EVALUATION REPORT

MID-TERM EVALUATION

THE MATERNAL HEALTH THEMATIC FUND CONTRIBUTION TO UNFPA SUPPORT TO MATERNAL HEALTH

Evaluation Branch

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THE MATERNAL HEALTH THEMATIC FUND CONTRIBUTION TO UNFPA SUPPORT TO MATERNAL HEALTH

Mid-Term Evaluation of the Maternal Health Thematic Fund

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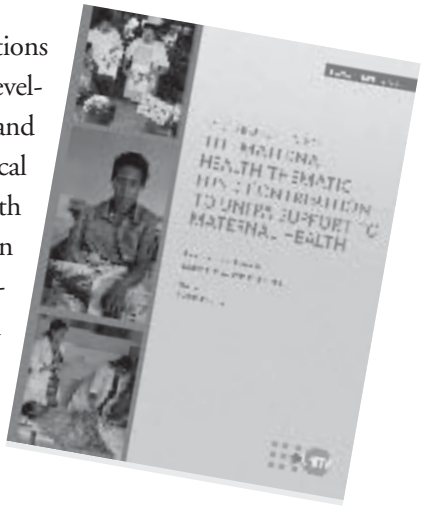
Foreword

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 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 155 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) in the overall context of UNFPA support to maternal health. The MHTF was designed as a rapid and flexible funding mechanism for those programme countries presenting the greatest maternal health needs. It aims at implementing and scaling up effective maternal and newborn health interventions as part of country-owned and country-driven initiatives to support the capacity of national health systems to achieve results in reducing maternal mortality and morbidity. After an initial selection of 11 countries, the MHTF now operates in 30 countries where it complements UNFPA core resources to support capacity development, as well as the provision of equipment, supplies and drugs in the area of maternal health.

This mid-term evaluation assesses the extent to which the MHTF has reached its objectives as set out in the MHTF Business Plan 2008-2011. It concludes that the MHTF funded interventions have led to catalytic effects in leveraging resources by, in particular, providing support to the development of well-articulated, comprehensive and budgeted plans endorsed by national governments

and to which development partners have contributed. With the MHTF, UNFPA has been instrumental in increasing attention to maternal mortality and in refocusing governmental priorities in maternal health. Specifically, the MHTF strong emphasis on midwifery and emergency obstetric and newborn care (EmONC) has constituted a strong basis for accelerating progress in these crucial areas. For the country offices, the MHTF has also been a valuable source of additional human resources as well as useful technical guidance and tools to reinforce their capacity and expertise. However, complementarities and synergies between MHTF funded interventions and the activities planned on core resources and other funds have not been optimally achieved with country-level plans remaining too fragmented despite efforts to coordinate them at the organizational level. Overall, the MHTF contribution has not been planned in a sufficiently strategic manner within the framework of UNFPA overall reproductive health component at country level to secure the continuation of interventions and ensure the sustainability of results.

The mid-term evaluation of the MHTF was conducted with a view to complementing the Evaluation Branch broader thematic evaluation on UNFPA support to maternal health with which it shares a number of important conclusions. In particular, both reports point at the insufficient guidance available to country offices for identifying and addressing the constraints and needs of the population groups most vulnerable in terms of maternal health. The mid-term evaluation also shows that the MHTF has not been able to establish strong mechanisms for reporting on results, hence reflecting the overall weaknesses of the monitoring system already highlighted in the thematic evaluation. It will therefore be useful for the reader to consider the contribution of the MHTF within the broader context of UNFPA support to maternal health and use the present report in conjunction with the thematic evaluation report.

To conduct this mid-term evaluation of the MHTF, 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 a group of independent experts from *AGEG Consultants eG*, and I am thankful to Martin Steinmeyer whose leading role was pivotal in ably guiding the evaluation team through the design, data collection and analysis as well as reporting phases. Within the broader framework of the thematic evaluation of UNFPA support to maternal health, Isabelle Cazottes carried out the mid-term evaluation of the specific contribution of the MHTF. I am most grateful to her for her commitment and dedication. Martin and Isabelle's work, together with the whole team of consultants (including local consultants for the field phase), enabled the complex scope of an evaluation of UNFPA support to maternal health including the contribution of the MHTF 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.

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 mid-term evaluation will be useful for UNFPA to strengthen the Maternal Health Thematic Fund so as to help focus attention and support to save the lives of women in those countries in greatest need, and thus further contribute to the progress towards MDG 5.

Louis Charpentier
Chief, Evaluation Branch

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List of Acronyms

AMDD	Averting Maternal Death and Disability
ARO	Africa regional office
AWP	Annual work plan
CARMMA	Campaign on Accelerated Reduction of Maternal, Newborn and Child Mortality
CIDA	Canadian International Development Agency
CMA	Country midwifery advisor
CO	Country office
CPAP	Country programme action plan
DHS	Demographic health survey
DOS	Division for Oversight Services
EmONC	Emergency obstetric and newborn care
FGM/C	Female genital mutilation/cutting
GNI	Gross national income
GPRHCS	Global Programme to Enhance Reproductive Health Commodity Security
H4+	UNFPA, UNICEF, the World Bank, WHO and UNAIDS
HEF	Health Equity Fund
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HMIS	Health Management Information System
HQ	Headquarters
HRH	Human resources for health
HSDP	Health Sector Development Programme
ICM	International Confederation of Midwives
ICMA	International country midwifery advisor
ICPD	International Conference on Population and Development
IDWG	Interdivisional Working Group
IEOS	Integrated Emergency Obstetric and Surgery
IFC	Individual, family, community
M&E	Monitoring and evaluation

MDG	Millennium Development Goal
MHTE	Maternal Health Thematic Evaluation
MHTF	Maternal Health Thematic Fund
MMR	Maternal mortality ratio
MoE	Ministry of Education
MoH	Ministry of Health
MTSP	Medium Term Strategic Plan
Lao PDR	Lao People's Democratic Republic
PMTCT	Preventing mother-to-child transmission
PPM	Policies and procedures manual
RHTF-IDWG	Reproductive Health Thematic Funds Interdivisional Working Group
RO	Regional office
SIDA	Swedish International Development Cooperation Agency
STI	Sexually transmitted infection
TD	Technical Division
ToR	Terms of reference
TWG	Technical Working Group
UBW	Unified Budget and Work plan
UN	United Nations
UNAIDS	Joint United Nations Programme on AIDS
UNDAF	United Nations Development Assistance Framework
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
UNV	United Nations Volunteers
US$	US dollar
WHO	World Health Organization

Executive Summary

Purpose and scope of the evaluation

The purpose of this mid-term evaluation is to assess the design, coordination, and added value of the Maternal Health Thematic Fund (MHTF) as a targeted effort to improve maternal health. The evaluation was carried out simultaneously with the thematic evaluation of UNFPA support to maternal health (MHTE) with a view to realizing the potential for synergies between the two exercises.

The mid-term evaluation is based on the strategic framework of the MHTF as contained in the MHTF Business Plan. The evaluation focuses on specific technical areas such as midwifery, family planning and emergency obstetric and newborn care (EmONC) and assesses the potential for the MHTF to act in a catalytic manner. The evaluation also covers the internal coordination and management processes of the MHTF (support to planning, programming and monitoring; coordination and management mechanisms; the MHTF progress in facilitating integration and use of synergies). Additionally, aspects of leveraging and visibility are assessed. Following the terms of reference, the evaluation covers the period from the launch of the MHTF in 2008 until 2010, and also includes information related to a number of interventions implemented in 2011.

Context

UNFPA has developed a broad range of interventions to help improve maternal health at the global, regional and country levels within its three core programmatic areas — reproductive health and rights, gender equality, and population and development. UNFPA resources support integrated reproductive health services and interventions to address maternal mortality, gender-based violence, harmful traditional practices, sexually transmitted infections including HIV, adolescent reproductive health, as well as family planning. During the period under evaluation, UNFPA has provided support to 155 countries, areas and territories.

Different funds at UNFPA such as the MHTF and the Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS) support specific areas of reproductive health. The GPRHCS provides technical assistance, commodities and financial support to selected programme countries.

The MHTF was launched in 2008 to help accelerate progress towards the achievement of the Millennium Development Goal 5 — *Improve maternal health*. The MHTF represents a focused effort in some of the poorest countries in the world with the greatest maternal health needs. It is intended to be a quick and flexible funding mechanism and a tool to make additional technical expertise available to UNFPA programme countries. The Campaign to End Fistula and the International Confederation of Midwives (ICM), Midwifery Programme, were also integrated into the MHTF umbrella fund in 2009.

The eligibility criteria for MHTF funding were: high maternal mortality (> 300 per 100,000 live births), recommendations from the H4+ group, the commitment of country teams (government and partners) and the support by the Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS).

The MHTF started in 11 countries and by 2010 was providing support in 30 countries, as well as in 12 additional countries for obstetric fistula only (through the Campaign to End Fistula). Most interventions started in 2009. The MHTF budget rose from 1 million USD in 2008 to 14 million in 2009 and 21 million in 2010.

Methodology

The evaluation assesses the relevance, effectiveness, efficiency and potential sustainability of the MHTF support, based on a set of eight evaluation questions.

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

chosen for an extended desk review. From this purposive sample, eight countries which received support from the MHTF (Burkina Faso, Cambodia, Ethiopia, Ghana, Lao PDR, Madagascar, Sudan, and Zambia) were selected for the field phase. Country case studies were also conducted in DRC and Kenya, two non-MHTF recipient countries.

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, the 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.

Main findings

The MHTF adequately focused on the countries with the greatest needs as well as on the most vulnerable groups within countries.
The MHTF has rightly based its selection of beneficiary countries on the intensity of their maternal health needs and on the degree to which their environment is conducive to bringing about the MHTF "catalytic action" e.g.– commitment of partners, capacity of country offices.

Although the MHTF has supported various initiatives targeting vulnerable groups (e.g., focus on specific geographical areas with low reproductive health indicators, maternity waiting homes, obstetric fistula programmes, etc.), few interventions led to the prioritization of vulnerable groups in national strategies.

MHTF has contributed to the strengthening of human resources planning and availability (particularly of midwives) for maternal health and newborn health.
The MHTF has contributed to addressing the urgent need for skilled health professionals, particularly midwives and other mid-level health providers, through a three-pronged approach: (i) generation of evidence; (ii) capacity development and (iii) policy dialogue. Significant support was given to increasing the availability of skilled health professionals and capacity development. However, the strengthening of human resources management – for example through supportive supervision, continuous education, quality assurance, or improved deployment and retention of maternal health care providers, has not been sufficient to ensure the improvement of midwifery services in the long term.

MHTF has contributed to scaling-up and increasing access to and use of family planning.
The MHTF contribution to scaling-up and increase access to family planning is limited. This is explained by the fact that most countries receive, in addition to MHTF funding, support from the GPRHCS. Only a few synergies could be observed through the integration of: (i) family planning updates in the midwifery curricula review; (ii) maternal health commodities in the list of reproductive health commodities; (iii) messages during awareness campaigns to create demand; and (iv) family planning data in the EmONC assessment. Coordination between the two initiatives was sometimes insufficient. In addition, MHTF funds were often used to fill gaps without sufficient prior analysis of potential complementarities.

MHTF has contributed to the scaling-up, utilization of, and access to EmONC services.
The focus of the MHTF on EmONC needs assessments and on the development of EmONC improvement plans has contributed to advancing EmONC in countries that had identified EmONC as a priority but where its operationalization had hardly progressed.

The evidence provided by the needs assessments is a strong basis for national and sub-national planning for improving EmONC services. However, in most countries it is still too early to predict whether governments or development partners will be in a position to fund these plans despite regular MHTF advocacy for maternal health. Regarding access to EmONC services, the MHTF efforts to help remove barriers (such as cultural and gender but also transportation and cost-related factors) have been insufficient to substantially improve the utilization of these services.

MHTF has contributed to the improvement of planning, programming and monitoring with a view to ensuring that maternal and reproductive health are priority areas.
The MHTF has emphasized advocacy and technical support, the provision of appropriate tools and the issuing of guidelines for specific areas such as midwifery and EmONC. However, its contribution to better positioning of maternal health within national strategies cannot be separated from longstanding UNFPA efforts. MHTF efforts to help countries produce evidence (such as baseline EmONC, midwifery data and maternal death audits) and monitoring plans for maternal health interventions have contributed to developing a culture of evidence-based planning and programming. However, further support is needed for the operationalization of monitoring systems geared at assessing results.

The MHTF has contributed to the improvement of the management mechanisms and internal coordination processes at all levels (global, regional and countries) hence leading to the enhancement of its overall performance.
Country offices received significant assistance in terms of additional staffing, technical support, knowledge sharing and various guidance documents and tools. Some gaps remain, particularly with regard to support for strategic planning as well as specific areas such as strengthening of human resources management, gender integration, and advocacy with government partners. The monitoring and evaluation capacities have not yet been sufficiently strengthened to allow for a measurement of MHTF achievements.

The achievement of synergies between the MHTF and other UNFPA thematic funds, has not been systematic.
Efforts toward integration of the thematic funds in the area of maternal health, (e.g. the GPRHCS, the Campaign to End Fistula, the UNFPA-International Confederation of Midwifes Midwifery Programme and the UNFPA HIV-Preventing Mother-to-Child Transmission programme) benefited from the introduction of joint planning and reporting. However, most countries still plan the different components and programmes in parallel and do not integrate all components into a single strategic reproductive health plan. As a result, programmes tend to lack coherence and efficiency and synergies are not optimized.

The MHTF has contributed to increase the visibility of UNFPA maternal health which in turn allowed the organization to leverage additional resources for maternal health.
MHTF has contributed to increasing the visibility of UNFPA in the areas of maternal health and sexual and reproductive health by ensuring a strong presence in key maternal health events at the global level, in the African Region, as well as in the international media. In MHTF-supported countries, UNFPA is considered a key player in maternal health. This is due to the strong focus of the MHTF on EmONC and midwifery, and its provision of additional technical expertise (through recruiting country midwifery advisors and maternal health technical advisors) as well as sound technical tools.

Nevertheless, a link between higher visibility in maternal health and the leveraging of substantial additional resources could not be fully established at the global level. One exception is the H4+[3] initiative, in which UNFPA and particularly the MHTF have been active and which has attracted additional funds for maternal health.

Country-level undertakings supported by the MHTF, such as the EmONC assessments and plans and midwifery edu-

cation, have attracted donors in search of technically-sound interventions to support. These interventions also led to additional government commitment to increasing personnel quotas (midwives) and to improving the development of infrastructures linked to EmONC improvement plans.

Main conclusions

The **MHTF acted as a catalyst in specific areas**, for instance, the support provided to developing coherent emergency obstetric and newborn care (EmONC) improvement plans that governments endorsed and to which development partners contributed. However, the catalytic effect of increasing complementarity and synergies was not optimally achieved. This can be attributed to the fact that, at country office level, MHTF interventions were not planned strategically within the framework of the overall reproductive health component. There was also insufficient coordination between all sources of funding for reproductive health.

For some MHTF interventions, policy dialogue, knowledge transfer and the strengthening of partnerships were used in order to produce sustainable effects. However, **sustainability prospects were at times compromised by a lack of strategic long-term planning**. For example, MHTF programming does not include handover or exit strategies that would guarantee the continuation of MHTF-funded initiatives once support is terminated.

The MHTF focus on midwifery and EmONC is relevant and appropriate. Due to the MHTF efforts in these areas, programme countries have since put maternal health higher on their agenda and have improved availability of midwifery and EmONC services. While the MHTF effectively responded to a global context of midwife shortage, lesser attention was given to follow-up strategies, such as ensuring that midwives are adequately deployed and remain at their place of posting.

MHTF investment in family planning is not justified in those programme countries that already receive major resources from the GPRHCS. In contrast, the MHTF involvement in family planning is especially relevant for those interventions aiming at fostering synergies with skilled birth attendance and EmONC.

In its efforts to address maternal health issues, the MHTF has not sufficiently prioritized demand creation. This has resulted in **gaps in the strategy to address the numerous barriers preventing access to skilled attendance at birth and EmONC services**. Comprehensive strategies to improve demand for and use of those services are not adequately developed within the overall efforts to reduce maternal mortality.

MHTF input has been instrumental in the policy dialogue to refocus government maternal health priorities and has led to increased national commitments. Nevertheless, insufficient emphasis was placed on identifying and addressing the specific needs of the most vulnerable groups.

MHTF support has contributed to laying the groundwork for improving midwifery and EmONC services by establishing standards and regulations. However, the MHTF did not sufficiently advocate for and support the development of quality assurance strategies and mechanisms for ensuring compliance with those standards and the long-term maintenance of service quality.

The MHTF **has established appropriate mechanisms to improve the technical capacity of country offices** with a view to supporting the maternal health component of the programme. However this support has mostly consisted in responding to the immediate needs triggered by the design and implementation of MHTF interventions. This support **may not be sufficient for ensuring the adequate follow-up of the interventions initiated under the MHTF**.

The MHTF has increased resources and provided useful technical guidance, mechanisms and tools (e.g., planning process, updating staff knowledge) **to strengthen the capacity of country offices to focus on**

key maternal health interventions. However, it has not made sufficient use of the support from regional offices. Moreover, a lack of coordinated guidance and clarity with regard to the reporting channels between regional (or sub-regional) offices and headquarters have resulted in unclear accountability lines.

Recommendations

R1 **Provide country offices with guidance for developing multi-year country strategic plans for the use of MHTF funds.** These plans should reflect the strategic vision of the MHTF (i.e., focus on key maternal health issues). The country MHTF multi-year strategic plans should be a part of the country programme action plan. These should also be integrated into a multi-annual reproductive health plan to be developed by country offices. They should also serve as the basis for the preparation of the annual work plans.

R2 **Provide country offices with guidance for assisting their respective governments in identifying the population groups most at risk and their particular needs in terms of maternal health.** Such support is consistent with UNFPA overall approach of working with vulnerable groups. Once identified, those groups should be the focus of the support provided by MHTF interventions as part of the country office approach to strengthening maternal health systems.

R3 **In collaboration with regional offices, support country offices in developing projections of their needs for technical support at the different phases of the MHTF interventions** (based on the multi-year plan). Ensure that appropriate support is made available (based on the identified needs) and strengthen technical expertise for country offices accordingly.

R4 **Provide country offices with support for ensuring that the MHTF adopts a more comprehensive approach to health system strengthening.** Such an approach should support national counterparts in the identification of key bottlenecks to improving maternal health. This approach should foresee the mobilization of resources to ensure that interventions initiated under the MHTF are appropriately followed up. Technical support and expertise should be available for countries to address these issues, namely by mobilizing the necessary expertise within UNFPA or through advocacy with partners, i.e., human resources for health.

R5 **Specific attention needs to be dedicated to those barriers preventing access to, and use of, maternal health services** — skilled attendance at birth, EmONC. These barriers must be taken into consideration in national strategies and MHTF-supported interventions must contribute to addressing them. It is recommended to support reviews of existing experiences and approaches at country level in addressing barriers, develop strategies to address them and provide technical support for the implementation and monitoring of these strategies with a view to scaling-up successes.

R6 **Provide country offices with support for ensuring that MHTF interventions include mechanisms for maintaining the level of quality of the outputs.** Quality assurance should be an integral component of all programming processes of MHTF-supported interventions by ensuring a quality assurance strategy is in place and by defining standards and regulations. It is also important to strengthen the capacity of government partners by providing technical support for developing or adapting the necessary quality assurance tools to ensure that standards and regulations are complied with and ensuring, through pretesting, that developed tools are well adapted to the field and that they are sufficiently practical.

CHAPTER 1

Introduction

1.1 Purpose of the evaluation

The objectives of the mid-term evaluation of the Maternal Health Thematic Fund (MHTF) are to assess to what extent MHTF support has been relevant, effective, efficient and sustainable in contributing to the improvement of maternal health. The mid-term evaluation focused on technical areas (midwifery, family planning and emergency obstetric and newborn care) and on the potential of the MHTF to act as a catalyst in these areas. The evaluation also covered the internal coordination and management processes of the MHTF (support to planning, programming and monitoring, coordination and management mechanisms, and the facilitation of the integration and use of synergies). Additionally, aspects of leveraging and visibility were assessed. The temporal scope of the mid-term evaluation covers the period from the launch of the MHTF in 2008 until 2010, and also includes information related to a number of interventions implemented in 2011.

