objectives in the field of maternal health, their logic and coherence, their *relevance* both to UNFPA objectives (in particular as formulated in the SRH Framework and MHTF's Business Plan) and to the needs of recipient countries, the intended results corresponding to each objective, and finally how these intended results fit within the overall objective of improving maternal health.

(ii) Assess *effectiveness* in terms of how far the intended results were achieved and also - to the extent that the interventions were effective - their efficiency in terms of how far funding, staff, regulatory, administrative, time and other resource considerations contributed to, or hindered the achievement of results.

(iii) Consider the *sustainability* of maternal health related activities in the context of sexual and reproductive health;

that is an assessment taking into account, in particular, the institutional capacity required to maintain results.

(iv) Keeping in mind that MHTF is only one additional source of resources (financial and technical expertise) for “priority country offices” to improve maternal health, the evaluators should adopt a comparative approach between recipient and non-recipient countries of MHTF funds so as to identify MHTF's potential added value.

Evaluation Phases

The Evaluation shall consist of 5 phases, subdivided in subsequent methodological stages (phases for which consultants' contribution is requested are marked in grey) and related deliverables.

Evaluation Phases	Methodological Stages	Deliverables
1. Preparation Phase (DOS/TD)	- preparation of ToR - Constitution of the reference Group	- Final ToR - Interoffice memorandum
2. Desk Phase 3. Field Phase 4. Reporting Phase	- Structuring of the evaluation - Data collection, verification of hypotheses - Analysis - Judgments on findings - recommendations	- One Inception report - One Desk Phase report - Two Final reports
5. Feedback and Dissemination	- management response - Dissemination activities	

5.1. Preparation Phase

Following their finalization by the evaluation managers (Evaluation Branch/DOS and MHTF/SRHB/TD), the present *Terms of References* (ToR) will be sent by DOS to PSB. PSB will prepare the standard International Competitive Bidding (ICB) document based upon the present ToR. The ICB will be posted in UNGM website and will also be circulated among recommended consultants identified by DOS. The ICB will keep open 21 days for prospective bidders.

The bidder should come with two kinds of proposals: technical and financial.

✓ the technical part of the bid: should contain at least: (i) the bidder's understanding of the ToR, (ii) the proposed composition of the core evaluation team with individuals' curriculum vitae and (iii) the proposed work plan. This proposal will be evaluated by the Evaluation Branch/DOS based on technical evaluation criteria.

✓ the financial proposal: the evaluation of the financial proposal will be performed by PSB.

The evaluation managers identify the persons to be invited to participate in the Reference Group (RG), which will ensure that the expertise of UNFPA on maternal health is fully utilized and all the relevant information is provided to the evaluators. The Reference Group shall consist of a maximum of 8 members and will provide balance expertise in maternal health/reproductive health as well as in evaluation.

5.2. Desk Phase

5.2.1 One Inception report

Following the selection of consultants, the work will proceed to the *structuring stage* which shall lead to the production of an *Inception Report*.

The Inception report will:

- ✓ Contain an analysis of all relevant key documents;
- ✓ Propose a set of criteria for selection of country studies. Based on these criteria, the evaluators should justify the choice of several *representative country case studies* to be examined in detail during the desk phase. The specific aspects of the situation as regards MMR and CO programmes for each selected country are to be highlighted;
- ✓ Specify the *methodological* tools that will be used;
- ✓ Present a two preliminary sets of evaluation questions (see section 6 below);

✓ Present a detailed *work plan*, specifying the organization and time schedule for the evaluation process.

The Contractor will present the *Inception Report* which shall be formally approved by the Evaluation Branch/DOS. The Reference Group will comment on the *Inception Report* and validate the evaluation questions and the proposed country case studies.

5.2.2 One Desk report

Upon approval of the *Inception Report*, the team of consultants will proceed to the Desk Phase of the evaluation. The desk phase shall be the moment when relevant information (in Headquarters as well as from country offices and regional offices – based upon the identified country case studies) is gathered and analyzed.

The desk phase reports take up the points dealt with in the Inception Report and goes into as much detail as necessary. In this stage, consultants are asked to:

- ✓ Present 2 *final sets of evaluation questions* along with appropriate judgment criteria and relevant quantitative and qualitative indicators;
- ✓ Present a *set of selected case studies*, the selection criteria applied and the relevant identified questions, judgment criteria and indicators;
- ✓ Present the *methodology for data and information collection and validation*, both for the desk phase and for the forthcoming field phase.
- ✓ Present the *methods of analysis* of the information and data collected in order to draw findings that would enable to draw general conclusions; due to the difficulty of this exercise any limitation should be made explicit;
- ✓ Present the preliminary findings responding to the evaluation questions and the first hypotheses to be tested in the field based.

At the completion of this work, the evaluation team will present one Desk Phase Report setting out the results of this first phase of the evaluation including all the above

listed tasks (the core part of the Inception Report will be annexed to the Desk Phase Report).

The RG will comment on the *Desk Phase Report* based on which the necessary amendments will be specified. The Evaluation Branch/DOS formally approves this report.

The country offices in countries selected for the field mission will be informed through a formal announcement letter from DOS.

5.3. Field Phase

Following satisfactory completion of the desk phase, the evaluation team will proceed to the field missions.

Prior to completion of each country visit the evaluation team shall prepare for the CO a debriefing presentation of the field mission results, seeking to validate the data and the gathered information.

For each country case study and following completion of the field mission, the team will proceed to prepare *case study notes* to be submitted to the Evaluation Branch at DOS within ten working days after returning from the field (see Annex 1 for an outline structure of the country reports). DOS will share the case study notes with the evaluation manager at MHTF/TD.

These notes will be annexed to the two *Final Reports*. When all field missions are conducted, and before the start of the reporting phase, the evaluation team shall present results of the field phase in a form of detailed debriefing for the Reference Group.

5.4. Reporting phase

Following the formal approval of the *Desk Phase Report* by the Evaluation Branch/DOS and SRHB/TD, the evaluators will submit two *Draft Final Reports corresponding to (1) the maternal health thematic evaluation and (2) the MHTF mid-term evaluation*.

The *Draft Final Reports* will follow the structure set out in Annex 2, taking due account of comments received during de-briefings in country offices and meetings with the Reference Group.

Each *Draft Final Report for the (1) maternal health thematic evaluation and (2) the MHTF mid-term evaluation* shall include the answers to the evaluation questions identified (inception report) and agreed upon (desk phase report) for each exercise. The *Draft Final Reports* shall also present a synthesis of the main conclusions of the evaluations.

The evaluation managers will verify the quality of the submitted draft reports. If the quality of the draft reports is acceptable, the managers circulate it to the Reference Group members for comments. The reports will then be discussed in the last RG meeting with the evaluation team.

On the basis of the comments expressed by UNFPA services (Evaluation Branch/DOS, RG members, country offices, regional offices) the evaluation team shall make appropriate amendments and submit the *Final Report*. If comments are rejected by the evaluation team, evaluators shall explain reasons in writing.

The *Final Reports* should clearly account for the observations and evidences on which findings are made so as to support the reliability and validity of the evaluation. The reports should reflect a rigorous, methodical and thoughtful approach. Conclusions and recommendations shall build upon findings.

Recommendations must be:

- Linked to the conclusions
- Clustered, prioritized and targeted at specific addressees
- Accompanied by a timing for implementation
- Useful and operational
- If possible, presented as options associated with benefits and risks.

The final version of the *Final Reports* shall be presented in a way that enables publication without need for any further editing. The *Final Reports (like previous Inception and Draft Reports)* shall be written in English and submitted to DOS in a timely manner (see calendar below).

The Final Reports will be formally approved by the Directors of DOS and TD.

5.5. Dissemination and follow-up

Following the approval of the Final Reports, reception of the management response, the evaluation managers will proceed to dissemination of the results (conclusions and recommendations) of the evaluation reports.

The evaluators may be required to assist in dissemination and follow-up activities. For instance, in coordination with Evaluation Branch/DOS and MHTF/SRHB/TD, they may be invited to present the conclusions and recommendations during a seminar.

6. Identification of the Evaluation Question/Issues

The evaluation will be based on 2 sets of key evaluation questions which are intended to give a more precise and accessible form to the OECD/DAC evaluation criteria and to articulate the key areas of interest of UNFPA services, thus optimizing the focus and utility of the evaluation.

Evaluators will identify the evaluation questions building upon the purpose and scope of the evaluation as specified under Section 3 above. The evaluation questions should also reflect particular interests from UNFPA services represented in the Reference Group.

The evaluators will propose 2 distinct sets of evaluation questions each being specifically tailored for (1) the MHTF mid-term evaluation and (2) the maternal health thematic evaluation. It is however expected that the questions proposed for the thematic evaluation (broader in scope) will build on, as well as include a number of questions formulated for the MHTF mid-term evaluation.

The following main topics/issues are of interest to DOS/TD:

- (1) The CO portfolio of maternal health activities (as part of RH) and the extent to which these are the result of an evidence-based programming and build upon proven interventions (SBA, EmONC, FP) to effectively reduce maternal death.

- (2) The status of demographic and maternal health information (incl. SBA, EmONC and FP) in Country and the role of CO to increase availability and reliability of data.
- (3) The role of UNFPA in ensuring that maternal health related interventions are given priority in national health plans.
- (4) The alignment of the national priorities/commitment – e.g.; as expressed by budget allocations for maternal health – with the above-mentioned triptych of proven interventions.
- (5) The synergies and coherence between CO activities developed under the RH component and activities programmed within the other mandate areas of UNFPA, notably data for development, gender equality (incl. violence against women), and the activities in the adolescent and youth sector.
- (6) The contribution of regional offices (and prior to ROs, the country support teams in regions) and regional programmes to country programmes in maternal health.
- (7) The contribution of the Global Programme (beyond the thematic fund) to maternal health.
- (8) The global leadership of UNFPA on maternal health (integrally and in specific areas).
- (9) Co-ordination, complementarity and synergies with other UN Agencies as well as bilateral and multilateral donors to effectively contribute to improve maternal health in the context of H4+.
- (10) CO monitoring and evaluation mechanisms to assess progress on results achieved and inform an evidence-based approach to programming in the area of maternal health.

