EVALUATION REPORT

INDEPENDENT COUNTRY PROGRAMME EVALUATION CAMEROON

2008 - 2011

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EVALUATION TEAM

Evaluation Branch at DOS:

Team Leader: Alexandra Chambel

Evaluation Adviser: Hicham Daoudi

Experts on:

Population & Development and Monitoring & Evaluation systems: Rafael Eguiguren

Reproductive Health and Gender: Olivier Appaix

Country Programme Evaluation: Cameroon

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Foreword

This is the report of an independent programme-level evaluation of the UNFPA support to Cameroon conducted by the Evaluation Branch at the Division for Oversight Services. This evaluation examines the strategic positioning of UNFPA support as well as its contribution to the results set out in the three focus areas – sexual and reproductive health, population and development, and gender equality – of the fifth UNFPA country programme in Cameroon (2008-2012).

This report represents both one of the very first country evaluations completed by the Evaluation Branch within the framework of the current UNFPA Strategic Plan (2008-2013), as well as a pilot exercise in the development of a custom-made methodology for designing and conducting country programme evaluations (CPEs). With this evaluation our aim has been to provide forward-looking recommendations to assist the UNFPA country office and its partners in the formulation of the next programme.

In accordance with the newly developed Handbook of the Evaluation Branch on *How to Design and Conduct a Country Programme evaluation at UNFPA*, the evaluation was based on a comprehensive review of documents covering both the programming and implementation stages. This was followed by an intensive field work for further data collection and validation of preliminary findings. The evaluation field work was carried out during the period 11 - 30 July 2011 and included individual and group interviews, focus groups and site visits. The evaluators worked to obtain the perspectives of all key stakeholders and systematically ensured the validity of collected data by means of triangulation techniques. Specific evaluation questions were formulated during the preparation phase which referred to (i) the evaluation criteria of: relevance, efficiency, effectiveness and sustainability in three focus area of the country programme and (ii) alignment, responsiveness and added value. The evaluation was complemented by an analysis of the monitoring and evaluation system of the country programme.

In line with the strategic plan, the country office has adopted a clear focus on disadvantaged and vulnerable groups – notably young girls and women as shown in both its gender-related activities and in its leading role in the introduction of financial schemes to improve access to health services. The country office has also demonstrated its capacity to respond quickly and in a flexible manner to national needs in the context of evolving priorities. The evaluation shows the country office added value across all three UNFPA mandate areas, and shows that it has been at the very forefront in engaging national counterparts on certain specific issues such as obstetric fistula or the census. The evaluation, however, points at a number of challenges to the sustainability of the UNFPA interventions. In particular, at times, capacity development via the recruitment of experts has led to substitution effects where technical assistance is concerned.

The evaluation also shows the severe difficulties encountered by the country office which result from the absence of a results-oriented monitoring system that, in turn, translates into the weak formulation of indicators and outputs, an overwhelming focus on inputs and activities, and the underutilization of evaluation findings.

Looking forward the evaluation makes a number of recommendations to inform the reflection of the country office on the upcoming programming cycle. In particular the report invites the country office to formulate interventions in a manner that foresees an exit strategy, thus creating conditions conducive to the sustainability of benefits while limiting substitution effects that are conducive to dependency. In order for its programme to be more inclusive of the poor, and notably to facilitate their access to health services, evaluators also recommend that the country office should work with its partners to develop pilot projects targeting the least privileged in urban centers and peri-urban areas. The challenges and shortcomings identified by the evaluation also point to issues that are relevant at the corporate level. In particular, evaluators have provided detailed guidance on the necessity for UNFPA to equip its country offices with an effective results-oriented monitoring systems and notably the development of mechanisms and control-tools to ensure that country programmes' results frameworks are systematically equipped with appropriate indicators, realistic outputs and accurate baselines.

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It is our hope that the forward-looking lessons and recommendations presented in this evaluation report will positively contribute to the strengthening of the on-going efforts of the country office. We also hope that the evaluation findings will be used at regional level in view of shared learning and improvement of UNFPA programming in African countries where other country offices may be facing similar challenges.

This evaluation would not have been possible without the commitment demonstrated by Alain Sibenaler, the Country Office Representative, who recognized the need for, and welcomed, this independent evaluation conducted by the Evaluation Branch. Throughout the preparation and implementation of our evaluation, he has provided support and very insightful views on the national context, the cooperation with the government of Cameroon and the implementation of the country programme. We naturally extend our thanks to all our colleagues in the country office for facilitating the team's work at every stage of the evaluation process. In particular the evaluators wish to thank: Germaine Ngoitima, the Special Assistant to the Representative, for assisting the team on the preparation of the agenda for the mission, and the three Assistant Representatives, Angélique Hongla, Nicole Eteki and Rose Njeck, for guiding the evaluators through the activities implemented under the country office mandate areas. Special thanks also go to the Programme Officers Rostand Njiki (north) and Joseph-René Boum (east) for their warm and efficient support during the evaluation field visits.

This evaluation also benefitted greatly from the continuous inputs provided by the Reference Group which was composed of: Yaovi Fanidji, the CO International Programme Specialist,

Reginald Chima, Regional Monitoring and Evaluation Advisor Africa Regional Office; Monique Clesca, Regional Desk Advisor for Africa and key national stakeholders. Special acknowledgements go to the Ministry of Economy, Planning and Regional Development, the Government counterpart of UNFPA.

Special thanks go to Konstantin Atanesyan, Senior Evaluation Officer, Independent Office of Evaluation, IFAD who, as an external reviewer, assessed the quality of the evaluation and completed the Evaluation Quality Assessment (EQA) grid which is available on the DOS evaluation branch website.

In the Evaluation Branch, I would like to thank Alexandra Chambel, who acted as a team leader, for effectively guiding the evaluation team through the design, data collection, data analysis and reporting phases. The evaluation team was also composed of Hicham Daoudi, Evaluation Adviser; two independent sectoral experts: Olivier Appaix (public health and gender) and Rafael Eguiguren (monitoring and evaluation systems and population and development issues) as well as Paz Redondo (field research assistant). I thank them all for their invaluable contributions and dedication to this evaluation.

Thanks also go to the Evaluation Branch staff for their support at different stages of the evaluation process. Valeria Carou-Jones, Evaluation Specialist, provided comments to the draft final report; Olivia Roberts, Evaluation Analyst, performed research work during the desk phase and edited the draft final report; Magalye Mars-Mompoint, Evaluation Assistant, provided administrative support and Oscar Luque, trainee, conducted preliminary research and data collection at design phase.

Finally, our sincere gratitude goes to all the people who have taken the time to respond to requests from the evaluation team: government officials, non-governmental organizations, development partners and donors, as well as the UN Country Team in Cameroon and last but not least a wide number of the country programme beneficiaries and members of the communities that the team visited during the course of the evaluation. A list of people interviewed is available in Annex 3 of the report.

Louis Charpentier
Chief, Evaluation Branch

Structure of the country programme evaluation report

The present report comprises an *executive summary* (a stand-alone document), seven chapters, and twelve annexes.

The introduction (chapter 1) provides the background to the evaluation, objectives and scope, as well as the methodology used including constraints and limitations encountered. The second chapter presents the development challenges faced by Cameroon in the three UNFPA focus areas as identified in national strategic documents produced by the Government. The third chapter refers to the response of the UN system and then leads on to the specific response of UNFPA country programme to the national challenges faced by Cameroon in reproductive health, population and development and gender equality including gender-based violence. The fourth chapter presents the findings of the evaluation for each of the three focus areas. Chapter 5 discusses the positioning of UNFPA in Cameroon (the fourth and the fifth chapters are structured around the evaluation questions). Chapter 6 presents an assessment of the monitoring and evaluation system of the country programme. Conclusions and recommendations follow in chapter 7.

Finally, annexes 3 and 4 present the documentation reviewed by the evaluators and the list of interviews conducted during the field phase in July 2011. The annexes 10 and 11 present the results of a focus group discussion with the media in Cameroon and the analysis of UNFPA in the press.

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Abbreviations and Acronyms

ACAFEJ	Association Camerounaise des Femmes Juristes/Association of Women Lawyers of Cameroon
ADB	African Development Bank
AFD	French Development Agency
AFRIYAN	Africa Youth and Adolescent Network on Population and Development
ALVF	Association for the Struggle Against Violence Against Women
AMIU	Aspiration manuelle intra-utérine/Manuel Vacuum Aspiration
ARV	Anti Rétroviraux /Anti-Retrovirals
AWP	Annual Work Plan
BIR	Rapid Intervention Brigade
BUCREP	Central Bureau of Census and Population Studies
C2D (CDD)	Contract Debt Reduction and Development
CAFD	Centre for Women in Need
CAMNAFAW	Cameroon National Association for Family Welfare
CAPR	Regional Centre for Pharmaceutical Supply
CARMMA	Campaign for the Accelerated Reduction of Maternal Mortality in Africa
CBC	Communication for Behaviour Change
CDC	Center for Disease Control
CEDAW	Convention on the Elimination of all Forms of Discrimination Against Women
CENAME	Regional Centre for Pharmaceutical Supply
CMA	District Medical Centre
CMPJ	Multifunctional Centre for Promotion of Youth
CNS	National Health Accounts
CO	UNFPA Country Office
CPAP	Country Programme Action Plan

CPFF	Centre for the Promotion of Women and Family
CPN	Prenatal Consultation
C-Section	Caesarean Section
CSI	Integrated Health Centre
CSO	Civil Society Organization
DHS/EDS	Demographic and Health Survey/Enquête Démographique et de Santé
DRH	Human Resources Directory
DRSP	Regional Delegation for Public Health
DS	Health District
DSCE	Growth and Employment Strategy Paper
DSF	Direction de la Santé Familiale/Department of Family Health
DSRP/PRSP	Poverty Reduction Strategy Paper
E-N	Far North of Cameroon
FCFA	Francophone African Financial Community FESADE/Women, Health, and Development in Sub-Saharan Africa (NGO)
FGM	Female Genital Mutilation
FP/PF	Family Planning
FS	Health Training
GATPA	Active Management of Third Stage of Labour
GBV	Gender-Based Violence
GIZ	German Agency for International Cooperation (formerly GTZ)
H4+	International health partnership on reproductive and neonatal health
HCR	High Commission for Refugees (of UN/United Nations High Commissioner for Refugees (UNHCR)

ABBREVIATIONS AND ACRONYMS (continued)

HIPC	Heavily Indebted Poor Countries Initiative
HR	Human Resources
ICPD	International Conference on Population and Development ('The Cairo conference')
ICT	Information and Communications Technology
IDER	Institute of Demographic Education and Research
IFORD	Institute for Demographic Training and Research
IGA/AGR	Income Generating Activities
INS	National Institute of Statistics
IPPF	International Planned Parenthood Federation
IRD	Institute of Development Research
IVG	Abortion/Interruption Volontaire de Grossesse
M&E	Monitoring and Evaluation
MICS	Multiple Indicator Cluster Survey
MINEPAT	Ministry of Economy, Planning and Regional Development
MINESEC	Ministry of Secondary Education in Cameroon
MINJEUNES	Ministère de la Jeunesse/Ministry of Youth Affairs
MINPROFF	Ministry of Women's Empowerment and the Family
MM	Maternal Mortality
MMR	Maternal Mortality Rate
MPA	Minimum Package of Activities (at the CSI/CMA level)
MINSANTE	Ministry of Public Health
NGO	Non-Governmental Organization
NSDS	National Strategy for the Development of Statistics
ONU Women	United Nations Entity for Gender Equality and the Empowerment of Women
OSC/CSO	Civil Society Organization
P&D	Population and Development
PASR/BAD	Project for the National Program of Reproductive Health

PBF	Performance-Based Financing
PCIME	Integrated Management of the Mother and Child
PMTCT/PTME	Prevention of Mother-To-Child Transmission (of HIV during delivery)
PNDS	Plan National de Développement Sanitaire/National Plan for Health Sector Development
PNSR	Plan National de Santé Reproductive/National Programme for Reproductive Health
RBF	Result-Based Financing
RC	Resident Coordinator
RCA	Central African Republic
RDC	Democratic Republic of Congo (previously Zaïre)
RDPH	Regional Delegation of Public Health
REDATAM	Retrieval of Data for small Areas by Microcomputer
RH	Regional Hospital
SIDA	Acquired Immune Deficiency Syndrome
SNIS	National Health Information System
SONEU	Obstetric and Neonatal Emergency Services
SONU	Obstetric and Neonatal Emergencies
RH	Reproductive Health
SRH	Sexual and Reproductive Health
SSS	Health Sector Strategy
TFP	Technical and Financial Partners
UNDAF	United Nations Development Assistance Framework
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
VIH	Human Immunodeficiency Virus
VSBC	Volunteer for Community-Based Health
WAHA	Women and Health Alliance International
WHO	World Health Organization

Table 1:

Key facts: Cameroon

Land	
Geographical location	Western Africa (2)
Land area	475,650 km[1]
Terrain	Diverse with coastline, mountainous and forested areas (2)
People	
Population	19,711,291 (2011 est.) (2)
Government	Republic; constitution adopted 1972 (2)
Key political events	Independence from colonial rule in 1960/61[2]
Seats held by women in national parliament	13.9% (2010, Inter-Parliamentary Union) (3)
Economy	
GDP per capita 2008 PPP US$	2219 (2010) (1)
GDP Growth rate	2.8% (2010) (2)
Main industries	Oil, forestry, food agriculture[3]
Social indicators	
Human Development Index Rank	131[4]
Unemployment	4.4%[5]
Life expectancy at birth	51.5 years (2010) (2)
Under-5 mortality (per 1000 live births)	131 (2008) (1)
Maternal mortality (deaths of women per 100,000 live births)	600 (2008) (1)
Health expenditure (% of GDP)	1.3% (2007) (1)
Births attended by skilled health personnel, percentage	63 (2006, UNICEF) (3)
Adolescent fertility rate (births per 1000 women aged 15-19)	127.5 (2008) (1)
Condom use to overall contraceptive use among currently married women 15-49 years old	22.3% (2006, UNICEF) (3)
Contraceptive prevalence rate	13%[6]
Unmet need for family planning (% of women in a relationship unable to access)	44%[7]
People living with HIV, 15-49 years old, percentage	5.3 (2009 est. Source World Factbook CIA)
Adult literacy (% aged 15 and above)	67.9% (both sexes) (2010) (3)
Total net enrolment ratio in primary education, both sexes	88.3 (2008, UNESCO)
Millennium Development Goals (MDGs): Progress by Goal[8]	
1 Eradicate Extreme Poverty and Hunger	Insufficient information
2 Achieve Universal Primary Education	Very likely to be achieved, on track
3 Promote Gender Equality and Empower Women	Off track
4 Reduce Child Mortality	Off track
5 Improve Maternal Health	Off track
6 Combat HIV/AIDS, Malaria and other Diseases	Possible to achieve if some changes are made
7 Ensure Environmental Sustainability	Insufficient information
8 Develop a Global Partnership for Development	Insufficient information

[1] Cameroon National Institute for Statistics
[2] MDG Progress Report 2003
[3] ibid
[4] http://hdrstats.undp.org/en/countries/profiles/CMR.html
[5] Mid-term review of UNDAF 2010
[6] Country Programme Document 2007
[7] ibid
[8] http://www.mdgmonitor.org/country_progress.cfm?c=CMR&cd=120

Population References		
Population growth rate (avg. annual %)	2005-2010	2.6[9]
Urban population growth rate (avg. annual %)	2005-2010	3.5
Rural population growth rate (avg. annual %)	2005-2010	0.1
Urban population (%)	2007	56.0
Population aged 0-14 years (%)	2009	40.9
Population aged 60+ years (women and men, % of total)	2009	5.8/5.0
Sex ratio (men per 100 women)	2009	100.0
Life expectancy at birth (women and men, years)	2005-2010	51.5/50.4
Infant mortality rate (per 1 000 live births)	2005-2010	86.9
Fertility rate, total (live births per woman)	2005-2010	4.7
Contraceptive prevalence (ages 15-49, %)	2006-2009	29.2
International migrant stock (000 and % of total population)	mid-2010	196.6/1.0
Refugees and others of concern to UNHCR	end-2008	83,268

Source: *World Statistics Pocketbook by UN Statistics Division. 14 May 2010.*

Age structure:	0-14 years: 40.5% (male 4,027,381/female 3,956,219) 15-64 years: 56.2% (male 5,564,570/female 5,505,857) 65 years and over: 3.3% (male 300,929/female 356,335)
Birth rate:	33.04 births/1,000 population
Death rate:	11.83 deaths/1,000 population
Net migration rate:	0 migrant(s)/1,000 population
Urbanization:	urban population: 58% of total population (2010) rate of urbanization: 3.3% annual rate of change (2010-15 est.)
Sex ratio:	at birth: 1.03 male(s)/female total population: 1.01 male(s)/female
Infant Mortality Rate:	total: 60.91 deaths/1,000 live births (comparison to the world: 32) male: 65.48 deaths/1,000 live births female: 56.2 deaths/1,000 live births
Life Expectancy at Birth:	total population: 54.39 years (country comparison to the world: 201) female: 55.28 years male: 53.52 years
Total fertility rate:	4.17 children born/woman (country comparison to the world: 39)
HIV/AIDS – Adult prevalence rate:	5.3% (2009 est.) (country comparison to the world: 13)

Source: *World Factbook CIA. 2011.*

References

(1) Human Development Indicators, UNDP http://hdrstats.undp.org/en/countries/profiles/CMR.html, accessed 1 April 2011;
(2) CIA World Factbook, 2011 https://www.cia.gov/library/publications/the-world-factbook/geos/cm.html accessed 1 April 2011
(3) UN Data http://data.un.org/Data.aspx?d=MDG&f=seriesRowID%3a589 accessed 1 April 2011

[9] Cameroon National Institute for Statistics

Executive Summary

Context

This report is the result of the evaluation of the UNFPA fifth country programme in Cameroon covering the period 2008-2011. The country programme has three components: (a) reproductive health, (b) population and development (P&D); and (c) gender. Its overall budget amounts to $17.75 million.

Objectives and scope

The objectives of the evaluation were (1) to assess the relevance and performance of the UNFPA country programme in Cameroon in its three components; (2) to analyse the UNFPA strategic positioning in the national development context; (3) to identify key lessons with a view to improving the next country programme, currently under preparation.

The terms of reference also foresaw an assessment of the quality of the monitoring and evaluation (M&E) system. The evaluation covered the whole UNFPA portfolio including soft aid activities.

Methodology

The evaluation relied on the methodology for country programme evaluations recently developed by the Evaluation Branch at the Division for Oversight Services, with a view to testing it.

The evaluation was based on a set of questions dealing with corresponding evaluation criteria. For the assessment of the three programme components, the four following evaluation criteria were examined: relevance, efficiency, effectiveness and sustainability. Three specific criteria were used for the analysis of the strategic positioning: strategic alignment, responsiveness and added value.

The quality of the monitoring and evaluation system of the country programme was assessed by way of the analysis of five different points: monitoring of inputs and activities, monitoring of outputs and outcomes, monitoring of assumptions and risks, integration of evaluations into the M&E system and support to national partners in their M&E system and capacity.

Further to an extensive review of programme and intervention-related documentation along with national public policies and strategies, evaluation tools consisted in direct interviews and focus groups involving a wide range of stakeholders across the country. Overall, the evaluation team consulted 311 people during their field mission.

In the conduct of the evaluation, the team faced a number of limitations, among which: (1) the country programme's over-ambitious results framework, particularly as regards the outputs of the reproductive health component; (2) an inadequate identification and formulation of indicators at outcome and output levels, impeding an objective assessment of the degree of effectiveness; (3) the limited availability of monitoring data and results of past evaluations at programme and intervention levels; (4) the poor quality of reporting. Limitations were addressed by organizing extensive stakeholder consultations to allow for the systematic triangulation of data, and by conducting an in-depth documentation review.

Main conclusions

Strategic level conclusions

UNFPA is contributing to the improvement of the coordination of a large and fragmented UNCT through its participation in different technical groups and, in some occasions, by taking the lead on major issues such as the launch of the CARMMA initiative and the consultation process for the coming UNDAF (2013-2017).