The mid-term evaluation of the MHTF was carried out in parallel to the maternal health thematic evaluation (MHTE) of UNFPA support to maternal health so as to make use of potential for synergies in the evaluation portfolio of UNFPA. The findings of the MHTE have been published in a separate report that is available at the web page of the Evaluation Branch of UNFPA.[4]

1.2 MHTF mandate and strategy in the field of maternal health

UNFPA launched the Maternal Health Thematic Fund (MHTF) in early 2008 to help accelerate progress towards the achievement of Millennium Development Goal (MDG) 5 and increase UNFPA support to high maternal mortality countries for reducing maternal mortality and morbidity. The MHTF adopted a three-pronged strategy of proven and evidence-based interventions that have the potential for contributing efficiently and effectively to improving maternal health, namely to ensure that:[5]

- All women have access to contraception to avoid unintended pregnancies;
- All pregnant women have access to skilled care at the time of birth; and
- All women with complications have timely access to quality emergency obstetric care.

With a focus on some of the world's poorest countries with the greatest maternal health needs, the MHTF is designed to be a quick and flexible funding mechanism and provide technical expertise. One of the fundamental principles underpinning the work supported by the MHTF is that it is country-owned and country-driven development and support for the national health plan. To this end, MHTF activities in each country are determined together with the respective governments and in a consultative process with key partners and stakeholders as well as in coordination with other UNFPA programmes.

[4] http://www.unfpa.org/public/home/about/Evaluation/EBIER/TE/pid/10094
[5] MHTF Business Plan 2008-2011.

The UNFPA Midwives Programme, in collaboration with the International Confederation of Midwives (ICM) and the Campaign to End Fistula, were integrated into the MHTF. The purpose of this integration was to ensure better alignment with national policies and greater aid effectiveness within the national maternal and reproductive health components of ongoing UNFPA country programmes.

The intervention logic of the MHTF was analyzed by developing a *diagram of expected effects* based on the MHTF 2008-2011 Business Plan. These diagrams represent a type of logic model that visualizes the main elements (activities or activity types, outcomes and impacts) that are expected to result from a given intervention or set of interventions (see Figure 1).

The MHTF seeks to contribute to the two targets of MDG 5—reducing the maternal mortality ratio and increasing the proportion of births attended by skilled health personnel—with the ultimate goal of reducing the maternal mortality ratio by three quarters between 1990 and 2015.

The main MHTF objective is to increase access to and utilization of quality maternal health services in order to reduce maternal mortality and morbidity. In this way, it will contribute to realizing Outcome 2 of the UNFPA Strategic Plan (MTSP) and Sexual and Reproductive Health Framework (2008–2013).[6]

The MHTF seeks to be catalytic and, in collaboration with governments and key partners, to support the following outputs (see Figure 1):

- An enhanced political and social environment for maternal and newborn health and sexual and reproductive health;
- Up-to-date needs assessments for the sexual and reproductive health package of interventions with a particular focus on family planning, human resources for maternal health, and emergency obstetric and newborn care (EmONC);
- A focus within national health plans on sexual and reproductive health, especially family planning and EmONC, with strong reproductive health/HIV linkages to achieve the health MDGs;
- National responses to the human resource crisis in maternal health, with a focus on planning and the scale-up of midwifery and other mid-level providers;
- National equity-driven scale-up of family planning and EmONC services and of maternal and newborn health commodity security;
- Monitoring and results-based management of national maternal health efforts;
- Leveraging of additional resources for MDG 5 from governments and donors.

In the following effects diagram[7] (see Figure 2), the logic of the MHTF Business Plan was expanded to include the intermediary outcomes. These intermediary outcomes are not explicit enough in the Business Plan although they are logically required to make a contribution to maternal health through the MHTF. These intermediate outcomes and the goals of the Business Plan have been used to define the evaluation questions (see Chapter 3), which were analyzed in this evaluation.

The MHTF was initially launched in 2008 in 11 countries, and by 2010 was operating in 30 countries to support maternal health[8] as well as in 12 additional countries as part of the Campaign to End Fistula which had been integrated into the MHTF. Most interventions started in 2009. Table 1 presents a summary of the MHTF scope and geographic coverage since its inception.

[6] More specifically, the MHTF is intended to contribute to outcomes 2.1, 2.3 and 2.4 of the MTSP. (2.1 Universal access to sexual and reproductive health; 2.3 Access to and utilization of family planning; and 2.4 Demand, access to and utilization of quality HIV and Sexually Transmitted Infection (STI) prevention services).

[7] See section 3.2.1 for more information.

[8] Afghanistan, Bangladesh, Benin, Burkina Faso, Burundi, Cambodia, Chad, Côte d'Ivoire, Democratic Republic of Congo, Djibouti, Ethiopia, Ghana, Guyana, Haiti, Lao People's Democratic Republic, Liberia, Madagascar, Malawi, Mali, Mozambique, Namibia, Nepal, Niger, Nigeria, Rwanda, Sierra Leone, Sudan, Uganda, Yemen and Zambia.

Figure 1: Overview of the MHTF Business Plan

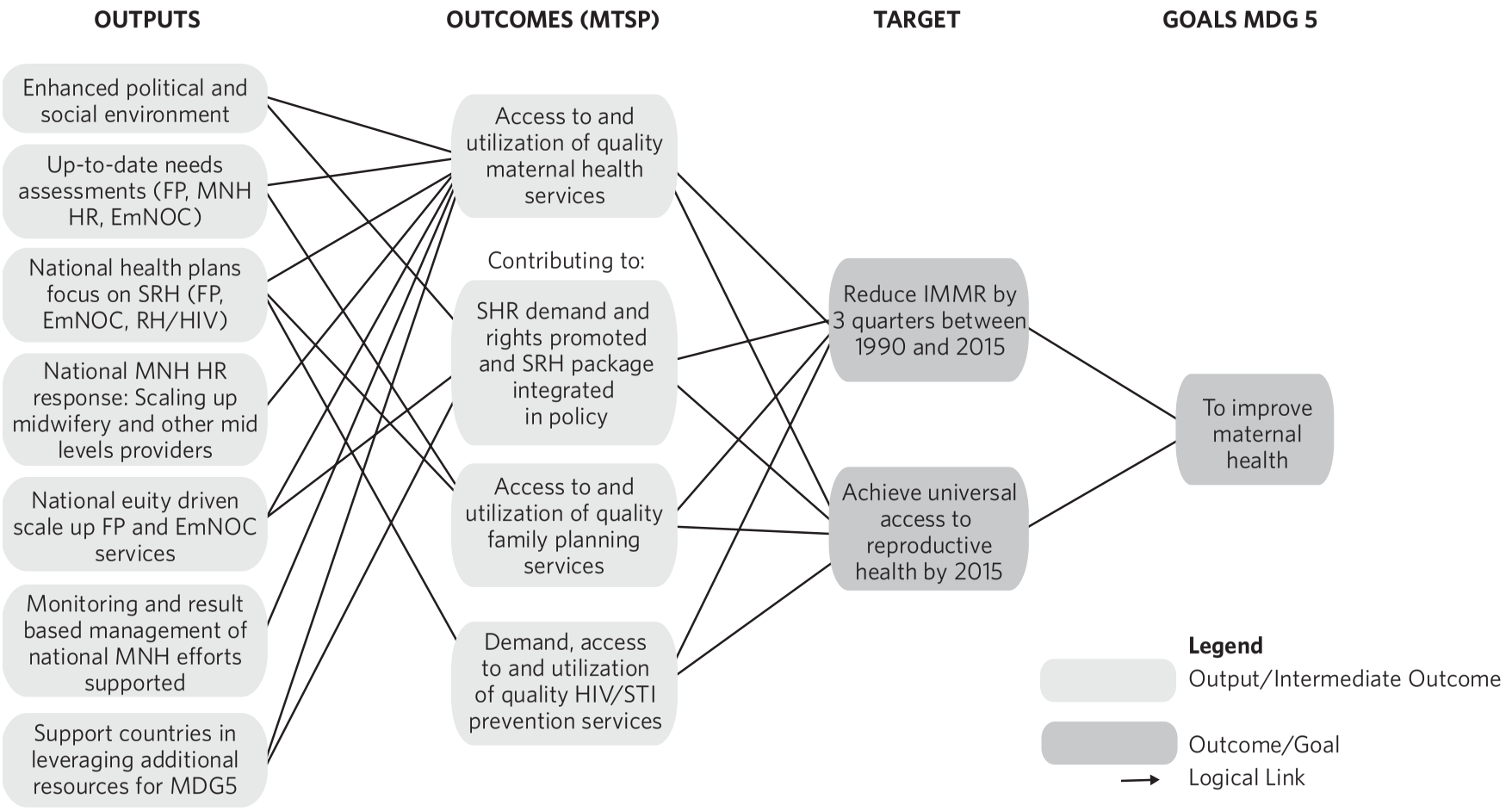


Figure 2: Effects diagram for MHTF Business Plan 2008–2011

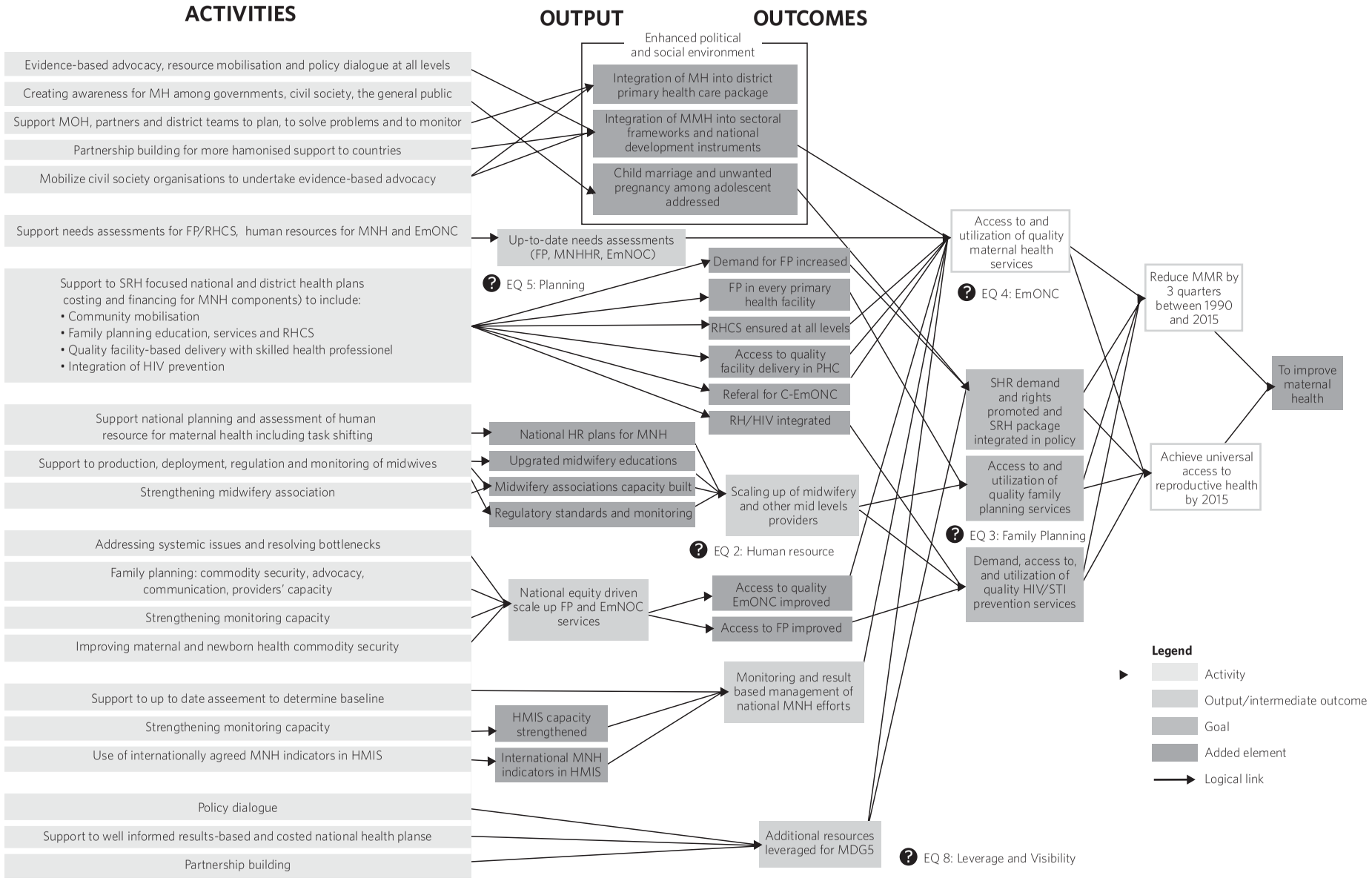


Table 1: Evolution of support to countries by the MHTF, 2008–2011

	2008: Launch of the MHTF	2009: First full year of operations	2010: Second year of operations	2011: Third year of operations[9]
Countries supported in maternal health overall	11	15	30	33*
Countries supported by the Midwifery Programme	-	15	22	30
Countries supported by the Campaign to End Fistula	-	25	42	43*
Total number of countries supported by the MHTF	**11**	**25**	**42**	**43**

Source: Technical Division, UNFPA.

Table 2: Overview of UNFPA expenditures in the field of maternal health

Item	2008	2009	2010	Total for the period of this mid-term evaluation
Overall UNFPA expenditures (in US$,000)[10]	340,400	366,200	347,800	*1,054,400*
Overall UNFPA expenditures for reproductive health (including maternal health) (regular sources, in US$,000)[11]	165,200	170,100	174,000	*509,300*
Number of countries receiving support from UNFPA	158	155	123	-
Expenditures of MHTF (total in US$,000)[12]	1,000	14,200	21,000	*36,200*
Number of countries receiving funding from MHTF[13]	*11*	*15*	*30*	-
Percentage of MHTF expenditures to UNFPA reproductive health expenditures	*0.6%*	*8.3%*	*12.1%*	-
Expenditures of the GPRHCS (total in US$,000)[14]	25,635[15]	87,100	93,550	*206,285*
Number of countries receiving funding from GPRHCS[16]	54	73	45	-
Percentage of UNFPA reproductive health expenditures that corresponds to GPRHCS expenditures	15.5%	51.2%	53.8%	-

Source: Evaluation team, based on different sources (see footnotes).

[9] In 2011, Sudan became two countries, which is reflected in the figures in this table.
[10] UNFPA annual reports 2008, 2009, 2010.
[11] UNFPA annual report 2008, 2009 and 2010.
[12] MHTF mid-annual review 2010.
[13] MHTF mid-annual review 2010.
[14] UNFPA GPRHCS annual report 2009.
[15] Estimation according to UNFPA GPRHCS annual report 2009.
[16] UNFPA GPRHCS annual report 2009 and 2010.

Countries were selected to receive MHTF support based on the following criteria:

- High maternal mortality (> 300 per 100,000 live births);
- Recommendations from the H4+ group, which identified 25 priority countries in 2008;
- Commitment of country teams (government and partners);
- Support by the Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS) to foster synergistic action between the two thematic funds.

Table 2 presents an overview of the expenditures of the MHTF until 2010 and related UNFPA expenditures for maternal health overall.

CHAPTER 2

Methodology

The following sections describe the main components of the methodology used for the mid-term evaluation of the MHTF. 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. Finally there is a description of how this information has been used as a basis for formulating judgments on the performance of the MHTF and for formulating answers to the evaluation questions.

2.1 Overview of the evaluation process

The MHTF mid-term 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 for finalizing 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 (see Section 2.3.1 for the methods and tools used in the desk review that was carried out during this phase).
- A *field phase* to implement the country case studies and to conduct interviews with key stakeholders at global and regional level (see Sections 2.3.2 and 2.3.4 for information on the methods and data collection tools used during the field 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 for the different tools and methods used in the design of this evaluation.

2.2.1 Analysis of the MHTF Business Plan

The specific scope of the MHTF mid-term evaluation was determined on the basis of a review of the MHTF Business Plan. The mid-term evaluation started with a detailed analysis of the MHTF Business Plan and its intervention logic, that is, the intended results and their underlying cause and effect relationships that were intended to contribute to the results of the overall UNFPA support in maternal health. In order to analyze the MHTF Business Plan, the evaluators constructed a series of *effects diagrams* (see Section 1.2) to help visualize the theory of change that MHTF had intended to use to improve the performance of the maternal health portfolio of UNFPA.

These effects diagrams helped the evaluators to:

i. comprehensively analyze the main elements, overall logic and intervention theory underlying MHTF support to maternal health; this helped the evaluators

improve and deepen their understanding of the MHTF approach,

ii. compare and contrast the approach and strategy of the MHTF with that of the overall strategy with regard to reproductive and maternal health.

The development of these diagrams occurred in two distinct phases:

- The drafting of a diagram that depicted the elements and linkages specifically mentioned in the MHTF Business Plan;

- The logical reconstruction of the intervention logic of MHTF by adding, where necessary, the elements (intermediate outcomes, etc.) and linkages needed to make the diagrams more logically coherent.

2.2.2 Evaluation questions and judgment criteria

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

a) reflect on the topics raised in the terms of reference (ToR) for this evaluation; *and*

b) focus on key components of the MHTF intervention logic, as analyzed and mapped in the effects diagrams in the previous steps.

c) analyze the MHTF strategy in accordance with four of the five standard DAC evaluation criteria (relevance, effectiveness, efficiency, sustainability).

The evaluation questions covered both internal issues of the MHTF, such as the internal coordination and management processes, as well as issues relating to the thematic portfolio financed by the MHTF.

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.

In order to show clearly and transparently how the evaluators sought to judge the performance of the MHTF, the evaluators then defined a set of **judgment criteria**[17] for each evaluation question and a set of qualitative and quantitative **indicators** for each judgment criterion. The judgment criteria specified which aspects of MHTF-supported interventions, their results, or MHTF internal procedures and mechanisms would become the basis for the evaluators' assessment. This approach allowed a more streamlined and focused collection and analysis of data. The judgment criteria, which form the basis to the answers for the evaluation questions, are specified for each evaluation question in Chapter 3.

2.2.3 The typology of MHTF-funded activities

The MHTF Business Plan, the MHTF Annual Report the corresponding country office Annual Work Plans (AWP), and joint reports of the reproductive health thematic funds 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 documents were not specific enough to reliably guide data collection (see section 2.3). The evaluators therefore developed a typology of MHTF-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 30 annual work plans (AWP) made available to the evaluators by country offices.

17 A judgement criterion specifies an aspect of the evaluated field or intervention that will allow its merits or success to be assessed.

2.2.4 Staged sampling to define the geographic scope of the evaluation

The evaluation team carried out a comprehensive staged sampling process to select the countries to be included in the Maternal Health Thematic Evaluation (MHTE) and the MHTF mid-term evaluation.[18] 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.[19]

In the second sampling stage, 22 countries out of the initial 55 were selected for inclusion in the extended desk phase. In order to ensure that different types of country context were included in this second-stage sample, the countries were grouped and selected according to the following criteria (see Table 3).

Table 3: 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).

In the third sampling stage, ten countries out of the group of 22 were selected for in-depth case studies (field phase);[20] eight of these countries were recepients of the MHTF (see table 4).

Overall, by 2010 MHTF supported 30 countries (and 12 additional countries were supported by the Campaign to End Fistula). The countries which received support from the MHTF are presented in Table 4 below.

Table 4: Programme countries of the MHTF[21]

Launch of MHTF in 2008	Launch of MHTF in 2009[22]	Launch of MHTF in 2010
Benin	Ivory Coast	Afghanistan
BURKINA FASO	GHANA	Bangladesh
Burundi	Uganda	Chad
CAMBODIA	ZAMBIA	DEMOCRATIC REPUBLIC OF CONGO
Djibouti		LAO PDR
ETHIOPIA		Liberia
Guyana		Mali
Haiti		Mozambique
MADAGASCAR		Namibia
Malawi		Nepal
SUDAN		Niger
		Nigeria
		Rwanda
		Sierra Leone
		Yemen

Source: MHTF annual reports 2008, 2009, and the MHTF mid-term review 2010.
Note: countries in capital letters were selected as country case studies.