More specifically, for the Maternal Health Thematic Fund mid-term evaluation it is expected that the following topics will be addressed:

- (11) The contribution of the MHTF to strengthening country office capacity for positioning maternal health and related interventions in policies and strategies at country level.
- (12) The contribution of the MHTF to enhance human resources for maternal and newborn health and particularly midwifery – e.g.;
 - Upgraded midwifery education and training programs with curricula based on the ICM essential competencies for basic midwifery practice.
 - Increased number of midwifery associations with capacity to advocate for and implement the scaling up of midwifery services in country.
 - In country policies, regulatory standards and monitoring systems that maintain quality of midwifery services in place.
 - Increased support at global and regional levels for midwifery as a key health workforce for the achievement of MDGs 4 and 5, and advocacy to this end.
- (13) The contribution of the MHTF to the availability of strategic information to governments and partners for advocacy, planning, scaling up of EmONC services, and monitoring of progress.
- (14) The contribution of the MHTF to advancing the monitoring and evaluation for maternal and newborn health programmes in priority countries.
- (15) Synergies and cooperation of the MHTF with the GPRHCS, HIV/AIDS as well as FMG/C programmes.
- (16) The role of MHTF in humanitarian settings.
- (17) Partnership Building: effectiveness of the coordination among partners at the global and regional level; role played by MHTF to enhance the leadership of UNFPA in the H4+.
- (18) The internal coordination and management of the MHTF: its effectiveness; analysis of current bottlenecks and ways to overcome these.

7. Management and Supervision of the Evaluation

The responsibility for the management and supervision of the evaluation will rest with the Evaluation Branch at the Division for Oversight Services in collaboration with MHTF/TD.

The progress of the evaluation will be followed closely by the Reference Group (RG) consisting of members of UNFPA services who are directly interested in the results of this thematic evaluation.

The principal function of the Reference Group is to follow the evaluation process and more specifically:

- to act as the interface between the consultants and the UNFPA services (in headquarters, regional and country offices) in particular to facilitate access to information and documentation;
- to advise on the quality of the work of the consultants;
- to facilitate and assist in feedback of the findings and recommendations from the evaluation.

Several Reference Group meetings (about 4/5) will take place during the process of the evaluation, as indicated below in the time schedule (see section 8)

8. Evaluation Team

This evaluation is to be carried out by a team with advanced knowledge and experience in development co-operation. Special expertise will be required concerning support in reproductive health and maternal health, particularly expertise in country health systems, midwifery, as well as UN process indicators assessment will be required.

Previous experience of conducting evaluations for international organizations (notably with the UN) will be considered as an asset.

The team leader must have a proven experience in evaluation methodology. Consultants should possess an appropriate training and documented experience in conducting evaluations as well as applying evaluation methods in field situations.

The team should comprise a reasonable mix of consultants familiar with the different regions of interest to UNFPA. The team must be prepared to work in English and possess excellent drafting skills. Knowledge of French and Spanish, in particular for the field phase, is required. The Evaluation Branch at DOS recommends strongly that consultants from beneficiary countries will be employed (particularly, but not only, during the field phase).

The team-leader shall have considerable experience in managing evaluations of a similar size and character. In addition, each country team should be led by an experienced member of the team (or directly by the team leader).

The agreed team composition may be subsequently adjusted if necessary in the light of the final evaluation questions and selected countries for the field phase once they have been validated by the Reference Group.

A declaration of absence of conflict of interest should be signed by each consultant and annexed to the offer.

9. Time Schedule

The evaluation should start in September 2010, the completion of the *Final Report* is scheduled for July 2011 and the *dissemination activities* will take place as of September 2011.

An *indicative* schedule appears below¹⁸⁸

10. Cost of the Evaluation and Payment Modalities

The overall cost of the evaluation should not exceed **800,000 USD**. **The contract will be awarded to the institute who will provide UNFPA with the most competitive technical and financial proposals.**

Indicative Time Schedule

Evaluation Phases and Stages	Notes and Reports	Dates	Meetings	Payments	Remarks
Terms of Reference		October 2010			Internal (UNFPA) arrangements
Tendering Process		November 2010			
Technical Evaluation		December 2010			
Presentations/ Interview		January 2011			
Final Technical Evaluation to PSB		February 2011			
Contracts Review Committee		March 2011			
Contract Award		March 2011			
DESK PHASE					
Staging Phase	Inter Office Memo	April 2011			
Structuring Stage	Inception Report (draft)	May 2011 (first half)	RG Meeting (mid-May)	Payment of 30% of Total budget upon approval (DOS) of Inception Report	
	Inception Report (final)	May 2011 (second half)			
Desk Study	Draft Desk Report	End of June 2011	RG Meeting (early July)		
	Final Desk Report	End of July 2011		Payment of 30% of Total budget upon approval (DOS) of Final Desk Phase Report	

¹⁸⁸The dates mentioned in the table may only be changed in view of optimizing the evaluation performance, and with the agreement of all concerned.

Indicative Time Schedule (continued)

Evaluation Phases and Stages	Notes and Reports	Dates	Meetings	Payments	Remarks
FIELD PHASE (September – November 2011)					
Field Phase	Debriefing presentations	Throughout above-mentioned period	Exit meetings in COs at the end of each mission; RG meeting upon return in New York		
	Case Study Notes	Mid-November 2011 (latest)			
REPORTING PHASE					
	Draft Final Reports	January 2012 (second half)	RG Meeting (late January)		
	Final Reports	Early March 2012		Payment of 40% of Total budget upon approval (DOS and TD) of Final Reports	
DISSEMINATION					
		As of April 2012			

Payments modalities shall be as follow: 30% at the acceptance of the *Inception Report*; 30% at acceptance of *Draft Final Report*; 40% at acceptance of *Final Report*.

The invoices shall be sent to the Division for Oversight Services only after the Evaluation Branch/DOS confirms in writing the acceptance of the reports.

Guidance on the country reports for the country case studies

Length: Each country report should be of a maximum 15-page length (excluding annexes).

The *Thematic Evaluation of the support of UNFPA in the area of maternal health* is partly based on a number of country case studies. These case studies allow the evaluation team to gather information on the interventions of UNFPA aiming at lowering maternal mortality ratio at the country level, which together with the desk phase findings should feed the global assessment reported in the Final Report.

The country reports are needed for transparency reasons, i.e.; to clearly account for the basis of the evaluation, and also to be able to have a factual check with the

concerned country and regional offices and other stakeholders.

At the end of the evaluation the country reports will be published as part of the overall evaluation exercise in annexes to the final report. These reports should be prepared after the missions, they should respect the agreed structure and they should go further than the oral presentations (exit meeting debriefings) conducted at the end of the missions in the premises of the country offices.

Note that the evaluation questions are formulated to be answered on the global level using the sum of the information collected from the different case studies and the desk study, and should hence not be answered at the country case study level.

Indicative structure for country reports:

1. Introduction (including: purpose of the evaluation; purpose of the country report; reasons for selecting this country as a case study country).
2. Data collection methods used (its limits and possible constraints)

3. Short description of the reproductive health sector in the country
4. Findings on the theme under evaluation (focused on facts and not going into analysis)
5. Conclusions at two levels: (1) covering the main issues on country office intervention to lower MMR in the context of the country and (2) covering the elements confirming or not confirming the desk phase hypothesis.
6. Annexes (including: list of people interviewed; list of documents consulted; list of the interventions, projects and programmes specifically considered; all project assessment fiches; all questionnaires; acronyms and abbreviation).

Outline structure of the final evaluation reports

Length: The overall length of the final evaluation reports should not be greater than 60 pages (including the executive summary). Additional information on overall context, programme or aspects of methodology and analysis should be confined to the annexes (which however should be restricted to the important information).

1. Executive summary

Length: 5 pages maximum

This executive summary must produce the following information:

- 1.1 Purpose of the evaluation;
- 1.2 Background to the evaluation;
- 1.3 Methodology;
- 1.4 Analysis and main findings for each Evaluative Question and short overall assessment;
- 1.5 Main conclusions;*
- 1.6 Main recommendations.*

* Conclusions and recommendations must be ranked and prioritized according to their relevance to the evaluation and their importance, and they should also be cross-referenced back to the key findings. Length-wise, the parts dedicated to the conclusions and recommendations should represent about 40 % of the executive summary.

2. Introduction

Length: 5 pages

2.1. Synthesis of UNFPA's mandate and strategy in the field of maternal health/reduction of MMR: the objectives, how they are prioritized and ordered, their logic both internally (i.e.; the existence – or not – of a logical link between the UNFPA's approach and expected impacts) and externally (i.e.; within the context of the needs of the country, government policies, and the programmes of other donors); the implicit assumptions and risk factors; the intended impacts of UNFPA's interventions.*

2.2. Context: brief analysis of the political, economic, social and cultural dimensions, as well as the needs, potential for and main constraints.*

2.3. Purpose of the Evaluation: presentation of the evaluative questions

* Only the main points of these sections should be developed within the report. More detailed treatment should be confined to annexes

3. Methodology

Length: 10 pages maximum

In order to answer the evaluative questions a number of methodological instruments must be presented by the consultants – these include in particular:

3.1. Data and Information Collection: Scope and methods for data collection. The consultants will indicate any limitations and will describe how the data should be cross-checked to validate the analysis.

3.2. Methods of Analysis of the data and information obtained for each evaluation question (indicating any eventual limitations);

3.3. Methods of judgment (incl. judgment criteria and indicators for each evaluation question)

4. Main findings and analysis

Length: 20 to 30 pages

4.1. Answers to each Evaluation Question, indicating findings and conclusions for each;

4.2. Overall assessment of the support of UNFPA in the area of maternal health with the aim of lowering the MMR. This assessment should cover:

- Relevance to needs and overall context, including development priorities and co-ordination with other donors;
- Effectiveness in terms of how far the intended results were achieved;
- Efficiency: in terms of how far funding, personnel, regulatory, administrative, time and other

resource considerations contributed or hindered the achievement of results;

- Sustainability: whether the results can be maintained over time.

5. A full set of conclusions and recommendations

Length: 10 pages

A full set of conclusions* and recommendations* (i) for each evaluation question; (ii) as well as an overall judgment.

*All conclusions should be cross-referenced back by paragraph to the appropriate findings.

Recommendations must be ranked and prioritized according to their relevance and importance to the purpose of the evaluation (also they shall be cross-referenced back by paragraph to the appropriate conclusions).

6. Annexes

Annexes should include the list of interventions/programs specifically considered; the country reports, list of people interviewed, list of documentation, terms of reference; any other information which contains factual basis used in the evaluation, etc.