The UNFPA country office is able to provide a quick and flexible response to demands from partners and to changes in national needs and priorities, notably thanks to its two regional sub-offices. However, the response, while of good quality, sometimes lacks a clear strategic justification.

The UNFPA country office has demonstrated a clear added value in its three focus areas by acting as a facilitator and engaging actively in policy dialogue. The ability of UNFPA to place sensitive themes on the national agenda is particularly recognized by its partners.

The absence of an exit strategy in the UNFPA programme puts at risk the sustainability of its benefits. Moreover, training activities that have often proved effective have not been conceived within an overall capacity development strategy. This appears to be a further limitation to sustainability.

Conclusions related to focus areas.

There are indications of tangible effects of UNFPA supported activities in the fields of reproductive health and gender. However, measuring their actual magnitude remains difficult. The interventions in reproductive health and gender also suffer from a lack of continuity, particularly as far as sensitization is concerned. At the decentralized level, the fifth country programme essentially focuses on rural populations. It leaves large urban centers uncovered, although a significant part of their population suffers from similar lack of access to services and information.

Integration of P&D issues is progressively being achieved in the Ministry of Economy, Planning and Regional Development at a general level. However, this integration did not translate into sectoral planning and policies. Furthermore it has not reached decentralized levels of government, with responsible staff at local level remaining insufficiently aware of the importance of P&D data for planning and management.

Conclusions related to the monitoring & evaluation system

The country office monitoring and evaluation system is of uneven quality. Monitoring of inputs and activities is, generally speaking, satisfactory. Monitoring of risks and assumptions is done in a regular and effective manner, yet not in a systematic and formalized manner. More importantly, the results-oriented monitoring (focused on outputs and outcomes) is not operational. Evaluations do take place yet they are not integrated in the M&E system and, as a result, remain underutilized.

Main recommendations

Strategic level

UNFPA should develop exit strategies within key programming and implementation documents.
A capacity development strategy for the entire programming cycle should also be designed. Both the country programme action plan (CPAP) and annual work plans (AWPs) should include an exit strategy that creates conditions for sustainability of benefits and prevents from substitution effects that generate dependency. To complement the CPAP, a five-year capacity development strategy should integrate knowledge sharing and the development of capacities of strategic partners.

UNFPA should provide support for the decentralization process in Cameroon as part of its strategy. There should be a larger allocation of the budget of UNFPA for the support to decentralisation, and a focus on high added value activities such as raising awareness and helping to integrate local data and census information into local planning and policy design. The country office should also support the National Institute for Statistics to address needs arising from the decentralization process.

Recommendations related to focus areas

The country office should strive to integrate its response to reproductive health (RH) challenges into the wider health care system. Supervision capacity in the healthcare system should be strengthened and primarily conducted by *Equipes Cadre de District*.

UNFPA should design a comprehensive strategy in order to ensure continuity in the provision of obstetrical fistulae related services.

UNFPA should consider a comprehensive strategy addressing female genital mutilation as a flagship activity. The strategy should address both the supply and demand aspects.

UNFPA should expand its work in the RH and Gender components beyond the current focus on rural areas with the aim to address the specific needs of the least privileged populations of urban centres and peri-urban areas.

UNFPA should focus its support in the P&D component to sectoral ministries with a view to ensuring the transformation of data into usable information for planning and policy making. Support for the interpretation of census data and its incorporation into planning should also be a core concern for UNFPA.

Recommendations related to the M&E system

UNFPA Headquarters should ensure a sufficient allocation of funds to allow the establishment of a results-oriented monitoring system (guidelines, tools and control mechanisms). The country office should request the hiring of a monitoring and evaluation coordinator for the set-up, supervision and accompaniment to the M&E system.

Résumé

Contexte

Ce rapport est le résultat de l'évaluation du cinquième programme de coopération entre le FNUAP et le Cameroun, couvrant la période 2008-2011. Le programme comportait trois composantes : (a) santé de la reproduction ; (b) population et développement ; et (c) genre. Le budget global du programme s'élevait à 17,75 millions de dollars.

Objectifs et champ de l'évaluation

Les objectifs de l'évaluation étaient : (1) d'apprécier la pertinence et la performance du programme du FNUAP au Cameroun dans ses trois composantes ; (2) d'analyser le positionnement stratégique du FNUAP dans le contexte du développement national du Cameroun ; (3) de dégager des enseignements utiles en vue d'améliorer le prochain programme de pays, actuellement en cours de préparation.

Les termes de référence prévoyaient également une analyse du système de suivi et d'évaluation du programme. Le champ de l'évaluation couvrait l'ensemble des activités du FNUAP au Cameroun, y compris l'aide immatérielle (*« soft aid activities »*).

Méthodologie

L'évaluation reposait sur la méthodologie d'évaluation des programmes de pays du FNUAP récemment élaborée par le Service de l'évaluation de la Division des services de contrôle interne. L'évaluation devait notamment permettre de tester cette méthodologie.

L'évaluation était basée sur un ensemble de questions auxquelles correspondaient un ou plusieurs critères d'évaluation. Pour l'analyse des trois composantes du programme, les critères suivants ont été utilisés : pertinence, efficience, efficacité et durabilité. Trois critères spécifiques ont été employés pour l'analyse du positionnement stratégique du FNUAP : alignement stratégique, capacité de réponse et valeur ajoutée.

La qualité du système de suivi et d'évaluation du programme a été analysée à travers l'examen des cinq éléments suivants : (1) le suivi des intrants (*inputs*) et des activités ; (2) le suivi des produits (*outputs*) et des résultats (*outcomes*) ; (3) le suivi des hypothèses et des risques ; (4) l'intégration des évaluations dans le système de suivi et d'évaluation ; (5) l'appui aux partenaires nationaux en matière de suivi et d'évaluation.

Outre une revue détaillée de la documentation relative au programme et aux politiques publiques nationales, les outils d'évaluation ont consisté en une série d'entretiens directs et de groupes focaux impliquant un grand nombre de parties prenantes et couvrant l'ensemble du pays. Au total, l'équipe d'évaluation a consulté 311 personnes au cours de la phase de terrain.

Dans la conduite de l'évaluation, l'équipe des évaluateurs a été confrontée à différentes contraintes et limitations telles que : (1) le cadre de résultats trop ambitieux du programme de pays, en particulier en ce qui concerne les produits de la composante santé de la reproduction ; (2) une formulation inadéquate des indicateurs au niveau des produits et des résultats, affectant la possibilité d'apprécier de manière objective l'efficacité du programme ; (3) l'insuffisante disponibilité de données de suivi et/ou de résultats d'évaluations passées, tant au niveau du programme qu'au niveau des interventions ; (4) la mauvaise qualité des rapports. Pour répondre à ces difficultés, les évaluateurs ont procédé à une large consultation des parties prenantes du programme en vue de garantir le croisement systématique des données collectées. Ils ont également mené une revue documentaire approfondie.

Conclusions principales

Conclusions de niveau stratégique

Le FNUAP contribue à l'amélioration de la coordination au sein d'un système des Nations Unies

large et fragmenté en participant à différents groupes techniques et, en certaines occasions, en prenant la tête d'initiatives cruciales telles que le lancement de la CARMMA au Cameroun ou le processus de consultation du prochain UNDAF (2013-2017).

Le bureau de pays du FNUAP est capable de fournir une réponse rapide et flexible aux demandes de ses partenaires ainsi qu'aux changements observés dans les besoins de la population et les priorités nationales, en particulier grâce à ses deux sous-bureaux régionaux. Bien que de bonne qualité, la réponse du bureau de pays manque cependant parfois d'une justification stratégique claire.

Le bureau de pays du FNUAP a démontré une claire valeur ajoutée dans ses trois domaines d'intervention en jouant un rôle de facilitateur et en s'investissant de manière active dans le dialogue de politique. La capacité du FNUAP à obtenir l'inscription de sujets sensibles à l'ordre du jour national est particulièrement saluée par ses partenaires.

L'absence d'une stratégie de sortie menace la durabilité des effets du programme du FNUAP. En dépit de leur efficacité, les activités de formation appuyées par le FNUAP n'ont pas été conçues dans le cadre global d'une stratégie de développement des capacités nationales et constituent de ce fait une limite supplémentaire à la durabilité du programme.

Conclusions relatives aux composantes du programme

Les activités soutenues par le FNUAP dans les domaines de la santé de la reproduction et du genre produisent des effets tangibles dont il est cependant difficile de mesurer l'ampleur. Les interventions du FNUAP dans les domaines de la santé de la reproduction et du genre souffrent par ailleurs d'un manque de continuité, en particulier en matière de sensibilisation.

Au niveau décentralisé, le cinquième programme s'est concentré essentiellement sur les populations rurales. En revanche, de grands centres urbains ne sont pas couverts alors qu'une part significative de leur population souffre également d'un manque d'accès aux services et à l'information.

L'intégration des questions de population et développement dans les politiques publiques est progressivement réalisée au Ministère de l'économie, de la planification et de l'aménagement du territoire. Cette intégration réalisée au niveau global n'est cependant pas déclinée au niveau de la planification et des politiques sectorielles. Par ailleurs, elle n'a pas atteint les niveaux décentralisés de l'administration, dont l'encadrement demeure insuffisamment informé de l'importance des données de population et développement pour la planification et la gestion.

Conclusions relatives au système de suivi et d'évaluation

La qualité du système de suivi et d'évaluation du bureau de pays n'est pas homogène. Le suivi des intrants et des activités est globalement satisfaisant. Le suivi des risques et des hypothèses est effectué de manière régulière et efficace mais il n'est cependant ni systématique ni rigoureusement formalisé. Le suivi orienté sur les résultats n'est quant à lui pas opérationnel. Certaines évaluations sont menées mais elles n'entrent pas dans le cadre d'un véritable système de suivi et d'évaluation et demeurent, de ce fait, sous-utilisées.

Principales recommandations

Recommandations de niveau stratégique

Le FNUAP devrait prévoir des stratégies de sortie dans ses principaux documents de programmation et de mise en œuvre. Une stratégie de développement des capacités nationales devrait également être

conçue pour l'ensemble du cycle de programmation. Le plan d'action du programme de pays (CPAP) et les plans de travail annuels (PTA) devraient inclure une stratégie de sortie afin de créer les conditions de la durabilité des effets du programme et de prévenir les risques d'effets de substitution, facteurs de dépendance des partenaires à l'égard du FNUAP. En complément du CPAP, une stratégie quinquennale de développement des capacités devrait inclure une politique de partage de connaissances et le développement des capacités d'un certain nombre de partenaires stratégiques du FNUAP.

Le FNUAP devrait soutenir activement le processus de décentralisation au Cameroun, comme un élément à part entière de sa stratégie. Une part plus importante du budget du FNUAP devrait être allouée à l'appui au processus de décentralisation. Une plus grande importance devrait également être accordée à des activités à haute valeur ajoutée telles que la sensibilisation à l'importance des données issues du recensement général de la population et l'appui à leur intégration dans la planification et la conception des politiques publiques au niveau local. Le bureau de pays devrait également soutenir l'Institut national de la statistique dans sa réponse aux besoins issus du processus de décentralisation.

Recommandations relatives aux composantes du programme

Le bureau de pays devrait s'efforcer d'inscrire sa réponse aux défis en matière de santé de la reproduction dans le cadre plus large du système de santé national. La capacité de supervision du système de santé devrait être renforcée. La supervision devrait être confiée en priorité aux équipes cadres de district. Le FNUAP devrait définir une stratégie permettant d'assurer la continuité des services relatifs au traitement des fistules obstétricales.

Le FNUAP devrait envisager l'élaboration d'une stratégie globale de lutte contre les mutilations génitales féminines ; cette stratégie aurait vocation à devenir une initiative phare du FNUAP au Cameroun. La stratégie devrait aborder de manière globale les aspects liés à l'offre et ceux liés à la demande.

Le FNUAP devrait étendre ses activités en matière de santé de la reproduction et de genre au-delà des seules zones rurales en vue de répondre aux besoins spécifiques des populations les plus défavorisées des centres urbains et péri-urbains.

Le FNUAP devrait concentrer ses interventions dans la composante population et développement en faveur des ministères sectoriels en vue d'assurer la transformation des données démographiques en informations utilisables pour la planification et la définition des politiques publiques. Le soutien à l'interprétation des données issues du recensement et à leur incorporation dans la planification devraient également au cœur de la stratégie du FNUAP.

Recommandations relatives au système de suivi et d'évaluation

Les services du siège du FNUAP devraient établir un système de suivi orienté vers les résultats (lignes directrices, outils et mécanismes de contrôle). Le bureau de pays devrait demander le recrutement d'un coordinateur du suivi et de l'évaluation pour la mise en place, la supervision et l'accompagnement du fonctionnement du système de suivi et d'évaluation.

CHAPTER 1

Introduction

1.1 Background

The UNFPA Strategic Plan 2008 – 2012 defines the organization's focus of work in three areas:

The role of the Evaluation Branch at the Division for Oversight Services (DOS) is: (1) to provide substantive support to the Executive Director's accountability function; (2) to support greater accountability of the country offices results to stakeholders at the country level; (3) to contribute to learning at corporate, regional and country levels; (4) and to conduct independent evaluations.

UNFPA has been asked by the Executive Board to not only increase the number of evaluations produced but also to ensure good quality evaluations, which were previously lacking, through the use of sound methodology. In response to this demand, in 2011, the Evaluation Branch developed a Handbook on How to Design and Conduct Country Programme Evaluations (CPEs). Cameroon and Bolivia CPEs were pilots for the formulation of this methodology. Once established, the methodology and related products will be replicated to guide and support UNFPA in conducting good quality CPEs.

1.2 Purpose and objectives of the country programme evaluation

The overall purpose of the exercise is to produce an independent and useful evaluation covering the period 2008 – 2011 and to contribute to the new country programme which is prepared by the country office and national stakeholders.

Table 2: The goals of UNFPA

Population and Development	to ensure a systematic use of analysis of population dynamics in order to guide increased investments in reproductive health and HIV/AIDS, gender equality, and youth development, with the aim of improving quality of life, sustainable development and poverty reduction.
Reproductive Health and Rights	to improve quality of life through universal access to reproductive health by 2015 and universal access to comprehensive HIV prevention by 2010.
Gender Equality	to advance gender equality and empowerment of women and adolescent girls to exercise their human rights, particularly their reproductive rights, and live free of discrimination and violence.

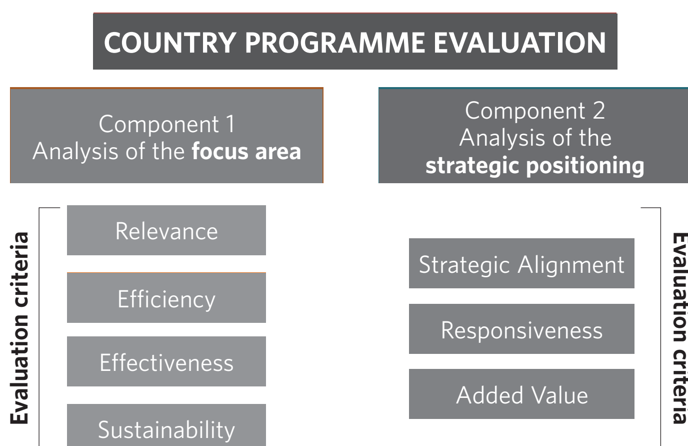
Table 3: Specific objectives of the CPE

1. to provide an independent evaluation of the progress, or lack thereof, towards the expected outcomes envisaged in the UNFPA programming documents. Where appropriate, the evaluation also highlights unexpected results (positive or negative) and missed opportunities;
2. to assess the Monitoring and Evaluation system in the country office.
3. to provide an analysis of how UNFPA has positioned itself to add value in response to national needs and changes in the national development context;
4. to present key findings, draw key lessons, and provide a set of clear and forward-looking options leading to strategic and actionable recommendations for the next Programming cycle.

1.3 Scope of the evaluation

The central scope of the evaluation is the UNFPA support to Cameroon, covering the current country programme document and respective country programme action plan for the period 2008-2011. The evaluation covers the UNFPA assistance financed by regular and other resources. The evaluation outcomes entailed a review of the on-going country programme portfolio and soft aid activities.

Diagram 1: Evaluation criteria in a country programme evaluation



1.4 Methodology and process

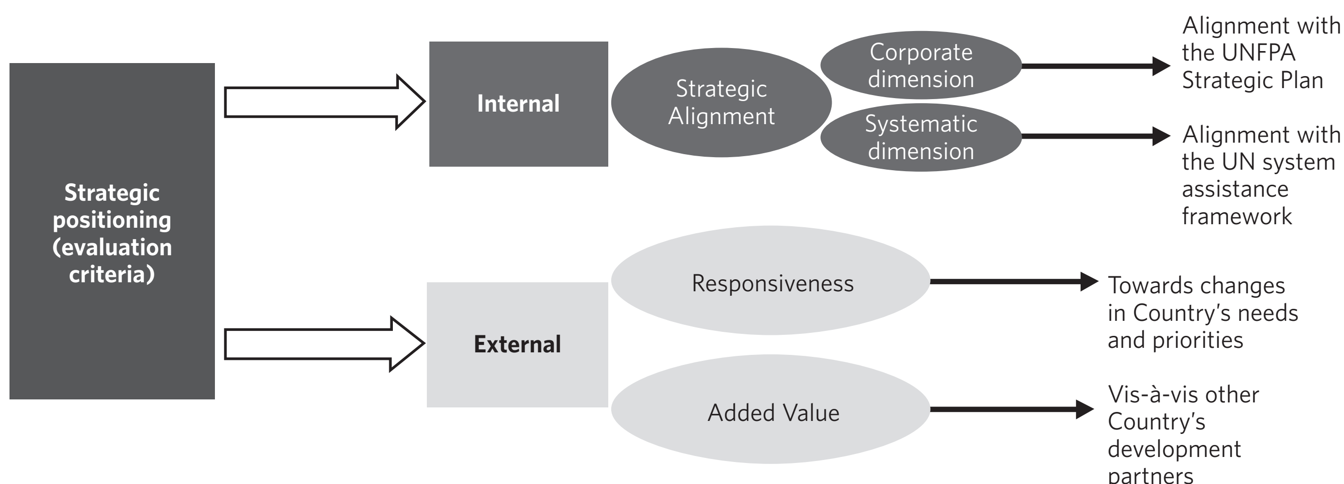
Based on the ToR (see annex 1), specific evaluation questions have been identified covering the evaluation criteria indicated in diagram 1.

The evaluation criteria – relevance, efficiency, effectiveness and sustainability were applied to the analysis of the focus areas: reproductive health, population and development and gender equality. The analysis of UNFPA strategic positioning was conducted according to the following evaluation criteria: strategic alignment both corporate and systemic, responsiveness and added value (diagram 2).

An evaluation matrix was used as a guide by the Evaluation Team members for data collection and analysis. Details on what to check, data sources and data collection methods for each of the evaluation questions have been included in this matrix (see annex 2).

The evaluation team also assessed the M&E system of the country programme[10]. The analysis of the M&E system included five different aspects: (1) Monitoring of inputs and activities; (2) Monitoring of outputs and

Diagram 2: Criteria for strategic positioning



[10] The scarcity and limited reliability of data is a structural weakness caused to a large extent by the absence of an effective results oriented monitoring. As explained in this section, the evaluation team has adopted a methodological approach (including a comprehensive stakeholders mapping by output, conducted a wide range of interviews, focus groups and site visits as well as an extensive document review) in order to mitigate this limitation. The current absence of an effective results oriented monitoring has also led to the decision to include the analysis of the M&E system as complementary objective of the evaluation.

outcomes (including the quality of the CPAP 2008 – 2011 indicators – see annex 7); (3) monitoring of assumptions and risks; (4) integration of evaluations into the M&E system and (5) support to national partners in their M&E system and capacity.

The evaluation team used a variety of methods to ensure validity of data, including internal team-based revisions and triangulation based on the systematic cross-comparison of findings by data sources and by data collection methods. This multiple method approach included document reviews, group and individual interviews, focus groups, and field visits.

Moreover, an analysis of UNFPA in the press was conducted to support the analysis of the strategic positioning of UNFPA in Cameroon (see annex 11).