[18] This combined sampling process (MHTE and MHTF) led to the inclusion of additional criteria to allow for synergies in the implementation of the evaluation.

[19] The sampling criterion has been selected to establish a close link to the MDG five indicators. The data have been taken from the H4 report "Trends in Maternal Mortality: 1990-2008" in agreement with UNFPA.

[20] Burkina Faso, Cambodia, DRC, Ethiopia, Ghana, Kenya, Lao PDR, Madagascar, Sudan, and Zambia.

[21] The Campaign to End Fistula supported 25 countries (Benin, CAR , Chad, Ivory Coast, Congo, DRC , Eritrea, Gabon, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Malawi, Mauritania, Niger, Nigeria, Senegal, Zambia, Afghanistan, Bangladesh, Nepal, Pakistan, Somalia and Sudan). An additional twelve countries received support for obstetric fistula programmes only: Cameroon, Central African Republic, Republic of Congo, Eritrea, Guinea, Guinea Bissau, Kenya, Mauritania, Pakistan, Senegal, Somalia, Timor-Leste.

[22] Those were only supported by the Midwifery Programme.

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 MHTF mid-term evaluation were then collected by means of:

- a desk-based review of existing evaluations, reviews and other documents;
- eight 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 that provided information, in particular on the internal management of the MHTF and the organizational integration of the MHTF into the overall organization of UNFPA (see Section 2.2.4);
- a series of face-to-face and telephone interviews with UNFPA staff associated with MHTF both at headquarters and in the regional and sub-regional offices[23] and other external partners, such as the H4+[24] group (see Annex 3).

The MHTF Business Plan and the periodic global MHTF reports provided an overview that was not sufficiently specific on the types of activity that had been funded. The evaluation team also tried to establish the portfolio of UNFPA and MHTF-funded activities and interventions by country on the basis of data from the ATLAS financial database and the AWP provided by the different countries. Unfortunately, ATLAS data does not provide sufficient detail on UNFPA interventions, such as full programme titles, description of activities, outputs and outcomes, etc. The AWP did not provide adequately detailed information to link specific activities to MHTF support. This situation meant that at the end of the structuring phase the evaluation team had only a limited idea of what types of activity and interventions country offices had carried out in support of maternal health with MHTF resources. This limited the extent to which the evaluators could develop a clear analysis of the theory of change underlying MHTF-supported interventions.

2.3.1 Desk review

The first round of data collection consisted of a review of existing documents, in particular available country programme evaluations, other evaluations, country office annual reports and joint reproductive health thematic funds reports. Unfortunately, since the MHTF only started operations in 2008, few UNFPA evaluations actually covered the 2008-2010 period in countries that had received MHTF funding. In addition, even those evaluations that had been carried out after 2008 generally did not distinguish between support provided with regular funds and the MHTF. Furthermore, none of the other available documents, such as the joint annual reports of thematic funds, provided any kind of assessment or contextual analysis of the MHTF. This made it impossible to compile a complete set of preliminary answers to the evaluation questions for the desk review and to identify a list of *issues to be assessed during the field phase* (see section 2.3.2 below).

As a result, the data collected from this desk review only provided substantial information on a few evaluation questions, i.e., in particular for evaluation question 1 on the relevance of the MHTF. For the other seven evaluation questions, the team decided to use the findings from the MHTF activity typology to conduct a gap analysis on the MHTF theory of change. The purpose of the gap analysis was to identify the main information gaps which needed to be analyzed during the field phase of the mid-term evaluation in order to allow an assessment of the expected outcomes of MHTF.

The evaluators used the gap analysis to identify the *issues to be assessed during the field phase* (in country case studies). These issues included the most critical parts of the MHTF strategy. The global list of *issues to assess* was then adapted to the respective context of each country case study.[25]

[23] Technical Advisor, Regional Team Coordinator, and Senior Programme Advisor.
[24] UNFPA, UNICEF, the World Bank, WHO and UNAIDS.
[25] Therefore, issues addressed may vary from one country case study to the other. Those are shown in the annexes to each country report

2.3.2 Country case studies

The evaluators conducted 10 country case studies in UNFPA programme countries (Burkina Faso, Cambodia, DRC, Ethiopia, Ghana, Kenya, Lao PDR, Madagascar, Sudan (North) and Zambia). The MHTF mid-term evaluation was conducted in eight countries, with the exceptions of Kenya and DRC as they did not benefit, or benefited only recently, from MHTF (see section 2.2.4). The overall list of issues to be assessed was tailored to the specific context of each country case study. During each country visit, the evaluation teams used a range of different tools to collect data and information from UNFPA:

- Individual interviews and collection of documents from the UNFPA country offices and UNFPA partners in the capitals of the eight programme countries. The team focused on collecting qualitative and quantitative data that would help describe the specific role of MHTF in the country. It would also provide contextual information on the MHTF portfolio, its contributions to overall UNFPA support in maternal health, and the role of MHTF in partnerships.

- Field visits to ascertain how MHTF contributions were translated into maternal health services on the ground; during these site visits, the teams also conducted focus group interviews with beneficiaries of MHTF support.

- Follow-up interviews with key partners in the capitals, and a debriefing with UNFPA staff (including MHTF-funded staff) in the country office.

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 above). These countries included 28 of the 30 programme countries of the MHTF.[26] The purpose of the survey was to collect quantifiable information, particularly on the technical support that the MHTF had made available to country offices for implementing MHTF-funded interventions, namely in midwifery, EmONC and family planning.

2.3.4 Key-informant interviews at global and regional level

In addition to the desk review, the country case studies and the online survey, the evaluators also conducted individual interviews with UNFPA staff in headquarters and in the regional and sub-regional offices, both face-to-face and on the telephone. A second round of individual interviews was conducted with global representatives of key UNFPA partners, such as the World Health Organization (WHO), UNICEF, the World Bank and the International Confederation of Midwives (ICM).[27]

The purpose of all of these interviews was to complement the insights gained from country level interviews on the added value and performance of the MHTF with the opinions and perceptions of those involved at global and regional levels.

2.3.5 Limitations to data collection

Table 5 (next page) lists the main limitations relating to data collection experienced by the evaluators.

As indicated in table 5, 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).

[26] From the MHTF programme countries, only Namibia and Guyana did not participate in the online survey. The survey included ten countries receiving MHTF support since 2008, four countries since 2009, and 14 countries since 2010.

[27] For a complete list of interviewees see Annex 3.

Table 5: Limitations in relation to data collection for the MHTF mid-term evaluation

Limitation regarding data collection	Evaluators' response/Implication for the evaluation
Little information on the types of activities that had been funded by MHTF was available during the initial structuring phase. This made it difficult to impart a sufficient degree of focus to the data collection strategy at the conclusion of the structuring phase.	The evaluators compiled a *typology of activities* from individual *annual work plans (AWP)* during the desk phase and used this typology to refine their analysis of the MHTF intervention logic and to develop a more concrete data collection strategy for the subsequent phases. For a more detailed description see Section 2.2.1 above.
Existing evaluations (e.g., country programme evaluations) did not identify the specific contributions of the MHTF as it had only started operations in 2009. As a result no critical assessment of MHTF interventions was available during the desk phase.	The evaluators conducted a gap analysis during the desk phase based in the *typology of activities*, identifying the missing steps in the *theory of change*, and refined their data collection strategy for the subsequent field phase based on the findings of this gap analysis. For a more detailed description see Chapter 2.2.2 above.
Complete sets of MHTF reports were not systematically available at the time of the visits, which made it difficult to determine which intervention had actually been undertaken. Furthermore the existing MHTF/joint RHTF annual reports were of varying quality, and their formats differed from one year to the next. Therefore the analysis of these reports did not allow a comprehensive assessment of the activities and their outcomes.	The evaluators reviewed specific MHTF activities in detail with UNFPA country office staff and its partners in order to assess their implementation and their possible outcomes.
In many countries MHTF resources had been used together with funds from the other reproductive health thematic funds and general budget to co-finance certain activities. This made it difficult to collect information on results stemming only from the MHTF support, that is, to isolate the effects of the MHTF.	Country teams analyzed annual work plans in country offices that had been funded with MHTF resources. Evaluators requested the financial staff of UNFPA country offices provide financial MHTF data that would help isolate MHTF-support activities.

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:

- Data from the initial desk review was analyzed by the evaluation team. The limitations of this stage were discussed in Sections 2.2.2 and 2.3.5 above.

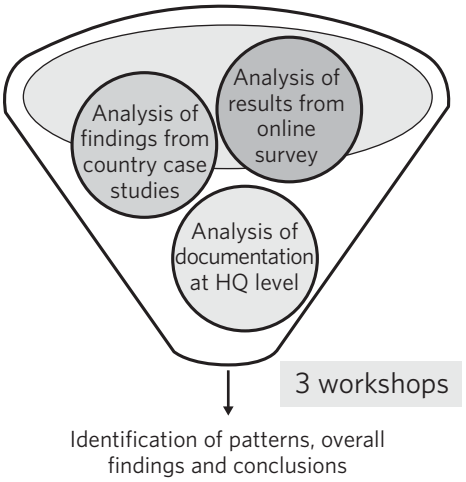
- Data from the country case studies were initially analyzed for each case study in the context of the specific UNFPA programme country, and the findings recorded in a separate set of country reports.[28]

- Data from the online survey were statistically analyzed. In a first analysis round, the evaluation team prepared an overview of the findings from each questionnaire item. 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).

- In a series of team workshops the evaluation team compared and contrasted the findings from the desk reviews, the country case studies, the online survey and the individual interviews with UNFPA staff and partners,

[28] The country reports are available at http://www.unfpa.org/public/home/about/Evaluation/EBIER/TE/pid/10094

Figure 3: Analysis of data and information obtained



using the Metaplan™ visualization approach[29] and mind-maps[30] to identify patterns and to draw conclusions on the basis of the entire body of evidence (see figure 3 above).

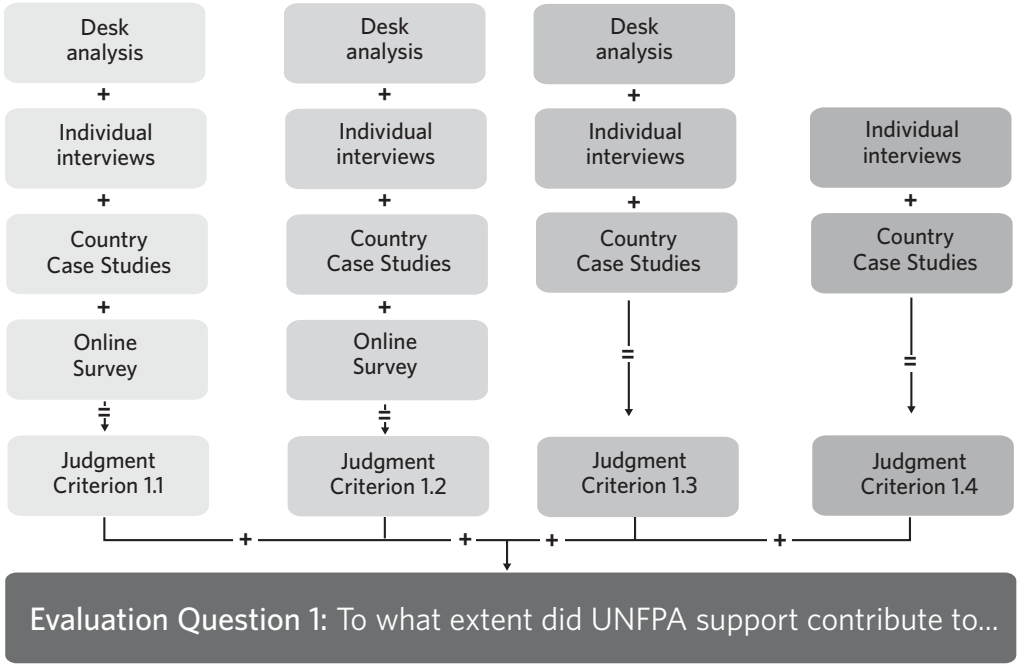
2.5 Methods of judgment

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) from the different sources. The process is illustrated in figure 4 below.

2.6 The approach to triangulation in this evaluation

The evaluators 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

Figure 4: Summation of evidence from different sources within and across judgment criteria



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

[30] 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 aim of representing connections between portions of information.

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);[31]
- 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.

Table 6 provides an overview of the different data collection tools that were used to collect information for each of the evaluation questions.

Table 6: Triangulation of data collection for different evaluation questions

Evaluation question	Desk review	Country case studies	Online survey	Individual interviews HQ/RO	Individual interviews UNFPA partners	Comments (if applicable)
1. Relevance	XX	X		XX	XX	The desk review and individual interviews provided, in particular, information on the country selection process and the targeting mechanism.
2. Capacity development – human resources for health	X	XXX	X	X	X	Besides the typology of activities few data were available during the desk review; findings are primarily based on country case studies.
3. Sexual and reproductive health services – family planning	X	XXX	X	X		
4. Sexual and reproductive health services – EmONC	X	XXX	X	X	X	
5. Health planning, programming & monitoring	X	XXX		XX	XX	Aside from the typology of activities, few data were available during the desk review; findings were primarily based on country case studies and feedback from UNFPA headquarters/regional offices and global UNFPA partners/H4+.
6. Management of MHTF	XX	XX	XXX	XX		Information used from different sources
7. Coordination & coherence	XX	XX	XXX	XX		
8. Leveraging & visibility	X	XXX		XX	XX	Findings are based primarily on country case studies, on feedback from UNFPA headquarters/regional offices and on review of headquarters level documents

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.

[31] The country reports are available at http://www.unfpa.org/public/home/about/Evaluation/EBIER/TE/pid/10094

CHAPTER 3

Main findings and analysis

This section presents the summary findings that emerged from the evaluation questions in the MHTF mid-term evaluation. The answers to the evaluation questions are based upon the assessment of the contribution of the MHTF to maternal health within the context of the overall UNFPA support. In particular, the evaluation examined the scope of the MHTF as an instrument to improve maternal health within the UNFPA framework as a whole. It also assessed how the MHTF, with limited resources, acted as a catalyst by bringing together various partners to perform the selected interventions.

The details of the findings are presented in the Evaluation Findings Matrix and the Presentation of Results from the Online Survey, included in the annex to this report (Volume 2). More detailed references to the findings are provided in the footnotes, which also provide examples and descriptions from the desk review, eight country case studies, the online survey and interviews.

3.1 Evaluation question 1 – Relevance

EVALUATION QUESTION 1

To what extent is MHTF support adequately focused on addressing the reproductive and maternal health needs of the vulnerable groups among countries and within countries?

- **Judgment criteria**

1.1. The selection processes of MHTF countries reflect the role of the MHTF as a strategic instrument to improve maternal health among the most vulnerable populations.

1.2. MHTF-supported national assessments yield sufficient and disaggregated data for needs orientation planning, programming and monitoring targeting the most vulnerable groups (including underserved groups).

1.3. National policies and sub-national level sexual reproductive health/maternal health planning and programming prioritizes the most vulnerable groups and underserved areas.

- **Evaluation criteria covered**

Relevance

Summary

The main criterion for selection as a beneficiary country for the MHTF is the degree of maternal health needs. Only countries with maternal mortality rate exceeding 300 deaths per 100,000 births were selected.[32] Country selection also took into account criteria such as government commitment, country office capacity and the existence of the H4+[33] initiative that allows capitalization on strengthened partnerships. This foundation, along with the groundwork already done by UNFPA and other development partners, is conducive to the proposed "catalytic action" of the MHTF.

At the country level, few MHTF-supported initiatives have led to the prioritization of vulnerable groups in national strategies, although the MHTF has supported various initiatives targeting vulnerable groups (e.g., a focus on specific geographical areas, maternity waiting homes, obstetric fistula programmes, etc.).

The national assessments supported by the MHTF, particularly the emergency obstetric and newborn care (EmONC) assessments, conducted for the first time in some countries, have helped to identify the bottlenecks hampering the provision of quality maternal health

(continued)

[32] Other criteria include (a) country faces significant maternal health needs due to a humanitarian crisis, and (b) potential exists for rapid success in view of (i) participation in recent global initiatives, in particular the International Health Partnership (IHP+), (ii) strong national commitment, and (iii) strong country office commitment and leadership.

[33] UNFPA, UNICEF, the World Bank, WHO and UNAIDS.

SUMMARY (continued)

services for all women. The EmONC assessments reviewed the accessibility of services in terms of geographical coverage. However, only a limited number of countries assessed the barriers to accessing these services, such as affordability or acceptability to the users. Thus, the constraints that affect access to maternal health services have not been sufficiently explored and taken into consideration.

The MHTF country selection process

The MHTF recognizes maternal mortality as the largest health inequality in the world. Disparities in access based on wealth, education and rural or urban residence have widened.[34] The MHTF has thus focused its support on countries with high maternal mortality ratios (MMR), which are MMR exceeding 300 deaths per 100,000 births. The selection process also included a number of other criteria, such as the commitment of the government; the capacity of country offices to implement programmes; the presence of other donors; existing available resources; and the degree of coordination of sectoral partnerships.[35] A first round of selecting countries was done in consultation with the regional offices, during which pre-funding assessments were undertaken in candidate countries to review the policy environment and to assess the previously mentioned criteria. The country offices then drafted a proposal that reflected the priorities highlighted in the assessment, sometimes with the support of the regional office. The allocation of the MHTF budget is usually based on such proposals.

This selection process ensured that the MHTF focused not only on countries with the highest maternal health needs but also on those with a stronger potential for progress due to their degree of stakeholder commitment or a generally conducive environment. Exceptions were made for countries in crisis situations, which could not have been expected to meet the general conditions, and in these cases the focus was mainly on maternal health needs (Sudan, DRC).[36]

The selection of countries to receive MHTF funding was also harmonized with the countries targeted by the H4+ initiative.[37] Combining the MHTF focus and joint H4+ programming created an increased synergy by strengthening the maternal and newborn care continuum. In joint projects, each H4+ agency ensured support for the different components of the maternal health care continuum in a coordinated way.[38] The MHTF focus on skilled birth attendance and emergency obstetric and newborn care (EmONC) helps UNFPA fulfill its mandate within the H4+ framework.

In some countries, stakeholders did not feel that the H4+ mechanisms brought any added value to ongoing coordination. For example, in Cambodia and Burkina Faso, H4+ was perceived as adding another level and label to existing coordination structures without really changing the dynamic of how partners work together. Conversely, in countries where coordination was less strong, the H4+ initiative helped improve the focus and understanding of responsibilities shared at a global level.[39] In some case study countries, the preparation of a joint programme helped to strengthen this collaboration,[40] increased the potential for a harmonized response and facilitated mobilization of additional resources (Zambia, Madagascar).[41]

Targeting the most vulnerable groups in MHTF-supported assessments

In its efforts to strengthen evidence-based planning, the MHTF has initiated or supported different needs assessments in the areas of EmONC services, midwifery and obstetric fistula. Some countries, such as Lao PDR, Cambodia, Burkina Faso, undertook midwifery and skilled birth attendance assessments with UNFPA support, namely in collaboration with the International Confederation of Midwives (ICM), prior to the introduction of the MHTF.

[34] "How Universal is Access to Reproductive Health? A review of the evidence," UNFPA September 2010.
[35] UNFPA interviews at regional and headquarter levels.
[36] See judgment criterion 1.1 in Volume 2.
[37] The H4+ group, i.e., WHO, UNFPA, UNICEF and the World Bank, and later UNAIDS, signed a joint statement for providing joint support to selected countries for "Accelerated Implementation of Maternal and Newborn Continuum of Care." This initiative concerns 25 countries.
[38] Madagascar, Burkina Faso.
[39] See MHTE Final Report, evaluation question 2.
[40] Although donor coordination and collaboration for maternal health pre-dates the introduction of H4+.
[41] See judgment criterion 1.1 in Volume 2.