ANNEX 2

Bibliography

Documents	Year
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UNFPA: Annual Joint Reporting for GP: RHCS & MHTF including Midwifery Programme	2009
UNFPA: Annual Report 2010	2010
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UNFPA: Annual Technical Report. West Darfur	2005
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UNFPA: Annual Work Plan for IPs in the reproductive health Component.	2010
UNFPA: Annual Work Plan for Midwifery and Fistula Programs.	2010
UNFPA: Annual Work Plans with Implementing Partners	2006-2011
UNFPA: Assessment of Development Results Supported by UNFPA CP4 for Lao PDR: Report and Recommendations.	2011
UNFPA: Barriers to family planning in Sudan: The Case of White Nile, Kassala and Al Gadarif States 2008	2008
UNFPA: Business Case for the Decentralization of UNFPA Offices in the RDC.	2010
UNFPA: Capacity Building of Master Trainers under the Project “Incorporating Gender Considerations in Reproductive Health and Communication”	2006
UNFPA: CO Humanitarian Report Ethiopia	2007
UNFPA: Concept Note – Early Marriages and Childbearing in Ghana	2006
UNFPA: Condom Destination Audit	2009
UNFPA: Country Annual Joint Reporting for the Reproductive Health Thematic Funds	2010
UNFPA: Country Annual Joint Reporting for the Thematic Funds	2009, 2010
UNFPA: Country Annual Joint Reporting for the Thematic Funds, North Sudan.	2009
UNFPA: Country Annual Joint Reporting for the Thematic Funds: Fistula	2007, 2008, 2009, 2010

UNFPA: Country Annual Joint Reporting for the Thematic Funds: Midwifery	2010
UNFPA: Country Annual Joint Reporting for the Thematic Funds: RHCS.	2010
UNFPA: Country Annual Joint Reporting for the Thematic Funds: RHCS and MHTF; Obstetric Fistula and Midwifery Interventions	2009
UNFPA: Country Annual Joint Reporting for the Thematic Funds: RHCS, Midwifery and Fistula	2010
UNFPA: Country Annual Report for Thematic Funds – Fistula.	2010
UNFPA: Country Office Annual Report (COAR) Ethiopia	2004, 2005, 2006, 2007, 2008, 2009
UNFPA: Country Office Annual Report (COAR) Lao PDR	2003, 2004, 2005, 2006, 2007, 2008, 2009
UNFPA: Country Office Annual Report (COAR) RDC	2004, 2006, 2007, 2008, 2009
UNFPA: Country Office Annual Report (RABP).	2004, 2005, 2006, 2007, 2008, 2009
UNFPA: Country Programme Action Plan 2009-2012.	2009
UNFPA: Country Programme Performance Summary	2008
UNFPA: Darfur MTR: Darfur Humanitarian Program	2011
UNFPA: Desk Review And Baseline Study Of Midwifery Pre-Service and In-Service Education For Planning Interventions Towards MDGs four, five & six	2009
UNFPA: Detailed Midwifery Work plans for 18 Midwifery Training Institutions and Ethiopia Midwifery Association.	2011
UNFPA: Distribution des Ressources des Projets aux Agences d’Exécution en 2009.	2009
UNFPA: Document de Projet entre Le Gouvernement du Burkina Faso Et Le Fonds des Nations Unies pour la Population (UNFPA) 2001-2005 (5 ^{ème} cycle); Appui aux activités de Santé de la Reproduction dans la région Sanitaire de Fada N’Gourma	2001
UNFPA, Division of Oversight Services: Country Programme Evaluation Cameroon, 2008-2011.	2011
UNFPA, Division of Oversight Services: Evaluación del Programa de País Bolivia, 2008-2011.	2011
UNFPA: Document de Projet entre Le Gouvernement du Burkina Faso Et Le Fonds des Nations Unies pour la Population Appui aux activités de Santé de la Reproduction dans la Région Sanitaire de Sahel; Appui aux activités de SR, DRS Dori	2001
UNFPA: Document de Projet entre Le Gouvernement du Burkina Faso et Le Fonds des Nations Unies pour la Population Appui aux activités de Santé de la Reproduction dans la Région Sanitaire de Tenkodogo; Appui aux activités de SR, DRS Tenkodogo	2001
UNFPA: Draft Country Programme Document for Burkina Faso (Programme Period: 2006-2010)	2005
UNFPA: Enquête MICS.	2011
UNFPA: Ethiopia Gender Survey. A Study in seven Regions	2010
UNFPA: Étude Socio Anthropologique des Fistules Obstétricales dans les Régions Sanitaires de l’Est du Centre Est et du Sahel au Burkina Faso	2004
UNFPA: Évaluation de la Composante Genre du 6 ^{ième} Programme Conjoint UNFPA-Burkina Faso Période 2006-2008	2009
UNFPA: Évaluation des Besoins Complémentaires en Maternité à Moindre Risque dans les Régions du Sahel, de l’Est et du Centre est Burkina Faso, Rapport final	2005

UNFPA: Évaluation des Besoins des Jeunes et de la Réponse Nationale Notamment en Matière de Santé de la Reproduction	2008
UNFPA: Évaluation des Besoins en Matière de Soins Obstétricaux et Néonataux d'Urgence à Madagascar	2010
UNFPA: Évaluation des Capacités des Partenaires de mise en œuvre du Programme Pays 2008-2009	2009
UNFPA: Évaluation des Capacités Nationales Susceptibles d'être les partenaires de mise en œuvre du 5 ^e programme	2004
UNFPA: Évaluation Finale du Programme de Coopération Burkina Faso-UNFPA 2006-2010 – Composante Population et Développement	N/A
UNFPA: Evaluation of GOG/UN System Programme for Promoting Gender Equality in Ghana	2004
UNFPA: Evaluation of Northern And Southern Sector Projects	2005
UNFPA: Expenditure Details Report for Funds Allocated by Commodity Security Branch for RHCS Activities Implementation	2009
UNFPA: Expenditure Report for funds allocated by TD under MHTF, UBW and GPRHCS funds: Fistula	2010
UNFPA: Expenditure Report for funds allocated by TD under MHTF, UBW and GPRHCS funds: Midwifery	2010
UNFPA: Expenditure Report GPRHCS & MHTF	2009-2010
UNFPA: Expenditures Report for Activities Against Thematic Trust Funds	2009
UNFPA: Field Monitoring Reports.	2010
UNFPA: Final Evaluation Report, 5 th Country Programme (2006-2010).	2010
UNFPA: Final Report on the Safe Motherhood Community-Based Survey, Ethiopia.	N/A
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UNFPA: Getting Midwifery on the Development Agenda. Communication Strategy for The State of the World's Midwifery – and beyond, draft.	
UNFPA: GoK/UNFPA 7 th Country Programme Recommendations Tracking Tool – living document.	2011
UNFPA: GPRHCS Mid-Year Progress Report	2010
UNFPA: Health Sector Information required for	2010
UNFPA: Idea Catalogue 2010: It Pays to Invest in Women Getting MDG 5 and maternal health on the media agenda in the lead-up to the global Women Deliver conference in June and the UN MDG High Level Summit in September 2010.	2010
UNFPA: Impact Assessment of CHAG-UNFPA Project 2006-2010: Improving Maternal Health and Youth Friendly Health Services	2011
UNFPA: Integrated Reproductive Health Response Project in Food-Insecure Areas, SNNPR. Project Evaluation Report	2009
UNFPA: Interim Report on Midwifery in Republic of Sudan.	2009
UNFPA: Investing in Midwives and Others with Midwifery Skills to Accelerate Progress towards MDG5: A Proposal for Three Years	2007