Three hundred and eleven people were consulted (see annex 4) – individual interviews and several group discussions were conducted with the main stakeholders and beneficiaries (such as: 2 separate group discussions with male and female refugees from central Africa) and three focus group discussions were organised with NGOs, Youth Organizations and Journalists (see annex 10).

1.4.1 Evaluation process

Design phase, the evaluation team conducted a desk review. A report was prepared, presenting the evaluation design which encompasses the stakeholders mapping, evaluation matrix and plan for data collection, including selection of field sites. *Field phase*, a mission of three weeks to the country was undertaken in line with the desk report. At the exit meeting of the mission, the evaluation team provided a detailed and comprehensive debriefing of the preliminary findings and recommendations to the country office, receiving initial comments and validating preliminary findings and recommendations. *Reporting phase*, the draft evaluation report was prepared by the evaluation team. The draft report was subject to a formal review process and quality assurance. This process entailed: (i) a review by the reference group focusing on factual errors, omissions and/or errors in interpretation; (ii) an assent of the quality of the evaluation by an external reviewer (an evaluation adviser from a sister UN organisation – IFAD). A *Stakeholders' workshop* was held in Yaoundé, Cameroon to present the draft final evaluation report to the national partners (government officials, civil society organizations, UN agencies, main donors and CO staff). The results of this discussion were taken into account on the final revision of the evaluation report. A *management response* to the recommendations of the evaluation was prepared.

Diagram 3: Multiple method approach

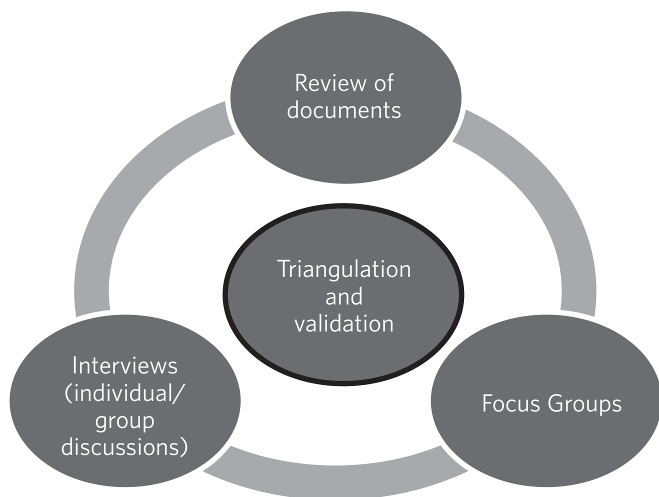
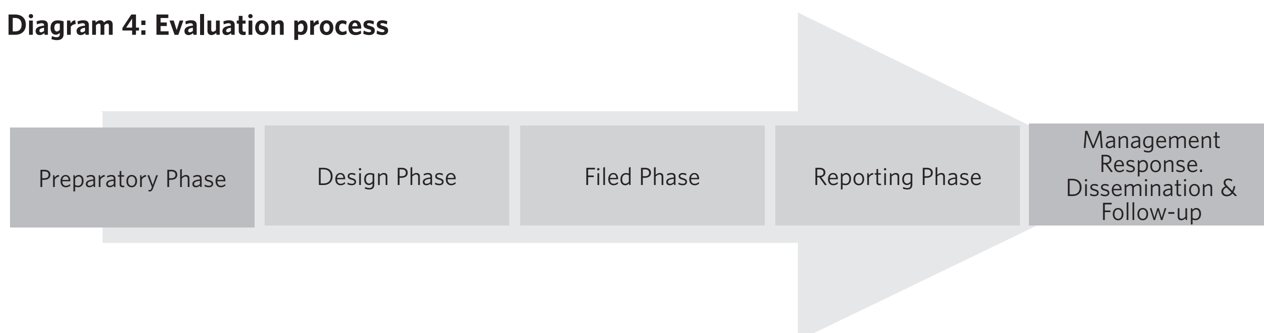


Table 4: Number of people consulted/site visits

Institutions	Number of people	Site visits
UNFPA	27	Yaoundé, Douala, Bafoussam, Bamenda, Mamfe, Abong, Mbang, Bertoua, Betare Oya, Maroua, Mokolo Kousseri
Central Government	36	
Regional Government	97	
International Organizations	31	
Civil Society	54	
Final Beneficiaries	87	
Other	6	
Total	**311**	

Diagram 4: Evaluation process



1.4.2 Limitations encountered

In conducting the CPE, the evaluation team was confronted with a series of obstacles, including: (1) overambitious results framework particularly the outputs of the reproductive health focus area; (2) inadequate identification and formulation of indicators at output and outcome levels, impeding an objective assessment of the degree of effectiveness; (3) limited availability of monitoring data and evaluations at programme and intervention levels; (4) poor quality of reporting (e.g. country office annual reports are often rather descriptive with limited reflection on results); (5) the limited duration of the field missions (in particular to the north) constrained the data collection and consultation with final beneficiaries. However, on the field mission to the east and with the logistical support of the CO, the team was able to overcome this limitation and reach final beneficiaries.

While attempting to remedy any gaps through triangulation, the team acknowledges that, despite efforts, in some rare cases information might be incomplete. Limitations were addressed by organizing more extensive stakeholder consultations to allow for the systematic triangulation of data, and by reviewing documentation in greater depth.

CHAPTER 2

The Country Context

2.1 Development challenges and national strategies

Cameroon is located in western central Africa and bordered by 6 countries. It is geographically and culturally diverse, with a very varied terrain. Following the general population census published in 2010,[11] the total population of Cameroon is estimated at 19,711,291 inhabitants. The population is estimated to be growing at an annual rate of 2.6%[12].

Cameroon has experienced relative political and institutional stability since independence and merging of former French and English colonies in 1961. It is a bilingual country with French and English as official languages. However, low participation of non-state actors makes state accountability weak for issues such as poor public services.[13] Decentralization of power to ten semi-autonomous regional authorities is enshrined into the constitution with local bodies responsible for design, financing and implementation of policies and programs[14]. Nevertheless, the law of decentralization of 2005 was not implemented until the issue of a decree in January 2011.

Cameroon has considerable natural resources, which have enabled steady economic progress after a period of economic crisis in the late 1980s and 1990s.[15] Growth in exports has been supported by rural development strategies including the Poverty Reduction Strategy Paper (PRSP) adopted in 2003.[16] However economic growth, which has remained fairly low over the past decade (3.4% over 1999-2009), is still slow (2.9% in 2008, 2% in 2009[17] and 3% in 2010).

In what regards the advancement to **Millennium Development Goal** (MDGs), recent assessments indicate that it is unlikely that Cameroon will meet its targets by 2015. A lower economic growth between 2001-2007 curtailed progress in addressing poverty as well as limiting resources available to improve public services (see annexe 12: on Progress of MDGs).

Between 1980 and 2010 **Cameroon's Human Development Index** (HDI) rose by 0.9% annually from 0.354 to 0.460 today, which **ranks 131th out of 169 countries** with comparable data. The HDI of Sub-Saharan Africa as a region increased from 0.293 in 1980 to 0.389 today, placing **Cameroon above the regional average.**[18]

Population growth in urban areas means that demand for housing exceeds availability and there are problems with insufficient supply of clean water (53% of the general population and 65% of the rural population lack access to clean water), as well as issues of waste removal (64% of households lack adequate waste removal facilities), all of which create public health challenges for poorer sectors of the population living in these informal neighbourhoods[19]. **Access to quality education** at all levels of the education system is poor and unequal (22.4% of women aged 15-49 are illiterate compared to

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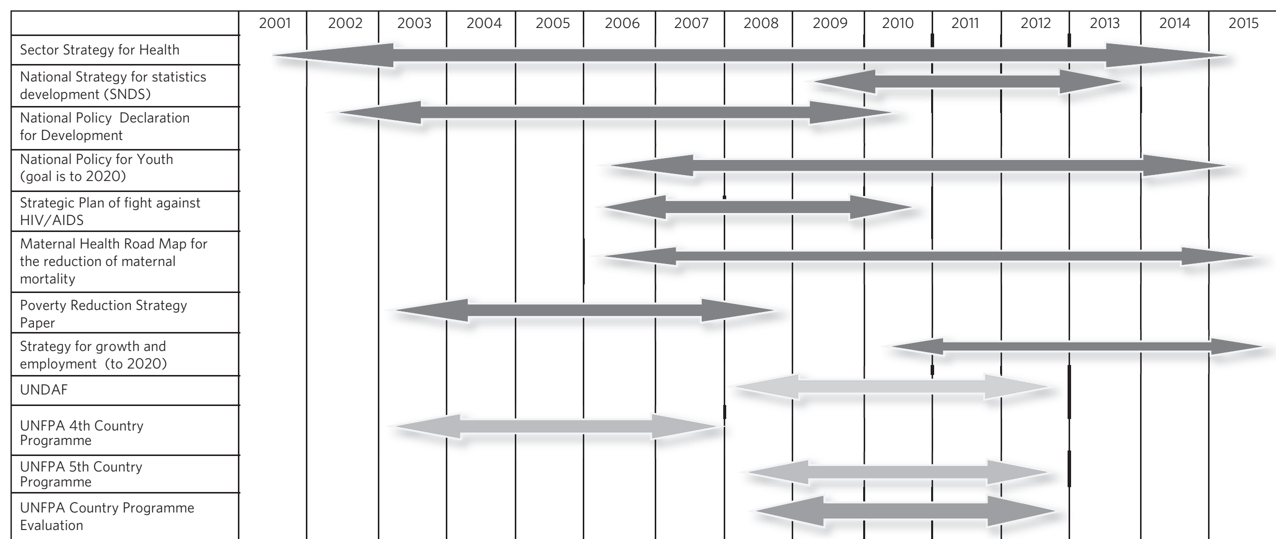
[11] OMS, Statistiques Sanitaires Mondiales. 2011.
[12] Cameroon National Institute for Statistics
[13] Common Country Assessment (2006)
[14] Mid-term review of UNDAF 2008-2012 (2010)
[15] Global Environment Facility Country Portfolio Evaluation 1992-2007 (2008)
[16] http://www.imf.org/external/pubs/ft/scr/2003/cr03249.pdf
[17] Data from the World Bank (« *Cameroon at a glance* » - Feb. 2011).
[18] The HDI is based on a broader definition of well-being and life chances and provides a compound measure of three basic dimensions of human development: health, education and income. http://hdrstats.undp.org/en/countries/profiles/CMR.html
[19] ibid

9.7% of men[20]). Enrolment rates for primary education are reasonably high although there are wide variations between regions, with lowest attendance in the northern parts of the country, particularly for girls.[21] For all other levels from secondary to higher education there are high costs associated with attendance, as well as shortage of qualified teachers. **The health situation** in Cameroon is characterized by high levels of incidence of infectious diseases associated with the public health challenges of poor access to clean water and adequate waste disposal previously mentioned.[22] The government's plan to improve health is the updated Health Sector Strategy (SSS), which aims to provide quality health services and care to all through construction and rebuilding of health centres and the Ministry of Public Health's human resource development plan for recruiting health workers.[23]

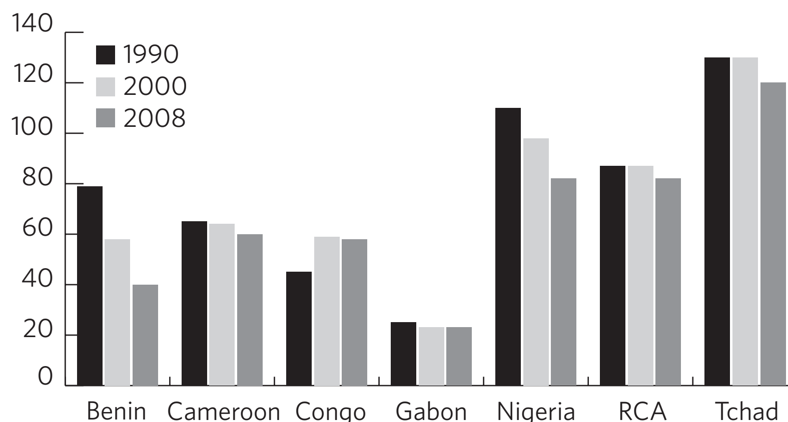
2.1.1 Reproductive health

Despite the efforts of government and its developing partners to reduce poverty and the vulnerability of women and children, the reproductive health indicators

Diagram 5: Key documents timeline



Graph 1: Maternal mortality rate in Cameroon's sub-region



Source: data from WHO's World Health Statistics 2011.

[20] ibid
[21] ibid
[22] ibid
[23] Poverty Reduction Strategy Paper - Progress Report (IMF, 2008)

Table 5: Reasons that lead to the direct causes of poor maternal and neonatal health outcomes[25]

• Incomplete attendance to prenatal care visits	▶	17% of pregnant women had not attended at all according the DHS III and only 60% had attended all 4 visits
• Still relatively low percentage of births attended by skilled personnel	▶	pregnant women go to prenatal care visits, they still prefer giving birth at home.[26]
• Lack of emergency obstetric care services both in terms of coverage and in terms of quality (use of harmful practices, weakness of capacity for care and treatment or complications – dystocic deliveries)		
• Disfunctional referral/counter-referral system.		

are still very worrisome and unfavourable. The maternal mortality rate (MMR) has been estimated at 669 for every 100,000 births by the DHS III (2004), which covers the 1998-2004 period. This showed a deterioration of the situation from the previous DHS (1998) which set the rate at 430/100,000. However, WHO data show rates of 680/100,000 in 1990 and 660 in 2000 (see graph 1). Past and present data diverge from different sources. We lack recent data, especially as death audits are not conducted in Cameroon, while health data are not well collected and dealt with, and as 40% of births take place at home. Current estimates range from 600 to 900-1,000/100,000[24].

Neonatal mortality is estimated at 26 per 1000 (2009, WHO). Morbid consequences of delivery and abortion are a major public health issue in Cameroon. Its magnitude is not fully known though. Reliable data are scarce in SRH and measurement is spaced in between long periods of time. Under-notification of maternal mortality is quite probable, including at the health facilities level. The deficiency in death audits is one of the causes for the lack of data.

A recent study of the ministry of Health including seven regions of Cameroon: (centre, east, littoral, north, extreme north, Adamawa and north west) has shown direct causes of maternal death to be: haemorrhage (42, 2%); dystocia (16.4%); pre-eclampsia; eclampsia (16%) with up to 40% of maternal deaths due to complications of unsafe abortions.

The survey conducted with the support of UNFPA in 2010 on the status of Emergency Obstetric and Neonatal Care (EmONC) services in health facilities[27] shows very low capacity to meet the SRH needs of the population. Very significant differences also appeared between regions, with the far north being the one with the highest level of capacity. However, the far north, the northern region, and the coast (littoral) are regions where the density of primary care services per capita is the lowest in the country[28], when the desire for children and the actual fertility rate are recorded as the highest (see EDS III[29]). In these three regions each primary care center (CSI or CMA) covers more than 10,000 people, against 6,900 on national average. Proximity is cited as the first factor that draws people to health facilities.[30] The far north has a very large population, with more than 3 million inhabitants, or close to 1/5 of the country's estimated population. The northern and far northern regions also show up as having the lowest rate of skilled attended births (around 25% according to EDS III). The three northern regions (including Adamawa – making up the "Septentrion") are where the qualification of health personnel is the lowest. All these factors are reflected in the lower than average health indicators there.

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24 Alain Sibenaler. *The case of MDG 5 in Cameroon: how to do things differently*. UNFPA. April 2010.

25 According to the « Feuille de Route pour la Réduction de la Mortalité Maternelle et Néonatale au Cameroun. 2006-2015. »

26 But the situation is much contrasted between urban and rural areas. In health facilities visited by the evaluation team in the north, far north and east regions, where UNFPA provides support, rates of only 25-30% are the norm.

27 République du Cameroun, Ministère de la Santé Publique. *Etude sur la disponibilité, l'utilisation et la qualité des SONU au Cameroun*. 15 janvier 2011.

28 République du Cameroun. Institut National de la Statistique. *2ème enquête sur le suivi des dépenses publiques et le niveau de satisfaction des bénéficiaires dans les secteurs de l'éducation et de la santé au Cameroun. Rapport principal. Volet Santé*. Décembre 2010. (PETS 2).

29 The number of desired children reported by EDS III reaches 8.3 per woman in the far north and 7.3 in the north, which is quite higher than in other regions of Cameroon. The national average, as of 2004, was 5.7.

30 Ibid.

Indicative of the low availability of quality services, in 2000 there was only 1 midwife for every 200,000 population, according to the statistics of WHO. At a high 5% birth rate per total population, that meant 1 midwife for every 10,000 births per year, which is extremely low. Mid-wives in Cameroon are mostly concentrated in Yaoundé and Douala. Their average age is high since none has been trained over the past 25 years.

The lack of health personnel, in general,[31] and of material and financial resources as well, is detrimental to both quality and attendance (lack of trust of the population). Other reasons that can be invoked include:

- poor nutritional state of the pregnant woman;
- socio-cultural factors like female genital mutilations that affect 1.4% of the population;
- very weak decision making power for women coupled with low female education;
- insufficient national budgetary allocations for FP methods in Cameroon; and
- lack of information for pregnant women and of communication in general.

Regarding Family Planning, the overall contraceptive prevalence was 29% in 2004, and only 13% for modern methods. Unmet needs for family planning account for 15% of families according to the "Feuille de route" (2005) and 20% according to WHO (2000-2009). Women's empowerment and, particularly, their capacity to negotiate spaced births is known to be one important factor of both women's and their children's overall health.

To meet its needs in reproductive health, and particularly in line with the MDG 5 agenda, Cameroon has elaborated a roadmap for the reduction of maternal and neonatal health for the period of 2006 -2015[32] which aims at reducing the MMR in half by 2010 and by 75% by 2015 (the MDG 5 target) as compared to "current levels" as stated by the "Feuille de Route" (elaborated in 2005). This would lead to levels of roughly 335/100,000 in 2010 and 170/100,000 in 2015. This seems challenging but the ongoing DHS will most certainly give a more accurate sense of where the country's women's health indicators are at and what their trends are (see Annex 9: Tables on - Maternal health indicators in Cameroon; Comparative levels of reproductive and neonatal health indicators in Cameroon and neighbouring countries).

2.1.2 Youth and adolescents

Youths below 20 years make up 50% of the population and most of them are exposed to sexually transmitted diseases including HIV. Adolescents, who contribute 25% of reproductive age women, make up 14% of total births among women in Cameroon. Teenage pregnancy is thus a major public health issue in Cameroon with 7% of adolescents of 15 years already sexually active and 23% of this group already mothers. Cameroon does not only have a low prevalence use of modern means of contraception (13%) but also has high disparity between the rural and urban areas as well as between the urban areas themselves.

2.1.3 Gender equality

There is low participation of women in Cameroon society, with women not granted equal status to men in certain aspects of civil law and custom[33]. Women in Cameroon experience discrimination and domestic violence; female genital mutilation of young girls is also practiced in some provinces.[34]

Among indicators of gender inequality in Cameroon is the schooling rate, whereby 17% of girls aged 10-14 not schooled in 2004 compared to 11.7% of boys in the same age bracket (see following tables).

Reflecting the wide social-cultural differences throughout the country, these gaps were also markedly more pronounced in some provinces than others, with

[31] For example, as regards MDs, an additional 40% would be needed to reach the minimum ratio of 1 per 10,000 population recommended by WHO, which would bring the ratio up from 1,346 to around 1,900. For dentists (numbering 32 in 2009), a multiplication by 6 would be in order, and it would to be by 48 for pharmacists, who number only 27 in the whole country.

[32] Feuille de route pour la réduction de la mortalité maternelle et néonatale au Cameroun. 2006-2015.