The MHTF then used the findings of these assessments as a basis for planning its various interventions, such as support to midwifery education (e.g. Zambia, Lao PDR).[42]

EmONC needs assessments have been conducted with MHTF support in collaboration with WHO, UNICEF and the Averting Maternal Death and Disability Programme (AMDD) in 14 countries, and are scheduled to be conducted in an additional six.[43] In the case study countries the EmONC needs assessments were performed in close collaboration with governments. UNFPA and other partners worked with the various ministries of health as well as research institutions to adapt the different assessment tools to the country contexts. For example, some countries chose to collect additional information on family planning (Burkina Faso).[44] The EmONC assessment tools[45] were of use in reviewing the extent to which the health system provides good quality EmONC services from the supply side. The tools made it possible to map out the geographical distribution of EmONC facilities and to highlight coverage gaps (according to international standards) with a view to improving services in underserved areas. However, the tools are not designed to assess the needs of the most vulnerable groups.

The MHTF has not facilitated any particular emphasis on vulnerable groups. However, MHTF could facilitate further analysis—taking into account existing data from demographic health surveys (DHS) or censuses—to help focus service improvement on disadvantaged areas, including those of a strong ethnic character or socio-economically deprived areas.[46]

Access to services, in particular EmONC, is linked to many factors such as distance to health facilities, cost of services and transportation, and decision-making within the family. A few countries, such as Madagascar and Lao PDR, have explored the factors that negatively affect access to services. The EmONC assessment tools supported by the MHTF are not designed to investigate the barriers to accessing EmONC services or how the services could be adapted to facilitate equitable access. However, some countries did explore means to address some of the well-known barriers. For instance, in Lao PDR, information was collected on the country's existing system of waiving maternity fees for poor women in EmONC facilities. The Lao PDR experience demonstrates how each country can adapt the tools to its needs, but so far this has rarely occurred since the supply side has been favoured to the detriment of the demand side.[47] Failing to address the various barriers that limit access to maternal health services is a missed opportunity.

Prioritization of the most vulnerable groups in maternal health planning and programming

The participation of UNFPA in maternal health policy dialogue – with different degrees of involvement – predates the introduction of the MHTF.[48] The contribution of the MHTF to policy dialogue can be described as having complemented the overall UNFPA effort in specific areas as follows:[49]

- Participation of MHTF-funded technical advisors in the various thematic working groups created to help ministries of health implement their policies and strategies;[50]
- Advocacy for midwifery;
- Support for EmONC assessment and EmONC service improvement programming;
- Support for promoting quality midwifery services through education and regulation.

However, the MHTF contribution to influencing government policies and strategies with a view to better targeting of vulnerable groups has been limited. For instance, although the MHTF has focused on midwifery education in all the countries visited, it has contributed to the

[42] See judgment criterion 1.2 in Volume 2.
[32] Adverting Maternal Death and Disability (AMDD) annual work plan (AWP) 2009 and 2011.
[44] See judgment criterion 1.2 in Volume 2.
[45] See details under evaluation question 4.
[46] See judgment criterion 1.2 in Volume 2.
[47] See judgment criterion 1.3 in Volume 2.
[48] E.g., Sudan, Ghana, Lao PDR, Zambia, Burkina Faso and Cambodia.
[49] See judgment criterion 1.3 in Volume 2.
[50] E.g., human resources for health in Lao PDR.

discussions or helped increase the priority placed on deployment and retention of midwives in rural areas[51] in only a few countries such as Lao PDR and Burkina Faso.

Similarly, the MHTF has generally had little influence on the allocation of subsidies for skilled attendance at birth or EmONC services for poor women. Exceptions include Cambodia, where the MHTF planned to support the Health Equity Fund (HEF) in selected geographical areas.[52]

The strong MHTF support to midwifery and EmONC services[53] has enabled the ministries of health in some countries[54] to increase the number of midwives, and thus their coverage, which in turn contributes to improving services in underserved areas. Similarly, efforts to support obstetric fistula programmes have motivated some governments[55] to provide care to women suffering from fistula. These women form a particularly vulnerable group since they are stigmatized and rejected by their communities. Initiatives such as support for maternity waiting homes for women living far from EmONC facilities also have the potential to positively influence the development of strategies. However, the success thereof is subject to the initiatives being adopted by the ministries of health as interventions specifically aimed at increasing access to skilled care by underserved groups.[56]

The aforementioned initiatives clearly target poor women living far from health facilities. However, a comprehensive strategy that promotes a clear definition of vulnerability and advocacy for prioritizing vulnerable populations has not yet been put in place.[57]

3.2 Evaluation question 2 – Capacity development – human resources for health

EVALUATION QUESTION 2

To what extent has the MHTF contributed to strengthening human resources planning and availability (particularly midwives) for maternal health and newborn health?

- **Judgment criteria**

2.1. The midwifery education of partner countries has been upgraded, through MHTF support, based on International Confederation of Midwives (ICM) essential competencies.

2.2. Strategies and policies have been developed to ensure the quality of midwifery services provision in programme countries through MHTF support.

2.3. Midwifery associations are able to advocate and support the scaling-up of midwifery services through MHTF support.

- **Evaluation criteria covered**

Effectiveness, sustainability

Summary

The MHTF has contributed to addressing the urgent need for skilled health professionals, particularly midwives and other mid-level health providers, through a three-pronged approach: (i) creation of evidence (needs assessments); (ii) capacity development (in-service and pre-service education, strengthening of training institutions, provision of equipment and supplies to newly-trained providers); and (iii) policy dialogue (advocacy, regulation, strengthening of midwifery associations).

The MHTF has supported these components in every country, with varying emphasis depending on the country context. Strongest support was given to increasing the availability of skilled health professionals and to capacity development, although this remains an important challenge considering the existing capacity gaps.

The engagement of the MHTF in strengthening human resources for health (HRH), including compulsory supportive supervision, continuous education, quality assurance and deployment and retention, has so far not been sufficient to ensure improvement of midwifery services in the long term.

As identified in the MHTF Business Plan, many countries face serious challenges in ensuring skilled attendance

[51] For example through providing incentives.
[52] In the meantime, the government has decided to scale up the HEF and to fund it through the common basket funding. It is unclear whether the MHTF has been instrumental in this decision; however, UNFPA certainly had a role due to its previous support to the HEF.
[53] See evaluation question 2.
[54] E.g., Ethiopia, Cambodia, Lao PDR.
[55] Ghana, Madagascar, Burkina Faso, Zambia.
[56] See judgment criterion 1.3 in Volume 2.
[57] See judgment criterion 1.3 in Volume 2.

at birth for all women due to major global shortages in the health workforce, particularly of midwives. To help countries address these challenges, the MHTF, including the midwifery programme, has increased the visibility of the need for midwives through advocacy events[58] and increased technical assistance given to this group of professionals. As a result, countries increasingly recognize the contribution of midwives as being indispensable to the effort to reduce maternal and neonatal mortality. The MHTF has focused its support on strengthening the three components of the midwifery programmes: (i) education, (ii) regulation, (iii) associations.

Support to improving midwifery education

The MHTF has been significantly involved in supporting midwifery education in all the countries visited, in particular through the technical assistance provided by MHTF – and ICM-funded country midwifery advisors. This support mostly consisted of:

- Analysis of the country-specific midwifery situation based on the three components of the midwifery programme;[59]
- Revision of the pre-service or in-service training curricula based on ICM competencies in most countries at different levels;[60]
- Strengthening of training institutions through upgrading of the competencies of teachers and instructors at clinical sites and provision of teaching materials such as mannequins and reference manuals.[61]

As the midwifery situation varies from country to country, the MHTF has adapted its responses accordingly. In some instances, the MHTF helped with streamlining midwifery education, at times together with nursing education. In other cases (Ghana, Lao PDR, Cambodia and Ethiopia), MHTF has assisted in developing curricula for different levels of midwifery (e.g., diploma, bachelors or masters programs) and in designing direct entry courses. In countries with an acute need for midwives, direct entry courses have also allowed for the training of a greater number of midwives.[62]

A recurrent issue in many countries is the low standard of teaching by both teachers and instructors. Different strategies were used depending on the country context to upgrade teachers' capacities (see Box 1). However, as results are still inadequate, further efforts need to be pursued.[63]

Box 1: Strategies for increasing the quality of midwifery education

Depending on national needs and capacities, the MHTF has supported development and implementation of different strategies for increasing the quality of teachers and instructors in midwifery education.

In some countries, strategies involved the training of teachers (Ethiopia, Cambodia, and Madagascar) and instructors (Burkina Faso). Another approach was to increase collaboration with neighbouring countries with a view to increasing capacities (Lao PDR). Additionally, mobilization of United Nations Volunteers to support training institutions (Lao PDR, planned in Sudan) provided valuable hands-on coaching.

Furthermore, quality assurance systems for monitoring the quality of teaching and coaching are not always in place (with a few exceptions such as Ghana, where a quality assurance system has been accredited, and Lao PDR, through the introduction of a national licensing examination).[64]

Despite strong support for midwifery education, the development of overall strategies to integrate the education component within human resource development plans has not been systematically facilitated by the MHTF. In Lao PDR, the skilled birth attendance plan is part of a comprehensive strategy for strengthening midwifery (including education based on projections). However, in other countries, initiatives to upgrade midwifery education are not part of an overall approach for the

[58] The International Day of Midwives was celebrated in most of the country case studies.
[59] Burkina Faso, Ghana, Ethiopia, Sudan, Zambia and Madagascar.
[60] Burkina Faso, Zambia, Ethiopia, Cambodia, Lao PDR, Ghana, Madagascar.
[61] Burkina Faso, Ethiopia, Lao PDR, Cambodia, Madagascar.
[62] See judgment criterion 2.1 in Volume 2.
[63] Lao PDR, Burkina Faso, Cambodia, Sudan, Ethiopia (see judgment criterion 2.1 in Volume 2).
[64] See judgment criterion 2.1 in Volume 2.

development of the health human resources. Midwifery education has not been sufficiently integrated into the overall context of human resources for health planning. This is a concern as most of the countries reviewed have significant capacity gaps. These include low absorption capacity of the training institutions (Burkina Faso), poor deployment strategies, and poor coordination between the training institutions and the human resources and technical departments (Lao PDR). However, in some cases, MHTF efforts to advocate midwifery at various levels have led to the involvement of other development partners in strengthening training institutions (Sudan and Burkina Faso).[65]

Support to midwifery programming

Some countries had already developed midwifery plans prior to the introduction of the MHTF (Zambia, Ethiopia, Lao PDR, Cambodia, Sudan). Other countries undertook midwifery desk reviews and gap analyses based on the three components of the MHTF-supported midwifery programme, thereby improving the availability of information on midwifery programming in these three areas.[66] However, as stated above, such programming is not sufficiently comprehensive and does not always link with human resources for health (HRH) planning. Even if national HRH plans increasingly address issues such as retention and deployment in order to ensure appropriate health services (often with WHO support), they do not always place emphasis on maternal health services. The MHTF has not always played an adequate advocacy role to highlight maternal health human resource issues.[67]

Moreover, midwifery plans are often not costed or separated from HRH plans (Cambodia is an exception). Only a few MHTF-supported country offices participated in discussions on long-term HRH plans for midwives that aim to ensure the sustainability of midwifery services provision. This is confirmed by the results of the online survey, which showed that little support was offered to countries in terms of human resource for health management and that the introduction of the MHTF brought no improvement in these areas.[68]

[65] See judgment criterion 2.1 in Volume 2.
[66] Burkina Faso, Ghana, Ethiopia.
[67] See judgment criterion 2.2 in Volume 2.
[68] See online survey question 25 in Volume 2.
[69] See judgment criterion 2.2 in Volume 2.

Support to ensuring quality midwifery services

Based on the findings of the midwifery assessments, different types of support were provided to ensure the quality of midwifery services (see Box 2).

Box 2: Types of support provided to improve midwifery regulatory standards

- Development or review of midwifery regulatory standards based on ICM competencies and standards, and the dissemination of these standards (Lao PDR, Ghana)
- Development of an ethical code of conduct (Burkina Faso, Cambodia)
- Advocacy for the creation of regulatory bodies (particularly in francophone countries where they have usually been non-existent)
- Review of legislation and acts of midwifery councils (particularly in francophone countries

Efforts toward ensuring that regulatory standards are available and widely disseminated are an essential initial step that MHTF has supported. However, strategies for ensuring and monitoring compliance with standards are often missing.[69]

Monitoring the quality of services is an area that has been supported by the MHTF in some of the countries visited, for example through supporting the Ministry of Health in developing an integrated reproductive health supervision guide (Burkina Faso), through supporting the mentoring of newly trained midwives (Cambodia, Zambia), or through developing supervisory strategies (Ethiopia). The strengthening of supervision, in particular, is of importance in improving services.

In some country case studies, coaching systems for new trainees were introduced with MHTF support (sometimes through the midwifery associations) once trainees had been deployed (Cambodia, Zambia). In some instances, MHTF gave support to equipping health facilities with the necessary materials and commodities in locations where the new trainees had been deployed (Ethiopia

and Lao PDR). Such support is important for providing newly-trained health personnel with the means to offer quality services. However, the development of the necessary follow-up strategies was not systematically facilitated at the national level.[70]

Support to midwives and midwifery associations

The MHTF has funded national and international country midwifery advisors (CMA) at country and regional levels in support of the midwifery programme.[71] The role which CMA can play varies from country to country and depends on individual competencies, seniority and the credibility they have with the government counterparts and within UNFPA offices. Some have sufficient expertise and experience, and can thus play an important role in strengthening education through coordinating curricula reviews and helping training institutions organize courses (with a special emphasis on laboratory or clinical practice). CMA also provide important institutional support to the midwifery associations.[72] Their ability to influence policy is usually more limited, as that role is generally assumed by senior reproductive health personnel, with the exception of the MHTF international midwifery advisors, who play an active part in related working groups and are well recognized in the policy arena.[73]

The MHTF efforts have contributed to strengthening the midwifery associations,[74] which are now increasingly accepted partners in policy and curriculum development. In some country case studies, the MHTF-supported advocacy events conducted by associations resulted in an increase in applications to midwifery schools[75] and in the number of registered midwives.[76] However, in most countries the midwifery associations were still in their infancy or had limited capacity. The associations will need more time to develop into independent entities and to be able to significantly influence the scale-up of midwifery.[77]

In its efforts to support midwifery associations, the MHTF has worked through the International Confederation of Midwives (ICM), regional advisors as well as the country midwifery advisors (CMA) to help form associations (e.g., Zambia) and to strengthen the capacity of these associations by providing them with coaching and equipment. For example, in Cambodia some equipment was provided and an MHTF-funded programme assistant was assigned to support the Cambodian Midwifery Association and council office in their activities. The main role of these associations, with MHTF support, was to take part in curriculum reviews and to set regulatory standards and codes of ethics (e.g., Ghana, Burkina Faso, Ethiopia and Cambodia), as well as to organize advocacy events such as the Celebration of International Midwifery Day. In some of the countries visited, CMAs were involved in resolving issues concerning the representation of midwives by both nurses and midwifery associations, which do not effectively represent the concerns of midwives. In other countries, the associations were mobilized to coach newly-trained midwives (e.g., Cambodia).

3.3 Evaluation question 3 – Access to sexual and reproductive health services – family planning

EVALUATION QUESTION 3

To what extent has the MHTF contributed to scaling-up and increased access to and use of family planning?

- **Judgment criteria**

3.1. Creation of an enabling environment to facilitate the scale-up of quality family planning services in priority countries through MHTF support.

3.2. Demand increased for family planning services in MHTF priority countries, through MHTF support.

- **Evaluation criteria covered**

Effectiveness, sustainability

[70] See judgment criterion 2.2 in Volume 2.
[71] The collaboration with the ICM is valued by country offices, particularly in the African Region. Two regional and one international advisor (funded by MHTF) are deployed in Accra and support the country offices in the region in all matters concerning the midwifery programme (see additional issues in Volume 2). Furthermore, the ICM global standards recently developed for education and regulation are a useful tool for countries.
[72] Through provision of technical support such as assistance for planning, drafting codes of conduct etc.
[73] See additional issues in Volume 2.
[74] See judgment criterion 2.3 in Volume 2.
[75] In Ethiopia, advocacy activities led to an increased enrollment of students in midwifery schools and greater recognition of the need to train more midwives.
[76] Mentioned during interviews, but no data could be obtained.
[77] See judgment criterion 2.3 in Volume 2.

Summary

The MHTF contribution to scaling-up and increasing access to family planning has been limited as most MHTF-supported countries were already benefiting from the Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS) to strengthen family planning provision. Only a few synergies emerged between the two thematic funding sources through the integration of (i) family planning updates in midwifery curricula review; (ii) maternal health commodities in the list of reproductive health commodities; (iii) messages during awareness campaigns to create demand; (iv) and the inclusion of family planning data in the EmONC assessment. Coordination is often insufficient and MHTF resources are often used to fill gaps without being accompanied by a strategic analysis of complementarity.

Support to create an enabling environment for the scaling-up of family planning services

MHTF resources were only used for the scaling-up of family planning services to a limited extent,[78] because most UNFPA efforts in family planning were also supported by the Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS), in particular the Stream 1 and 2 countries which already received intensified support for family planning. The main mandate of the GPRHCS is to strengthen family planning services by focusing on commodity security. More recently it paid a growing attention to training for service providers and demand creation. Moreover, the availability of family planning expertise in country offices prior to the launch of the MHTF (resulting from prior long-term UNFPA involvement in the area) precluded the need for any additional human resources from the MHTF. Among the case study countries, the only instance of MHTF support being used for the procurement of family planning commodities was the MHTF contribution to the pool fund in Ethiopia.

However, the two thematic funds have not been as coordinated as expected and programming is still done independently. The funds are managed by different staff members who do not necessarily work in close collaboration or who fail to coordinate interventions based on prioritized needs.[79] This lack of coordination has hampered the efforts of country offices to achieve the desired synergy between the three key pillars for maternal health (family planning, EmONC, skilled birth attendance).

In order to work toward the integration of all reproductive health components, which are strongly promoted by UNFPA, MHTF-supported interventions have included family planning components (see Box 3). This integration was a key objective and was facilitated by MHTF-supported advisors.

Box 3: Examples of the integration of family planning in MHTF-supported activities

- The review of curricula—in particular midwifery curricula—included the updating of family planning technologies as well as counseling and service provision (Burkina Faso, Lao PDR, Zambia, Sudan, Cambodia, and Madagascar).
- Most of the country case studies have ensured that maternal health (EmONC) commodities are included in the list of the overall reproductive health commodities.
- In a few of the country case studies, a family planning component has been added in the MHTF-supported EmONC assessments (e.g., Burkina Faso, Ghana) in order to gather data on family planning services.
- Another intervention is support for the revision of existing family planning policies and guidelines to ensure availability of family planning services in facilities providing post-abortion services in Cambodia (as a link to EmONC services). This component was not encountered in any of the other country case studies.[80]

[78] See judgment criterion 3.1 in Volume 2.
[79] See details in evaluation question 7.
[80] See judgment criterion 3.1 in Volume 2.

Creating demand for family planning

The desk review suggests that while the MHTF-supported initiatives[81] aimed to increase the demand for family planning in some countries, only a few specific initiatives were undertaken with MHTF support in the case study countries. Examples included advocacy events combining the different reproductive health issues (Ghana, Madagascar) or the training of community health workers to promote utilization of maternal health services and family planning (Madagascar).

The MHTF input to creating demand for family planning was not planned strategically and it has served mainly to fill funding gaps within the overall UNFPA portfolio. Thus, the MHTF contribution cannot be considered as having had a significant effect on increasing the demand for family planning.[82]

3.4 Evaluation question 4 – Sexual and reproductive health services – Scaling-up EmONC

EVALUATION QUESTION 4

To what extent has the MHTF contributed to the scaling-up and utilization of EmONC services in priority countries?

- **Judgment criteria**

4.1. Creation of an enabling environment that facilitates the scaling-up of EmONC services through MHTF support.

4.2. Utilization of and access to EmONC services improved through MHTF support.

- **Evaluation criteria covered**

Effectiveness, sustainability

Summary

The focus of the MHTF on emergency obstetric and new-born care (EmONC) needs assessments and the development of EmONC improvement plans has contributed to advancing EmONC in a number of countries. Many of these countries had identified the improvement of EmONC services as a priority area in their policies, but had not necessarily progressed with regard to its operationalization prior to the involvement of MHTF.