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UNFPA: Joint Reporting for the Thematic Funds Ethiopia	2009
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UNFPA: Lao PDR Annual Report	2001-2002
UNFPA: Lao PDR Application to the MHTF	2010
UNFPA: Lao PDR Proposal for GPRHCS and MHTF	2010
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UNFPA: Management Work Plan: Assist Psychosociale Urgence Victimes vs Ango & Aketi	2008-2009
UNFPA: Management Work Plan: La Prévention et la Réponse aux Violences Sexuelles	2006-2010
UNFPA: Management Work Plan: Prévention et Réponse aux SGBV contre refoulés K Occ	2008-2009
UNFPA: Management Work Plan: Prise en Charge Médicale et Psychosociales des VVS	2008-2009
UNFPA: Maternal Health: the National Situation	2011
UNFPA: MDG Achievement Fund: Joint Programme Monitoring Report: Conflict Prevention and Peace Building	2010
UNFPA: Media plan 2010: It Pays to Invest in Women - Getting MDG 5 and maternal health on the media agenda in the lead-up to the global Women Deliver conference in June and the UN MDG High Level Summit in September.	2010
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UNFPA: MHTF Result Framework	2011
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UNFPA: MHTF Results Frameworks, Indicators, Baselines and Targets (South Sudan)	2010
UNFPA: MHTF Results, Frameworks, Indicators, Baselines and Targets	2011
UNFPA: MHTF Results, Frameworks, Indicators, Baselines and Targets: Midwifery Indicators	2009
UNFPA: MHTF Review Annual Reports 2009/AWP 2010	2010
UNFPA: MHTF Review Annual Reports 2009/AWP 2010	2009-2010
UNFPA: Mid-Term Reporting for the Thematic Funds	2011
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UNFPA: Midwives Programme 2009-2011 Annual Work Plans and Monitoring Tool for Implementation Partners	2011
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UNFPA: Rapport Conjoint pour le Fonds Thématique Santé Maternelle, Programme Global, Projet Sage-femme, Programme Fistule	2010
UNFPA: Rapport d'Étape Type: Genre.	2009
UNFPA: Rapport d'Étape Type: Population et Développement	2008-2009
UNFPA: Rapport d'Étape Type: Santé de la Reproduction.	2008-2009
UNFPA: Rapport de Mission d'Évaluation Projet de Réinsertion des Ex-Fistuleuses Mandritsara.	2009
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UNFPA: Review of the Country Annual Joint Reporting for Thematic Trust Funds (Annual Report 2009/PTA 2010) RDC.	2010
UNFPA: Review's Report of Annual Report: Cas de Madagascar	2009
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UNFPA: Revue à Mi-parcours du Programme de Coopération 2001-2005: Rapport du Sous Programme Santé de la Reproduction (SR).	2003
UNFPA: Second Quarter Progress Report Ethiopia	2009
UNFPA: Sécurité Contraceptive à Madagascar	2008
UNFPA: Situation des Refoules Congolais de l'Angola.	2009
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UNFPA: Southern Sudan Midwifery Report	2010
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UNFPA: Summary of all Expenditures in Components reproductive health, population and development and Gender	2009-2011
UNFPA: Support for Implementation of the National Skilled Birth Attendance Plan: Reducing Maternal & Newborn Mortality and Morbidity in Lao PDR	2009
UNFPA: Synthèse des projets et programmes santé de la reproduction/santé maternelle et néonatale de UNFPA Burkina Faso.	2010
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UNFPA: Technical Report of Family Planning Training for GOAL Midwives in Kutum	2011
UNFPA: Template for Country Annual Joint Reporting for the Thematic Funds (South Sudan)	2009
UNFPA: The Effects of Conflict on the Health and Well-being of Women and Girls in Darfur	2006
UNFPA: The Maternal Health Thematic Fund (MHTF) – Sudan Proposal.	2010
UNFPA: The Maternal Health Thematic Fund, 2011 Guidance Note. Accelerating Progress towards Millennium Development Goal 5 - Focus, Partnerships, Results.	2011
UNFPA: The Maternal Health Thematic Fund, the Midwives Programme & Resource Mobilization Strategy.	2010 - 2013.
UNFPA: The PAPP Monitoring and Evaluation Calendar, Country: Burkina Faso; CP Cycle: 6 ^{ème} programme 2006 à 2010	2006
UNFPA: The Policy and Legal Framework Protecting the Rights of Women and Girls in Ethiopia	N/A
UNFPA: The State of the World's Midwifery - Delivering Health, Saving Lives.	2011
UNFPA: Thematic Evaluation of National Programmes and UNFPA Experience in the Campaign to End Fistula. Kenya Desk Review (draft)	2009
UNFPA: UN Workplan Life-saving, comprehensive, and multi-sectoral prevention and response to GBV survivors in Darfur.	2010
UNFPA: UNFPA en Action	2010
UNFPA: UNFPA in Darfur: 2011 health priorities and needs for Reproductive Health support	2011
UNFPA: UNFPA Sudan Strategic Planning Meeting 2011 – Presentation of Financial Performance and Operational Issues	2011
UNFPA: UNFPA-HRU Sudan CO Reproductive Health/GBV Consultancy Report.	2011
UNFPA: Unified Budget and Work plan UNFPA Broad Activities, Key Outputs with Indicators and targets related to MHTF and GPRHCS.	2010-2011
UNFPA: Utilisation du Téléphone Portable pour la Surveillance des Décès Maternels et Néonataux et des Intrants de Santé de la Reproduction	2011
UNFPA: Work Plan and Monitoring Tool	2010
UNFPA: Zambia Mid-Year RHCS Report for the Reproductive Health Thematic Funds	2011
UNFPA-Cambodia: Briefing Kit.	2009

UNFPA-Cambodia: Country Programme Action Plan 2011-15 for Programme of Cooperation between The Royal Government of Cambodia and United Nations Population Fund	2011
UNFPA-Cambodia: Second Health Sector Support Programme II/UNFPA 2010 AWP Budget Revision	2010
UNFPA-Cambodia: UNFPA and the 2008 Population Census of Cambodia”	2008
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United Nations in Cambodia: United Nations Development Assistance Framework 2011-2015	2010
United Nations: Country programme document for Cambodia	2005
United Nations: Final Country programme document for Cambodia.	2010
United Nations: HIV/AIDS Joint Support Programme and Operational Plan and Budget 2011-2015.	2011
United Nations in Cambodia: United Nations Development Assistance Framework 2006-2010	2005
United Nations: Situation Analysis of Youth in Cambodia	2009
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USAID: Zambia: Reproductive Health Commodity Security Assessment.	2010
What you count is what you target: the implications of maternal death classification for tracking progress towards reducing maternal mortality in developing countries. Suzanne Cross ^a , Jacqueline S Bell & Wendy J Graham. <i>Impact</i> , University of Aberdeen. <i>Bulletin of the World Health Organization</i> 2010;88: 147-153. doi: 10.2471/BLT.09.063537	2009
WHO Country Cooperation Strategy (CCS) in the Lao PDR 2009-2011	2009
WHO, UNFPA, UNICEF, The World Bank: A country level communications project supporting joint UN action to improve maternal and newborn health in priority countries	2010
WHO, UNFPA, UNICEF, The World Bank: Africa Region-wide Knowledge-Sharing and Capacity-Building for Sexual and Reproductive Health, including HIV Prevention. Workshop report - Johannesburg, South Africa	2009
WHO, UNFPA, UNICEF, The World Bank: Africa Region-wide Knowledge-Sharing and Capacity-Building Sexual and Reproductive Health, including HIV Prevention. Workshop report - Accra, Ghana	2010
WHO/UNFPA: Enquête Confidentielle des Décès Maternels	2010
WHO: Global Health Observatory Data Repository	2011
WHO: Strategy and Planning Framework for the Integrated Package of Maternal, Neonatal and Child Health Services 2009-2015	2009
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Yusuf: Report on the Mid Term Review of UNFPA CPAP – reproductive health Component Ethiopia.	2009

ANNEX 3

List of People Interviewed

List of persons met in New York

Organization	Name	Position
UNFPA	Attina, Teresa	Programme Associate for the Maternal Health Thematic Fund
UNFPA	Bergevin, Yves	Co-ordinator, Maternal Health Thematic Fund, Sexual and Reproductive Health Branch, TD
UNFPA	Brasseur, Olivier	Director, Division for Oversight Services (DOS)
UNFPA	Carou-Jones, Valeria	Evaluation Specialist, Evaluation Branch, Division of Oversight Services
UNFPA	Charpentier, Louis	Chief, Evaluation Branch, Division of Oversight Services
UNFPA	Collins, Lynn	Technical Adviser, HIV and Women, HIV AIDS Branch, TD
UNFPA	De Bernis, Luc	Maternal Health Advisor, secondment from WHO, Sexual and Reproductive Health Branch, TD
UNFPA	Fauveau, Vincent	Senior Maternal Health Advisor, TD, Geneva
UNFPA	Franca, Etienne	Media Specialist, Campaign to End Fistula, Media and Communication Branch, Information and External Relations Division
UNFPA	Guzman, Jose Miguel	Chief, Population and Development Branch, TD
UNFPA	Hounton, Sennen	Technical Specialist, Maternal Health Thematic Fund, Sexual and Reproductive Health Branch, TD
UNFPA	Iversen, Katja	Media Specialist, Media and Communication Branch, Information and External Relations Division
UNFPA	Kadibey, Monica	Deputy Director, TD
UNFPA	Laski, Laura	Chief, Sexual and Reproductive Health Branch, TD
UNFPA	Lin, Yanming	Regional Desk Advisor, Asia and the Pacific, Programme Division
UNFPA	Loaiza, Edilberto	Monitoring and Evaluation Adviser, Population and Development. Branch, TD
UNFPA	Martinelli-Heckkadon, Sonia	Regional Desk Advisor, Latin America and Caribbean, Programme Division
UNFPA	Melo Luz, Angela	Human Rights Adviser, Gender, Human Rights and Culture Branch, TD
UNFPA	Nelson, Gayle	Technical Adviser, Gender, Gender, Human Rights and Culture Branch TD
UNFPA	Ogbuagu, Kechi F.	Technical Advisor/Coordinators Global Programme on RHCS, Commodity security Branch, Technical Division
UNFPA	Roberts, Olivia	Evaluation Analyst, Evaluation Branch, Division for Oversight Services
UNFPA	Pedersen Simoni, Klaus	Resource Mobilisation Adviser, Resource Mobilisation Branch, Information and External Relations Division
UNFPA	Usmani, Farah	Planning Adviser, Environmental Scanning and Planning Branch, Programme Division

List of persons interviewed by phone

Organization	Name	Position
ICM	Bridges, Agneta	Secretary General, International Confederation of Midwives
The World Bank	Mills, Samuel, Dr.	Senior Health Specialist , Health, Nutrition, & Population Human Development Network, The World Bank
UNFPA	Addico, Gifty	Technical Adviser, Reproductive Health Commodity Security, SRO
UNFPA	Azandegbe, Nestor, Dr.	Reproductive Health/Maternal Health Technical Advisor - UNFPA sub-regional office Dakar SRO
UNFPA	Dairo, Akinyele Eric, Dr.	Senior Programme and Technical Advisor - UNFPA Africa regional office ARO - Johannesburg
UNFPA	Kongnyuy, Eugene	MHTF Technical Specialist, Madagascar country office
UNFPA	Mathai, Saramma Thomas, Dr.	Regional Team Coordinator and Maternal Health Advisor - UNFPA Asia Pacific regional office APRO - Bangkok
UNFPA	Oryem-Ebanyat, Florence	Technical Adviser Reproductive health/MH - UNFPA sub-regional office for Eastern & Southern Africa, Johannesburg SRO
WHO	Bathija, Heli, Dr.	Area Manager for the African and Eastern Mediterranean Regions, Department of Reproductive Health and Research (RHR) - Cluster of Family, Women and Children Health (FWC) - World Health Organization
WHO	Mason, Elisabeth, Dr.	Director Department of Maternal, Newborn, Child and Adolescent Health, World Health Organisation, WHO, Geneva

List of persons from UNFPA who attended the RG meetings

Name	Position
Addico, Gifty	Technical Adviser, Reproductive Health Commodity Security, SRO
Bergevin, Yves	Co-ordinator, Maternal Health Thematic Fund, Sexual and Reproductive Health Branch, TD
Carou-Jones, Valeria	Evaluation Specialist, Evaluation Branch, Division of Oversight Services
Chambel Alexandra	Evaluation Advisor, Evaluation Branch, Division of Oversight Services
Charpentier, Louis	Chief, Evaluation Branch, Division of Oversight Services
Collins, Lynn	Technical Adviser, HIV and Women, HIV AIDS Branch, TD
Daoudi, Hicham	Senior Evaluation Advisor, Evaluation Branch, Division of Oversight Services
Haug, Werner	Director of Technical Division
Hounton, Sennen	Technical Specialist, Maternal Health Thematic Fund, Sexual and Reproductive Health Branch, TD
Iversen, Katya	Media Specialist, Media and Communication Branch, Information and External Relations Division
Kaidbey, Mona	Deputy Director of Technical Division
Kongnyuy, Eugene	MHTF Technical Specialist, Madagascar country office
Lal, Geeta	Midwifery Programme Coordinator
Loaiza, Edilberto	Monitoring and Evaluation Adviser, Population and Development. Branch, TD
Machefsky, Rachel	Programme Associate/Consultant
Mars-Mompoint, Magalye	Evaluation Assistant
Nelson, Gayle	Technical Adviser, Gender, Gender, Human Rights and Culture Branch Technical Division