[33] Social Institutions and Gender Index, http://genderindex.org/country/cameroon accessed 31 March 2011

[34] (Ireland: Refugee Documentation Centre, *Cameroon: FGM in Cameroon - Extent of practice in rural areas, Evidence of FGM being performed on adult women as opposed to children, State protection for women at risk of FGM*, 30 April 2009, available at: http://www.unhcr.org/refworld/docid/4a082dc40.html [accessed 31 March 2011)

Table 6: Schooling rate percentage

	Girls			Boys		
10-14 year olds	Urban	Rural	Total	Urban	Rural	Total
Not in school	8.3	25.0	17.0	6.9	15.7	11.7
Primary	66.8	69.0	68.0	67.8	78.6	73.7
Secondary	24.9	6.0	15.1	25.3	5.8	14.6

	Girls			Boys		
15-19 year olds	Urban	Rural	Total	Urban	Rural	Total
Not in school	39.9	62.5	49.3	27.4	37.3	31.6
Primary	7.9	17.4	11.8	12.4	32.2	20.8
Secondary	51.4	20.1	38.4	59.4	30.5	47.2
Higher	0.8	0.0	0.5	0.9	0.0	0.5

Source: Population Council, 2004.

northern regions sending far fewer girls to school, proportionally, than the central and southern regions. Coincidently, the marriage rates of girls in the 15-19 age brackets follow very similar patterns and disparities, with northern provinces seeing a three to five times higher rate of marriage (40% to 50%) than on the coast (10% in Douala and 15% in the Littoral province).

On health indicators comparatively applicable to both females and males, disparities also appear clearly. For example, the HIV prevalence rate, which stood at an estimated 5.5% in 2009 for the 15-49 year old, was 6.8% for women and 4.1% for men.[35] For the 15-24 year range, the differential of prevalence is even wider, according to UNAIDS: 3.9% for women and 1.6% for men estimated for 2009.[36]

These few indicators point to the low capacity that Cameroonian women have to protect themselves and to exercise decision making power over their health problems in general and their reproductive health issues in particular.

In response to the challenges in the area of gender rights, Cameroon has ratified the Convention for the Elimination of all forms of discrimination against women (CEDAW).[37]

2.2 The role of external assistance

One of the characteristics that defined Cameroon at the outset of the 2008-2012 period was its marginal dependency on external assistance, with percentages oscillating around 1% of GDP. In consequence, domestic resources play a protagonist role in the development process, and the national administration's capacity to manage internal and external resources to achieve improved and equitable development takes centre stage. Responding to this framework, the effort of the donor community was initially directed to support structural adjustment, public administration and macroeconomic stabilization. Afterwards -during the period 2008-2012- donors pursued a broader focus that included issues related to governance, infrastructures and rural development.

The United Nations System is well represented in Cameroon in particular, OMS, UNICEF, UNESCO, UNIFEM, ONUDI, UNDP, UNFPA, FAO, PAM etc., with variable intervention levels and –in some cases- regional competences.

The two largest donors during 2008-2012 -France and Germany- specifically targeted the health and education sectors, infrastructure, natural resources, rural development and decentralization, with the gradual

[35] Growth and Employment Strategy Paper (2009)
[36] UNAIDS. Statistical annex to the 2010 UNAIDS report.
[37] MDG progress report 2003

Table 7: Cameroon ODA

ODA Receipts	2007	2008	2009
Net ODA (US$ million)	1928	549	649
Bilateral share (gross ODA)	89%	79%	52%
Net ODA/GNI	9.5%	2.4%	3.0%

Health general (US$ million; all donors)	6.97	9.76	9.15
Primary education	18.36	8.67	4.23
Population policy and administrative management	2.87	3.46	2.90
Reproductive health care	1.87	0.78	3.33
Family planning	-	-	4.17
Basic life skills for youth	0.52	0.70	0.65
Human Rights	0.46	0.70	1.50
Women's equality organizations and institutions	1.26	1.23	0.40

ODA 2008-9 average US$ million	
Germany	336
France	241
IMF	78
EU Institutions	65
AfDF	43
IDA	40
Global Fund	27
United States	24
Spain	17
Arab agencies	16
UNICEF (i)	6
UNFPA (i)	3
UNDP(i)	3

http://www.oecd.org/dataoecd/1/16/1879783.gif
(i) Additional data on United Nations Agencies obtained from OECD Query Wizard for International Development Statistics; database report accessed 11 May 2011

incorporation of private sector activities. Owing to its regional location and to its economic potential, Cameroon accommodates several bilateral cooperation agencies and programmes. The main ones are the aforementioned French cooperation, the German cooperation (GTZ, DED, and KFW) which is increasingly active, the European Commission, Japanese JICA, Canadian CIDA and Dutch SNV. Other donor initiatives are the US supported African Growth and Opportunities Act, the Global Fund to fight AIDS, tuberculosis and malaria and the African Development Bank contributions to roads, water initiative and governance enhancement.

The main donors, on average, during the 2008-9 period were Germany and France, with $336 and $241 million assistance respectively, and smaller donors include IMF, EU institutions, and the African Development Fund.[38]

[38] The information presented in this section is mainly collected from the following sources: (i) *Country Strategy Paper 2010-2014 Cameroon* by African Development Bank (2009). (ii) *Country Strategy Paper & NIP 2008-2013* by the European Commission (2007); (iii) *Critical assessment of Aid Management & Donor Harmonisation. Cameroon Case*, by the African Forum and network on Debt and Development (2007); (iv) Different web sites including the World Bank, DFID and SNV.

CHAPTER 3

United Nations/UNFPA Response

3.1 UN response

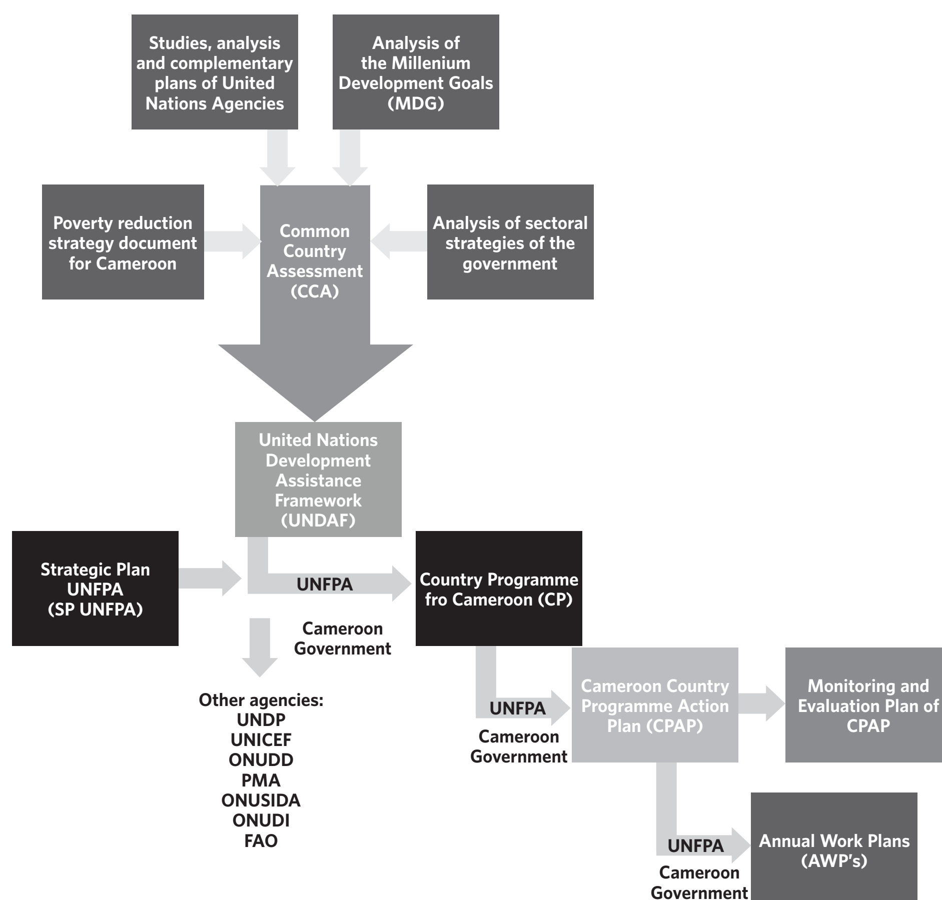
3.1.1 Programming flow

The programming process started with the analysis of national and United Nations strategies. This provided a framework of national priorities which were described in the Common Country Assessment (CCA).

The United Nations Country Team[39] outlined the planned responses to the identified needs, by agency, in the United Nations Development Assistance Framework (UNDAF). The goals outlined in the UNFPA Strategic Plan and the UNDAF framed the preparation of a five year country programme (CP) and respective action plan (CPAP). Yearly, sets of budgeted activities were agreed with national implementing partners and included in annual work plans (AWPs).

Diagram 6 represents the linear links between key global and national documents that led to the formulation of the UNDAF, CP, CPAP and AWP documents.

Diagram 6: Programming flow



[39] The Resident UN agencies form the UN Country Team, which is led by the UN Resident Coordinator.

3.1.2 Reconstructing the intervention logic

The analysis of UNDAF, UNFPA Strategic Plan and the CPAP has enabled the evaluation team to reconstruct the intervention logic of UNFPA in the framework of its co-operation with Cameroon. The reconstructed intervention logic of the programme is presented in a diagram of intended effects (see Diagram 7). This tool presents a snapshot of the logic behind the "intervention" in Cameroon. The Effects Diagram for Cameroon articulates how the outputs of the CPAP are aligned with the strategic documents that outline and inform the UNFPA fifth Programme Cycle in Cameroon: UNDAF and UNFPA Strategic Plan. The diagram illustrates that the UNFPA country programme has specifically contributed to two of the five UNDAF outcomes and seven of the thirteen UNFPA Strategic Plan outcomes.

3.2 UNFPA response through the country programme

3.2.1 UNFPA previous country programme cycle

Previous UNFPA assistance in Cameroon (2003-2007) focused on increasing consideration of population issues in national policies, building national capacity in quality reproductive health services and supporting the promotion of gender equality and women's empowerment.

UNFPA provided support for the third General Population and Housing Census. However delays to the final results from the census have limited the use of national statistics by relevant government staff. The reproductive health activities of UNFPA were focused on integrating a minimum package of high-quality reproductive health services into the health-care system. UNFPA provided support to strengthen community-based reproductive health services, particularly maternal health referrals and contraceptive promotion, alongside other contraceptive distribution initiatives. UNFPA interventions to reduce maternal mortality including piloting of emergency obstetric care services comprising development of cost-sharing mechanisms for treatment of obstetric complications. Gender activities implemented by UNFPA include development plans and training resources for leaders of women's associations and training of government staff. Dialogue with local leaders and community mobilization activities have helped the implementation of a number of activities, in particular utilization of reproductive health services and support for obstetric fistula services.

3.2.2 UNFPA current country programme cycle

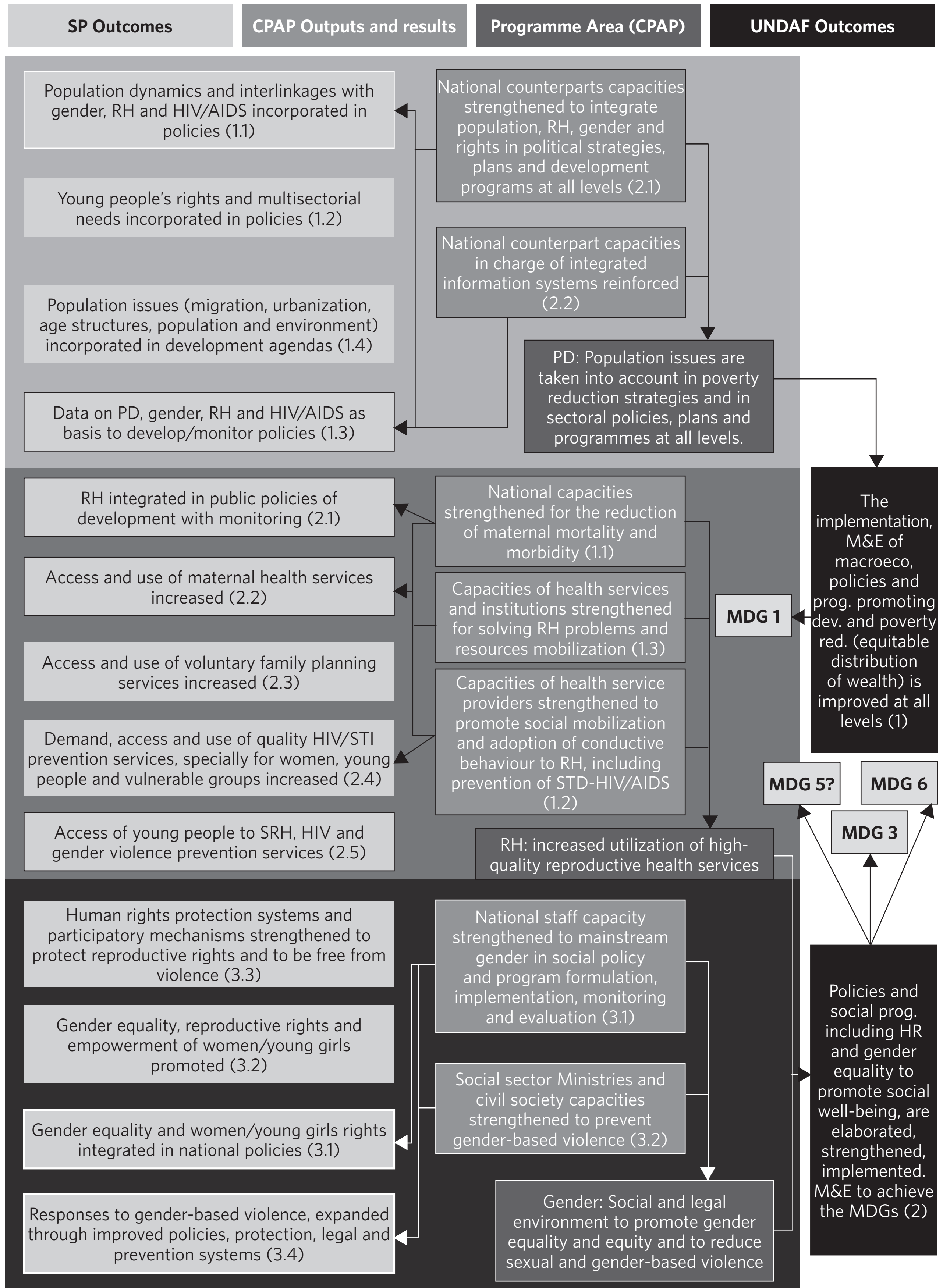
The fifth UNFPA country programme (2008-2012) focuses on support for the implementation of the Health Sector Strategy, particularly the strategic repositioning of family planning and the intensification of efforts to reduce maternal mortality through emergency obstetric care. The UNFPA programme focuses on women and young people and supporting the government to build national capacity to: improve socio-economic

Table 8: Programme areas of support for current and previous programme cycles

Focal Areas	Outcomes Previous Cycle	Outcomes Current Cycle
Reproductive Health and Rights	Improved utilization of high-quality reproductive health services	Increased utilization of high-quality reproductive health services
Population and Development	Updated population policy implemented	Population issues are taken into account in poverty reduction strategies and in sectoral policies, plans and programmes at all levels
Gender Equality	Reduced inequality and inequity between men and women	A favourable social and legal environment to promote gender equality and equity and to reduce sexual and gender-based violence

Source: CPAP 2008-2012

Diagram 7: Effects diagram — Cameroon



conditions, increase access to basic social services, promote sexual and reproductive rights.

UNFPA continues to focus on **reducing maternal mortality and morbidity** by strengthening national capacity and by commencing work on the strategic repositioning of family planning to ensure availability of family planning services including supply and securitization of contraceptives. Support for the provision of quality emergency obstetric and neonatal care continues through strengthening of technical and institutional capacity, as well as extension of fistula prevention and treatment services. Promotion of community based activities also continues, maintaining the focus on youth. Reproductive services in private-sector companies are expanded in key areas, incorporating both family planning and HIV/STI prevention through training of health sector and community health staff and provision of equipment and supplies. UNFPA supports increased capacity of health systems through continuation of work on improved planning and information systems (HMIS), as well as humanitarian response/crisis preparedness activities. In the CPAP the interventions were planned to be implemented in 9 provinces out of 10 for Sexual Reproductive Health but finally concentrated in 5 out of 10 regions.

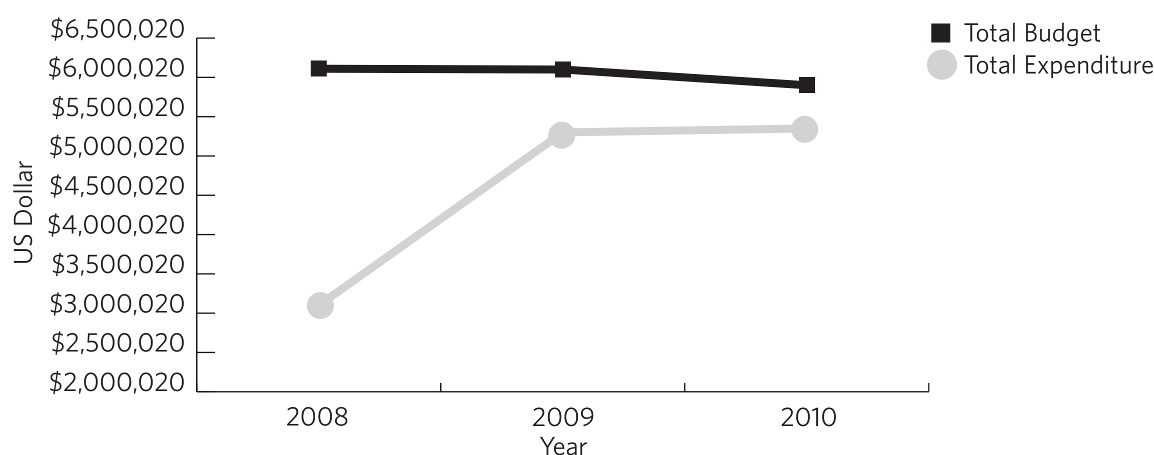
UNFPA continues to support the **integration of population** issues in poverty reduction strategies and in sectoral policies, plans and programmes. This is a prolongation of previous activities of UNFPA, including advocacy to and training of national counterparts involved in planning, development of tools for integration of population issues into national policies, as well as conducting studies on population and development trends. UNFPA support for information management also continues, through support for greater collection and use of data, including support for statistical systems and consolidation of existing information systems.

In what regards **gender equality and sexual and gender-based violence** issues, the development of tools by UNFPA continues, with a focus on methodologies to support national staff to integrate gender into sector strategies, particularly poverty reduction strategies. Research activities include studies of views on gender, as well as updating of statistics and budget studies. The work of UNFPA with parliamentarians also continues, along with support for NGOs and community groups, to prevent and treat gender-based violence. UNFPA is also beginning to address the issue of Female Genital Mutilation through studies on incidence, raising awareness with community leaders as well as their involvement with other stakeholders in education activities.

3.2.3 The financial structure of the programme

The Country Programme Document for the fifth UNFPA country programme stated proposed UNFPA assistance of $17.75 million: $12.5 million from regular resources and $5.25 million through co-financing modalities and/or other for a five year period. The following diagrams illustrate budget compared with expenditure for the period under review.