The evidence provided by the needs assessments is a strong basis for national and sub-national planning and provides clear directions to governments and their partners on how to improve EmONC services. Moreover countries where the implementation of the EmONC improvement plan has been included in the pool fund provide an example of a likely catalytic effect of MHTF (Cambodia). However, in most countries it is still too early to predict whether governments or development partners will be in a position to fund these plans, although a conducive environment is in place which is reinforced by ongoing advocacy for maternal health.

Other MHTF involvements such as curriculum review and task shifting initiatives contributed to increasing the provision of quality EmONC services. However, the technical assistance requirements for the implementation of EmONC plans should not be underestimated. The translation into quality services remains a challenge as many of the target countries have major capacity shortfalls.

The effect of MHTF on utilization is limited as issues relating to the access barriers are not being systematically and strategically addressed. Efforts in this direction remain very anecdotal despite a real potential for improving access.

The MHTF has the mandate to support, in collaboration with partners, national health systems to ensure universal access to EmONC, one of the three pillars for improving maternal health.[83] Before the introduction of the MHTF, EmONC had been promoted at the global level for almost a decade, particularly in Africa where development partners had promoted the Road Map for Accelerating the Attainment of the Millennium Development Goals (MDGs) relating to maternal and newborn health in 2004 and the Maputo Plan of Action[84] in 2006. Although EmONC was recognized as a key component to

[81] Such as strengthening communication and community mobilization for creating demand for family planning through supporting the design of communication and mobilization strategies, mass media communication and advocacy campaigns.

[82] See judgment criterion 3.2 in Volume 2.

[83] The three pillars for improving maternal health are: family planning, skilled care in pregnancy and childbirth, including quality facility deliveries, emergency obstetric and newborn care.

[84] Or the *Sexual and the Reproductive Health and Rights Plan of Action*, endorsed by the African Ministers of Health.

reducing maternal mortality and morbidity, and although some activities had been undertaken to improve services by governments and development partners (in particular WHO and UNFPA), efforts to strengthen EmONC services generally remained insufficient. In many countries,[85] gaps in the provision of EmONC services had been partially addressed through the provision of EmONC training, infrastructure and equipment and in some countries through EmONC surveys (Ghana, Cambodia and Sudan),[86] albeit not in a comprehensive manner.

Box 4: Example of the implementation of an EmONC improvement plan

In Cambodia, the National Mother, Newborn and Child Health Centre formed a special EmONC unit to start implementation of an MHTF-supported EmONC improvement plan with the technical support of a national programme officer for maternal health. This technical support proved valuable and was recognized by the national counterparts, particularly as it involved hands-on support in the field and the setting-up of monitoring mechanisms.

Needs-based EmONC programming

One of the strongest MHTF contributions to the improvement of maternal health is its support to countries for initiating and conducting EmONC needs assessments.[87] In many countries, such assessments were undertaken for the first time. The assessments provided evidence on existing EmONC services and gaps, usually for the whole country. The partnership with WHO, UNICEF and the Averting Maternal Death and Disability (AMDD) programme to develop capacity at the regional and country levels for the use of tools, as well as provision of technical assistance by AMDD during the execution of the surveys, was critical to ensuring the quality of these assessments.

Partners value the EmONC assessments as useful and technically sound guidance for EmONC programming. During the evaluation, some case study countries were in the process of developing EmONC improvement plans based on the assessment findings (Burkina Faso, Cambodia, Ghana and Lao PDR). Although often initiated by UNFPA, the whole process was supported by different stakeholders and the government partners demonstrated real ownership of the process.

In other country case studies it is too early to predict whether the EmONC improvement plans will become integrated into the respective national strategies, although this is advocated by the MHTF. Moreover, there is still uncertainty in most of these countries as to whether the EmONC plans will be funded, even if they have been approved. Exceptions are Ethiopia and Cambodia, where EmONC improvement (including training) is funded from the pool fund. In Sudan, EmONC was included in the Maternal and Newborn Health Road Map prior to the MHTF, although MHTF helped to support the costing of the Road Map.[88]/[89]

Through its support to the generation of evidence for improving EmONC services, the MHTF has accelerated the implementation of maternal death audits. The latter are a useful tool for understanding the underlying factors, including the three types of delay[90] that led to maternal death beyond medical causes. The MHTF also supported the development or adaptation of training modules (Sudan, Lao PDR, Madagascar, Ethiopia, and Burkina Faso).[91] In addition, it supported efforts to institutionalize such practices by establishing a National Audit Committee for maternal deaths (Madagascar) and through the development and piloting of maternal death audit tools (Lao PDR).

Support to EmONC capacity improvement

The approach to modalities to conduct EmONC assessment was mostly consistent across the different countries. However, MHTF support to strengthening EmONC capacities varied across countries and such support

[85] E.g., Burkina Faso, Madagascar, Ghana, Zambia.
[86] See MHTE final report evaluation question 2.
[87] See evaluation question 1.
[88] See judgment criterion 4.1 in Volume 2.
[89] The technical assistance that most countries require for the implementation of the EmONC improvement plans should not be underestimated, particularly in terms of human resources management and monitoring of implementation, including quality assurance. EmONC technical expertise will have to be reinforced as no countries have sufficient resources to ensure quality on a large scale.
[90] The three types of delay are: delay in decision to seek care, delay in reaching care and delay in receiving care.
[91] Countries where it had been introduced by other partners: Ghana, Zambia and Cambodia.

Table 7: Type of MHTF support to strengthening EmONC capacities in the different country case studies

Type of MHTF support	Country case studies
In-service training curricula reviewed to upgrade the EmONC component based upon WHO guidelines[93]	Burkina Faso, Cambodia, Zambia, Madagascar, Sudan, Ethiopia and Ghana[94]
In-service EmONC (basic and comprehensive) training for EmONC teams in referral health facilities	Burkina Faso, Cambodia, Ethiopia and Madagascar
Improvement of certain aspects of EmONC services such as anesthesia	Ethiopia
Courses on life-saving skills in target geographical areas	Ghana, Lao PDR

depended on contextual factors such as government policies and the role of the different development partners. MHTF assistance ranged from support for midwifery training institutions[92] to the review of training curricula and training courses and the upgrading of skills of the EmONC service providers (see Table 7).

The MHTF-supported revision of training course curricula was organized in partnership with relevant agencies, professional associations and resource persons to ensure that the EmONC life-saving signal functions and international standards were introduced into the curricula.[95] In many countries the International Confederation of Midwives supported the review of midwifery pre-service training curricula that was funded by MHTF.[96]

Although the interventions responded to specific country needs, they were fragmented and lacked a clearly defined underlying strategy for strengthening the capacity of EmONC training, except in countries where EmONC improvement plans had been developed. The EmONC assessment and improvement plans are therefore considered as an appropriate means of streamlining these training approaches, as observed in Cambodia.[97]

Few initiatives were observed that focused on ensuring quality over time. One example was the "Strategy for Quality Improvement Process",[98] part of the EmONC improvement plan in Cambodia. Such an approach is not widespread and maintaining the quality of services remains a challenge. This was illustrated by weaknesses in newborn care in many of the visited facilities.

Catalytic effect of supported interventions in EmONC

The MHTF has been instrumental in boosting EmONC in those countries, where it (i) served as a catalyst by initiating the EmONC needs assessments; (ii) supported overall implementation of the EmONC improvement plan; and (iii) helped with upgrading of the training curricula.

In countries where it supported innovative approaches such as task shifting,[99] MHTF support also has potential

[92] See evaluation question 2.

[93] *Managing Complications in Pregnancy and Childbirth: A Guide for Midwives and Doctors* (WHO/UNFPA Strategic Partnership Programme) and *Pregnancy, Childbirth, Postpartum and Newborn Care: A Guide for Essential Practice* (WHO/UNFPA Strategic Partnership Programme).

[94] See evaluation question 2.

[95] See judgment criterion 4.1 in Volume 2.

[96] See evaluation question 2.

[97] See judgment criterion 4.1 in Volume 2.

[98] The Strategy for Quality Improvement Process seeks to (i) enhance service providers' self-confidence and performance, (ii) institute a team approach to support better quality EmONC, (iii) involve communities in quality improvements, and (iv) maintain quality through a system of certification and rewards at all levels of the health system.

[99] In Ethiopia, based on the experience from a tracer project in Tigray, UNFPA has supported the Ministry of Health and Education to develop a master's degree in Integrated Emergency Obstetric and Surgery (IEOS) for non-physician clinicians. An innovative programme, it is designed to alleviate the shortage of skilled human resources, particularly in rural areas, by employing a "task shifting" approach for emergency obstetric care. The capacity development of training institutions is co-funded by the MHTF and the GPRHCS through the Millennium Development Goal performance pool fund and includes training of trainers, instructors, non-physician clinicians, study tours, conferences, vehicles for student transport, equipment for clinics and training centers, and the review and development of curricula.

for a catalytic effect. The concept of task shifting was introduced in some countries to provide an alternative to the scarcity of specialized physicians (Ethiopia, Cambodia and Zambia) as well as at the regional level.[100] However, insufficient follow-up reduces the potential for catalytic effects. Provision of equipment (Ghana) or selective training for EmONC service providers are less likely to contribute to a sustainable result unless it is part of an overall strategy for ensuring the availability of the necessary equipment over the long term.

Information on referral mechanisms forms part of the data collected during the EmONC needs assessments. In some country case studies, the assessments reported that referral systems were weak (Cambodia, Lao PDR, Ethiopia, Burkina Faso). While EmONC improvement plans usually include the improvement of EmONC referral facilities, the identified gaps concern the overall referral system at all levels (from the community to the referral facility) as well as transport and communication. However, it is too early to assess whether the overall system will be adequately addressed during the implementation of the plan.

Utilization of and access to EmONC services

Utilization of and access to health services is expected to increase automatically with improvements in services and well-resourced facilities. Nevertheless, barriers to access not only relate to poor quality services but need also to be explored from the perspectives of female service users. As presented in evaluation question 1, the EmONC situation analyses performed with MHTF support did not explore these barriers, with a few exceptions. In some countries, barriers have been studied under other UNFPA funding sources (Madagascar, Lao PDR and Burkina Faso). However, in other countries the actual constraints to accessing EmONC services are not yet fully known and thus cannot be addressed appropriately.

One of the recurrent barriers is cost, including the cost of transport, which deters women from travelling to the health facility to seek EmONC services. Having recognized such constraints, development partners in some countries have been advocating the introduction of free maternal health services, even prior to the introduction of the MHTF. In other countries, MHTF-supported advisors also took part in advocacy efforts (Lao PDR). In Cambodia, it was initially planned that the MHTF would create a Maternal Health Equity Fund for poor women in target areas. However, as an interim measure the government then adopted the universal Health Equity Fund, which included maternal health. The initial discussions undertaken by the MHTF with its government partners helped promote advocacy for and definition of the modalities for the Maternal Health Equity Fund and thus influenced the government's decisions.

Several interventions aimed at addressing barriers to EmONC services that have been funded by the MHTF are described in Box 5.[101]

Box 5: Examples of MHTF activities to increase utilization of and access to EmONC

- The MHTF has funded sensitization campaigns in communities on danger signs during pregnancy that require skilled health care (Madagascar) and on the prevention of obstetric fistula (Ghana, Sudan).
- In Cambodia, the MHTF has supported the implementation of maternity waiting homes in its target areas. This intervention contributes to decreasing the risks of maternal deaths.[102] However, scaling-up would require that results are well-documented and monitored.
- The MHTF has supported implementation of the WHO Individual, Family, Community (IFC) approach,[103] which facilitates a participatory assessment and planning of interventions aimed at developing mechanisms such as birth and emergency preparedness, community transportation schemes and emergency funds (Burkina Faso, Lao PDR). The IFC approach contributes to empowering communities and to building awareness and partnerships on maternal health improvement from the local level to the district level.

[100] During a regional experience-sharing workshop held in Addis Ababa in 2009.
[101] See judgment criterion 4.2 in Volume 2.
[102] Women from isolated and remote places move to live near the EmONC facility some time before childbirth and can easily access skilled care in case of emergency or at the time of delivery.
[103] "Working with individuals, families and communities to improve maternal and neonatal health".

Although the interventions (presented in Box 5) have the potential for improving the access to and demand for EmONC services, country offices have only implemented them in a limited way,[104] and without promoting the interventions or supporting the development of comprehensive strategies for addressing the constraints to the utilization of and access to these services. Thus, overall the use of MHTF resources for improving access and utilization is not significant.[105]

3.5 Evaluation question 5 – Support to health planning, programming and monitoring

EVALUATION QUESTION 5

To what extent has the MHTF contributed toward improving planning, programming and monitoring to ensure that maternal and reproductive health are priority areas in programme countries?

- **Judgment criteria**

5.1. Improved positioning of maternal and reproductive health within national strategies and policies through MHTF support.

5.2. National plans consider sustainable funding mechanisms for sexual and reproductive health/maternal health through MHTF support.

5.3. National and sub-national health plans include clear monitoring and evaluation frameworks for family planning, skilled care in pregnancy and child birth, EmONC, obstetric fistula and reproductive health/HIV linkages.

- **Evaluation criteria covered**

Effectiveness, sustainability

Summary

The MHTF contribution to improve the positioning of maternal health within national strategies cannot be separated from long-standing UNFPA efforts in this area. The MHTF emphasized specific areas such as midwifery and EmONC through advocacy efforts as well as through provision of evidence and appropriate tools, guidelines and technical assistance. This resulted in high priority given to these areas in some programme countries, whereas in countries where they were already prioritized, the MHTF helped accelerate their operationalization.

The MHTF efforts to help countries produce evidence, such as baseline EmONC and midwifery data and maternal death audits as well as monitoring plans for maternal health interventions, have contributed to developing a culture of evidence-based planning and programming in programme countries. However, further support is needed for the operationalization of monitoring systems geared at monitoring results.

Although the MHTF has been supporting countries with a view to developing detailed plans such as EmONC improvement plans, its contribution to advocating the costing mechanisms as well as to promoting funding of maternal health plans remained insufficient to secure the necessary resources for their implementation.

Contribution to maternal health policy dialogue

Prior to the launch of the MHTF, UNFPA had already been advocating for maternal health and greater participation in the maternal health policy dialogue in most case study countries, albeit to different degrees (Sudan, Ghana, Lao PDR, Zambia, Burkina Faso and Cambodia). The participation of senior members of national governments in global[106] and regional[107] events resulted in higher mobilization at the country level as well as a higher level of concern for maternal health-related issues.

The contribution of the MHTF in policy dialogue can be described as having complemented the overall UNFPA efforts as follows:

[104] Often as pilot projects in a limited geographical zone.
[105] See judgment criterion 4.2 in Volume 2.
[106] Women Deliver Conference, UN Secretary-General Strategy on Women and Children Health where First Ladies participated as national advocates for maternal health (e.g., Cambodia, Burkina Faso), 2010 Global Women Deliver Conference.
[107] CARMMA, Five-year review of the Maputo Plan of Action by the African Union in July 2010.

Table 8: Examples of MHTF contribution and its effects on maternal health in countries

Contribution of MHTF to policy dialogue	Effect on maternal health
The MHTF-funded technical advisors played an important role in policy dialogue while participating in technical working groups (e.g., in Lao PDR and Madagascar). Where MHTF-funded staff is less active in this area, UNFPA reproductive health advisors are fulfilling this role (in Burkina Faso).	The close working relationships established with the Ministry of Health counterparts allowed these technical advisors to play an important role in strengthening implementation strategies, particularly in countries where the advisors are recognized for their expertise.
Programming: The EmONC needs assessments[108] provided useful evidence and clear guidance for informing EmONC service improvement planning and programming.	For instance, in Ethiopia district level data were included in the Health Sector Development Programme, including human resource projections for midwives, thanks to MHTF support.
Support for promoting quality midwifery services through education and regulation.[109]	The emphasis put upon midwifery led to an increase in government commitment to midwifery.[110]
Support for some regional events such as the Conference on Human Resources for Maternal and Newborn Survival and Task Shifting held in Addis Ababa in 2009. National partners were also sponsored by the MHTF to attend regional conferences and workshops.[111]	The participation of national counterparts in these events contributed to putting maternal health on their agendas.
Specific advocacy events such as the Celebration of the International Day of the Midwife, complemented by the advocacy efforts that UNFPA undertook with parliamentarians, the media and other influential groups.[112]	The advocacy for midwifery contributed to raising the profile of midwifery and to increase awareness of the importance of skilled birth attendance.
In Zambia, the country midwifery advisor closely cooperated with the Zambian General Nursing Council.	This contributed to the development of a National Nursing and Midwifery Strategic Plan.
In Ethiopia, MHTF funds have been used to contribute to the pool fund.	This facilitated a stronger voice and progress in the maternal health agenda.[113]

The combination of (i) advocacy to raise concerns on maternal health issues, (ii) increased evidence on gaps, and (iii) visible and recognized technical expertise to provide guidance on ways of addressing those concerns, has resulted in increased government awareness of the importance of addressing these issues. It also provided partners with greater clarity about the action to be taken and increased their level of commitment. As a result, some countries took steps to increase the number of maternal health staff, particularly midwives (Ethiopia, Burkina Faso).[114]

Support to sustainable funding mechanisms for maternal health

The detailed EmONC improvement plans developed with MHTF support provide a good basis for accurate costing and constitute a sound decision-making tool to enable either the government or the development partners to commit themselves to supporting this plan financially. However, the MHTF has only been directly involved in supporting the costing of strategies in a few country case studies (Sudan, Ghana and Madagascar).[115]/[116]

[108] As described under evaluation questions 1 and 4.
[109] In many of the case studies.
[110] See evaluation question 2.
[111] See evaluation question 8.
[112] Burkina Faso, Lao PDR, Cambodia.
[113] See judgment criterion 5.1 in Volume 2.
[114] See judgment criterion 5.1 in Volume 2.
[115] In Ghana, an MHTF-funded consultant guided the costing of the Accelerated Framework to Reduce Maternal and Neonatal Mortality of the MDG. The costing model is currently used by the Ghana Health Service.
[116] See judgment criterion 5.2 in Volume 2.

The needs of partner governments for technical assistance in supporting costing of strategies suggest that improvement is needed (as mentioned in the MHTF Business Plan), either through partnership with the development partners already involved in providing such support[117] or through developing expertise within UNFPA/MHTF.[118]

Monitoring of national maternal health plans

Having identified monitoring and results-based management of maternal and newborn health initiatives as an area of importance, the MHTF has supported a number of initiatives aimed at strengthening maternal and newborn health monitoring. Its support to partners has helped integrate internationally-agreed maternal and newborn health indicators in national health information systems (HMIS) in many country case studies.[119] However, the information obtained through HMIS needs to be used with caution, as reliability is often an area of concern despite the efforts of other agencies to strengthen national monitoring systems. Countries often rely on national surveys (e.g., demographic health surveys) to assess progress. The MHTF input to help refine the definition of indicators for maternal and newborn health has contributed to improving the measurement of these indicators.[120] In Madagascar and Cambodia, for example, EmONC plans include a monitoring plan with standard international indicators.[121] The operationalization of the monitoring plan was supported by the MHTF-supported maternal health advisor in Cambodia, which contributed to developing the capacity of the government partners and to strengthening a monitoring culture within the Ministry of Health.

The MHTF has also promoted the use of maternal death audits[122] and policies for mandatory notifications of maternal deaths.[123] Both types of information are valuable for increasing understanding of the extent and causes of maternal mortality. However, maternal death audit tools have neither been adapted nor institutionalized in all programme countries, and further inputs are required for their institutionalization (for example further advocacy and capacity development). The EmONC assessments, as well as midwifery assessments supported by MHTF, also offered baseline data that can be used for monitoring, provided the appropriate mechanisms are in place. For example, the support for establishing a midwifery database provides an important human resource monitoring tool, especially considering that many countries have very poor databases on health personnel (Ghana).[124]

3.6 Evaluation question 6 – Management of the MHTF

EVALUATION QUESTION 6

To what extent have the MHTF management mechanisms and internal coordination processes at all levels (global, regional and countries) contributed to the overall performance of the MHTF in fulfilling its mission?