(continued)

List of persons from UNFPA who attended the RG meetings (continued)

Name	Position
Ortayali, Nuriye	Technical adviser, family planning, sexual and reproductive health Branch, TD
Pedersen, Klaus Simoni	Resource Mobilisation Advisor, Resource Mobilisation Branch, Information and External Relations Division
Roberts, Olivia	Evaluation Analyst, Evaluation Branch, Division for Oversight Services
Usmani, Farah	Planning Adviser, Environmental Scanning and Planning Branch, Programme Division
Vanderree, Marleen	Programme Associate/Consultant

List of persons met in country offices of MHTF countries

Organization	Level	Name	Position
Abakrampa Health Clinic Ghana	country	Sophia Forson	Midwife
Academy of Health Sciences, Sudan	country	Abd Al Rahman	Director
Academy of Health Sciences, Sudan	country	Dr. Daffalla Alam Elhuda	Director
Academy of Health Sciences, Gadaref	country	Dr. Laila Tanions Gergis	Supervisor and Teacher
ADB Lao PDR	country	Dr. Phoxay Xayavong	Project Officer
ADB Lao PDR	country	Barbara Lochmann	Sr. Social Sector Specialist
Advisor	country	Juliana Tunguzi	Midwifery
ArLaeng Village, Chrey Bak commune, Kampong Chhnang District, Kampong Chhnang province	country	Pao Chuom	Women in the community (18)
ASAFF (OBC)	country	Gouem Moumouni	President ASAFF
ASAFF (OBC)	country	Palé Marguerite	Comptable
ASAFF (OBC)	country	Bancé Safiatou	Suivi Évaluation
ASAFF (OBC) Burkina Faso	country	Yamba Askandar	Coordonnateur PADS
Assemblée Nationale Burkina Faso	country	Deputé Ouédraogo Jacob	Membre
Association Chrétienne pour le Développement de la Femme et de l'Enfant DRC	country	Mr. Julien	Directeur Exécutif
Breastfeeding Association of Zambia	country	Ruth Muzumara	Programme Officer
Chu Tuléar. Madagascar	country	Équipe de la maternité du Chu	CHU
Clinton Health Access Initiative Zambia	country	Tracy Rudne Hawry	Programme Manager, HRH
Clinton Health Access Initiative Zambia	country	Chikusela Sikazwe	Programme Manager, Male Circumcision

List of persons met in country offices of MHTF countries (continued)

Organization	Level	Name	Position
CNOSFM/ABSF	country	Zerbo Georgette	Membre de l'Association
College of Health Science, of Champasack, Champasack Province	country	Dr. Vilaysack Boungnarith	Deputy Director, College of Health Science of Champasack (Gyneco-obstetric specialist)
COMOG	country	Abdul Manan	Programme Officer
Conseil national de l'ordre des sages femmes maïeuticiens(CNOSFM)/ABSF	country	Ouedraogo Karidja	Membre de l'Association
Council of Ministers, National Committee for Population and Development (NCPD) Cambodia	country	HE. Katika Chamroeun	Under Secretary General
Council of Ministers, National Committee for Population and Development (NCPD) Cambodia	country	Dr. Maneth Nhem	Head of Training Department
CSPS 2 Burkina Faso	country	Zabré Drissa	Infirmier Chef de Poste
CSPS 2 Burkina Faso	country	Minoungou Rasolgwendé	Accoucheuse Auxiliaire
Curious Minds Ghana	country	Emmanuel Ashong	Programme Officer
Clinton Health Access Initiative Zambia	country	Tracy Rudne Hawry	Programme Manager, HRH
Council of Ministers, National Committee for Population and Development (NCPD) Cambodia	country	HE. Katika Chamroeun	Under Secretary General
Council of Ministers, National Committee for Population and Development (NCPD) Cambodia	country	Dr. Maneth Nhem	Head of Training Department
CSPS 2 Burkina Faso	country	Zabré Drissa	Infirmier Chef de Poste
CSPS 2 Burkina Faso	country	Minoungou Rasolgwendé	Accoucheuse Auxiliaire
Curious Minds Ghana	country	Emmanuel Ashong	Programme Officer
Doka Hospital Sudan	country	Dr Abd Al Aziem	Medical Doctor
DRS Burkina Faso	country	Ganou Marc	Point Focal de la DRS
DRS du Sahel (organisation de la collecte des données)	country	Dr Yanou Saidou	Directeur Régional de la Santé
DSME Burkina Faso	country	Dr Naré	Directeur de la Santé des Adolescents, des Jeunes et des Personnes Âgés
DSME Burkina Faso	country	Serges Sary	Service de Planification Familiale
DSME Burkina Faso	country	Dr Nobila Sawadogo	Responsable Service de Maternité à Moindre Risque

(continued)

List of persons met in country offices of MHTF countries (continued)

Organization	Level	Name	Position
DSME Burkina Faso	country	Sanou Ouedraogon Djénéba	Directrice
École Nationale de Santé Publique (ENSP) Burkina Faso	country	Mathieu Ouéréssé	Directeur Régional d'École Nationale de Santé Publique
Enfants du Monde Burkina Faso	country	Sankara T. Tene	Représentant de l'ONG
Ethiopian Midwives Association	country	Hiwot Wubeshet	Executive Director
Ethiopian Society of Obstetricians and Gynecologists	country	Dr Dawit Desalegn	ESOG Board Member and Project Coordinator
Ethiopian Society of Obstetricians and Gynecologists	country	Selamawit Kifle	ESOG Board Member and Project Coordinator
Family Care international Burkina Faso	country	Dr Bassané	Responsable Pays FCI
Family Guidance Association of Ethiopia	country	Haregewoin Kiflom	Technical Assistant Manager
Family Guidance Association of Ethiopia, South Western Area Office	country	Dessalegn Workineh	Area Manager
Family Guidance Association of Ethiopia, South Western Area Office	country	Dr Zewdie Mulissa	Clinical Director
Federal Ministry of Health Ethiopia	country	Miheret Hiluf	Rural Directorate Director
Federal Ministry of Health, Disease Prevention and Health Promotion Department Ethiopia	country	Dr Mengistu H/mariam	Disease Prevention and Health Promotion General Directorate
Fédération des sages-femmes Madagascar	country	Jeannine Amélie	Secrétaire général de la Fédération des sages-femmes
FHOK Youth Friendly Center at Eastleigh	country	Angela Tatua	Centre Coordinator
Fistula Center Kassala	country	Dr. Amira Okod	Director
Fondation pour le développement Communautaire (FDC)/IFC Burkina Faso	country	Bargo Aminata	Représentante de l'ONG
Gadaref Midwifery School	country	Zeinab Mohamed Ahmed	Director
General Director State MoH, North Darfur, Officer in Charge	country	Dr. Muneer Mohammed Matar	Emergency Humanitarian Action/ NGOs Coordinator
Ghana Health Service	country	Peace Akormedie	Family Health Unit
Ghana Health Service	country	Dr. Yaa Osei Asante	Family Health Unit
Ghana Health Service	country	Dr. Gloria Quansah Asare	Director of Family Health Unit
Ghana Health Service	country	Claudette Diogo	Family Health Unit
Ghana Health Service	country	Rejoice Nutakor	Family Health Unit
Ghana Health Service (GHS)	country	Dr. Patrick Aboagye	Family Health Unit

List of persons met in country offices of MHTF countries (continued)

Organization	Level	Name	Position
Ghana Health Service Central Region	country	Esther Oyinka	Director, Public Education Unit (UNFPA Desk Officer)
Ghana Health Service Central Region	country	Matthew Ahwireng	Regional Health Promotion Officer
Ghana Health Service Central Region	country	Mr. Kyeremateng	Deputy Regional Director
Ghana Nursing and Midwifery School (Korle Bu, Accra)	country	Netta Ackon	Programme Head
Ghana Nursing and Midwifery School (Korle Bu, Accra)	country	Gloria Tetteh	Principal
Ghana Registered Midwives Association (GRMA)	country	Joyce Jetuah	President
Ghana Registered Midwives Association (GRMA)	country	Gifted Mantey	Treasurer
Ghana Statistical Service	country	Sylvester Gyamfi	Head of Programmes
Ghana Statistical Service	country	Dr. Philomena Nyako	Deputy Government Statistician in charge of Operations and Demography
Ghana Statistical Service	country	Anthony Pharin	Head of Survey Organisation
Ghana Statistical Service (GSS)	country	Magnus Ebo Duncan	Head of Economics Statistics
GPRTU Project	country	Kofi Osea Addo	GPRTU Member
GPRTU Project	country	Oheneba Adjei	GPRTU Member
GPRTU Project	country	Peter Kofi Amoah	GPRTU Member
GPRTU Project	country	S. K. Amposah	GPRTU Member
GPRTU Project	country	Mark Appiah	GPRTU Member
GPRTU Project	country	Francis Bentum	GPRTU Member
GPRTU Project	country	Adjei Boakye	GPRTU Member
GPRTU Project	country	Issah Bukari	GPRTU Member
GPRTU Project	country	Matthias Coffie	GPRTU Member
GPRTU Project	country	Anthony Ekow Daatse	GPRTU Member
GPRTU Project	country	Amos Dadzie	GPRTU Member
GPRTU Project	country	Isaac Kow Eduful	GPRTU Member
GPRTU Project	country	K. A. Gyasi	GPRTU Member

(continued)

List of persons met in country offices of MHTF countries (continued)