Graph 2: Finance evolution for period 2008-2010



Graph 3: Total budget expenditure evolution

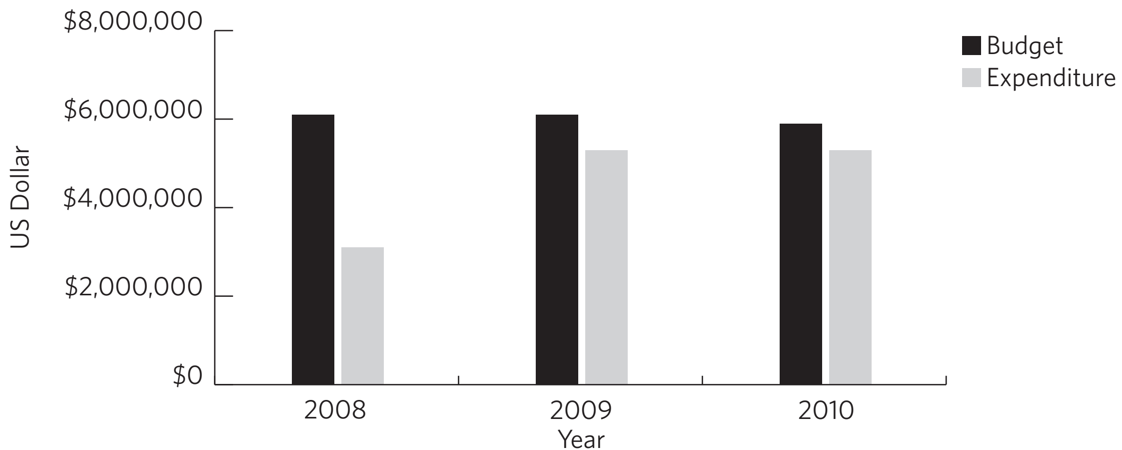
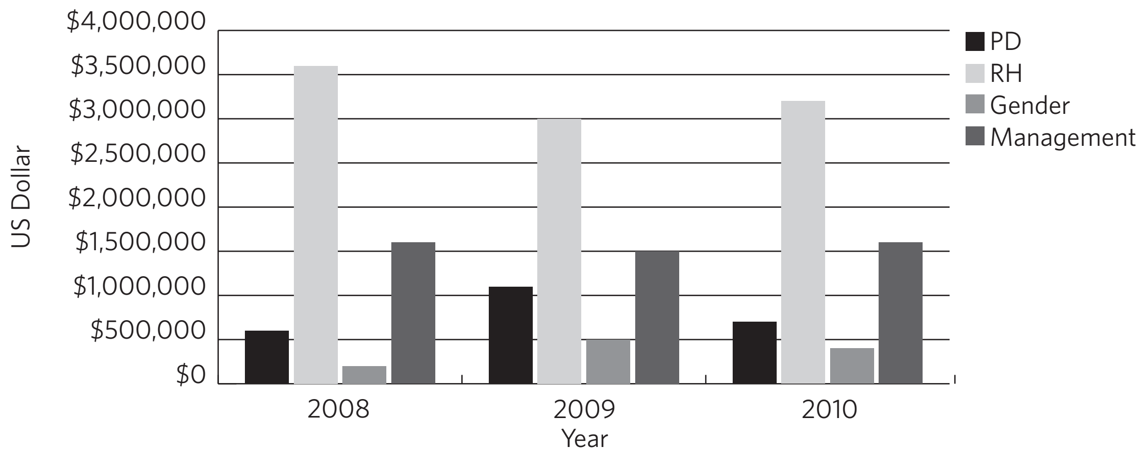


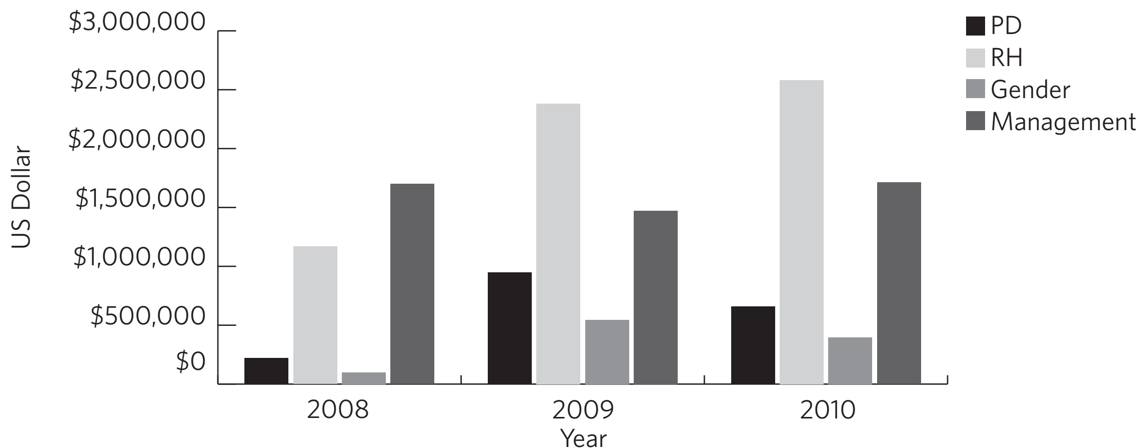
Table 9: UNFPA Cameroon country programme budget 2008-2010

	P&D	SRH	Gender	Management	Total ($million)
Budget	$2,406	$9,762	$1,205	$4,807	$18,182
Expense	$1,828	$6,135	$1,008	$4,888	$13,859

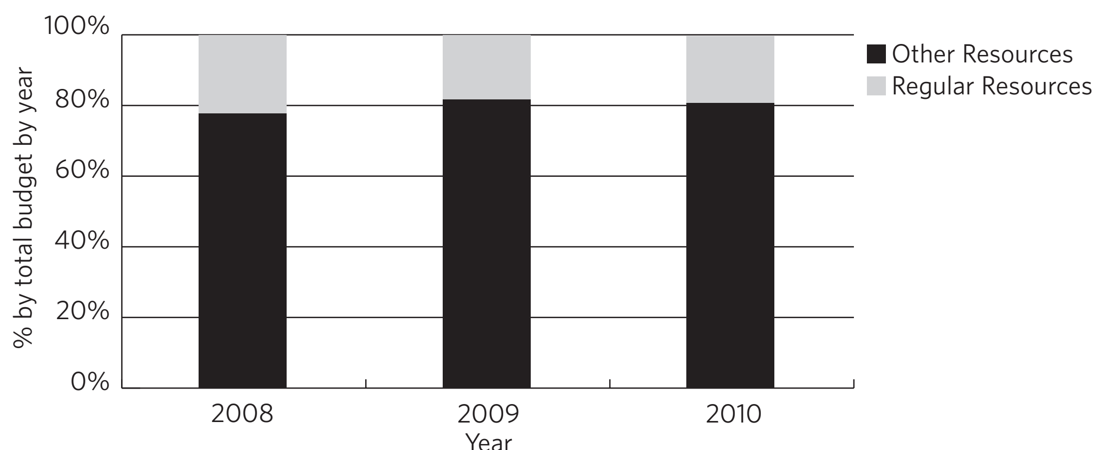
Graph 4: Budget distribution



Graph 5: Expenditures distribution



Graph 6: Budget resources origin



The budget remained reasonably constant (2008-2009: $6.1million; 2010: $5.9 million) despite almost half the 2008 budget remaining unspent in 2008, with underspend occurring across all programme areas.

The budget distribution also remained reasonably consistent throughout 2008-2010, with the largest proportion of funding spent on Reproductive Health, ranging from 58% of the budget in 2008, to 48% in 2009 and 53% in 2010. Gender programming accounted for less than 7% of the budget on average during this period, an average of 13% of the budget was allocated for Population and Development programming, with the rest of the budget allocated for management costs.

As noted earlier, there was significant underspend of funds by UNFPA Cameroon country office in 2008-9 but this expenditure increased significantly and by 2010 80% of budgeted funds for reproductive health were expended. Over 90% of the budgeted funds for Gender and Population and Development were also expended in the same year. This was a consistent level of expenditure as a percentage of budgeted funds for both these mandate areas throughout this period.

Table 10: Funding sources, period 2008-2010

	Budget	Expenditure ($million)
Regular Resources	$14,630	$12,278
Other Resources	$3,551	$1,581
Total	**$18,182**	**$13,859**

Source: Atlas

Funding sources remained reasonably consistent in the period 2008-2010, with the majority of budgetary funding originating from regular resources.

CHAPTER 4

Focus Area Analysis

This chapter presents the analysis of the levels of achievements of results within each focus area. The report briefly presents the UNFPA response to the country context and development challenges highlighted in Chapter 2, emphasizing major interventions as well as soft aid activities (e.g.; advocacy, major consultations, policy dialogue) as an illustration.

While taking into account the standard evaluation criteria (as defined by the OECD-DAC) of relevance, efficiency, effectiveness and sustainability, this evaluation was organised around a set of specific evaluation questions. The four criteria were translated into the evaluation questions presented below.

This report assesses the UNFPA fifth country programme (2008-2012), although its implementation will continue for one more year. Hence, the evaluation team assessed the programme up to July 2011.

4.1 Reproductive health

4.1.1 Relevance

Question 1: To what extent is the UNFPA support in the field of reproductive health (i) adapted to the needs of the population (ii) and in line with the priorities set by the international and national policy frameworks? Are planned interventions adequately designed to reach the stated goals?

a) Alignment with international and national agendas and frameworks

Rapid demographic growth and deteriorating health indicators for both mothers and children are the reasons why an urgent and steady intervention in the area of mother and child health in Cameroon is necessary.

The specific objectives defined in the ICPD SRH chapter are:

- to ensure that comprehensive, factual information and full range of reproductive health-care services, including family planning, are accessible, affordable, acceptable and convenient to all users;
- to enable and support responsible voluntary decisions about child-bearing and methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law and to have the information, education and means to do so;
- to meet changing reproductive health means over the life cycle and to do so in ways sensitive to the diversity of circumstances of local communities.

NOTE: The technical flaws of the results framework, especially the inadequate identification and formulation of indicators (see details in Chapter 6: Monitoring and Evaluation System) at outcome and output levels, impedes an objective assessment of the degree of effectiveness. Nevertheless, the perusal of documents, observation and extensive interviews undertaken during the field visits gives indications about the levels of achievement. These achievements are analysed under effectiveness and by focus area.

Particularly critical to the improvement of mother and child health is the much needed improvement in sexual and reproductive health (SRH), an area where indicators have also been deteriorating. SRH constitutes the most ambitious of the UNFPA three areas of intervention as per its fifth country programme, both in terms of funding and of programming.

The country programme goals and strategies in SRH are aligned with the major international agendas and with the national policies and strategies in health and development. As regards the alignment with the reproductive health agenda of the ICPD, the fifth country programme does match the objectives set by the 1994 conference.

For example, "causeries éducatives" (educational group discussions or conversations organized with the population) promote the free flow of information on key themes covered by the ICPD SRH agenda. This includes the need for birth spacing, the use of family planning techniques, the prevention of risks associated with pregnancy and sexually transmitted diseases, including HIV/AIDS, counseling, etc. The affordability of quality SRH services, including family planning products and services, is advocated by the ICPD, and is promoted by the fifth country programme in Cameroon. The use of non-governmental organizations to promote family planning is advocated by the ICPD, and is part of the response that UNFPA implements in Cameroon, particularly for information and communication interventions.

Similarly, the emphasis given to adolescent health in the SRH component is aligned with the ICPD recommendations, which were expounded in a dedicated chapter on SRH, covering adolescent SRH. This chapter included the prevention of early marriages, which is also addressed by interventions sponsored by UNFPA in its fifth country programme.

In the SSS 2001-2015 and the latest two (2006-2010 and 2011-2015), SRH, including FP, features as a priority area of intervention, in line with the MDG agenda (MDG 5 more particularly: reduction of maternal mortality by 3/4 between 1990 and 2015), as part of the Maternal and Child Health cluster. This is one of four clusters of interventions addressed by UNFPA, along with the fight against diseases, prevention and health promotion. Refocused prenatal care (PCNR), including family planning (FP), and births attended by skilled personnel (in a context of a greater availability of quality emergency care), are central to the attainment of the objectives contained in these strategies and policies.

However, the country programme document[40] does not explain how the choice of products and strategies was made and how that choice is articulated with the various national strategic documents (SSS, PNDS, PNSR), which are not referred to in the country programme. The only strategic documents mentioned are the PRSP, ICPD and UNDAF. It is therefore difficult to understand how the programme actually relates to the national policy and strategic frameworks.

Similarly it is not clear, or at least it is not made explicit, how strategies and activities identified by the CPAP (and the AWPs) relate to these national strategic plans (especially PNDS and PNSR). As a consequence it is difficult to ensure that the activities selected fall in line with the objectives and priorities set by the government in health and in SRH in particular.

b) Meeting the population needs

Only about 60% of deliveries take place in health services in Cameroon. Furthermore, there are very significant disparities between urban and rural areas, as well as among regions. In the health districts visited by the evaluation team, in the north, far north and in the east, where UNFPA supports health facilities with training, equipment, materials and consumables, rates of only 25-30% are currently the norm. In those areas, even if they attend prenatal consultations, many women do not give birth at the health center or the hospital, but rather at home. The C-section rate nationally is 2% with rates of about 0.3% in the northern regions. WHO recommends 5% and the UNFPA country programme objective is 3%.

[40] *United Nations Population Fund - Country Programme Document for Cameroon* (2008-2012). 23 July 2007.

[41] For example, in the case of medical doctors, another 40% would be needed in order to reach the ratio of a minimum of 1 per 10,000 population recommended by WHO (meaning going from 1,346 to about 1,900). For dentists, (32 of them in 2009) a multiplication by 6 would be needed, and for pharmacists (27) by 48.

Reasons for the low level of achievement of SRH indicators in Cameroon are well known: acute lack of resources (human,[41] material and financial), harmful cultural practices, weak procedures at health facilities (detection of and care for complications, follow up care, referral and counter-referral, etc.), lack of information among women and general poor communication on key issues. To face those numerous challenges, which relate to the level of the health system as much as to the status of the woman and of health in society, the SRH component has been granted the largest budget in the UNFPA country programme. With a budget of 9.75 million USD (out of a total budget of 17.75 million), SRH accounts for 55% of the total budget, including 7.25 million USD from UNFPA directly out of a total contribution of 12.5 million, or 58% of that total.

The low level of health indicators – and more particularly of SRH indicators – in the northern and eastern regions (see Chapter 2), justifies the selection by the CO of these three (out of five) regions to concentrate its field interventions. It should be noted that, as of 2008 programming, UNFPA had planned to cover 9 regions out of the country's 10. UNFPA subsequently decided, with reason, to concentrate its activities in the field to 5 regions only: north, far north, east, center, and south. The concentration of support in rural areas rather than urban ones also seems appropriate due to the low level of SRH indicators. The survey of SRH response capabilities, sponsored by UNFPA in 2010,[42] confirms the low quality of services and details significant disparities between regions, with the far north providing the best quality of services by far. However, as highlighted by the survey, the northern regions have the least dense network of health facilities, the least availability of mother and child primary care services (together with the littoral region),[43] with more than 10,000 population per health center– CSI and CMA, as compared to 6,900 for the national average. According to DHS III (2004), approximately 75% of deliveries take place at home in those regions, and the contraception prevalence rate is extremely low (2.6% in the north and 3.3% in the far north as compared to 26% for the whole country). The three northern regions (including Adamawa) are also those where the qualifications of health personnel performing deliveries is the least advanced. The infant mortality rate in those regions is the highest in the country (discussed further in Chapter 2). In conclusion, it seems particularly appropriate to provide support to the development of the health care system, and particularly in the area of reproductive health, in these regions. The 26 health districts that receive direct support are mostly located in rural areas, sometimes far from urban centers (Mvangan or Mokolo for example) with some mid-sized or small cities at their center (Figuil, Pitoa or Garoua Boulaï for example). This seems appropriate as, in general, rural areas have significantly worse indicators than urban areas. However, it should be noted that about half of the Cameroonian population lives in urban areas. In large urban centers, such as Douala and Yaoundé, or Garoua and Maroua, a significant proportion of the population lives in dire socio-economic situations, in slums such as the "Briquetterie" in Yaoundé, where indicators are also depressed.

Besides specifically SRH-related activities, the fifth country programme has introduced activities that take into account the broader domain of mother-and-child health. Thirty eight percent of children's deaths in Cameroon occur in the first month of life (neonatal deaths). In response, UNFPA provides training in integrated mother-and-child care (PCIME or IMCHC) as well as the introduction of neonatal care in training through Emergency Obstetric and Neonatal Care (EmONC also known as SONU in Cameroon).

Similarly, the launch of the Campaign for the Acceleration of the Reduction of Maternal Mortality in Africa (CARMMA) in 2010, under the leadership of UNFPA, aims at addressing the daunting task of inverting the trends recorded during the past decade. This initiative is appreciated and acknowledged by the sectoral partners and stakeholders of UNFPA.

As a response to the lack of human resources faced by the Cameroon health system, in particular as far as midwives are concerned, UNFPA has started to provide

[42] République du Cameroun, Ministère de la Santé Publique. *Etude sur la disponibilité, l'utilisation et la qualité des SONU au Cameroun*. 15 janvier 2011.
[43] République du Cameroun. Institut National de la Statistique. *2ème enquête sur le suivi des dépenses publiques et le niveau de satisfaction des bénéficiaires dans les secteurs de l'éducation et de la santé au Cameroun. Rapport principal. Volet Santé*. Décembre 2010. (PETS 2).

support (in 2011) to the implementation of midwifery schools – actually to four out of a total of eight. However, doubts remain as to the relevance in the choice of the number of schools to be opened and on their location (two schools are planned in one location, Bafoussam, west region). Moreover, no real planning has taken place as regards their opening and implementation, and the data needed to calculate training needs (number, location, selection criteria for recruitment) have not been established.

Abortion is illegal in Cameroon and post-abortion care is mentioned in Strategy 2 of Product 1 in the SRH component (and post-abortion kits have been delivered to health facilities)[44] although this does not translate into specific measures in the country programme, whereas adverse consequences of abortions were estimated to account for 20-40% of maternal mortality[45] at the health facility level.[46] Physiological and even social consequences of abortion can have lasting effects on women undergoing an abortion. Whilst Strategy 2 of Product 1 mentions the « renforcement des capacités techniques et institutionnelles à offrir des SONU de qualité et des soins après avortement pour une prise en charge des complications »[47], abortion and its consequences are not identified as a specific area of intervention in the CPAP. There is no reference to communication initiatives in this area. While "causeries éducatives" do take note of abortion, the illegality of abortion in Cameroon may explain why it has not been selected as an area of intervention.

Blood transfusion, a major area of healthcare service affecting SRH outcomes (and the outcomes of other health issues), is not addressed by the fifth programme. The question of availability and security of blood (for transfusion) remains a major handicap for the improvement of obstetrical services. The national blood transfusion policy is impaired by the fact that the corresponding law, signed in 2003, has not been enforced so far, in the absence of an implementation decree. In case of acute bleeding (hemorrhage), complication that appears mainly in the post-partum phase, it is difficult to intervene successfully without the availability of pre-positioned blood bags or at least of plasma, which, in turn, requires the existence of secure blood banks. The current unavailability of blood banks, particularly troubling in a country with a 5.1% HIV prevalence rate (1.1% to 12% of pregnant women tested at health facilities visited by the evaluation team) makes it particularly difficult to address that type of complications. Although HIV/AIDS is a major public health problem in Cameroon, where a National Council on HIV/AIDS (CNLS) has been in place since 2001, there still is no national blood transfusion and securitization policy. The MINSANTE refers to the expected creation of a commission on the subject, and the US Centers for Disease Control (CDC) have just recently (July 2011) initiated support for the creation of a blood bank in Yaoundé. However, these are still preliminary actions and do not constitute a real policy. UNFPA and the CNLS do not seem to have a close working relationship, apart from the organization of such campaigns as "vacances sans sida"[48], despite the integration of the fight against HIV/AIDS and SRH services being a prominent part of the international health agenda.

c) Scope of the programme

UNFPA attempts to address all the weaknesses that have been identified in the area of SRH in Cameroon, to the notable exception of blood transfusion. The CO focuses on both the supply of services and the demand for them and utilizes relevant and proven interventions. This includes leadership activities (CARMMA, participation in several working groups and committees, a prominent role at annual celebrations around RH and health issues), as well as documenting the magnitude of the issues at stake and providing support to the development of capacities.

In some cases, UNFPA provides support to activities that are usually taken care of by other agencies, as is the case of the design of District Health Development Plans (PDSD). This activity would probably be better served

44 64 of them in southern and central regions in 2009, for example (ADB annual report on UNFPA programme for 2009).
45 Studies have shown that the mortality rate in the case of abortion is at least 3 times as high as it is in the case of deliveries (see for example : http://www.ivg.net/les-risques-de-avortement).
46 According to data provided by the « Déclaration de la Politique Nationale de Population (mars 2002) ».
47 "strengthening technical and institutional capacity to provide quality EmONC and post-abortion care for treatment of complications"
48 'AIDS-free holidays'

by WHO or bilateral aid agencies which have extensive experience in those domains and are better equipped to mobilize resources for that type of activity.