- **Judgment criteria**

6.1. Coordination of the MHTF contribution within the overall UNFPA support to maternal health.

6.2. Instruments and mechanisms developed by the MHTF to strengthen country office capacities to manage the fund at global and regional level.

6.3. Monitoring and evaluation of the MHTF-supported proposals, including financial monitoring.

- **Evaluation criteria covered**

Effectiveness, sustainability

Summary

Following the introduction of the MHTF, country offices received resources and significant assistance in terms of additional staffing, technical support, knowledge sharing and various guidance documents and tools.

(continued)

[117] For instance, the MBB (Marginal Budgeting for Bottlenecks) developed by UNCEF and the World Bank.
[118] See judgment criterion in Volume 2.
[119] Exceptions include Sudan.
[120] See judgment criterion 5.3 in Volume 2.
[121] Based on: WHO, UNFPA, UNICEF, AMDD (2009) *Monitoring Emergency Obstetric Care: A Handbook*.
[122] See evaluation question 4.
[123] So far, only three of the country case studies had made the notification of maternal deaths mandatory.
[124] See judgment criterion 5.3 in Volume 2.

SUMMARY (continued)

Such support allowed for an increased focus on key maternal health interventions and strengthened the level of technical assistance that the country office provides to its government partners in areas such as evidence-based planning and midwifery education.

Some gaps remain, particularly with regard to support for strategic planning and in specific areas such as improvement of human resources for health, gender integration, and advocacy with government partners. Moreover, monitoring and evaluation have not yet been sufficiently strengthened to make the measurement of MHTF achievements possible, and country offices generally lack support in this area.

Mechanisms to strengthen the capacity of country offices

The MHTF Business Plan provides country offices with an overall framework for reducing maternal mortality and morbidity in collaboration with partners. Generally, country offices develop the MHTF annual work plans (AWP) following the pre-funding assessments based on the different outputs envisaged in the MHTF Business Plan, the UNDAF[125] and UNFPA country programmes. In some country case studies, improved coherence in planning was observed over time. However, this was not the case for all countries, and sometimes reproductive health thematic funds are also planned separately from the reproductive health component. Moreover, because the MHTF plan-

Box 6: Mechanisms established by the MHTF to strengthen the capacity of country offices

Since the launch of the MHTF, countries recognized that the increased resources enabled them to provide relevant technical support to counterparts, and the following mechanisms have been put in place:[126]

- A significant increase in expertise through funding of country or international midwifery advisor positions to support midwifery programmes in 19 countries; sexual reproductive health or maternal health advisors in six countries (reproductive health/maternal health advisors are under recruitment in five countries, of which three are co-funded by the Global Programme for Reproductive Health Commodity Security); and two sexual reproductive health/maternal health regional advisors in the African Regional Office (ARO) and the Dakar sub-regional office.
- In some countries, the international country midwifery advisors (ICMA) helped strengthen the country office ability to manage not only the MHTF but also the other reproductive health components (Lao PDR, Ethiopia). It should also be noted that senior UNFPA reproductive health staff are often fully involved in the MHTF, with staff funded from different sources working as a team and fulfilling different demands (although not all positions are filled yet).
- The tools provided to countries are deemed useful by the country office teams, particularly the EmONC needs assessment, as well as the International Confederation of Midwives (ICM) tools.[127]
- Support received from the ICM advisors[128] who provide technical assistance relating to the midwifery programme, along with a well-appreciated regional professional network, was valued by the country offices.
- Regular support was provided to the country midwifery advisors (CMA), dating from an initial MHTF orientation meeting in Accra in 2009, and through subsequent regular encounters.
- Support for developing joint reproductive health annual work plans (AWP) and regular reviews and feedback,[129] including capacity development regional workshops, were appreciated by most country offices.
- Various mechanisms for knowledge sharing between countries have been established, for example workshops (e.g., task shifting workshop in 2009) and on-the-job training in a number of countries.[130]
- On-demand support from headquarters was valued for its flexibility, whereas support from regional and sub-regional offices was comparatively weaker.
- Guidance notes were developed in 2011 to refocus MHTF inputs, building on the first years of MHTF experience and the latest international debates.

[125] United Nations Development Assistance Framework.
[126] See judgment criteria 6.1 and 6.2 in Volume 2.
[127] I.e. ICM publications: 'Gap Analysis on Education, Regulation, and Association Development' and 'Global Standards for Midwifery Education and Regulation'.
[128] Deployment of two regional and one international ICM advisors (see evaluation question 2).
[129] AWP review was done as a peer review as well as by headquarters and during annual planning workshops.
[130] The Eritrea Ministry of Health came to Ghana to observe the fistula repair hospital, its management and linkage with the setting up of rehabilitation and re-integration of patients; the Ethiopian Midwifery Association came to learn about regulations, standards and codes.

ning cycle is annual, country office teams have less incentive to engage in a long-term projection of the required support.

Aside from the MHTF Business Plan, other mechanisms, tools and additional resources have been provided by the MHTF to countries in support of their efforts (see Box 6).

Constraints related to lengthy approval procedures were also identified. These led to delays in the availability of funds, thereby preventing a timely start for planned country activities. Staff faced problems of accessing certain guidance documents and other resources that are only available in English. The MHTF/ICM collaboration attempted to address this issue in part through assigning one English-speaking midwifery advisor to support Anglophone countries and one French-speaking country advisor for Francophone countries.[131]

The MHTF is managed and coordinated at the global level by the MHTF unit within the Sexual and Reproductive Health Branch of the Technical Division (TD). The MHTF unit had direct links with selected countries to enable these countries to perform pre-funding assessments,[132] and to develop proposals and AWP based on the country situation and within the MHTF mandate.[133] The role of regional and sub-regional offices varied between regions but was generally limited to a consultative role, mainly to reviewing the AWP and sometimes to participating in the pre-funding assessments. This meant that the communication channels used by the MHTF did not correspond to the overall UNFPA structure (regional and sub-regional offices).[134] The regional offices were not in a position to provide the necessary support to the country offices,[135] which created frustration and ambiguity with regard to accountability.[136]/[137] This situation did not help to ensure that MHTF-funded interventions became fully

Box 7: Country office feedback on support from regional and sub-regional offices since the launch of the MHTF

The online survey[138] showed that MHTF-funded countries in the Sub-Saharan Africa region reported an overall improvement in regional-level assistance since the introduction of the MHTF. The countries in the Asia and Pacific region reported comparatively less improvement.

One of the main improvements concerns the provision of guidance documents for both regions. Technical assistance was reported as having generally improved for obstetric fistula, EmONC, midwifery, family planning and reproductive health commodities (although only 30 percent of countries in the Asia and Pacific region saw significant improvements in support for midwifery).

Approximately 50 per cent of the MHTF-funded countries responding to the online survey did not receive any technical assistance for human resources for health, sexual transmitted infections, and integration with gender and population and development.[139]

More than half of the countries received assistance from UNFPA regional level in the field of programme planning and management, mainly in annual programme planning for maternal health. Little improvements were reported for the assistance provided for monitoring.[140]

Countries supported by the Dakar sub-regional office considered that the skill mix of staff in their office was improved mainly in the fields of evidence-based technical contributions to promoting maternal health. However, the skill mix did not improve in other areas, such as effective policy advocacy for maternal health with governments and development partners or the appropriate monitoring and evaluation of maternal health interventions.

In other sub-regions, the provision of technical contributions (e.g., leading technical working groups, provision of technical guidance on maternal health) has not improved.[141]

[131] See judgment criterion 6.2 in Volume 2.
[132] See evaluation question 1.
[133] As described in the MHTF Business Plan.
[134] Whereas the usual reporting lines go from country offices to sub-regional and regional offices and these to headquarters, for MHTF-related communications country offices report directly to the MHTF Unit in the headquarters.
[135] Regional offices faced a significant decrease in their response capacity due to the combined effects of staffing gaps and the dissolution of country support teams that limited the support role of the regional office/sub-regional office advisors.
[136] Sub-regional offices/regional offices are requested to monitor country offices, to review annual work plans and to coordinate with headquarters. However, this coordination has not been as effective as anticipated. Most issues are decided by headquarters, and the sub-regional offices only get instructions. For example, if there is a visit from headquarters, the sub-regional office/regional office is not involved and in some instances did not receive timely information.
[137] See judgment criterion 6.1 in Volume 2.
[138] See presentation of results from the online survey in Volume 2.
[139] Population and development component of country programmes.
[140] See presentation of results from the online survey in Volume 2.
[141] See presentation of results from the online survey in Volume 2.

integrated into the overall reproductive health strategies, and the MHTF consequently remained as a separate component.

The positive responses obtained in the online survey from the Sub-Saharan Africa region countries regarding some improvements (see Box 7) that occurred after the launch of the MHTF are possibly linked to the duration of MHTF support, as these were the first countries to be supported. This can be taken as a sign that further developments may occur over time.

Overall coordination

In line with the policies and procedures manual (PPM), a joint Reproductive Health Thematic Funds Interdivisional Working Group (RHTF–IDWG) was established in 2010 by UNFPA to provide strategic and technical guidance and to coordinate technical and financial resources provided by the reproductive health thematic funds. The RHTF–IDWG has been providing overall direction and has encouraged integration.[142] However, the RHTF–IDWG does not meet as often as initially planned and the IDWG decision-making processes have been compromised by gaps in documentation and by inadequate analyses of existing documentation.[143] The fact that this mechanism is not used in an optimal manner is a missed opportunity given the importance of coordination between the different thematic funds and of the reproductive health component for generating increased synergies.[144]

Internal monitoring and reporting

As seen above, planning and monitoring processes have gradually been harmonized between countries and between thematic funds. A unified reporting system has been introduced for all reproductive health funds and templates were provided to countries for this purpose in 2010.[145] Joint reports are more informative compared with the general UNFPA reporting. They provide information on the activities undertaken as well as a certain degree of analysis of the context in which the achievements were attained. However, the analysis of the contribution of activities to expected outputs, and its significance in relation to the contribution made by government and other partners, varies considerably.

A review of MHTF annual reports revealed that countries do not have the same level of reporting on progress made toward the MHTF outputs, and that many of these reports are not in line with the indicators of the MHTF monitoring and evaluation framework. The MHTF results framework could be a useful tool for establishing a dialogue and for strengthening the capacities of programme countries to measure progress toward improving maternal health. However, it has not been systematically used to this end. The framework has not been adapted to the context of the respective countries so as to ensure that the various indicators match the indicators measured in the countries themselves.

During the evaluation, recurrent feedback from country offices was that there is no monitoring mechanism that helps UNFPA country offices capture the contribution of the MHTF (or UNFPA) to improving maternal health by means of process indicators for measuring whether MHTF interventions contribute to achieving national-level output indicators. Appropriate country office log-frames with indicators at various levels are lacking.[146]

Financial monitoring is based on UNFPA regulations, policies and procedures. It measures implementation rates based on actual expenditures reported in the ATLAS[147] system. Some reporting on implementation rates does takes place, but there is no systematic reporting across countries. The overall monitoring situation does not

[142] RHTF–IDWG meeting minutes.
[143] Division of Oversight assessment of the UNFPA Thematic Trust Funds (TTF) – DOS - March 2010.
[144] See judgment criterion 6.1 in Volume 2.
[145] Template for Country Annual Joint Reporting for The Reproductive Health Thematic Fund - Technical Division, UNFPA - Global Programme for Reproductive Health Commodity Security and Maternal Health Thematic Fund.
[146] See judgment criterion 6.3 in Volume 2.
[147] ATLAS is the financial information system of UNFPA.

provide sufficient information and prevents MHTF management from linking resources to results.

Furthermore, the financial reporting deadlines for the MHTF and the Global Programme to Enhance for Reproductive Health Commodity Security (GPRHCS) are different, which has created difficulties for the country office teams. The potential for synergies in financial reporting and management is not being fully exploited between the two funds.

Summary

Although efforts toward integration of the thematic funds benefited at the global level from the introduction of joint planning and reporting, most countries still plan the different components and programmes in parallel. Annual planning does not integrate all components into a single strategic reproductive health plan, which results in programmes that lack coherence and efficiency and does not allow optimal achievement of synergies.

3.7 Evaluation question 7 – Coordination and coherence

EVALUATION QUESTION 7

To what extent has the MHTF enhanced and taken advantage of synergies with other UNFPA thematic funds, e.g., the Global Programme on Reproductive Health Commodity Security (GPRHCS), the Campaign to End Fistula, the UNFPA-ICM[148] Midwifery Programme and HIV-PMTCT,[149] in order to support maternal health improvements?

- **Judgment criteria**

7.1. Integration of the components of the Campaign to End Fistula into maternal health programmes after the integration in MHTF.

7.2. Joint and coordinated planning at the country level with the GPRHCS.

7.3. Integration of strategic directions of the Midwifery Programme into MHTF plans in countries.

7.4. Harmonized MHTF integration strategies and mechanisms at global and regional levels.

7.5. MHTF plans integrate HIV activities in synergy with core funds, Unified Budget and Work plan (UBW) and other resources.

- **Evaluation criteria covered**

  Coherence, efficiency

Annual planning in some UNFPA country offices takes into account multiple sources including core funds, MHTF, the Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS) and other funding sources (Ghana, Burkina Faso). Regardless of the funding sources, all interventions are planned by country offices with a view to achieving the UNDAF[150] and country programme action plan (CPAP) outcomes. Reproductive health thematic funds are seen as complementary to the reproductive health interventions funded from other sources within the framework of their mandate. It was observed during the evaluation that a single reproductive health plan contributes to increased harmonization and more strategic planning.

However, in other countries visited, joint planning concerned only the reproductive health funds themselves, the GPRHCS and MHTF, and did not relate to the overall reproductive health component of the country. This then led to a fragmented country reproductive health programme with little coherence.[151]

Integration with obstetric fistula

The Campaign to End Fistula was integrated into the MHTF in 2010, alongside the integration of indicators relating to obstetric fistula interventions into the MHTF results framework. The main focus of the Campaign to End Fistula has been on increasing access to and utilization of quality fistula treatment services, for which several training events were organized by the MHTF.[152] In some

[148] International Confederation of Midwives.
[149] Preventing Mother-to-Child Transmission.
[150] United Nations Development Assistance Framework.
[151] See Volume 2.
[152] Thematic Evaluation of National Programmes and UNFPA Experience in the Campaign to End Fistula - Assessment of national programmes - Synthesis Report - HERA & ICRH - December 2009.

countries, the CMA is in charge of fistula (Ethiopia), while in others the fistula advisor shares responsibilities with the CMA (Zambia).

Obstetric fistula has been integrated into national maternal health programmes to different degrees in the countries visited. Differences can be explained by the degree of prevalence of obstetric fistula in the various countries[153] and by the way in which the existing interventions of the Campaign to End Fistula had been planned.

Box 8: Positive examples of integrating obstetric fistula in overall maternal health programming

In Ghana and Madagascar, the MHTF aimed to integrate obstetric fistula into the maternal policies and strategies so as to allow for a systematic focus on obstetric fistula in the maternal health services.

In Zambia, obstetric fistula prevention and identification were included in the revised training curricula for nurses and midwives, and issues around fistula were part of the sensitization of nurses, midwives and communities.[154] In Zambia, the potential for increasing advocacy for the prevention of obstructed labour as a direct cause of obstetric fistula was also demonstrated.

Such a degree of integration is rare, as shown in the country case studies for this evaluation and in the previously conducted obstetric fistula thematic evaluation.[155] Although most country offices have midwifery and EmONC service components that contribute to the prevention of obstetric fistula, planning is usually done in parallel[156] and reporting is separate as a consequence of reporting requirements.

Integration with the Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS)

The GPRHCS and the MHTF initially operated separately as they focus on different aspects of health system strengthening. The GPRHCS focused on commodities and logistics and on family planning-related interventions, whereas the MHTF focused on strengthening human resources for maternal health and on providing maternal health technical assistance.

At the country level, areas of convergence could be observed such as combined needs assessments (Burkina Faso, Ghana),[157] joint planning and inputs for maternal health commodities and equipment (Cambodia, Madagascar and Ethiopia), coordination of family-planning-related training (Ghana, Lao PDR) and combined sensitization on family planning and maternal health (Madagascar).

The facilitation of joint planning and reporting by headquarters has initiated common procedures and increased collaboration. However, in most countries, each programme remains separate, with its own staff members. Programme activities are collated in the AWP without real coordination, whereas both thematic funds should be part of the same reproductive health strategy since they (i) tend to achieve the same objectives, (ii) often work with the same partners and (iii) apply to the same beneficiaries.

Integration of the Midwifery Programme

The three components of the Midwifery Programme (education, regulation and association) have been integrated into MHTF plans in most countries. In addition, advocacy activities were undertaken for increased recognition of midwives, particularly the Celebration of the International Day of Midwives.[158] The activities are reported in the joint report of the reproductive health thematic fund and in the annual reports, in a separate chapter.

In African countries collaboration with the International Confederation of Midwives has helped the country midwifery advisors support the implementation of the three components, although lines of accountability are not always clear between the ICM and UNFPA.[159] Similar

[153] In countries where female genital mutilation is widely practiced, obstetric fistula prevalence is higher.
[154] Information from fistula AWPs and annual reports; as well as UNFPA interviews.
[153] In countries where female genital mutilation is widely practiced, obstetric fistula prevalence is higher.
[155] Thematic Evaluation of National Programmes and UNFPA Experience in the Campaign to End Fistula - Assessment of national programmes - Synthesis Report - HERA & ICRH - December 2009.
[156] Although being part of the joint plan.
[157] See evaluation question 3.
[158] See evaluation question 2.
[159] Regional ICM advisors have very little contact with UNFPA Regional Offices.

collaboration has been initiated in Asia and the Pacific Region since 2010.

Sexual and reproductive health/HIV integration

The growing awareness of the importance of integrating HIV/AIDS into reproductive health programmes was reflected in the Unified Budget and Work plan (UBW), which provides a framework for integration. However, in most countries HIV activities are still run by UNAIDS in parallel with the reproductive health programmes. Within UNFPA, HIV activities are usually part of the sexual and reproductive health programmes for young people, which are not within the scope of the MHTF.

In some countries, the role of the MHTF was to ensure that preventing mother-to-child transmission (PMTCT) was introduced in midwifery curricula (Ghana, Burkina Faso and Madagascar). In other countries, PMTCT was already included in midwifery education prior to the start of the MHTF.[160] Actual PMTCT implementation often depends on HIV prevalence and the priority given to HIV/AIDS in the respective countries. Initiating PMTCT activities is still problematic owing to the weak capacity of the health system to absorb this component (Lao PDR).

In Madagascar, HIV sensitization campaigns, whether for the general population or for target groups such as adolescents, were part of the overall reproductive health sensitization campaign and have been supported in target areas by the MHTF.[161] This is, however, an exception.

3.8 Evaluation question 8 – Leveraging and visibility

EVALUATION QUESTION 8

To what extent did the MHTF increase the visibility of UNFPA sexual and reproductive health/maternal health support and help the organization to leverage additional resources for maternal health at global, regional and national levels?

- **Judgment criteria**

8.1. MHTF-facilitated presence of UNFPA in global and regional maternal health initiatives.

8.2. Effect of MHTF on (increased) external financial commitments to UNFPA/MHTF for maternal health support (at global, regional, country levels).

8.3. Effect of the MHTF on (increased) financial commitments of partner governments to sexual and reproductive health/maternal health.

- **Evaluation criteria covered**

Visibility

Summary

The MHTF has contributed to increasing the visibility of UNFPA in maternal health by ensuring a strong presence in key maternal health events at the global level and in the African Region as well as in the international media. In MHTF-supported countries, UNFPA is considered a key player in maternal health due to the contribution of the MHTF with its strong focus on emergency obstetric and newborn care (EmONC) and midwifery, its provision of additional technical expertise through the country midwifery advisors and maternal health technical advisors, and the provision of sound technical tools.

Nevertheless, a link between higher visibility in the maternal health sector and the leveraging of substantial additional resources could not be fully established at the global level. One exception is the H4+[162] initiative, in which UNFPA and particularly the MHTF have been active, and which has attracted additional funds for maternal health. Country-level undertakings supported by the MHTF, such as the EmONC assessments and plans and midwifery education have rallied other donors in search of technically-sound interventions to support. These undertakings also led governments to increase personnel quotas (midwives) and commit to infrastructure linked mainly to EmONC plans.