Organization	Level	Name	Position
GPRTU Project	country	William A. Kporvie	GPRTU Member
GPRTU Project	country	Kofi Menu	GPRTU Member
GPRTU Project	country	Matthew Quansah	GPRTU Member
GPRTU Project	country	Francis Sam	GPRTU Member
Health Center Chrey Bak, Chrey Bak commune, Kampong Chhnang District, Kampong Chhnang province	country	Sokun Meas	Head of health centre
Health Center Chrey Bak, Chrey Bak commune, Kampong Chhnang District, Kampong Chhnang province	country	Sothear Rath	Vice head of health centre
Health Center Chrey Bak, Chrey Bak commune, Kampong Chhnang District, Kampong Chhnang province	country	Sothear Rath Kong	Health centre staff
Health Center Chrey Bak, Chrey Bak commune, Kampong Chhnang District, Kampong Chhnang province	country	Leng Channe	Commune Chief, and health staff of health centre Health Centre Management team and Women and children's focal point
Health Center Chrey Bak, Chrey Bak commune, Kampong Chhnang District, Kampong Chhnang province	country	Chhum Pao	
Health Center Chrey Bak, Chrey Bak commune, Kampong Chhnang District, Kampong Chhnang province	country	Yoeum Keo	
Health Center Chrey Bak, Chrey Bak commune, Kampong Chhnang District, Kampong Chhnang province	country	Im Koeun	
Health Center Chrey Bak, Chrey Bak commune, Kampong Chhnang District, Kampong Chhnang province	country	Piny Phuok	
Health Center Chrey Bak, Chrey Bak commune, Kampong Chhnang District, Kampong Chhnang province	country	Sao Sambor	
Health Poverty Action Lao PDR (Former HU)	country	Ketsadasak Kiattisack	Project Manager
Hospital of National Maternal and Child Health Center (NMCHC) Cambodia	country	Thavy Heing	Chief of OPD and
Hospital of National Maternal and Child Health Center (NMCHC) Cambodia	country	Sophornary Say	Midwives of NMCHC hospital
Hospital of National Maternal and Child Health Center (NMCHC) Cambodia	country	Bou Rum Bun	
ICM Ghana	country	Dr. Jemimah Dennis-Antwi	Regional Midwives Adviser
IFP Madagascar	country	Amélie Tatavy	Directeur des Instituts de formation paramédicale, IFP

List of persons met in country offices of MHTF countries (continued)

Organization	Level	Name	Position
IPPF Field Office Lao PDR	country	Dr. Ketkeo Soudachan	National Project Coordinator
IRSS Burkina Faso	country	Dr Kouanda	Épidémiologiste, responsable de la Section Santé Publique, Chef d'Équipe
IRSS Burkina Faso	country	Thieba Millogo	Assistant de Recherche
Kasempa District Health Office	country	Mr. Shikelenge	Public Health Officer
Kasempa District Health Office	country	Joyce Kamwana	Reproductive health focal point person
Kayayei Youth Association Ghana	country	Mohammed Salifu	Founder Leader
Kayayei Youth Association Ghana	country	Fati Alhassan	Vice Chairperson
Kayayei Youth Association Ghana	country	Ayisha Zakaria	First Trustee
Kayayei Youth Association Ghana	country	Laraba Ibrahim	Branch Leader
Kayayei Youth Association Ghana	country	Jemilah Fuseini	Group Leader
Kayayei Youth Association Ghana	country	Asana Alhassan	Organizer and Collector
Kayayei Youth Association Ghana	country	Ayishetu Alhassan	Organizer
Kayayei Youth Association Ghana	country	Amatu Issakah	Organizer
Kayayei Youth Association Ghana	country	Sumaiya Mohammed	Savings Member
Khmer Youth Association (KYA)	country	Chansen Sun	President of KYA
Kralanh Operation District, Siem Reap Province	country	Dr. Siravuth Long	Director of Operational District
Kralanh Operation District, Siem Reap Province	country	Neary Reak Duong	Director of MCH of Operational District
KYA	country	Kosal Phan Pheab	Project Coordinator
Lao Women Union	country	Kaysamy Latvilayvong	Deputy Director of Development Department
Lux-Development Lao PDR	country	Dr. Frank Haggerman	Health System Advisor
Marie Stops Madagascar	country	Baholisoa Randrianasalom	Médecin Chef
Marie Stops Madagascar	country	Thierry Ramananantsoa	Project manager Misoprostol
Marie Stops Madagascar	country	Sylvie Ramandrosoa	Directeur financier
Maternité de Kitambo	country	Dr Katoba	Médecin Directeur

(continued)

List of persons met in country offices of MHTF countries (continued)

Organization	Level	Name	Position
Ministère de la Jeunesse et des loisirs Madagascar	country	Marie Ange Tifana	Coordonnateur du programme de la santé des jeunes
Ministère de la Santé Burkina Faso	country	Claude Congo	Chef de Service Recrutement et Formation
Ministry of Finance and Economic Planning (MoFEP) Ghana	country	Stella Williams	Assistant Director, UN Projects
Ministry of Finance and Economic Planning (MoFEP) Ghana	country	Nana Yaw Yankah	Desk Officer for UNFPA Projects
Ministry of Finance Zambia	country	Mainga Lowabelwa	Chief Planner
Ministry of Finance Zambia	country	Francis Mpampi	Principle Planner
Ministry of Finance Zambia	country	Pamela Kauseni	Principle Planner
Ministry of Finance Zambia	country	Belinda Lumbula	Principle Planner
Ministry of Health - Gadaref State	country	Dr. Ali Abd Al Rahman	Director General
Ministry of Health - Gadaref State	country	Amira Mohammed	Reproductive Health Statistician
Ministry of Health - Gadaref State	country	Aziza Abd Alrahim	Nurse
Ministry of Health - Gadaref State	country	Dr. Abd Allh Al Bashier	PHC Director
Ministry of Health - Gadaref State	country	Ekhlas Hassan	Inspector Health Visitor, MW teacher
Ministry of Health - Gadaref State	country	Gebriel Mohammed Ali	Health Information System Officer, Reproductive Health
Ministry of Health - Kassala State	country	Dr. Moataz Abd Allah Abd Al Hadi	Director General
Ministry of Health (MoH) Ghana	country	Dr. Afisa Zakaria	Director, Programmes, Projects, Monitoring and Evaluation (PPME)
Ministry of Health/UNFPA	country	Abraham Cingalika	RHCS Coordinator
Ministry of Health/Department of Human Resource and Development (HRD)	country	Dr. Sam Song Phom	Deputy Director of HRD
Ministry of Health Cambodia	country	Prof. Huot Eng	Secretary of State, Director of Health Sector Support Project
Ministry of Health Cambodia	country	Dr. Sokhan Chhoung	Vice Rector of department of Drug and Food (DDF)
Ministry of Health Lao PDR	country	Dr Anan Sacdpaseuth	Chair of Obstetric Society, Mahosoth Hospital
Ministry of Health Lao PDR	country	Dr Bounfeng Phoummalaysith	Deputy Director General of the Cabinet
Ministry of Health Lao PDR	country	Dr Kaisone Choulramany	Director of Mother and Child Health Centre

List of persons met in country offices of MHTF countries (continued)

Organization	Level	Name	Position
Ministry of Health Lao PDR	country	Dr Khamphithoun Somsamouth	Deputy Director of Centre of Information Education for Health
Ministry of Health Lao PDR	country	Dr Phouthone Vangkonevilay	Deputy Director General Department of Organization & Personnel
Ministry of Health Lao PDR	country	Dr Somchit Ackhavong	Deputy Director General Department of Hygiene & Diseases Prevention
Ministry of Health Lao PDR	country	Dr. Chanheme Somnavong	Dean, Faculty of Nursing Science
Ministry of Health Lao PDR	country	Dr. Thanome Insane	Director of Medical Drugs Supply Centre
Ministry of Health Lao PDR	country	Phengdy Inthaphanith	Chief of Nursing and Midwifery Division, Department of Health Care
Ministry of Health Zambia	country	Dr Elizabeth Chazema Kawesha	Director Public Health
Ministry of Health Zambia	country	Dr Max Bweupe	Deputy Director PH
Ministry of Health Zambia	country	Dr Reuben Kamoto Mbewe	Director Technical Services and support
Ministry of Health Zambia	country	Dr. Ruth Bweupe	Family Planning Officer
Ministry of Health, Health Sector Support Programme 2009-13 (HSSP2)	country	Dr. Veasan Kiri Lo	Programme Coordinator of HSSP2
Ministry of Health, Personnel Department (PD)	country	Sambor May	Director/Deputy Director of PD
Ministry of Health, Personnel Department (PD)	country	Dr. Sary Vannark Oeng	Head of staff management unit
Ministry of Health, Personnel Department (PD)	country	Dr. Sony Lay	
Ministry of Health/Department of International Cooperation (DIC)	country	Dr. Or Vandine	Director of DIC
Ministry of Health/Cambodia Midwives Council (CMC)	country	Radalng	President of CMC
Ministry of Health/Cambodia Midwives Council (CMC)	country	Pros Nguon	President of CMC
Ministry of Interior Cambodia	country	Malyna Yin	Director, deputy director, and officer of Department of local administration
Ministry of Interior Cambodia	country	Meng Sean Yam	
Ministry of Interior Cambodia	country	Sopheak Say	
Ministry of Planning and Investment Lao PDR	country	Phonevanh Outhavong	Deputy Director General, Department of Planning

(continued)

List of persons met in country offices of MHTF countries (continued)

Organization	Level	Name	Position
Ministry of Planning Cambodia	country	HE. Sy Than San	Director general of National Institute of Statistics
Ministry of Planning Cambodia	country	Nirmita Hou	Director of women and health department
Ministry of Planning Cambodia	country	Danine Sengphal	HIV technical officer of women and health department
Ministry of Planning Cambodia	country	Hak Chhun The	Deputy director of women and health department
Ministry of Sports Youth and child development Zambia	country	Toddy Mulonga	Permanent Secretary
Ministry of Sports Youth and child development Zambia	country	Collins A. Mulonda	Director Youth
Ministry of Sports Youth and child development Zambia	country	Abigail Malikutilla	Senior Youth Development Officer
Ministry of Sports Youth and child development Zambia	country	Muma K. Mukupa	Chief Youth Development Officer
Ministry of Sports Youth and child development Zambia	country	Ivy Mbangi	Chief Youth Development Officer
Ministry of Women and Children's Affairs Ghana	country	Efua Anyanful	Director of Research and Economics Statistics
Ministry of Women and Children's Affairs Ghana	country	G.K. Kumor	Director 1
Moree Health Centre Ghana	country	Juliana Abban	Midwife
Mwansa Young Women's Action Zambia	country	Loindsay	Programme Officer
Nairobi City Council	country	Dr. Robert Ayisi	City Hall Director of Public Health
Nairobi City Council, Urban Slums Project	country	Mary Kimani	Project Coordinator
National Aids Council Zambia	country	Dr Ben Chirwa	Director General
National Assembly Lao PDR	country	Dr Somphou Douangsavanh	Deputy Director General of Commission for Socio-Culture of the LAPDD
National Assembly Lao PDR	country	Bounlert Louandouangchanh	Secretary of LAPDD, Deputy Director General of Socio-Culture Department
National Center for Health Promotion, Ministry of Health	country	Sokun Ouk	Deputy Chief of Technical Bureau of National Center for Health Promotion
National Coordinating Agency for Population and Development, NCPD	country	Dr. Boniface Omuga K'Oyugi	Chief Executive Officer
National Maternal and Child Health Center (NMCHC) Cambodia	country	Prof. Rathavy Tung	Deputy Director of NMCHC and National Reproductive Health Programme Manager