The programme in SRH is extremely ambitious, with three products, 13 different strategies and a very large number of activities, both in the CPAP and in AWPs. The confusion stems, in part, from the fact that activities that address both the demand and supply sides of accessing SRH services are present in all three products, hence preventing the clear delineation of activities. For example, some activities are planned for in two different outputs (such as the development of cost-sharing or funding mechanisms and the use of BCC). Furthermore, in the third output of the SRH component, activities have been planned for the development of a contingency plan, which lacks a logical link with the output and which would be more appropriate in the gender component of the fifth country programme. As a result, it is difficult to understand the logic behind the selection of the outputs. The fact that the number of AWPs and the breadth of these have been modified after 2008 seems to acknowledge that confusion. This weakness can be associated or paralleled with the lack of clear articulation between the CPAP (and the products) and the national sectoral and sub-sectoral policy and strategic frameworks.

Summary of findings:

The SRH component is very much aligned with the ICPD agenda as well as with national policy frameworks in health and more particularly SRH. It recognizes the weaknesses affecting SRH coverage, lack of resources, and many other ailments. However, reflecting the very wide scope of action intended by the ICPD, the CPAP attempts to cover a very large array of interventions, sometimes even beyond the UNFPA mandate, thus creating a somewhat confusing framework for action.

4.1.2 Efficiency to date

Evaluation Question 2: How appropriately and adequately are the available resources (funds and staff) used to carry out activities? To what extent were activities managed in a manner to ensure the delivery of high quality outputs?

Whilst the reduction in the number of Annual Work Plans (AWPs) enabled a leaner planning process, there have been varying and significant delays in the signature of AWPs. This has subsequently led to significant delays in the availability of funds and in the initiation of activities to be performed:

- In 2008, the first AWPs were not signed until May that year. The late recruitment of the new Assistant Representative in SRH (April 2008) is partly responsible for this delay.

- In 2009 AWPs were signed in March-April.

- In 2010 AWPs were signed in January-February, marking a clear improvement. However there were significant delays in the availability of funds for the southern and central regions that year.

As a result of delays in planning and availability of funding, especially in 2008 when funds were not disbursed until November, many planned activities were not conducted and had to be postponed until 2010. This was the case for training in facilitating supervision, planned for 30 people (31 were eventually trained but only in the south and central regions and from the Department of Family Health (DSF) of the Ministry of Health), or for the training of traditional midwives (200 planned in 2009 and only 80 actually trained in 2010). In 2010, a six-month delay was also experienced due to the fact that ADB funds to cover activities in the central and south regions were not disbursed until August that year. This was due to a significant lead time at ADB for the approval of the annual activity report by ADB headquarters. As a consequence, funds were not disbursed until September 2010.

The agreement that links the ADB with the government of Cameroon and UNFPA (whereby funds are requested from ADB by the Cameroon government but are disbursed to UNFPA which executes) has taken a considerable period of time to get started. The first agreement, signed for the 2005-2008 period, was not implemented until 2007. An extension to the agreement was signed in 2009 in order to complete execution of that programme. However, due to a slow pace and low rate of execution, further 6-month extensions were subsequently signed, and were still being issued in July 2011.

a) Managerial and logistical issues

Besides these long lead-times, other structural managerial and logistical issues affect efficiency in the programme implementation.

The benefits provided by the distribution of materials and consumables (including preservatives, kits and other materials) are constrained by the weakness of the distribution chain and of inventory management. Accounting systems are either non-existent or insufficient and procurement systems have serious lapses. These are compounded by the existence of a separate management system of FP products at the public procurement agency - CENAME[49] and by serious problems of communication between the CENAME and the CAPR (regional centers for pharmaceutical supply), and, more than often, absence of communication between the latters and health facilities about the availability of pharmaceuticals and other consumables. This leads to frequent and long stock shortages (sometimes for several months) in areas as crucial as HIV/AIDS (tests and ARVs) and FP (condoms and other contraceptives). This also leads to lapses of procurement of FP products at the community level, where community health workers are supposed to be delivering products. As a result, UNFPA has enforced a parallel distribution system for FP products to compensate for the above-mentioned inefficiencies. FP products are now delivered to the regional level by UNFPA itself. This procurement of products and materials, especially in the case of FP products as it is national in scale, should be contributing to the development of the national procurement system. In fact, it is not. This has for consequence an unforeseen increase in the cost of operation of the programme.

The ADB funding, through the PASR project, is relatively complex: funds are donated to the government but sent to UNFPA headquarters in New York, which then send them to the Cameroon country office. The PASR itself suffered from a very slow start (activities that were supposed to start in 2005 did not until 2007) and several extensions were signed. The project has experienced very long administrative and financial delays, as exemplified by the approval of activity reports previously mentioned. AWPs are also signed very late during the year, and are no longer separate but integrated into UNFPA AWPs. Furthermore, the Yaoundé ADB office is not technically equipped with specialized personnel and therefore relies on UNFPA to ensure a good monitoring of the activities.

Overall, for National Execution (NEX) activities, the administrative and financial procedures are very complex and demanding. On the other hand, Direct Execution (DEX) activities, which cover humanitarian responses, are clearly reactive and flexible in their implementation processes, as seen with support provided in the case of cholera epidemics in the northern regions (procurement of obstetrical and dignity kits).

Independent of the UNFPA mandate and capacity, administrative and logistical difficulties and obstacles, such as the need for security clearance and the obligation of using military escorts in the northern regions, further hinders the efficiency of the sub-offices' interventions. In the northern regions, more particularly, the capacity of the Garoua sub-office to organize field visits and conduct supervision has been constrained by these difficulties. This is compounded by the poor state of some of the roads in the area around Garoua and long distances between regional centers and some of the health districts supported by the fifth country programme. As a result, there are relatively few visits to the far north region from the Garoua sub-office.

b) Regional sub-offices and experts

The existence of sub-offices in two of the country's regions (north and east) makes a very positive contribution to the greater efficiency of the programme implementation. UNFPA staff can maintain permanent contact with local authorities and with a variety of actors and stakeholders (including local populations or their representatives). In particular, they help speed up the information flow from the central planning level (the central office of UNFPA and the various Ministries' central offices) to the regional institutional level (the ministries' regional delegations in particular). SRH experts in regional health delegations (in the RDPH of the far north, the east, and the central region) also contribute to a greater efficiency in the flow of information and implementation of

[49] Centre National d'Approvisionnement en Médicaments et Consommables Médicaux Essentiels

activities. In particular, they ensure the continuity of action and the conduct of activities in a manner that takes fully into account the local context. However, there have been delays in activities arising from the provision of copies of the AWPs or information on activities agreed upon between UNFPA and the government. Despite the lack of information provided by the central planning level, the delegations capacity is a key factor affecting the start of activities. The capacity of local authorities to execute activities and manage their own funds has been enhanced by the January 2011 decree that sets in motion the 2005 law of decentralization, which had not been implemented. However, the parallel reduction of decentralized budgets contradicts the intention of the law (30-50% reductions in operational budgets from 2010 to 2011). This seriously impairs, for example, the capacity of decentralized structures to conduct supervision.

Summary of findings:

Due to long administrative lead-times and complex managerial (especially financial) procedures, long delays have affected the efficiency of implementation of the fifth country programme so far. This is compounded by a lack of communication between administrative levels within the Cameroonian state, and by logistical roadblocks. However, UNFPA has been able to overcome some of these obstacles thanks to the creation of its two regional sub-offices in Garoua and Bertoua, together with the presence of experts at the regional level.

4.1.3 Effectiveness to date

Question 3: To what extent were the expected outputs of the CPAP achieved or are likely to be achieved? To what extent were the targeted groups of beneficiaries reached by UNFPA support and are these beneficiaries taking advantage of benefits from the interventions supported? Are there any unplanned positive or negative effects stemming from UNFPA support?

4.1.3.1 Level of achievement by product

Activities conducted with UNFPA funding committed to the area of reproductive health encompass a very broad range of interventions, as reflected in the 2008-2012 CPAP. Over the first four years of the programme implementation, there has been a progressive intensification of activities, especially as regards training and strengthening of capacity at the local level (health providers, community-based health workers) and in the provision of equipment, materials and other goods to health facilities. At the national level, there has been intensification too, especially in relation to the implementation of a sector-wide approach and the building up of partnerships. This materialized through the participation of UNFPA in various working groups and committees on HR-related issues as well as the launch of the Campaign for the Acceleration of the Reduction of Maternal Mortality in Africa (CARMMA) in 2010, an initiative for which UNFPA played a leading role.

The review of the SRH component, similarly to the review of its other components, sticks to the structure of the CPAP. The SRH component is based on three outputs.

OUTPUT 1:

Strengthening of national capacity for the reduction of maternal morbidity and mortality (Capacités nationales renforcées pour la réduction de la morbidité et de la mortalité maternelle).

This area of intervention has seen activities aiming, mostly, at:

a) Developing the knowledge base and knowledge producing capacity in the area of sexual and reproductive health;

b) Increasing the quality and the quantity of SRH care provided, particularly for the management of delivery and of its complications, including the surgical repair of obstetrical fistulae (OF);

c) Building up a wider and stronger institutional community around SRH in Cameroon.

a) Knowledge base and development of national capacities

Increasing knowledge on SRH issues is a key component of the response to SRH challenges. In order to do so, in an area where data are scarce and sometimes unreliable, UNFPA has supported the documentation of the status of the response to SRH challenges in Cameroon. An important survey was conducted in health facilities in 7 of the country's 10 regions in 2010.[50] This survey provides a very valuable and comprehensive picture of the availability and capability of SRH services. In particular, it reveals the severe limitations of the country to meeting SRH needs at the health facility level. Only the far north region had a satisfactory capability, but it has a low density of health facilities.

Activities in this area have also included initiating a survey of SRH indicators in all 26 health districts[51] covered by the programme. However, only 10 have responded; and none from the far north where the regional health Delegation has deemed the survey unfit because of the M&E system already in place and the fact that indicators did not match.

In order to ensure the development of national capacities to perform research and further develop the understanding of the SRH situation in Cameroon using national resources, health cadres from both the central level and from southern and central regions supported by UFNPA through the PASR-ADB programme have been trained in operational research (55 in 2010, 60 in all).[52]

b) Quality and quantity of care and support.

In terms of increased quality and quantity of care and support, UNFPA, which is active in a total of 26 districts and 5 regions, has so far achieved important outputs. These cover increased quality of care provided during pregnancy and delivery, with a particular emphasis on: (i) the prevention of, and care for complications associated with pregnancy and delivery (including surgical repair of Obstetrical Fistulae – OF), and (ii) the development of community-based care and support.

As regards quality of care, work has focused on the provision of training to health workers and on the procurement of equipment, materials and consumables to health facilities in order to enhance their capacity to perform interventions.

Training has been delivered in five main domains:

- Essential Emergency Obstetric and Neonatal Care (EEmONC also known as SONEU in the programme and in the health sector) delivered to a large number of health personnel in 26 health districts of 5 regions where the programme is implemented, as well as to health staff from other health districts, as seen in the far north. Training includes training of trainers (over 40 trainers have benefited from SONU/SONEU training, and over 80 in FP). Over 300 health providers have been trained by these trainers;
- Integrated mother-and-child healthcare (or PCIME);
- Surgical reparation of Obstetrical Fistula;
- Training of traditional midwives (80 in two health districts in 2010: Bafia and Lolodorf[53] - these health districts were covered by ADB funding). Trained midwives have also been equipped with materials, including communication material;
- In order to ensure the continuity of the quality of care, training in facilitating supervision is also being delivered (for 31 health cadres in 2010) – but only as part of the ADB-funded component of the programme covering the central and southern regions. It has also included personnel from the central level (DSF).[54]

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50 République du Cameroun, Ministère de la Santé Publique. *Etude sur la disponibilité, l'utilisation et la qualité des SONU au Cameroun.* 15 janvier 2011.

51 Health Districts of Abong-Mbang, Batouri, Bétaré-Oya, Garoua-Boulai and Kette in the east; Figuil, Golombe, Guider, Pitoa and Lagdo in the north. *Source: 5ème programme de coopération gouvernement-UNFPA. Evaluation des indicateurs clé de la composante de santé de la reproduction.* Youssoufa Soulaymanou. Avril 2011.

52 FNUAP. Activités opérationnelles du projet d'appui au programme de la santé de la reproduction. *Rapport annuel des activités 2010*. Par Dr Essomba.

53 FNUAP. Activités opérationnelles du projet d'appui au programme de la santé de la reproduction. *Rapport annuel des activités 2010*. Par Dr Essomba.

54 République du Cameroun. Ministère de la Santé Publique. Secrétariat Général. Direction de la Santé Familiale. 5ème programme de coopération gouvernement du Cameroun-UNFPA. Composante Santé de la Reproduction. *Rapport annuel d'activités 2010*. Janvier 2011.

Procurement covers:

- equipment and materials for health facilities to increase their referral capabilities (ambulances, motorcycles) as well as their technical capabilities (labor tables, delivery tool boxes, aspirators and suction cups – ventouses);[55]
- family planning products at the national level (preservatives) through CENAME and CAPR;
- key obstetrical products (delivery kits – including C-section kits), which also reach populations affected by humanitarian situations (refugee camps, cholera outbreaks – obstetrical and dignity kits);[56]

Finally, follow-up of training delivered on the surgical repair of OFs and campaigns to detect women suffering from this extremely debilitating condition and to provide them with the intervention were funded by UNFPA in the past 2 years, including the coverage of the financial cost to women for the intervention. Campaigns have provided surgery to about 150 women in total[57] : about 60 in the east in 2009, 90 in the north and far north in 2010, with a success rate of approximately two-thirds. Following the intervention, psycho-social and economic support was provided to affected women.

In addition to these activities, UNFPA also works at developing the capacity of both health personnel and the general population to prevent complications associated with pregnancy and delivery.

c) *Institutional community around SRH in Cameroon.*

The UNFPA country office has been very active in building an institutional community around SRH in Cameroon. In particular, this is illustrated by the launch of the CARMMA[59] (Campaign for the Reduction of Maternal Mortality in Africa), of which UNFPA has been the driving force during the first three and a half years of the fifth country programme. This has confirmed the role of UNFPA as a major national leader

Training to prevent complications associated with pregnancy and delivery

At the healthcare level:

- training of health personnel on "re-centered" prenatal consultation (CPN), FP, and Adolescent Reproductive Health (ARH).

At the general population or community level:

- capacity strengthening of community-based health workers (or assistants). Hundreds of VSBC (Volontaires de Santé à Base Communautaire) from the health districts covered by the programme have been trained in various capacities, particularly as regards sensitization around SRH issues, the distribution of FP products, and the promotion of self-referral to health facilities. In 2009, for example, 220 VSBC were trained in the central and south regions.[58]
- training delivered to youth peer-educators. Subsequently, VSBC and peer-educators organize discussion sessions, or "causeries éducatives", which aim at sensitizing women and men to the prevention of early pregnancy, of risks associated with pregnancy and delivery, and to the need for birth spacing. Those sessions cover other aspects, including gender-related issues. Many more "causeries" have been organized by peer-educators and VSBC in their respective communities, as reported during monitoring visits conducted by UNFPA staff.
- VSBC also deliver FP products and conduct home visits. For example, in 2010, VSBC have performed a total of 10,253 home visits in the south and central regions (where ADB implements the programme), have counseled 2,421 persons, and have performed over 3,000 "causeries éducatives" that have reached an estimated 35,000 people in all (53% of whom were women and 47% men).

[55] For example, 48 have been delivered to health facilities in the south and central regions in 2009 (ADB activity report for 2009).

[56] Besides the pre-positioning of kits through the C2D project (funded by the debt relief provided by France), UNFPA has procured in the order of 1,000 kits for simple deliveries and 165 kits of C-sections.

[57] The figure indicated by UNFPA (*UNFPA Cameroun Magazine, Bulletin d'information n°001, 1er semestre 2010*) is 147 in total. Data collected on the field are: 93 in northern provinces and, 56 to 57 in the east.

[58] Projet d'Appui à la Santé de la Reproduction – PASR/BAD/UNFPA – *Rapport annuel 2010 des activités des VSBC.* Par Ernest D.ESSOMBA (Dr), Gestionnaire-Coordination Projet BAD/ UNFPA.

[59] The CARMMA follows upon the commitment made by African states to tackle maternal mortality both at Maputo (2006) and Addis Ababa (2009). Maputo's action plan aims at reaching "universal and complete access to sexual and reproductive healthcare services in Africa by 2015".

(if not the main leader) in the area of sexual and reproductive health. The CARMMA brings together all major stakeholders. In parallel, UNFPA is also involved in the H4+ group on reproductive and neonatal health, together with UNAIDS, UNICEF, WHO, and the World Bank. UNFPA also participates very actively in the organization and conduct of the Journée Africaine pour la Réduction de la Mortalité Maternelle et Néonatale (JARMMN), which has been taking place every May 8th since 2007. UNFPA is also a member of several committees and working groups around SRH issues.

This active and diverse coordination closely meets the objective set by partners and the government, and subscribed to by UNFPA,[60] of establishing a SWAP mechanism in the health sector. However, it can also be seen as a vertical and somewhat fragmented approach to tackling health issues, in contradiction with the general - "sector-wide" -approach.

With regard to its very (if not too) ambitious and somewhat confusing framework for Output 1 there are a few areas where activities are not conducted or where little is being achieved:

√ death audits are not conducted at the health facility level. This results in a lack of information on causes of death for women (implementing a death audit system and conducting death audits were part of the AWPs as soon as the 2008 ADB AWP);

√ expansion of SRH services in private sector companies: an activity is being conducted with the support of the Garoua sub-office towards SODECOTON and Brasseries du Cameroun; SODECOTON has thus contributed to covering part of the cost of surgical repairs;

√ some of the regulatory or procedural work that was planned in AWPs has not been produced, particularly as regards the elaboration of a local conceptual framework ("cadre conceptuel local") for referral/counter-referral;

OUTPUT 2:

Strengthening the capacity of providers to promote behavior change in SRH

Part of this output is actually addressed through activities already conducted as part of Output 1 (work done with VSBC and peer-educators), with community-based activities allowing for knowledge building and the promotion of behavior change through communication and information (BCC). As part of this output, the CO has conducted activities aiming at promoting ARH services. At the community level, peer-educators have been trained to promote behavior change among the youth: approximately 200 have been sensitized and trained on SRH and FP topics (30 in 2008, 90 in 2009 and 80 in 2010).

As regards HIV/AIDS, which is also incorporated into BCC activities, Voluntary Counseling and Testing (VCT) is now systematically available in health facilities where "re-centered" CPN is in place. According to our informants, VCT services are being increasingly used by the targeted population (both women and the youth).

OUTPUT 3:

Capacités renforcées de gestion du système de santé; réponse aux situations de crise (Capacity to manage the healthcare system is developed; response to humanitarian crises).

This output gathers a wide variety of areas of intervention. It is not very clear how they relate to each other. These have, mainly, focuses on:

a) Capacity development at the central and peripheral levels, particular in the area of Monitoring and Evaluation (M&E) and of normative and procedural frameworks;

b) Improving affordability of access to SRH services;

c) Contingency plan.

[60] See for example: République du Cameroun. Ministère de la Santé Publique. Secrétariat Général. Direction de la Santé Familiale. 5ème programme de coopération gouvernement du Cameroun-UNFPA. Composante Santé de la Reproduction. *Rapport annuel d'activités 2010*. Janvier 2011.

a) Institutional support and development

Institutional support is being provided by UNFPA to develop capacity at both the central and the peripheral levels. At the central level (DSF), an SRH expert has been made available, focusing particularly on M&E. At the regional delegations' (RDPH) level, permanent technical assistance is also provided as well as through the recruitment of external consultants who support the development of national policies, strategies and implementation guidelines. Support has also been provided at the health district level for the development of operational planning capacity. District Health Plans (PDSD) have been developed with UNFPA support; however, in most cases, they have not been operationalized.

Monitoring & Evaluation (M&E) and supervision of SRH-related activities have taken place at the health district, health facility and community levels. They were led both by the central and sub-offices levels. There has been a significant effort to develop M&E capabilities on SRH information and indicators by the central staff and experts of UNFPA, placed at the DSF and the sub-offices. However, for various reasons, many of which are beyond the control of UNFPA (such as the death of the former head of the "Cellule du SNIS" at the MINSANTE and the lack of visibility of that sub-department) no significant results have been achieved in that area. Consequently, the overall capacity in SRH M&E in the healthcare system remains low.