Visibility at the global and regional levels

UNFPA has had an increasing role in efforts to improve maternal health and to meet the Millennium Development Goal (MDG) 5 target of reducing the maternal

[160] For example, in Zambia, Cambodia, Lao PDR and Ethiopia.
[161] See judgment criterion 7.5 in Volume 2.
[162] UNFPA, UNICEF, the World Bank, WHO and UNAIDS.

mortality ratio by 2015 through its involvement as a member of the H4+ initiative at the global level. In the African Region, UNFPA has supported the launch of the Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) as well as the implementation of the Maputo Plan of Action in fighting obstetric fistula and strengthening midwifery.[163]

The MHTF has contributed to UNFPA positioning through its support for the conceptualization of the H4+ initiative[164] and the presence of UNFPA at various key events on maternal health at the global level[165] and in the African Region, as well as through supporting UNFPA participation in the development of key documents.[166]

The Media and Communication Branch of the Information and External Relations Division at UNFPA headquarters supports these undertakings through advocacy and communication strategies and materials that:

- illustrate individual stories of women who survived pregnancy and childbirth in difficult contexts;
- ensure wide media coverage; and
- support advocacy in global and regional events.

The Media and Communication Branch moreover develops communications-related catalogues, strategies and toolboxes for H4+[167] as well various tools and strategies for country offices.

The main target groups are the media, partners and decision-makers at global and national levels.[168] However, the tools provided by the Media and Communication Branch at the global level are not always taken into consideration by country offices and only some advocacy messages and suggested activities have been utilized.[169]

Visibility at the country level

As discussed in the previous evaluation questions, UNFPA had already been involved in maternal health improvements at the country level prior to the start of the MHTF. However, the launch of the MHTF has raised the UNFPA profile in maternal health through:

- focusing its endeavours on specific areas such as EmONC and midwifery strengthening;
- introduction of recognized tools and guidelines, e.g., EmONC needs assessment tools, International Confederation of Midwives (ICM) standards, midwifery situation analysis;[170] and
- funding of participation by maternal health advisors in the different health forums and working groups.[171]

The role that MHTF played in increasing UNFPA visibility at the country level is shared by the Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS) given its strong commodity security component, which is valued by all partners. In all the case study countries that benefited from both funds, UNFPA is well recognized for its contribution to both reproductive health commodity security and to midwifery and EmONC.

The MHTF-supported participation by national partners (government technical counterparts, EmONC assessment

[163] High-level Plenary Meeting of the General Assembly - GOAL five Improve Maternal Health – Fact Sheet - United Nations Summit - 20-22 September 2010, New York.
[164] The MHTF coordinator drafted the H4+ joint statement. UNFPA/MHTF was an active coordinator for six months (rotating coordination).
[165] Liaison with the Muskoka Initiative in which the Canadian International Development Agency (CIDA) has committed to help strengthen maternal and reproductive health; the Women Deliver Conference 2010; the UN Secretary General global initiative aimed at "improving reproductive, maternal and newborn health" through involving First Ladies as national advocates and champions for maternal health (e.g., Cambodia, Burkina Faso).
[166] "Countdown to 2015: Taking stock of maternal, newborn and child survival," the MDG 2010 report, the State of World Population report as well as the conceptualization and development of the State of the World Midwifery report 2011.
[167] A country-level communications project supporting joint UN action to improve maternal and newborn health in priority countries - WHO, UNFPA, UNICEF, The World Bank - April 2010.
[168] For instance, the MHTF-supported documentary film "Ghana Midwives Deliver" has been widely broadcast internationally and nationally and was used by the MHTF for global advocacy.
[169] See judgment criterion 8.1 in Volume 2.
[170] See judgment criteria 2.1 and 2.2 in Volume 2.
[171] See evaluation question 2.

teams, representatives of midwives associations) in various regional and global workshops and conferences[172] had a noticeable effect on the visibility of UNFPA at country and regional levels. In some countries, the Celebration of the International Day of Midwives,[173] supported by the MHTF, received broad media coverage, which provided more visibility to UNFPA within the respective country (Lao PDR).

Leveraging

MHTF support has contributed to securing the commitment of donors to provide additional funds for maternal health through different processes. The UNFPA/MHTF built on the H4+ commitment at the global level, which led to joint funding of EmONC needs assessments in several countries (Ethiopia, Ghana, Lao PDR, Burkina Faso) and to the development of national-level cooperation projects that were submitted to other donors for funding (Burkina Faso proposal to CIDA).[174]

At the country level, bilateral donors and development banks (World Bank, Asian Development Bank) are in need of technical guidance from the UN agencies. MHTF assistance to design and cost plans[175] provided a good basis for persuading donors to invest in those plans.

Additional funding was mobilized by governments for some interventions initiated with MHTF support. Persuading governments and other development partners to commit funding for maternal health had been an aim of UNFPA prior to the start of the MHTF. However, success varied by country and the MHTF-supported initiatives have not led to any direct national budget increase or the creation of particular budget lines for maternal health.

Box 9: Positive examples of leveraging funds due to MHTF

- The World Bank has committed to support midwifery training institutions in Burkina Faso.
- SIDA (Sweden) has funded midwifery in Ethiopia.
- The Netherlands and other donors have supported obstetric fistula, midwifery and EmONC services in Ghana.
- In Cambodia, the EmONC improvement plan has been funded through the pool fund.[176]

However, some governments have endorsed EmONC improvement plans based on MHTF support and which involve investments such as increasing the number of midwives to be integrated in the public health system, capacity development, refurbishing of EmONC facilities and the general upgrading of facilities. Such investments are usually supported by the national budgets (Ethiopia, Cambodia and Burkina Faso).[177] In countries that conducted EmONC assessments more recently, the improvement plans may lead to increased commitments by the governments, although it is too early to assess that effect.

In the Sub-Saharan African Region, the Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) aims at promoting sustainable financing to ensure availability and use of universally accessible quality reproductive health services.[178] CARMMA was launched in several countries with MHTF[179] support (financially supported by UNFPA at the regional level). However, in

[172] E.g., EmONC assessment in Dakar; regional workshops, conducted by the ICM, aimed at orienting UNFPA and government staff from different countries to the latest midwifery skills and standards of education and regulation; and the Launch of the State of the World Midwifery report at the 29th Triennial Congress of the International Confederation of Midwives in 2011.
[173] See evaluation question 2.
[174] Through the Muskoka initiative - G8 Muskoka Declaration - Recovery and New Beginnings - Muskoka, Canada, 25-26 June 2010.
[175] See evaluation question 4.
[176] See judgment criterion 8.2 in Volume 2.
[177] The results of the EmONC assessment showed that EmONC services were not sufficient at the district level and one of the proposed actions was to upgrade the health centers to provide B-EmONC.
[178] Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) Factsheet - Department of Social Affairs - African Union Commission - May 2009.
[179] Some non-MHTF countries also launched CARMMA with UNFPA support.

most cases these high-profile launches have not been sufficiently exploited to enable the leveraging of additional resources.[180]

At the global level, the Resource Mobilization Branch at headquarters has developed a strategy that aims at mobilizing additional funds from donor countries and private donors for the MHTF. Despite those efforts, the group of donors funding the MHTF has remained approximately the same since its inception, and commitments depend on the current global economic situation.[181]

[180] See judgment criterion 8.3 in Volume 2.
[181] See judgment criterion 8.1 in Volume 2.

CHAPTER 4

Conclusions

This section provides conclusions based on an analysis of the main findings presented for each evaluation question. The conclusions are categorized according to transversal themes identified during the analysis workshops,[182] namely: relevance of the MHTF approach and its effects on maternal health; the strategic and catalytic nature of the MHTF; the organizational issues for MHTF; and the contribution of the MHTF to UNFPA visibility.

4.1 Long-term vision, catalytic effect of MHTF and sustainability of interventions

CONCLUSION 1

MHTF inputs led to catalytic effects in specific areas, for instance in providing support for developing coherent improvement plans for emergency obstetric and newborn care (EmONC) that governments endorsed and to which development partners contributed. However, the MHTF contributions has not always been planned strategically and sufficiently integrated within the framework of the overall reproductive health component of the country office. This, in turn, prevented achieving the full catalytic effects initially sought for.

- **Origin:** (Evaluation questions 1, 2, 5, 6 and 7)
- Also see final report, MHTE Conclusions 8 and 9
- **Evaluation criteria:** Effectiveness, efficiency, sustainability

The MHTF Business Plan provides a framework for guiding country offices in selecting interventions that will contribute to reducing maternal mortality and morbidity. However, it does not provide a clear delineation of roles between the MHTF and UNFPA core business units. Also, a time frame to help country offices to plan sustainable interventions with exit strategies is lacking. Country offices have not developed a coherent medium-to-long-term strategic vision for MHTF funds within UNFPA programming. As a result, they are not equipped with a logical framework with regard to MHTF funding that could be usefully integrated into their respective programmes for the reproductive health mandate area. Moreover, the necessary linkages between UNFPA core programmes and the Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS) were also found to be insufficient. As a result, the interventions as a whole are rather disparate and disjointed and in need of streamlining to ensure the expected catalytic effect.

UNFPA partners (governments as well as development partners) joined in to support implementation, in countries where MHTF inputs contributed to putting in place well-articulated, comprehensive and budgeted plans. They were motivated by clear prioritization of actions, clear coordination frameworks and the prospects for achievement of the expected results. Global orientations such as the H4+ initiative and regional guidance (e.g., Maputo Plan of Action or CARMMA) reinforced this commitment to some extent. In addition, the consultative processes adopted for designing MHTF-supported interventions[183] together with governmental counterparts contributed to stronger national ownership.

[182] See sections 2.3 and 2.4.
[183] E.g., EmONC assessment, update of midwifery curricula.

The pre-funding country situation analyses, while of value for the MHTF planning process, are insufficient in scope to allow for an assessment of the catalytic potential of the MHTF. In particular, they have gaps in the analysis of the available resources, the capacity requirements and the absorption capacities of national partners at all implementation levels. The likely commitment of the different stakeholders and the possible synergies with existing interventions are further aspects that have not been fully examined. Such deficiencies in the MHTF planning process echo shortcomings of the overall UNFPA planning process. For instance, the MHTF has funded a number of one-off interventions (e.g., family planning training courses for only a few health personnel) which lacked sufficient strategic planning and which were not adequately linked with the UNFPA reproductive health component. This type of contribution has not led to increased synergies and has not had the catalytic effect that the MHTF seeks to trigger or facilitate.

CONCLUSION 2

In cases where the MHTF has effectively contributed to policy dialogue, knowledge transfer and the strengthening of partnerships, MHTF support has the potential to produce lasting results. However, the absence of strategic long-term planning, including hand-over or exit strategies, compromises the sustainability of the MHTF initiated interventions once MHTF support is terminated.

- **Origin:** (Evaluation questions 1, 2, 4, and 5)
- Also see final report, MHTE Conclusions 8 and 9
- **Evaluation criteria:** Effectiveness, sustainability

Partnerships created at global and country levels have increased opportunities to engage in more sustainable interventions. As such, partnerships are characterized by more comprehensive and longer-term action. In countries where the MHTF has been effectively involved in knowledge transfer (mainly in policy dialogue) and in strengthening partnerships, MHTF support has the potential to produce sustainable effects. For instance, advocacy and technical support for the inclusion of the midwifery workforce in national maternal health strategies are effective interventions to scale-up midwifery services in the long term.

The main shortcoming is that sustainability was never specifically outlined as a priority in the planning process. In that context, follow-up of the interventions and exit strategies have not been systematically planned with a view to ensure continuity. This means ensuring that the government, UNFPA core business or alternatively other development partners take over once MHTF support ends.

4.2 Appropriateness of implementation strategies

CONCLUSION 3

The MHTF focus on midwifery and emergency obstetric and newborn care (EmONC) is relevant and appropriate as it has been concomitant with the momentum in maternal health at global, regional and country levels. It has allowed building a strong basis for increased attention to maternal health and for boosting both areas.

CONCLUSION 4

The MHTF focus on pre-service training and institutional support for training institutions is appropriate. However, the sustainability of the interventions is limited given the low emphasis on follow-up strategies with regard to maternal health human resources. For example, issues such as deployment and retention are presently not systematically addressed.

- **Origin:** (Evaluation questions 1, 2, 4, and 5)
- Also see final report, MHTE Conclusion 8
- **Evaluation criteria:** Relevance, effectiveness, sustainability

The MHTF Business Plan (2008-2011), based on the latest global evidence for improving maternal health, commits to ensuring universal access to family plan-

ning; skilled care in pregnancy and childbirth including quality facility deliveries; and emergency obstetric and new-born care (EmONC). At the country level, this was translated into a strong emphasis on strengthening midwifery to ensure skilled attendance at birth and scaling-up of EmONC services which have proved to be a relevant "niche" for MHTF.

Overall, MHTF support to midwifery education, particularly pre-service training, is appropriate and clearly responds to the global demand for midwives. Several countries started direct-entry midwifery courses to allow midwives to graduate within a shorter time, thereby increasing the pool of trained midwives more rapidly. This will contribute to improving access to midwifery services and to "realize the right of every woman to the best possible health care during pregnancy and childbirth." Both the updating of course curricula and the institutional support to training institutions are appropriate interventions that contribute to quality education. However, MHTF support has not systematically ensured that issues relating to maternal health care personnel (including midwives) are specifically taken into consideration in human resources for health (HRH) strategies and plans (such as deployment following initial training and retention). For example, one issue in need of attention is the midwife shortage in rural areas. Young midwives are often deployed in isolated and remote areas face several difficulties which discourage them from remaining at their assigned post. As a result, the women requiring their services and who live in those areas have less access to skilled care.

MHTF involvement in support for family planning has remained very limited because of a major investment in this area by the Global Programme on Reproductive Health Commodity Security (GPRHCS) in Stream 1 and 2 countries as well as UNFPA core funds.[184] In addition, family planning expertise is already available in country offices due to the long-term involvement of UNFPA in this field. The main area of GPRHCS support concerns commodity security, although it has been expanding to other areas such as capacity development for service providers and demand creation.

The promotion efforts undertaken by the MHTF for the integration of family planning with the various reproductive health elements have been important and relevant in particular in training course curricula. However, MHTF financial investment in family planning interventions is not relevant since its limited resources are prone to be diverted from its main focus (EmONC and midwifery). On the other hand, countries continue to be in great need with regard to capacity development for quality family planning service provision that cannot be addressed through MHTF limited funds.

CONCLUSION 5

Although family planning is one of the three pillars for improved maternal health, MHTF financial investment in this area is not justified in countries belonging to Stream 1 and 2. This is due to the major inputs and focus of the GPRHCS and the UNFPA core funds in family planning.

- **Origin:** (Evaluation questions 3 and 7)
- **Evaluation criteria:** Effectiveness, efficiency

CONCLUSION 6

The lack of a comprehensive strategy for improving the demand for and use of skilled attendance at birth and EmONC services goes hand in hand with knowledge gaps concerning the nature and characteristics of the barriers to accessing such services.

- **Origin:** (Evaluation questions 1, 2, 3 and 4)
- **Evaluation criteria:** Relevance, effectiveness, sustainability

[184] In the same countries that are supported by the MHTF.

4.3 Contribution to policy dialogue

CONCLUSION 7

MHTF input has been instrumental in refocusing government maternal health priorities. In some cases this has led to increased government commitments (e.g., additional staff positions or infrastructure). However, less emphasis has been placed on identifying and addressing the needs of the most vulnerable groups. This may adversely affect progress towards the reduction of maternal mortality and morbidity.

- **Origin:** (Evaluation questions 1, 2, 3, 4, 5, and 8)
- Also see final report, MHTE Conclusion 8
- **Evaluation criteria:** Relevance, effectiveness, sustainability

Promoting maternal health in policy dialogue had been initiated prior to the introduction of the MHTF by different development partners, including UNFPA. The launch of the MHTF helped governments prepare the ground for accelerating implementation. For instance, the support to the emergency obstetric and newborn care (EmONC) assessments provided the necessary information for developing plans for rationalizing and improving the coverage and the quality of EmONC service provision. Support by the MHTF for costing the plans is a further step toward the operationalization of the maternal health road maps. In most countries, the push by the MHTF toward boosting midwifery triggered better positioning of midwives within the health systems. This, in turn, contributed to increase skilled attendance at birth. The support for improving regulatory systems, norms and standards for midwifery education as well as for midwifery services led to an increased emphasis on service quality as a whole. All these elements have been integrated into government policies and strategies, and in some cases have led to additional government funding commitments (e.g., additional staff positions or infrastructure plans). However, it should be noted that core-funded reproductive health staff in country offices were more involved in policy-level interactions while MHTF-supported national country midwifery advisors were dealing mostly with technical related issues.

The MHTF has not sufficiently advocated the prioritization of the populations most at risk in terms of maternal health. Since vulnerable groups experience the highest maternal mortality rates and the lowest skilled birth attendance rates, they must be given priority, particularly where resources are limited. The overall evidence-based planning process supported by the MHTF (and UNFPA as a whole) did not sufficiently identify the specific constraints (including gender constraints) preventing women from accessing maternal health services. Nor has the planning process identified and prioritized the population groups facing the most barriers. These shortcomings greatly limit the potential of the national planning process to reduce maternal mortality.

CONCLUSION 8

The overall MHTF support for evidence-based planning has improved maternal health programming, in particular through needs assessments. The MHTF has also contributed to the further development of an evidence-based culture in programme countries.

- **Origin:** (Evaluation questions 1, 2, 3, 4, and 5)
- **Evaluation criteria:** Relevance, effectiveness, sustainability

MHTF efforts to help countries produce a wide range of maternal health evidence contributed to informing the programming of maternal health services improvements. Examples of the maternal health evidence are the EmONC needs assessments, midwifery situation analyses, maternal death audits, and compulsory maternal death notifications.

Based on a precise methodology, the EmONC needs assessments have provided a clear picture of the EmONC service situation. The assessments also offer a basis for developing and costing EmONC service improvement plans. The implementation of such plans has the potential to offer quality EmONC services to the population in terms of infrastructure, equipment and qualified personnel.

The gap analyses funded by the MHTF and supported by the International Confederation of Midwives have helped gather evidence on the three components of the midwife-

ry programme with a view to inform maternal health programming. Similarly, maternal death audits promoted by the MHTF are particularly useful for understanding the underlying factors, including the three delays that lead to maternal death beyond medical causes.

CONCLUSION 9

The MHTF results-based framework has the potential for strengthening the capacities of counterparts to monitor progress in areas of maternal health. However, the use of the framework is constrained by weak health information management systems and by insufficient adaptation to country situations. Most monitoring tools are inappropriate for measuring the specific MHTF contribution to the expected results. These monitoring gaps, together with weaknesses of the overall UNFPA monitoring system for core-funded projects, are major constraints for improving both country offices and government partners programming in the area of maternal health.

- **Origin:** (Evaluation questions 1, 2, 3, 4, 5, 6, 7, and 8)
- Also see final report, MHTE Conclusion 7
- **Evaluation criteria:** Efficiency, effectiveness, sustainability

The MHTF results-based framework provides a useful tool for strengthening the capacity of counterparts to monitor progress in maternal health. Its introduction in countries was often accompanied by successful advocacy efforts to include key international maternal health indicators in national information systems. However, country offices have not used the results-based framework systematically with partners as a follow-up tool, namely because it has not always been adapted to the country context. Its use is also constrained by weak health management information systems (HMIS) – an area that other development partners seek to strengthen and that MHTF can only address in an insufficient manner due to the limits of its mandate and resources.

MHTF monitoring is part of the overall UNFPA monitoring system, which itself has not been effective at generating data on the results of UNFPA support in maternal health. MHTF reporting is more informative than overall UNFPA reporting due to the introduction of specific reporting templates. However, monitoring only focuses on the achievements of partners and does not measure the extent to which MHTF (or UNFPA) efforts have contributed to the expected results. As for the overall UNFPA portfolio, monitoring capacities are low. Moreover, monitoring is an area that receives little support from the central and regional levels.