List of persons met in country offices of MHTF countries (continued)

Organization	Level	Name	Position
National MCH Center, JICA Project	country	Yasuyo Osanai	Chief Advisor
National Ministry of Health Sudan	country	Dr. Sawsan Eltahir Suleiman	Director of National Reproductive Health Programme
National Youth Authority (NYA) Ghana	country	Henry Adu	Regional Officer, Central Region
NGOCC Zambia	country	Nalucha Nganga Ziba	Communication & Advocacy Coordinator
NPC Ghana	country	Marian Kpapka	Director, Technical
NPC Ghana	country	Dr. Stephen Kwankye	Executive Director
OBYGN Hospital Gadaref	country	Dr Abd Al Gader Mohammed Osman	Medical Director
OBYGN Hospital Gadaref	country	Dr. Hussien Ameen	MDR Resident Doctor
OBYGN Hospital Gadaref	country	Dr. Sami Al Safi	MDR Resident Officer
OMS Burkina Faso	country	Ouanga Jean Gabriel	Administrateur de Programme et Promotion de la Santé Familiale
ONUSIDA Burkina Faso	country	Jean Baptiste Gatali	Chargé de suivi évaluation
Ordre national des sages-femmes Madagascar	country	Omega Ranoromalala	Présidente Ordre national des sages-femmes
Ordre national des sages-femmes Madagascar	country	Amélie Tatavy	Vice Présidente Ordre national des sages-femmes
Ordre national des sages-femmes Madagascar	country	Bernadette Raharisoa	Secrétaire général Ordre national des sages-femmes
PADS Burkina Faso	country	Dr Guira Matilibou	Suivi Évaluation
PADS Burkina Faso	country	Sanou Salamata	SE PADS
PADS Burkina Faso	country	Bationo Rodrigue	FDC
PADS Burkina Faso	country	Berehoudougou Diane	Suivi Évaluation
PADS Burkina Faso	country	Ouedraogo Olivia	AES/B
PADS Burkina Faso	country	Ouedraogo Lucien	ADRK
PADS Burkina Faso	country	Sawadogo Alice	ABBEF Bobo
PADS Burkina Faso	country	Belem Boukari	Projet Bobo
PADS Burkina Faso	country	ONADJA Genevieve	IPC
PADS Burkina Faso	country	Sawadogo Emmanuel	ABBEF
PADS Burkina Faso	country	Kaboré Adama	SOS Sahel International

(continued)

List of persons met in country offices of MHTF countries (continued)

Organization	Level	Name	Position
PADS Burkina Faso	country	Koné Ablasse	SOS Jeunesse et Défis
PADS Burkina Faso	country	Wend Yam	SOS Jeunesse et Défis
PADS Burkina Faso	country	Kaboré Celestin	SOS Jeunesse et Défis
Parliamentary Commission Cambodia	country	H.E. Damry Ouk	Secretary-general and 6th Commission National Assembly
Parliamentary Commission Cambodia	country	Vannak Heng	Programme Coordinator
Personnel du District de Koupela	country	Guigemde Armand	Médecin chef de district (MCD)
Personnel du District de Koupela	country	Namoano Mamoussa	Responsable Programme Élargi de Vaccination (PEV)
Personnel du District de Koupela	country	Diasso Abdramane	Responsable SR
Personnel du District de Koupela	country	Kaboré Madi	Centre d'Information Sanitaire et de Surveillance Épidémiologique (CISSE)
Personnel du District Sanitaire de Tenkodogo	country	Yanogo Mathieu	Service de Planification
Personnel du District Sanitaire de Tenkodogo	country	Diallo Adama	Médecin
Personnel du District Sanitaire de Tenkodogo	country	Traoré Bakary	Médecin, MCD
Personnel du District Sanitaire de Tenkodogo	country	Yameogo Nadia	Médecin
Personnel du District Sanitaire de Tenkodogo	country	Zongo Pascal	Régisseur
Personnel du District Sanitaire de Tenkodogo	country	Ouandago Hermann	Régisseur
Personnel du District Sanitaire de Tenkodogo	country	Swadogo Siméon	CISSE
Planned Parenthood Association of Zambia (PPAZ)	country	Henry Kaimba	Programme Manager
Planned Parenthood Association of Zambia (PPAZ)	country	Edford Mutuna	Programme Manager
PNUD Burkina Faso	country	Cyimana Ingrid	Directrice PNUD
PNUD Burkina Faso	country	Dieudonne Kini	Administrateur de Programme et Gouvernance
PNUD Burkina Faso	country	Zoungrana Salif	Coordonnateur de la Campagne de Plaidoyer pour les OMD
PPAG	country	Albert Odamatey	Director
Prestataire Madagascar	country	Équipe du Centre ami des jeunes Tanambao	Structure publique

List of persons met in country offices of MHTF countries (continued)

Organization	Level	Name	Position
Prestataire Madagascar	country	Equipe de la Maternité Marie Stops	Marie Stops
Prestataire Madagascar	country	Angeline	Responsable de la pharmacie de gros de district. Manipulatrice du logiciel CHANEL
Prestataire Madagascar	country	Trois (03) femmes ayant bénéficié du projet FO	Communauté
Programme d'Appui au Développement Sanitaire (PADS)	country	Harouna Diarra	Gestionnaire, Intérimaire du Directeur
Programme de santé sexuelle Droits Humains (PROSAD) (GIZ) Burkina Faso	country	Dr Guy Zoungrana	Chargé de la Composante SR et Lutte contre le VIH SIDA
Projet de Lutte contre les Fistules Obstétricales dans la Région du Sahel	country	Béré Yolande	Conseillère Technique Nationale en SR
Provincial Health Department (PHD) of Siem Reap	country	Dr. Kheng Darasy	Deputy of maternal and child health
Provincial health department of Kampong Chhnang province	country	Sam Maly	Chief of MCH
Provincial hospital of Kampong Chhnang province	country	Dr. Tirathany Sorin	Director of provincial hospital
Regional Training Center (RTC) (for Midwifery training), Battambang Province	country	Chhor Vaeng Ouk	Deputy of RTC
Regional Training Center (RTC) (for Midwifery training), Battambang Province	country	Sopheha Meak	Head of administration
Regional Training Center (RTC) (for Midwifery training), Battambang Province	country	Channary Moeung	Head of training unit
Regional Training Center (RTC) (for Midwifery training), Battambang Province	country	Ladar Kiev	Teacher and Students
Relief International, North Darfur	country	N/A	Head of Office
Réseau des Associations Islamiques en Population et Développement Burkina Faso	country	Cisse Ahmad Nassour	Président
Solwezi Provincial Health Office	country	Dr George Llabwa	Provincial Health Officer
Solwezi Provincial Health Office	country	Dr Winard Mumba	Clinical Specialist
Solwezi School of Nursing	country	Ngambo Mushikula	Principal Tutor
Solwezi School of Nursing	country	Martha Mushi	THET (Tropical Health Education Trust)
Solwezi Urban Clinic	country	Mulomba M.M. Chilumbu	Clinical Instructor
Solwezi Urban Clinic	country	Doris Mpatisina	Nurse/Midwife

(continued)

List of persons met in country offices of MHTF countries (continued)

Organization	Level	Name	Position
Solwezi Urban Clinic	country	Charity M.N. Libwa	Nurse/Midwife MCH
Solwezi Urban Clinic	country	Mable Muyupi	Nurse/Midwife
Solwezi Urban Clinic	country	Makwala Sandra	2nd Year student nurse
Solwezi Urban Clinic	country	Mercy Mataliro	2nd Year student nurse
The World Bank, Cambodia country office	country	Timothy A. Johnston	Senior Health Specialist
Time With Grandma/Grandpa Project (GHS, CR) Ghana	country	Margaret Awotwie	Grandma/Adviser in Abresea Community
Time With Grandma/Grandpa Project (GHS, CR) Ghana	country	Janet Sakyi	Grandma/Adviser in Abresea Community
Time With Grandma/Grandpa Project (GHS, CR) Ghana	country	Victor Ocran	Teacher/Project Facilitator
Time With Grandma/Grandpa Project (GHS, CR) Ghana	country	-	Group of Youth/Pupils
UNDP Lao PDR	country	Minh H. Pham	Resident Coordinator United Nations Resident Representative
UNDP Lao PDR	country	Eiko Narita	Head of office of the UN Resident Coordinator
UNFPA	country	Kongnyuy, Eugene	MHTF Technical Specialist, Madagascar country office
UNFPA Burkina Faso	country	Kante, Mamadou	UNFPA Représentative
UNFPA Burkina Faso	country	Compaore Zoungana, Cecile	Assistant Représentative
UNFPA Burkina Faso	country	Zafiryadis, Christelle	JPO Genre
UNFPA Burkina Faso	country	Zerbo, Lacina	Programme Assistant
UNFPA Burkina Faso	country	Kabore, Saidou	National Programme Officer (NPO) Pop. and Dev.
UNFPA Burkina Faso	country	Kone, Andre	NPO Monitoring and Évaluation
UNFPA Burkina Faso	country	Kone, Ali	Programme Assistant
UNFPA Burkina Faso	country	Belemvire, Seydou	NPO
UNFPA Burkina Faso	country	Sankara, Olga	NPO SR MMR
UNFPA Burkina Faso	country	Dah, Judith	Operations Manager
UNFPA Burkina Faso	country	Zerbo Awa	Chargée de la Formation des Sages Femmes

List of persons met in country offices of MHTF countries (continued)