As a complement to institutional development, UNFPA supports the development and updating of normative and strategic SRH frameworks. More specifically, it has provided support to the development of a national policy on SRH (PNSR) and of the "feuille de route" (roadmap). New norms, procedures and techniques have also been introduced at the practical level via incorporation in training modules, for example GATPA (active management of third stage of labour) and the use of Partogrammes.

b) Affordability of services

With regard to this output, UNFPA provides strategic and creative thinking in its support to local health authorities (mainly through its SRH national experts located in regions and its sub-offices) for the design of gynecological "forfaits" (flat-rate packages of services). This generates demand for care, as opposed to performance-based financing or results-based financing, which incentivizes the development of supply. For example, gynecological "forfaits" (which have a fixed price that includes a variable number of services) for pre/antenatal care have been implemented in the east (Bétare Oya), where women are required to pay 3,500 FCFA for four antenatal visits, including laboratory exams and one insecticide impregnated bednet, and 3,000 FCFA for a simple delivery. If all four visits are not completed, the cost of delivery is raised to 3,500 FCFA. Another scheme for Cesarean Sections (C-sections) at the Bétare Oya district hospital (where a convention has been signed with the municipal authorities) helps share the cost through a 25 FCFA levy on each medical visit. This covers 20% of the total cost of 92,000 FCFA for a C-section, with another 20% covered by the municipality, and women pay 35%, i.e., 32,000 FCFA.

The implementation of pre-positioned obstetrical kits (which started in June 2011) in all three northern regions (north, far north, Adamoua) is another example of creative service delivery and funding mechanisms. UNFPA has contributed to the design and the implementation of the system in the northern regions which comprises simple delivery and C-section kits. This is funded by the C2D (HIPC initiative managed by the AFD). Women pay the cost of the delivery (6,000 F for a simple one, 45,000 for a C-section) but further cost-sharing or micro-insurance mechanisms have not yet been envisaged.

c) Contingency plan

Though it is not very clear how these activities relate to the overall Output 3, UNFPA has implemented activities for the development of a contingency plan that includes SRH. In particular, it has sponsored an important situation analysis of Gender-Based Violence

(GBV) in Cameroon (2010),[61] and the development by the Ministry of Women's Empowerment and the Family (MINPROFF) of a harmonized referral system. It has also supported the creation of a National Center for Women in Danger (*Centre National d'Accueil de la Femme en Détresse*) in Yaoundé II. However, that center has not been able to use the equipment and materials procured by UNFPA in August 2009 since the building does not meet the safety norms. The Center is a national referral center that provides psycho-social support, training for income-generating activities (IGA), with 300 women currently being trained, and sensitization sessions on SRH/FP. IGAs have been initially supported by a national fund financed by HIPC to provide micro-credit to women which is common to all CPFF.

It should be noted that although these activities include aspects that are related to RH, they would be more appropriate as part of the gender component of the programme.

4.1.3.2 Effects at the level of the focus area

This section analyses the effects of the activities performed in the SRH focus area on a number of indicators and variables that affect the status of RH (quality and quantity of care and support). The depth and breadth of effects are also examined, particularly the outreach to the poorest sections of the Cameroonian population.

a) Health indicators

It is difficult to conclude on the effects of UNFPA-sponsored activities in SRH in terms of health indicators. Data collected in the field points to a general improvement in the quality of services provided to pregnant and delivering women due to the implementation of the country programme activities. UNFPA's intervention has also allowed the development of adolescent-specific SRH (ARH) services that were previously non-existent. The number of visits to ARH increases rapidly, as documented in the east despite the persistent lack of dedicated space for the confidential treatment of adolescents in health facilities. One of the reasons mentioned by informants for the increasing interest of adolescents for SRH services lies in the communication and encouragement between peers to attend health facilities. This clearly justifies the training of peer-educators.

b) Qualitative effects

Training in SONEU and FP, as well as the procurement of materials and equipment in health districts that receive support, has allowed the development of personnel skills, which was confirmed by staff interviewed in all health facilities visited.[62] Risks and complications at birth have decreased as a result of this intervention and their treatment and management have improved thanks to a better quality of attention and care, due to the following:

- "re-centered" CPN where more potential complications can be detected early, to the care provided at delivery and at the post-partum stage;
- the elimination of bad practices (such as the prohibition to feed and hydrate during labor);
- the improvement in the use of techniques and procedures (such as the correct use of Oxytocin);[63]
- the introduction of new techniques (such as GATPA, delivery planning, partograms, AMIU, etc.);
- the procurement of equipment and materials that were either lacking (suction devices, kits), or were not available in sufficient quantity and quality (labor tables, delivery tool kits);
- and a more welcoming environment for patients at health centers.

c) Quantitative effects

Some quantitative effects can already be documented, as identified through interviews with staff and review

[61] République du Cameroun, Ministère de la Promotion de la Femme et de la Famille. *Etat de lieux des violences basées sur le genre au Cameroun.* UNFPA. Décembre 2010.

[62] In the north: SRH of Garoua, DH of Lagdo, CSI of Djippordé; in the far north: SRH of Maroua, district hospital of Mokolo; in the east: SRH of Bertoua, CSI of Mokolo I (Bertoua), CSI of Bazzama, faith-based health center (CSI) of Nkol-Bikon (Bertoua), district hospital of Betaré Oya, district hospital of Abong-Mbang.

[63] Hormone that favors uterus contraction but the use of which should be avoided during labor because it can provoke tearing.

of registries of health facilities. For example, there has been a very significant increase in the number of attended births at health facilities in districts supported by UNFPA: a doubling between 2009 and 2010, with a slightly lower increase in 2011. Health staff attribute this, to the improved care provided to pregnant women and better management of delivery, which, in turn, becomes known through their communities. Concurrently, there has been a decrease in the number of C-Sections taking place in some district hospitals, which is interpreted by interviewees as a sign of better care being provided at the CSI level in case of complicated deliveries. In any event, these trends and their causes will have to be more thoroughly monitored and analyzed. With the help of the hundreds of trained community volunteers, thousands and even tens of thousands of community members are being reached, through home visits, "causeries" and counseling sessions, as reported by supervision visits performed by UNFPA staff[64] and by the programme activity reports.[65] Approximately 200 youth peer-educators have been sensitized and trained on SRH and FP topics (30 in 2008, 90 in 2009 and 80 in 2010). Materials and sessions are adapted to their specific age range and seem appropriate.

Overall, through their activities and interaction with the population, these persons contribute to sensitizing families and the youth to the benefits of SRH services, including CPN and assisted delivery, family planning (including through the distribution of preservatives – male condoms essentially) and the importance of HIV testing and counseling (for example peer-educators motivate their school-mates and the youth in their neighborhoods to get tested and attend ARH services, with apparent positive effects).

However, there is a lack of studies that could clarify which variables affect demand and supply of health services in Cameroon, and how, especially as regards the effect of health volunteers (VSBC) on referral. Information gathered during field work does not substantiate a major role or effect of VSBC on practices. The VSBC do distribute condoms, as measured by annual reports. However, it is not clear whether their role also helps to increase attendance at CPN and at health centers or hospitals maternity wards for delivery. In fact, as far as SRH is concerned, the incentive for community volunteers to encourage the population to self-refer, women in particular, is limited since financial incentives are non-existent or insufficient. This is different from what seems to be happening with community health workers used by other programmes (also known as "Délégués de Santé Villageois" – or "village health delegates"), such as EPI, onchocercosis (river blindness) and HIV/AIDS. The drop-out rate for VSBC is approximately 15%, annually,[66] which is a significant concern when compared to the rates in other programmes, and is high enough to point to a certain lack of motivation, which VSBC themselves acknowledge. However, this analysis is still speculative and would require a more thorough enquiry at the community level. Some monitoring visits conducted by UNFPA personnel do provide some indication but are not sufficient for a thorough understanding of the effects of volunteers and peer-educators on key SRH and FP indicators (including service utilization rates and the rate of contraception prevalence).

Furthermore, the lack of supervision of VSBC's activities, as mentioned by reports reviewed for this analysis and highlighted by some of the VSBC visited by UNFPA staff,[67] limits the capacity to grasp the magnitude of the actual effects of their activities. It also limits the capacity of the programme to draw lessons from its implementation and to make corrections if needed. This remark also applies to activities performed by peer-educators and health staff who have benefited from training, and is confirmed by the evaluators' visit in the field.

[64] Ibid.

[65] For example, in 2010, VSBC have performed a total of 10,253 home visits in the southern and central regions (where ADB implements the programme), have counseled 2,421 persons, and have performed over 3,000 "*causeries éducatives*" that have reached an estimated 35,000 people in all (53% of whom were women and 47% men). The proportion of the population that is reached out by these activities is approximately 40% of the *Aire de Santé* (a sub-division of the health district) where they are implemented.

[66] This estimate stems from the field visits (10% was mentioned to the evaluation team by informants) and from an ADB report on the implementation of the VSBC component in the central and southern regions which indicates a loss ratio of 13%. Informants have also mentioned higher estimates (of up to 20% in the central region).

[67] For example in a visit at Ngog Mapubi (central region) in December 2009.

d) Effect on affordability of services to patients and their families

Despite its stated alignment with the PRSP and UNDAF agendas, there can be serious doubts as whether activities and interventions sponsored by UNFPA reach out to women and girls from poor households, with the relative exception of the repair of obstetrical fistulae. Indeed, families in targeted districts still have to pay for the services (about 1,000 FCFA for a prenatal care visit for example). The cost of interventions varies significantly from one health facility to another, with prices indicated to the evaluation team ranging from 3,000 to 6,000 FCFA for a simple delivery (as reported by informants)[68] to the 60,000-90,000 range for C-sections. Furthermore, these reported amounts are not necessarily what women and families actually pay (some informants reported a doubling of costs).[69] There are also other costs, as mentioned by some of the health staff interviewed, sometimes very candidly, which include laboratory tests, medication, and other consumables. As a consequence of this, and other factors including the condition of premises, many women do not stay after delivery and typically leave the facility after 3-6 hours for a normal birth, according to our enquiries. The fact that the actual cost of delivery or of any single intervention at the health facility level is not known is a common issue in the healthcare system in general (in Cameroon and in many other countries). This explains, in part, why the amount charged ranges from one health district to another and why the type of interventions charged also vary.

Overall, the cost to patients remains high, and is particularly difficult to meet for people living in rural areas where most households live on subsistence farming and have very little extra money available. Moreover, it is known that health is not a top priority when it comes to spending, especially when it comes to prevention of risks and preparation for delivery. In addition to the previously mentioned costs, there is also an additional cost of transportation, which in most cases is borne by families, and may easily range from 3,000 to 10,000 FCFA.[70]

The institution of cost-sharing systems does not solve the problem of the financial inaccessibility of services for the vast majority of the poor, with the exception of some compensating mechanisms that have been put in place on an ad hoc basis (in the absence of an explicitly stated policy). For example, a varying proportion of delivery kits are being used for women who are unable to pay. This is left to the appreciation of the staff in each health facility. These systems help to improve the availability of SRH products and services, as demonstrated in the past with the delivery kits provided by the "PASSAGE" project sponsored by the IRD (85% cost recovery rate). However paying for services at the full rate remains out of reach for a good proportion of the population and explains the low rate of births attended by skilled personnel in those regions and districts.

It is important to note that health personnel report concerns about the implementation of the pre-positioned kit system, in particular the potential loss of income. Out of the cost for a simple delivery (6,000 FCFA), 2,000 FCFA is meant to be shared as compensation amongst the health team involved. In the case of a C-section that amount is 8,500 FCFA out of a total cost of 40,000. This, apparently, is significantly less than the fees health facility staff usually earn from these services.

Information gathered on the field indicates that:

1. Health staff will not be able to purchase consumables on the parallel market for re-sale to patients as is recurrent practice for deliveries – this in itself is a positive effect, in principle, of the delivery kit system;

2. It is apparent that a number of procedures, which are not always necessary, are systematically added to the care delivered (such as antibiotics and analgesics given at the post-partum stage) in order to generate further revenue;

3. There was anecdotal evidence that care provided in case of complications is charged as an additional cost, even when it is normally included in the kit's cost.

[68] Studies conducted as part of the preparation of the pre-positioning of obstetrical kits since June 2011 in the northern regions with C2D support, show that the actual cost of a simple delivery stands around 12-15,000 FCFA.

[69] We also know (*2ème enquête sur le suivi des dépenses publiques et le niveau de satisfaction des bénéficiaires dans les secteurs de l'éducation et de la santé au Cameroun. Volet Santé. Décembre 2010*) that price lists are usually not displayed in health facilities or not conspicuously, and that prices vary between health facilities and between health personnel, which is contrary to legal dispositions.

[70] UNFPA. Visite de supervision des VSBC (à Akonolinga). Dr Ernest Essomba; Ngo Itima. 6.08.2010.

Health personnel interviewed interpret that the cost of the intervention corresponds to the cost of the delivery itself ("l'acte"). Other interventions remain separated and at the woman's or families' expense. The only significant difference for women with the cost recovery system, therefore, resides in the fact that the amount asked for the delivery intervention itself can be paid later and in installments, while it is "normally" charged in advance in the absence of the pre-positioned kit system. This is a significant difference since it removes an obvious access barrier to the services. Another important difference, for health staff, with the proposed pre-positioning system is that incentives (or part of the costs) are not paid to health staff until the full cost has been recovered. However, in the first weeks of the system's implementation, the cost recovery rate was 98.7%.

The same remark can, to some extent, be applied to the obstetrical fistulae repair campaigns, although it may appear at contradicting conventional wisdom. A young lady, whose fistula was repaired in Bertoua during the 2009 campaign, revealed to the evaluators that she was charged 15,000 FCFA for a variety of side services. While this is a reasonably small amount compared to the actual estimated cost of the surgical intervention (approximately 200,000 FCFA), 15,000 FCFA still is a very large sum of money for the vast majority of Cameroonian households. This is especially true for fistulae patients who are often marginalized and rejected by their relatives, hence facing dire financial, economic and social situations. There is evidence that campaigns for the surgical repair of OF have a limited scope in terms of coverage. In Maroua, for example, only 50 women benefited from the intervention in 2010, out of almost 200 women who showed up for service at the regional hospital.

This raises the issue of resource allocation in healthcare. For example in Cameroon, dialysis is heavily subsidized but affects mainly those with kidney failure or the elderly. The question of what is more cost-beneficial and cost-effective to society and to individuals and their families in economic terms is generally not addressed by the programme itself or by health strategies in Cameroon. However, allocating resources to fistula repair encompasses the social issues that affect women with fistulae, who bear a huge psycho-social cost. It could be argued that OF repair would be a good cause for the State, communities and their partners to come together on a larger scale to tackle the problem and reduce the prevalence. It is known that only a small fraction of women with OF are identified by detection and surgical campaigns. UNFPA activities alone are not sufficient to address the magnitude of the issue (although the CO works actively on preventing the incidence of new cases), unless it makes it an absolute priority. An advocacy and social mobilization campaign, coupled with political commitments and financial support (from both public and private sources) is needed.

The question of healthcare financing is central to consolidating what has already been capitalized in SRH and beyond, for the sustainability of the healthcare system and the improvement of population's health. Policies implemented or designed in Cameroon (cost recovery, community-based insurance, cost-sharing), either at the level of the general health services or at the more specific level of SRH ("forfaits", pre-positioning), only provide partial responses that do not meet the needs of all. The State tries to remediate this situation through the expansion of medical insurance on a national scale. In particular, it has created a national social insurance policy, which envisions the creation of one community-based insurance scheme for each of the 178 health districts in the country. However, this policy has yet to be adopted as is the case for many other reforms and laws for which final approval or implementation decrees are still pending. However, many schemes have been started, with support from donors (ADB, GTZ), but they experience high failure rates. This is particularly due to the lack of continuity in the support provided to these schemes after initiation and because many of them are created for the prime economic benefit of a handful of investors with visions of short-term economic return.[71]

Finally, as regards the procurement of FP products by the country, although UNFPA actions have allowed the procurement of goods at the national level, there are still significant shortcomings in the provision

[71] As exemplified by community health insurance schemes created, respectively, with the support of the ADB (one of the four components of its PASR project – of which UNFPA's support to the southern and central regions is part), of the GTZ (now GIZ).

of these goods at the facility and community levels. Shortages are still experienced by health facilities. This certainly constrains the effects on family planning, although it is not possible to measure them precisely. Moreover, it is a little disconcerting that UNFPA remains its main source, despite the fact that FP and SRH are major and well-known demographic and health concerns in Cameroon, and despite the fact that they feature prominently in the national development and sectoral strategic documents.

Summary of findings:

The SRH component is a very broad and ambitious area of intervention organized in three major outputs, covering a very large number of strategies and activities. This makes for a rather confusing framework of intervention.

There are indications of better quality of service but it is not clear to which extent.

4.1.4 Sustainability

Evaluation Question 4: To what extent are the benefits likely to continue beyond program termination? Has UNFPA been able to support its partners and the beneficiaries in developing capacities, mechanisms to ensure the durability of effects? Were the activities, designed in a manner that ensured a reasonable hand over to local partners?

4.1.4.1 Obstacles to the sustainability of effects

The increase in the volume of activity in the area of SRH in HDs that benefit from the UNFPA support points to the greater capacity developed for care and support of pregnant and delivering women. However, there are several factors that could jeopardize this achievement and its sustainability and could lead to a reduction in the number of visits to health facilities.

Among the most important factors are:

a) Monitoring of the SRH health facilities work

Visits of health facilities have revealed the absence of “facilitating supervision”. Abong Mbang appeared as an exception with the head of the district hospital and the health district chief medical officer being involved in regular (monthly) monitoring visits to health centers, with an emphasis on SRH and FP. However, there are indications that supervisions take place as indicated by the 2010 survey of budgetary execution in health .[72] The enquiry indicates that integrated health centers (CSI) and medical center districts (CMA) surveyed (for a total of 138 health facilities spread throughout the national territory)[73] have respectively benefited from 5 and 6 monitoring visits (on average) in 2009. The average for DHs was 3. However, these visits, according to our informants, are not sufficient or centered enough on SRH/FP issues. Moreover, there are significant disparities in how and where they are conducted: 1/5th of CSI/CMA have not received any visit in 2009. Most Health districts that were visited by the evaluation team (mostly in rural areas) did not benefit from supervisory activities. This is particularly unfortunate since, according to interviewees, visits performed have positive effects as they help limit the referral of patients to the higher level of the health system pyramid.

b) Operational planning

The absence of an effective operational planning at the health district and health facility levels, despite UNFPA support in that sector, is one of the obstacles to the effective implementation of supervision. Although UNFPA provides support to the development of health planning at the district level (PDSD), documents are generally not practical, not realistic from a budgetary point of view nor are they operationalized (absence of AWPs or AWPs not implemented). As a consequence informants state that those documents are not utilized in their daily work. This is detrimental to the effective planning of supervisory activities, both from the regional and the district levels.

The lack of transportation and long distances are other obstacles. In the east, one health area (“Aire de Santé” of

[72] République du Cameroun. Institut National de la Statistique. *2ème enquête sur le suivi des dépenses publiques et le niveau de satisfaction des bénéficiaires dans les secteurs de l’éducation et de la santé au Cameroun. Rapport principal. Volet Santé.* Décembre 2010. (PETS 2).

[73] The survey has covered a total of 176 health facilities, of which 38 DH, 30 CMA et 108 CSI.

Bitom) of the Betaré Oya health district is 320 km away from the district hospital.

The lack of financial and human resources (and of qualified resources) remains, however, the most important limiting factor for the implementation of an effective monitoring.

It is common that only 3 to 4 deliveries are performed each month in CSI. With volumes so low, it is difficult to maintain the level of expertise and quality of services that is needed. The danger here is that staff revert to harmful practices and that more referrals will be conducted, rendering it difficult for families to pay, and leading to a deterioration in their confidence in the quality of care. Referral of cases that should have been taken care of at another level of the health pyramid can already be seen in the far north, although this region has been identified as the best at delivering SONU according to the study conducted in 2010.