4.4 Support to quality assurance in maternal health

CONCLUSION 10

MHTF interventions have contributed to laying the groundwork for improving midwifery education and services and for the scaling-up of EmONC services. However, the MHTF did not sufficiently advocate for, and support, the development of quality assurance strategies and mechanisms to ensure that quality of service is guaranteed in the long term.

- **Origin:** (Evaluation questions 2, 4, 5, 6, and 8)
- Also see final report, MHTE Conclusion 9
- **Evaluation criteria:** Effectiveness, sustainability

MHTF interventions have contributed to preparing the ground for an increased quality of midwifery education through the upgrading of course curricula and capacity strengthening for training institutions as well as on-site training. Mechanisms to upgrade the quality of teaching, such as licensing examinations and capacity development for teachers, were put in place. However, mechanisms for supervising and maintaining the quality of training are still insufficient.

The MHTF helped initiate mechanisms to ensure the quality of midwifery services by supporting the development of norms, standards and regulatory systems, of supervision guides and occasionally strategies. However, its contribution in this regard was not always sufficient to al-

low countries to maintain the improved quality over time. Moreover, the modalities and long-term strategies for the implementation of norms, standards and guides are unclear, for the following reasons:

- Appropriate support to ensure that trainees can properly implement what they learned during the MHTF-supported training is not systematically planned.
- MHTF support has not always contributed to establish mechanisms for supportive supervision.
- MHTF support has not always foreseen advocacy within UNFPA reproductive health programmes and with the other partners for larger-scale supportive supervision as a means of improving service quality—despite the demonstrated value of supporting supervisory systems.
- Professional midwifery bodies are not yet strong enough to take on the responsibility of regulating the midwifery profession.

4.5 Strengthening capacity to provide technical assistance to partners

CONCLUSION 11

The MHTF has established an appropriate set-up to strengthen the technical capacity of country offices to support maternal health, in particular with regard to responding to the immediate needs of MHTF interventions. However, due to limitations in such areas as quality of care, policy dialogue and human resources for health management, the set-up will not allow responding to the technical support requirements associated with the follow-up of interventions.

▶ **Origin:** (Evaluation questions 2, 4, 5, and 6)

▶ Also see final report, MHTE Conclusion 9

▶ **Evaluation criteria:** Effectiveness, sustainability

The MHTF has established a technical support network and useful mechanisms aimed at enabling country offices to focus on key maternal health interventions and to provide the necessary support to its government partners. This has led to recruitment of additional staff in country offices, particularly the deployment of country midwifery advisors and maternal health specialists in certain countries, thereby increasing the overall technical capacity of country offices. Deploying national country midwifery advisors (CMA) in programme countries is a suitable strategy for providing the necessary technical support for midwifery, namely with regard to education, regulation and association (with International Confederation of Midwives (ICM) support). Follow-up support in some areas such as quality of care and human resources management have not been sufficiently planned and coordinated within UNFPA and with the various partners. The skills mix of the UNFPA reproductive health team has the potential to respond to these gaps, provided the team has the necessary competencies and receives the appropriate guidance. However, this is constrained by shortages in the UNFPA reproductive health staff.

The collaboration with the ICM (for further support to the midwifery programme at the regional level) and with the Averting Maternal Death and Disability (AMDD) programme (for coaching in conducting EmONC needs assessments) has been valuable and has enhanced the technical expertise of the country teams. The increased presence and availability of sound technical assistance in certain areas (EmONC, midwifery) has contributed to bolstering the visibility of UNFPA and to making maternal health a higher-priority agenda item for governments and development partners.

The above-mentioned set-up made additional technical support available, allowing programme countries to initiate different processes. However, this technical support is no longer sufficient to ensure the follow-up of interventions. For example, while technical expertise has been made available during the EmONC assessment and planning phase, the implementation phase will require a wider range of expertise. Thus, MHTF priority countries may not be sufficiently equipped to continue the MHTF interventions. Long-term planning with capacity needs projections is missing. Moreover, the various options for making the additionally required expertise available

through MHTF or UNFPA support, or, if MHTF support is discontinued, through linkages with other partners (e.g., international non-profit health organizations such as JHPIEGO or WHO) have not yet been explored.

4.6 MHTF organizational structure and management/internal coherence

CONCLUSION 12

The MHTF Business Plan provides a useful framework for guiding country offices in focusing on interventions to reduce maternal mortality and morbidity. However, it is not sufficiently explicit on: (i) how the MHTF planning should relate to UNFPA as a whole; (ii) how to coordinate the reproductive health thematic funds and the overall UNFPA reproductive health components at all levels of the organization; and (iii) how the MHTF-supported country interventions should be planned in the most strategic way (i.e., with the highest added-value for complementarity and synergy).

- **Origin:** (Evaluation questions 2, 3, 6, and 7)
- Also see final report, MHTE Conclusion 9
- **Evaluation criteria:** Efficiency, effectiveness, sustainability

The MHTF Business Plan and the other tools provided to country offices are useful to guide them in focusing on interventions that will help reduce maternal mortality and morbidity.

However, the Plan lacks a clear definition of the role of the MHTF in contrast to the role of maternal health funding from core resources. The reproductive health thematic funds have maintained parallel structures that are not conducive to integration, despite efforts to coordinate them at the global level and the integrated reproductive health approach promoted by UNFPA. Technical guidance remained vertical, country-level plans were often fragmented, and MHTF-supported country interventions were planned without seeking optimum complementarity and synergy. As a result, specific areas such as EmONC or midwifery were dealt with in isolation, i.e., separately from the broad reproductive health picture. The MHTF Business Plan is not sufficiently explicit on how MHTF planning should relate to UNFPA as a whole. This can be seen as a missed opportunity since, at the service delivery level, all the reproductive health components are delivered by the same health personnel, which calls for integrated action for achieving the highest effects on reducing maternal mortality.

CONCLUSION 13

The MHTF has increased the resources and created useful technical guidance, mechanisms and tools (e.g., planning process, updating staff knowledge) to strengthen the capacity of country offices to focus on key maternal health interventions. However, the MHTF has not taken advantage of the support from regional offices. Parallel guidance and reporting channels between regional (or sub-regional) offices and headquarters has led to unclear accountability lines.

- **Origin:** (Evaluation questions 2, 3, 6, and 7)
- **Evaluation criteria:** Efficiency, effectiveness

The staff positions financed by the MHTF strengthened the capacity of the country offices and their expertise in maternal health related areas. These additional staff positions allowed country offices to intensify their engagement in areas such as EmONC and midwifery and to provide technical guidance to government partners.

Technical support provided by the MHTF team in headquarters (for instance tools developed by the MHTF team in partnership with the H4+ partners), AMDD support at the global level and the International Confederation of Midwives support at the regional level proved to be valuable additional technical support. This support flows directly to country offices. As a result, the MHTF technical support bypasses the regional office structure of UNFPA (and its technical support staff). Although this lack of coordination with the UNFPA technical support network at

the regional level can be attributed to a noticeable decrease in regional capacity at the technical level, this situation led to inefficient use of resources. It further resulted in insufficient technical support to county offices and lack of clarity in reporting channels.

4.7 Visibility

CONCLUSION 12

Intensified advocacy and stronger presence of UNFPA facilitated by the introduction of the MHTF has contributed to strengthening the position of UNFPA as a key actor in maternal health at the global level and in MHTF-supported countries

- **Origin:** (Evaluation questions 5, 6, and 8)
- **Evaluation criteria:** Efficiency, effectiveness, sustainability

The intensified advocacy, communications outreach and presence of UNFPA at the global level following the creation of the MHTF has contributed to positioning UNFPA as a key actor in maternal health. In particular, the role of UNFPA in the H4+ group, where MHTF has been active, has been strengthened at the global level. This higher visibility led to additional funding for joint maternal health programmes in some countries.

At the country level, the MHTF has further increased UNFPA visibility as shown by the prioritization of maternal health on the national agendas of programme countries. This was achieved through boosting specific maternal health interventions (EmONC, midwifery). It also enhanced the presence of UNFPA by making resources for technical support available in focus areas (EmONC, midwifery).

CHAPTER 5

Recommendations

The following section presents the recommendations of this evaluation, which have been developed on the basis of the conclusions presented above. The recommendations are prioritized by level of importance, namely very high, high and medium. The recommendations are directed to MHTF management at various levels:

- MHTF unit in the Technical Division in UNFPA headquarters
- Management and reproductive health teams of UNFPA country offices in countries that benefit from MHTF
- Regional offices

5.1 Strengthening long-term vision, catalytic effect of MHTF and sustainability of interventions

RECOMMENDATION 1

Provide guidance to country offices to develop *multi-year country strategic plans* for the use of MHTF funds. The plans must reflect the strategic vision of the MHTF contribution (focus on key maternal health issues). These plans should be part of UNFPA country programme action plans and country offices' multi-annual reproductive health plans. The multi-year country strategic plans should also serve as a basis for the annual work plans.

▶ **Priority:** Very High

▶ **Target level:** Technical Division

▶ **Based on conclusions:** C1, C2, C9

▶ Also see final report, MHTE Recommendation 1

OPERATIONAL IMPLICATIONS

- Prepare a documented and detailed pre-funding assessment of maternal health that includes at minimum: (i) existing needs assessments; (ii) mapping of stakeholders; (iii) interventions; (iv) policy and legal frameworks; (v) existing capacities; and (vi) existing resources and opportunities for increased resources.
- Strengthen the capacity of country office staff on strategic thinking, for instance on issues related to:
  - how MHTF can act as a catalyst;
  - how to increase synergies with the UNFPA mandate areas and the reproductive health subprogrammes (including UNFPA regular resources and reproductive health thematic funds); and
  - the extent to which MHTF involvement in family planning is relevant in countries that are neither GPRHCS Stream 1 nor Stream 2 countries.
- Develop a MHTF multi-year strategic plan, through joint planning with the stakeholders, as part of the overall UNFPA multi annual reproductive health plan. The plan must:
  - focus on prioritized maternal health interventions with the highest potential to reduce maternal mortality;
  - detail the necessary resources: financial and technical support;
  - aim for coordination to achieve the maximum complementarity, coherence and synergies between the various UNFPA reproductive health

sub-programmes and reproductive health thematic funds and other sources of funding;

- focus on interventions with the highest catalytic effect, based on the analysis of the county context;
- ensure that all reproductive health issues are integrated (including STI/HIV/AIDS) at all levels;
- ensure that all MHTF-funded interventions detail a clear exit strategy and hand-over process with a view to sustain results.

- Define a logical framework matrix that specifies the intended theory of change. The logical framework matrix should present different levels of indicators, including process indicators that can measure whether MHTF interventions contribute to achieving the expected outcomes.

- Develop a monitoring and evaluation plan aimed at measuring the MHTF logical framework indicators.

5.2 Improving guidance for contribution to policy dialogue

RECOMMENDATION 2

Provide guidance to country offices with regard to assisting government counterparts in defining the population groups most at risk in terms of maternal health and their particular needs; and ensuring that MHTF interventions focus on those groups as part of the effort to strengthen the maternal health systems.

▶ **Priority:** Very High

▶ **Target level:** Technical Division

▶ **Based on conclusions:** C6, C7

OPERATIONAL IMPLICATIONS

- Ensure that appropriate support is provided to government counterparts and implementing partners, so they can identify the specific maternal health issues and needs of the most vulnerable segment(s) of the population for any MHTF initiative (for example the provision of specific methodologies such as qualitative surveys).

- Help partners establish the links between maternal health issues specific to vulnerable groups (e.g., barriers to access to services, gender constraints) and maternal mortality and morbidity.

- Develop advocacy tools based on the analysis of the relationships between vulnerability and maternal mortality.

- Advocate for the targeting of the most vulnerable groups and the improved prioritization of their needs within national policy frameworks and national maternal health policies.

- Support government partners in developing strategies and interventions that address and prioritize these specific needs within the national policies.

- Support the piloting of approaches to maternal service delivery for vulnerable groups (in areas not supported by other development partners) in order to create models for the government and other development partners.

5.3 Strengthening capacity to provide technical assistance to partners

RECOMMENDATION 3

In collaboration with regional offices, provide support to country offices in drawing up projections of the technical support needs for the different phases of MHTF interventions (based on the multi-year plan). Ensure that the appropriate support is available based on the identified needs, and improve technical expertise for country offices accordingly.

▶ **Priority:** High

▶ **Target level:** Technical Division and regional offices

▶ **Based on conclusions:** C11, C13

OPERATIONAL IMPLICATIONS

- Establish mechanisms for conducting capacity needs assessments. These assessments should be based on the MHTF multi-year strategic plan and serve to support country offices and programme countries. Support country offices to develop plans that indicate the technical support necessary for the implementation of the MHTF plans. The plans should include terms of reference for long-term position staffing as well as short-term expertise.

- Set up coordination mechanisms in order to mobilize UNFPA resources at different levels, thereby allowing to respond to the technical support requirements of the country offices for the implementation of the MHTF plans. This should be done in consideration of the global and regional level division of responsibilities. Alternatively, provide complementary technical support in the case of gaps in the overall UNFPA support system (including staff shortages).

- Ensure that the regional technical support network and resources have the capacity to make short-term expertise available for country offices when necessary. This capacity can be assessed by establishing and updating the database of available support.

- Make an inventory of available country-based resources for technical assistance related to maternal health (e.g., WHO) and establish linkages and coordination mechanisms for mobilizing them.

RECOMMENDATION 4

Provide targeted support to country offices allowing the MHTF to adopt a more comprehensive approach to health system strengthening taking into consideration the key bottlenecks to maternal health.

▶ **Priority:** High

▶ **Target level:** Technical Division

▶ **Based on conclusions:** C1, C2, C3, C6, C10

OPERATIONAL IMPLICATIONS

- Support the government counterparts and implementation partners in carrying out comprehensive analysis of the bottlenecks to maternal health improvement and their prioritization.

- Support the government counterparts and implementation partners to design plans that fully address the key bottlenecks identified. For example, ensure that capacity development interventions are accompanied by measures that address human resources issues such as deployment or appointment of staff.

- Support the government counterparts to map out the available resources in countries, thereby allowing for partnerships that can address particular system-strengthening aspects outside the scope and the expertise of UNFPA.

- Ensure that technical support and expertise are available for countries to address these issues, namely by mobilizing the necessary expertise within UNFPA or through advocacy with partners, i.e., human resources for health.

RECOMMENDATION 5

Ensure that barriers to access and use of maternal health services (skilled attendance at birth, EmONC), are taken into consideration in national strategies and that MHTF-supported initiatives help address them.

▶ **Priority:** High

▶ **Target level:** Technical Division

▶ **Based on conclusions:** C6, C7

OPERATIONAL IMPLICATIONS

- Support the identification of factors affecting utilization of and access to maternal health services by reviewing existing literature or supporting qualitative studies that will explore those factors in depth.

- Help identify and support reviews of existing experiences that were useful in addressing these factors, including community mobilization and empowerment approaches.

- Support the development of strategies aimed at addressing the factors affecting maternal health and barriers that hinder the use of the available services, based on successful experiences in the country.

- Provide technical support for the implementation and monitoring of these strategies in order to inform national programming with a view to scaling-up successes.

- Support the piloting of community mobilization and empowerment approaches in order to inform national programming.

5.4 Support to quality assurance in maternal health

RECOMMENDATION 6

Provide guidance to country offices to enable them to ensure that MHTF-supported maternal health-related interventions encompass mechanisms for maintaining the level of quality of the outputs.

▶ **Priority:** Medium

▶ **Target level:** Technical Division

▶ **Based on conclusions:** C10

OPERATIONAL IMPLICATIONS

- Advocate to ensure that quality assurance is an integral component of all programming processes of MHTF-supported interventions in any area (e.g., education or services) by:

  - Ensuring that all plans contain a quality assurance strategy;

  - Defining standards and regulations.

- Strengthen the capacity of government partners by providing technical support for:

  - Developing or adapting the necessary quality assurance tools to ensure that standards and regulations are complied with (e.g., supervisory guides and check lists; additional clinical guidance; follow-up training; peer support, for example through midwife associations; etc.)

  - Ensuring, through pre-testing, that developed tools are well adapted to the field and that they are sufficiently practical.

ANNEX 1

Terms of Reference

1. About UNFPA

UNFPA, the United Nations Population Fund,[185] 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

[185] 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/operations 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 Heath 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.[186] 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,

[186] 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 535000 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 mortality [187] 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.[188] 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 rate[189] 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).[190]

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.

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

[188] Indicating that in the absence of HIV, there would have been 281,000 maternal deaths worldwide in 2008, ibidem.

[189] Births per 1000 women aged 15–19 years.

[190] 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:

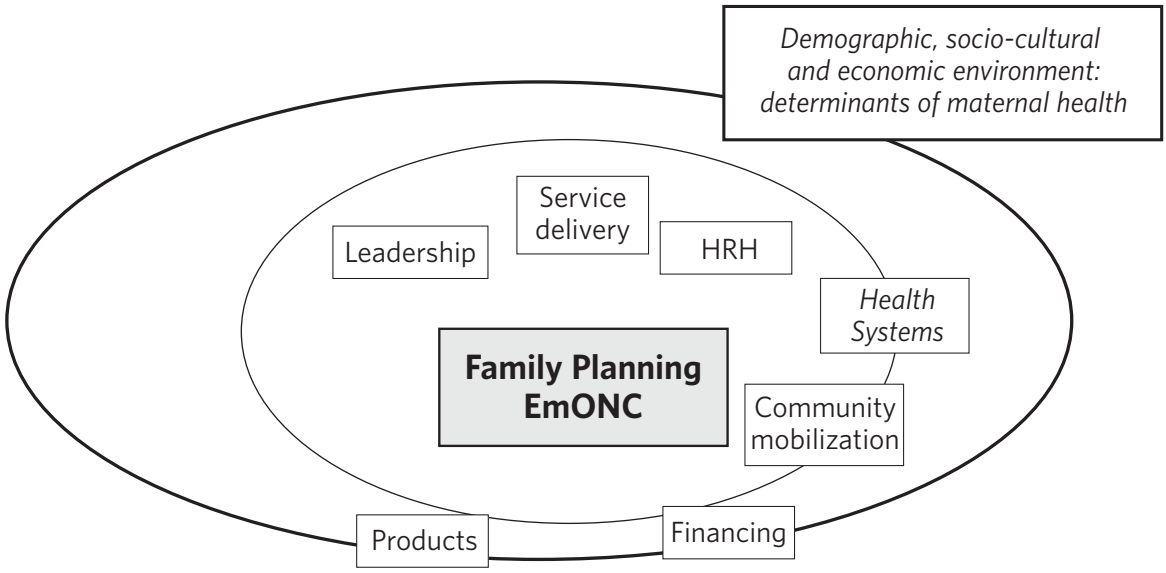
A. The maternal health thematic evaluation will assess to what extent the overall assistance of UNFPA– i.e.; the support of UNFPA from all sources: core resources, co-financing and all thematic funds — has been relevant, effective, efficient and sustainable in contributing to the improvement of maternal 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 Thematic 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.[191]

The contribution of UNFPA to the Campaign to End Fistula having been recently the subject of an in-depth evaluation[192], 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.

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[191] 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.

[192] Two volumes available at: http://www.endfistula.org/UNFPA__Fistula_Evaluation_VOL%20_I.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 below[193]

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	

[193] The 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
10 years of UNFPA Programs in Lao PDR (2001-2011)	2011
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Annual Work Plan : UNFPA Support to Reproductive Health Component of Health Sector Support Project (HSSP)	2006-2008
Annual Work Plan: MHTF.	2010
Annual Work Plan: Reproductive Health-Khmer Youth Association	2006-2011
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Chattoe-Brown, A., Weil, O., & Braddock, M. (2011). UNFPA Global Programme to Enhance Reproductive Health Commodity Security Mid Term Review. HLSP.

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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 Advisor, 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 Wubeshest	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	Gifty 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 Kiettisack	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	Sophornnary 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 Malikutila	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 Mbangu	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, NCAPD	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	Sophea 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 Zoungrana, 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	Ayehualem 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	Dorithy Temu-Usin	Program Specialist
UNFPA Sudan	country	Elqurashi Musa	Reproductive Health Officer
UNFPA Sudan	country	Hibat Abbas	Program Assistant
UNFPA Sudan	country	Lamya 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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