Organization	Level	Name	Position
UNFPA Burkina Faso	country	Siaka Traoré	NPO CCC Plaidoyer
UNFPA Cambodia	country	Dr. Marc Derveeuw	Representative
UNFPA Cambodia	country	Sarah Knibbs	Deputy Representative
UNFPA Cambodia	country	Tum May	Assistant Representative
UNFPA Cambodia	country	Pon Rieng	Finance Associate
UNFPA Cambodia	country	Muong Sopha	Programme Associate-EmONC, UNFPA Country Office
UNFPA Cambodia	country	Dr. Vandara Chong	National Programme Officer; Youth SRH and HIV
UNFPA Cambodia	country	Sophanara Pen	Communications Associate
UNFPA Cambodia	country	Sochea Sam	National Officer of MCH
UNFPA Cambodia	country	Yi Soktha	National Officer of Population and Development
UNFPA Cambodia	country	Dr. Marc Derveeuw	Representative
UNFPA Cambodia	country	Dr. Sathiarany Vong	RH Specialist
UNFPA Ethiopia	country	Helen Amdemikael	Assistant Representative
UNFPA Ethiopia	country	Bethlehem Solomon	National Programme Assistant
UNFPA Ethiopia	country	Dr. Michael Tekie	NPO reproductive health NOB
UNFPA Ethiopia	country	Dorothy Lazaro	International Midwifery Advisor
UNFPA Ethiopia	country	Beza Nardos	Programme Assistant
UNFPA Ethiopia	country	Ayehuallem Tameru	NPO HIV NOC
UNFPA Ethiopia	country	Dursit Abdishekur	NORAD NPO (Programme Coordinator)
UNFPA Ethiopia	country	Berhanu Legesse	NPO NOC GENDER
UNFPA Ethiopia	country	Behailu Gebremedhin	NPO NOB M&E
UNFPA Ethiopia	country	Tsigereda Tiruneh	National Midwifery Advisor
UNFPA Ethiopia	country	Wondimagegn Fanta	Humanitarian Office
UNFPA Ghana	country	Dr. Bernard Coquelin	Country Representative
UNFPA Ghana	country	Bawa Amadu	Assistant Representative

(continued)

List of persons met in country offices of MHTF countries (continued)

Organization	Level	Name	Position
UNFPA Ghana	country	Esther Abaka	Personal Assistant to the CR
UNFPA Ghana	country	Esi Awotwe	HIV/AIDS Analyst
UNFPA Ghana	country	Doris Mawuse Aglobitse	NPO Adviser RM
UNFPA Ghana	country	Mercy Osei-Konadu	NPO Gender
UNFPA Ghana	country	Fredrica Hanson	NPP Midwife Adviser
UNFPA Ghana	country	Dr. Robert Mensah	Reproductive Health Specialist
UNFPA Ghana	country	Staff	Staff
UNFPA Ghana, Northern Region, Tamale Office	country	Mammah Tenei	Project Officer, Fistula Project
UNFPA Lao PDR	country	Dr. Bouathip Phongsavath	MNCH/SBA Project Officer
UNFPA Lao PDR	country	Dr. Douangchanh Xaymounvong	Programme Officer
UNFPA Lao PDR	country	Dr. Sengsay Siphakanlaya	Programme Officer IEC/BCC
UNFPA Lao PDR	country	Latsamy Sengvongdeuan	Finance Associate
UNFPA Lao PDR	country	Della Sherratt	SBA International Coordinator
UNFPA Lao PDR	country	Meiko Yabuta	Representative of CP4 (Interviewed by Skype)
UNFPA Lao PDR	country	Natasha Bolhman, Midwife	SSA-Midwife/Nurse Clinical Training Advisor
UNFPA Lao PDR	country	Pafoualee Leechuefoung	Assistant Representative - Gender (Interviewed by Skype)
UNFPA Lao PDR	country	Sally Sakulku	MNCH Coordinator
UNFPA Lao PDR	country	T.A Garagghan	SSA-ASRH/HIV Programme Specialist
UNFPA Madagascar	country	Cheikh Tidiane Cissé	Représentant
UNFPA Madagascar	country	Eugène Kognyuy	Conseiller Technique, Santé Maternelle
UNFPA Madagascar	country	Edwige Ravaomanana	Chargée de programme santé de la reproduction
UNFPA Madagascar	country	Dotiane Wanogo Ali	Conseiller Technique Principal - SPSR
UNFPA Madagascar	country	Nohisoa Rabenampoizina	Chargée de programme suivi et évaluation
UNFPA Madagascar	country	Ratsarazaka Solomandresy	Chargée de programme humanitaire

List of persons met in country offices of MHTF countries (continued)

Organization	Level	Name	Position
UNFPA Madagascar	country	Lordfred Achu	Conseiller Technique Principal - SR
UNFPA Madagascar	country	Philemon Ndremana	Chargé de programme Santé Reproductive des Adolescents et VIH/SIDA
UNFPA Madagascar	country	Onja Ramiliarijaona	Spécialiste en Genre
UNFPA Sudan	country	Aline Bizimana	Interim Operations Manager
UNFPA Sudan	country	Anas Jabir	Assistant Representative
UNFPA Sudan	country	Dorothy Temu-Usin	Program Specialist
UNFPA Sudan	country	Elqurashi Musa	Reproductive Health Officer
UNFPA Sudan	country	Hibat Abbas	Program Assistant
UNFPA Sudan	country	Lamy Badri	Gender Officer
UNFPA Sudan	country	Omer Gtayeb	Programme Associate
UNFPA Sudan	country	Pam Delargy	Acting Representative
UNFPA Sudan	country	Sally Ahmed	Programme Officer
UNFPA Sudan, Sub-office, North Darfur	country	Moamar Eltalib	Reproductive Health Officer
UNFPA Zambia	country	Dr. Duah Owusu-Sarfo	Country Representative
UNFPA Zambia	country	Dr. Sarai Malumo	National Programme Officer - Reproductive Health
UNFPA Zambia	country	Charles Banda	National Programme Officer - Population and Development
UNFPA Zambia	country	Elizabeth Kalunga	Country Midwifery Advisor
UNFPA Zambia	country	Jenipher Mijere	Country Fistula Advisor
UNFPA Zambia	country	Andrew Kumwenda	National Programme Officer - HIV & AIDS
UNFPA Zambia	country	Precious Zandonda	National Programme Officer - Gender
UNFPA Zambia	country	Carnet Mulenga	Safe Motherhood Officer
UNFPA Zambia	country	Clara Mwala	ASRH/Team Leaders
UNFPA Zambia	country	Wilson Mumba	Officer Assistant
UNFPA Zambia	country	Mercy Kazungula-Ngandu	Finance/Admin Assistant

(continued)

List of persons met in country offices of MHTF countries (continued)

Organization	Level	Name	Position
UNFPA Zambia	country	Mary Kate Bwalya	Reproductive Health Officer/Acting PNO
UNFPA/DSME Burkina Faso	country	Coulibaly, Norbert	Admin. de Planification et SPSR
UNHCR Office East Sudan, Kassala	country	Kriston Antonson	Health and Nutrition Officer
UNICEF Burkina Faso	country	Maurice Hours	Chef de Section Santé Nutrition
UNICEF Burkina Faso	country	Bandayé Yemdame	
UNICEF Cambodia	country	Viorica Berdaz	Chief of Health and Nutrition
UNICEF Lao PDR	country	Dr. Ataur Rahman	Officer of Health and Nutrition Section
UNICEF Madagascar	country	Paul Ngklakum	Chargée de santé et nutrition
UNICEF Madagascar	country	Denis Mahuza	Spécialiste en santé
UNICEF Madagascar	country	Paul Richard Ralairinina	Spécialiste en santé
University of Zambia - School of Population studies	country	Dr Namuunda Mutombo	Head
University of Zambia - School of Population studies	country	Vesper H. Chisumpa	Lecturer
University Teaching Hospital Zambia	country	Dr Lackson Kasonka	Managing Director
University Teaching Hospital Zambia	country	Sr Masopela	Sister in Charge - Fistula Ward
UNPFA Sudan	country	Mohammed Abdalaziz	National Project Professional Personnel - Kassala State
UNPFA Sudan	country	Mohammed Abdulkareem	Reproductive Health Officer
UNPFA Sudan	country	Mohammed Ahmed	NPO
UNPFA Sudan	country	Mohiadin Abubaka	DDR Consultants
USAID Cambodia	country	Dr. Sophea Narith Sek	Development Assistance Specialist
USAID Madagascar	country	Jocelyne Andriamiadana	Chargée de programme, bureau santé, population et nutrition
USAID Zambia	country	Dr. Susan Brems	USAID Zambia - Mission Director
USAID Zambia	country	Dr. George Sinyangwe	Senior Health Advisor
USAID Zambia	country	Dr. Musuka Mussunali	Health Advisor
Visite de terrain à Tuléar Madagascar	country	Raymond Daniel	Directeur régional de la santé
Wad Sharefi Refugee Camp - Hospital	country	Asha Ahmed	Assistant Health Visitor

List of persons met in country offices of MHTF countries (continued)

Organization	Level	Name	Position
Wad Sharefi Refugee Camp - Hospital	country	Hassina Mohammed Adam	Midwife
Wad Sharefi Refugee Camp - Hospital	country	Jehan Hassan	PMTCT Counselor
Wad Sharefi Refugee Camp - Hospital	country	Khadija Siraj	Midwife
WHO Ethiopia	country	Dr Atnafu Getachew	Maternal and Newborn Health Team
WHO Lao PDR	country	Dr. Liu Yungo	WHO representative
WHO Madagascar	country	Masy Harisoa	Administrateur de programme de Sante Familiale
WHO Sudan	country	Dr. Nada Yahya Hamza	National Program Officer
WHO Sudan	country	Dr Shah Waliullah Siddiqi	Health Cluster Coordinator
WHO Sudan	country	Dr. Hanan Abdo	
WHO Zambia	country	Patricia Kananga	Safe Motherhood Officer
World Bank Ethiopia	country	Dr Miraf Tadesse	Project Coordinator: Ethiopia and Diaspora Health and Education Professional Mobilization Project
World Bank Lao PDR	country	Dr. Phetdara Chanthala	Health Specialist
Youth Assembly Elmina, CR Ghana	country	Salamatu Halidu	Presiding Member
Youth Assembly Elmina, CR Ghana	country	Owura Essel	Member
Youth Assembly Elmina, CR Ghana	country	Sophia Mensah	Member



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