A similar analysis can be applied to the surgical repair of OFs. Skills have been developed thanks to training provided with the support of UNFPA, and practice has developed due to repair campaigns (partly led by personnel from Yaoundé). However, only a handful of cases have been handled between campaigns. The last campaign supported by UNFPA took place in 2010. Another campaign was organized in October 2010, with funding from WAHA, in the far north (33 beneficiaries). It has helped to sustain the effort, yet it is not sufficient either to maintain a high level of quality of service or to make a significant impact on the problems created by OFs.

c) Referral/counter-referral

The lack of capacity for referral limits the consolidation or capitalization of the learning curve. It is also a serious handicap when it comes to implementing cost-sharing or health insurance schemes. In the gynecological/obstetrical area, these should include transportation and care provided at all levels of the health system. According to a recent survey, only one district hospital (out of 5) has a working ambulance.[74] This proportion is only 1 in 10 in the rural areas since they usually have far fewer resources than health facilities in urban areas. Budgetary execution ratios, which are generally weak as already commented upon, are even lower there.

d) Health personnel

In most health centers (CSI, CMA) in rural areas, there are only 1 to 3 professionals working, with a few volunteers (whom are no longer allowed following a recent MINSANTE directive). In health districts, only one medical doctor is the norm. In the east, there is only one qualified gynecologist for a population of about 1 million. The majority of positions needed to manage the MPA are therefore not covered. Moreover, a high turn-over of staff reduces the capacity of health facilities that have benefited from training to capitalize on their newly acquired competencies. Other factors that limit the capacity to sustain achievements include:

- the lack of laboratory capabilities, especially for prenatal care;
- the decrepit condition of health facilities, the lack of running water and of electricity,[75] low levels of maintenance (which leads to the deterioration of materials and equipment such as sterilizers, aspirators, surgery lamps)[76];
- the weak management of inventories, stock shortages for a variety of key pharmaceutical products as well as for preservatives,[77] and the severe lack of certain materials (suction devices, aspirators).

An important condition for the sustainability of results achieved in the SRH area lies in raising the budgets for salaries and operational funding in maternity wards, as a complement to the effort made on training, which is

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[74] Ibid.

[75] Ibid. The inquiry notes that only two health facilities out of ten have access to water in rural areas (pipes, well, river and other means), while it is seven out of ten in urban areas. In the Lagdo health district (north), which was visited by the evaluation team, only two health facilities out of 13 have access to water and electricity.

[76] As noted the 2nd survey of public expenditures and the satisfaction level of beneficiaries in the health sector in Cameroon (December 2010), power outages damage equipment, while capacities and resources for their maintenance are very limited.

[77] This confirms findings made by the survey on RH indicators (5ème programme de coopération gouvernement-UNFPA. *Evaluation des indicateurs clé de la composante de santé de la reproduction*. Youssoufa Soulaymanou. Avril 2011).

an investment. In reality, health budgets are shrinking. The government allocation to the Ministry of health (MINSANTE) in the national budget has shrunk by 20%, from 120 to 100 billion FCFA, between 2010 and 2011. The increase in total health budget (from 120 to 150 billion, or a 25% increase for the same period) is due to a higher commitment from donors. However, technical and Financial Partners (TFPs), which account for one third of the total budget, generally put emphasis on investments (including capacity development), not on operational financing (salaries, consumables, maintenance and other operations), to the notable exception of UNFPA, which funds the procurement of FP products. Beyond the actual reduction in budgetary appropriation, it is important to note the fairly low level of budget execution rates over the years, despite an increase (from 60% to 78%) between 2005 and 2009.[78]

Similar points to those discussed above regarding the sustainability of actions had been raised by the evaluation of the fourth country programme (2003-2007): absence of supervision, insufficient funding from the State (lack of commitment of financial contributions to the programme), general lack of human resources (there is currently only one medical doctor in Lagdo, north region, a health district with 142,000 inhabitants), and shortage of materials and consumables. Despite UNFPA support, progress has been limited in those areas. It is true that, these aspects mainly depend on the government's action, which remains inadequate.

The fact that some health personnel are not inclined to implement the payment schemes or gynecological or obstetrical "forfaits" (flat-rate packages) due to the potential loss of income is yet another obstacle to the sustainability of preliminary effects identified by the evaluators. This is particularly the case with personnel recruited on HIPC funding. Indeed, the personnel interviewed had not been paid for the last two years and were thus facing a very difficult situation. They are left with very few options: (i) leave the public health sector altogether and establish private practices (for the best qualified), (ii) establish private practice alongside their work in public facilities, or (iii) remain in the public sector where equipment and materials are paid for by donors and get financial compensation from patients. This last point, which is a critical issue, is actually not limited to personnel contracted on HIPC funding. It is a general fact and one of the most severe limitations to the implementation of policies that aim at removing financial barriers preventing accessibility to health services.

e) Exit strategy

There is no clear indication of strategic thinking and planning being conducted in order to ascertain that some of the strategies funded and implemented by UNFPA will be transferred to the government entirely and in a timely manner. This is, for example, the case for the procurement of family planning products. UNFPA is the main source of funding and is also, currently, the main distribution channel for these critical inputs. But this is not a sustainable approach and should be a clear mandate of the government. Advocacy for the allocation of more funds and resources to the health sector in general, and to SRH in particular, can be associated with an "exit strategy" that would aim at phasing out support in certain areas, be they strategic or not, and help concentrate the support of UNFPA where capacity is still insufficient. The case can also be made for technical assistance provided at various levels of the health system.

Support provided by UNFPA for the creation of eight midwifery schools should, theoretically, contribute to bridging the gap in human resources. However, despite DSF indicating that in 2011, 1.5 billion FCFA were made available to regions for supervision and training activities, past experience leads to a low level of expectations for capacity development outcomes.

The duration of training sessions is more of a concern than their content or their organization. Duration seems insufficient when considering the objectives, the breadth of concepts, procedures and techniques taught. An earlier SONU training session took up to 3 months, but was then reduced to 21 days, then to 11 days, which now seems to be the normal duration for trainings. While the cost of training is an important factor to consider when designing and conducting training sessions, it is also a problem to remove health staff from

[78] République du Cameroun. Institut National de la Statistique. *2ème enquête sur le suivi des dépenses publiques et le niveau de satisfaction des bénéficiaires dans les secteurs de l'éducation et de la santé au Cameroun. Rapport principal. Volet Santé*. Décembre 2010. (PETS 2).

their work for long periods of time when they are in very short supply, particularly in rural areas.

In Cameroon, it is clear that UNFPA has become a leader in the SRH area. Several informants have stated that the agency has "planted the seeds of SRH in Cameroon", but they also stressed the fact that, at times, "replaced the State". Some estimate that UNFPA accounts for 80% of the DSF's activities. This is a concern given the high cost paid by society for poor maternal and child health and the deterioration of indicators over the past 20 years. This also reflects the fact that resources allocated to health-care are insufficient and do not match the government's commitments (15% of total expenditures as decided by African states in Abuja in 2001). Total health appropriation nears 7-8% of the government's budget of which only 6% go to the MINSANTE. The question of the financial commitment of the Cameroonian State, from its own resources, to the operational funding of health infrastructures and public health activities therefore remains unresolved. This is also reflected in the lack or very low level of the State's financial contribution to donors' programmes (including the contribution of UNFPA), the fact that key activities (such as contraceptives) are paid for by donors, and are a major handicap in the long-term sustainability and appropriation of activities funded or sponsored by UNFPA.

Summary of findings:

The sustainability of the benefits already reached is doubtful, in part because of the very low level of financial commitment of the Government of Cameroon to reproductive health interventions and management in general, and in part because not all actions undertaken by the fifth country programme would be picked up without further support from UNFPA and other donors. Developing capacity, through training for example, is, theoretically, a long-term investment. However, the lack of resources (human, material and financial alike) at the primary and secondary care level, , limits the capacity of the healthcare system to absorb and sustain a higher volume of care. On the other hand, that volume is still too low for health facilities and personnel to be able to maintain in the long run the level of competence acquired through support from UNFPA. The dependency of the Cameroonian healthcare system on foreign aid, which is limited and potentially further constrained by budgetary restrictions, does not bode well for the future.

4.2 Population and development

Question 5: To what extent is UNFPA support to Cameroon aligned to the objectives in the Growth and Employment Strategy Paper 2010-20 (DSCE) and "Vision – 2035" and responding to the national priorities? Is the design of the strategy appropriate vis-à-vis the needs as expressed in the DSCE and "Vision 2035" documents?

4.2.1 Relevance

The Population and Development (P&D) component has been designed in close and continuous consultation with the Cameroonian authorities in a participatory process that has combined demand-driven initiatives with UNFPA proposals. The careful and respectful implementation of this mutual consultation approach has ensured a very satisfactory level of alignment that is reflected both in the discourse of Government officials and in the content of the key strategic documents of the country (e.g. initially the Strategic Document for Poverty Reduction (DSRP) and then the, known as DSCE, and Vision 2035, details below).

An exception to the good functioning of mutual consultative processes needs to be mentioned. At the start of the programme cycle UNFPA and the Government encountered important problems in their capacity to communicate and consult with each other, severely hampering programme implementation in 2008.

The strategic integration of P&D issues into policy, and the main subcomponents are highly relevant to Cameroon:

- the census is essential for an overview of key data needed for policy planning;
- the support to a better coordination of the statistics system in the country is crucial for reliable statistics; and
- the support to the administrative statistical sources is fundamental to ensure the regular provision of basic statistics.

The situation was resolved with the arrival of the new UNFPA representative who actively worked to build trust and reinforce the consultation process. This timely reaction enabled the programme to resume its execution in a climate of consensus and the overall relevance of the programme was maintained throughout.

From the citizens' point of view, the relevance of the programme should be assessed at the macro-policy level, i.e., the quality of services available to citizens as final beneficiaries. The relevance of the programme stems from the advantages it offers through the evidence-based planning of policies to enable a good service to citizens, given the insufficient integration of P&D issues in government policies and the weakness of data collection and analysis systems in Cameroon.

Reflecting on the relevance of the strategy in the framework of national needs vs. sub-national needs at regional or municipal level, the evaluation team considers that, given the baseline at the moment of programme design, the decision to concentrate efforts at central level was reasonable in a framework of limited resources.

Summary of findings:

The UNFPA support has been highly relevant in the framework of Cameroon's strategic policy documents and political discourse. UNFPA has granted careful attention to dialogue and consultative processes at the programming phase and throughout implementation. This is a key aspect to ensure continuous relevance. Aside to a short period of time at the beginning of the programme, the flow of communication and trust building actions have developed a sense of partnership that has been instrumental for both the relevance of the programme and the cooperation during implementation. Decentralization poses new challenges to be addressed in the upcoming cycle.

4.2.2. Efficiency to date

Question 6: How appropriately and adequately are the available resources (funds and staff) used to carry out activities? To what extent were activities managed in a manner ensuring the delivery of high quality outputs?

Most of the activities originally planned have been implemented without major delays, with the exception of some subcomponents. For instance, the support to the census was implemented but subject to significant delays; the support to administrative sources was partially executed; the production of thematic studies was not implemented. Additionally, disbursements have been allocated in coherence with strategic priorities and generally in a timely manner.

The AWPs have been embedded in the appropriate institutions, which is a key aspect to enable an efficient implementation of the programme. Undoubtedly, the existence of two separate major institutions with responsibilities on statistics – *Institut National de la Statistique* (INS) and *Bureau Central de Recensement et d'Etude de la population au Cameroun* (BUCREP) - one of which is new, has rendered many processes less efficient and more difficult to coordinate. As this was a sovereign decision of the Government, UNFPA has responded appropriately in terms of AWP partnerships and its support to both INS and BUCREP has mitigated some of the inefficiencies inherent to this institutional arrangement.

Apart from technical considerations, it is worth stressing that in the cultural and professional framework of Cameroon, an inadequate personal relationship with the leadership of a ministry blocks the possibility of any practical result. In this context, the delays prior to the arrival of the new representative deferred the signature of the 2008 AWPs and severely limited implementation in 2008. This has been resolved thanks to the commitment of the new UNFPA representative to rebuild a partnership with key Government personnel. The regaining of this positive environment has been accompanied by a programme execution supported by the technical capacity of the key UNFPA staff in the P&D component.

Overall, the present structure and number of staff of UNFPA in the CO is adequate for work at central level but insufficient if the intention is to work "at all levels" as envisaged in the formulation of objectives in the CPAP. Aside from these general assessments on efficiency, two actions within the programme deserve a special comment: the census and the EDS.

a) The third general population and housing census

A rapid overview of the milestones of the census shows that it was initially intended to start in 1997 (10 years after the previous census). Data collection started in 2005, but little progress was made in 2006 and 2007, mainly due to lack of funds. Data collection resumed in 2008 and the census was finished in 2009. In 2010, partial data were officially published and the analysis of the 14 selected key themes had only started.

It is important to consider some key reasons for the delays in the census. In a context marked by general budgetary cuts and a global economic crisis, the decision to start the census was the expression of a clear political will,[79] yet it was not ascertained by a solid commitment from the different partners. This proved highly inefficient, as the census is very sensitive to timing in terms of credibility loss. The time gap between the data collection and data analysis (as well as the need to repeat the cartography) had negative effects on the perception of the donor community. For this reason, donors did not feel comfortable being involved in a project of such uncertain implementation and timing, which in turn limited the possibilities of obtaining funding and created a vicious circle. Additionally, the fact that the census was delayed has led to other inefficiencies, such as the fact that actors (e.g. line ministries) that needed information have decided to proceed with data collection on their own,[80] thus duplicating functions and resources.

In this extremely difficult context, UNFPA has not only been the single major donor supporting the census but has also helped to mitigate many of the inefficiencies of the process in support of the Government. For example, UNFPA contributed with advocacy initiatives to allow the usage of Heavily Indebted Poor Countries Initiative (HIPC) funds for the census, and was able to provide timely support with logistics[81] or funding at key moments, thus avoiding further delays.

Furthermore, the support of UNFPA in providing technical advice through the provision of criteria for well-informed decisions on the different steps of the census, on their importance and on the consequences of different approaches, is a contribution towards better effectiveness and also helps improve efficiency of the process. The technical advice given by UNFPA has led to a higher efficiency in the usage of resources, e.g., convincing BUCREP that the usage of optical readers was inappropriate due to the conditions of heat and sand in Cameroon is a good illustration.

b) Demographic and health survey IV (DHS/EDS)

The DHS process started with an analysis of needs which was then presented to the donors. This represents a significant departure from, and efficiency improvement as compared to the preparation of the census. In an attempt to capitalize upon synergies, it was planned to combine the DHS with the MICS (by UNICEF) and to have access to the financial contribution of the World Bank and USAID. Unfortunately, this approach proved highly inefficient due to the long process required to agree on a Memorandum of Understanding, particularly on the financial procedures and the requirements to purchase equipment. As a result the equipment was only received in 2010. Consequently, training took place in December 2010 and data collection began in January 2011 (for 6 months, with some areas in the north still to be covered).

Summary of findings:

After the initial blockage in implementation in 2008, the P&D component can be considered efficient as of 2009 onwards for those aspects under the control of UNFPA. Conversely, overall efficiency – that is, the efficiency of implementation taking into account both the efficiency of UNFPA *and* the efficiency of the government- has not been uniform, with elements of both efficiency and inefficiency in each subcomponent.

79 Shown repeatedly by direct declarations and actions even at the level of President of the Republic, or with the visit of the Minister of MINEPAT to UNFPA HQ in New York to ask for extra support, or with the special leave given to teachers to help conduct the survey due to insufficient enumerators.

80 For example, the Ministry of Labour undertook a survey on the informal sector without waiting for census data or coordinating it with INS.

81 UNFPA provided cars for the data collection and equipment for the analysis. The challenge posed by logistics should not be underestimated, for example, as an illustration of this point, what could look as a relatively simple process -bringing the census questionnaires answered in the north back to Yaoundé-, was creating a blockage that needed the intervention of the President to allow the usage of military airplanes to solve the problem.

4.2.3 Effectiveness to date

Question 7: To what extent were the expected outputs of the CPAP achieved or are likely to be achieved? To what extent were the targeted groups of beneficiaries reached by UNFPA support and are these beneficiaries taking advantage of benefits from the supported intervention? Are there any unplanned positive or negative effects stemming from the support of UNFPA?

In order to assess the effectiveness of UNFPA support in the P&D component, a general reference is: (i) outcome 2 of the CPAP: "Population issues are taken into account in poverty reduction strategies and in sectoral policies, plans and programmes at all levels", and (ii) its two ensuing outputs which will be analysed separately.

OUTPUT 1:

The technical and institutional capacity of national counterparts is strengthened to integrate population, reproductive health, gender, culture and human rights issues into development policies, strategies, plans and programmes at all levels.

Ascertaining the level of achievement of output 1 requires the analysis of the following sub-areas.

a) Integration of P&D in the two key national strategic documents

b) Integration of P&D in the political discourse

c) Integration of P&D into sectoral policies and programmes

d) Integration of P&D at all levels: Decentralization

a) Integration of P&D in the two key national strategic documents

UNFPA has been a protagonist in the formulation of the two main documents that serve as a reference for the government action in the coming years: the *Vision 2035* document and the *Growth and Employment Strategy Paper* 2010-2020 (DSCE). Through an iterative consultation process, UNFPA has contributed to improve the strategic nature and quality of both documents, helping in particular the integration of P&D issues. This integration takes place only in general terms and concerns broad strategic intentions that lack much specificity. However, the effectiveness of the support of UNFPA should be assessed taking into consideration the fact that: (i) these documents have a general strategic nature, which justifies the integration of P&D issues only at general level; and above all, (ii) the tone and content of both documents, giving priority to P&D issues and making numerous references to demographic data, are in themselves an achievement. Indeed, previous policy documents were less committed to long-term strategic objectives, and were also marked by a focus on structural adjustment and economic data with a marginal significance of P&D issues. Without the support of UNFPA, the documents would have been of inferior quality and their emphasis on P&D would have been less prominent.

b) Integration of P&D in the political discourse

One of the areas where progress can be measured in comparison with previous cycles is the progressive integration of P&D issues in political discourse. Within MINEPAT this integration has taken place at all levels of the administration, from the Minister[82] or Directors General to the general staff, both at central and regional level. This increased awareness can be attributed to the systematic efforts of UNFPA in engaging with MINEPAT during the past 5 to 6 years. In line ministries, P&D issues are also present at central level, but only superficially. Generally speaking, the decentralized structures of line ministries have not yet incorporated P&D issues in the discourse.

[82] Regular explicit references to P&D issues are made in his public speeches, including the most recent during Population day on 11th July 2011.

c) *Integration of P&D into sectoral policies and programmes.*

Until now, the level of integration of P&D issues in sectoral policies is at best superficial. It lacks an analysis of the links between population data and resulting alternative scenarios. The causes and consequences of planning with or without P&D data at sectoral level is also absent. This superficial coverage of P&D issues occurs in every sector, but can be considered especially regrettable in priority policies such as: the Youth National Policy, Employment Strategy, Energy Strategy, Education Strategy, and Health. In spite of the important implications of demographics for planning, line ministries rarely request in-depth studies from IFORD or other relevant institutions on these links.[83] The guide for integration of P&D issues into policies produced by UNFPA is an important first measure to address this challenge. However, it has not yet been distributed and therefore its value cannot be assessed yet.

At the macro level, the crucial links between demographic growth and economic growth, as well as between risks and opportunities, are not sufficiently understood and exploited. This, in turn, constitutes a fundamental gap for evidence-based policy-making for the government as well as for any agency willing to support development in Cameroon.

The evaluators consider that the CO decision not to prioritize specific thematic studies constitutes a lost opportunity. High quality studies targeted at crucial policies could have indeed constituted tangible models which could have been assessed and replicated in other sectors. The census has confirmed the key importance of two elements in the development process of Cameroon: the significant proportion of young people in the population and the relentless and still uncontrolled process of urbanization. When we assess the youth situation, we observe that it is not only related to a large portion of the problems that the country is facing (e.g., unemployment), but more importantly it contains the potential for their solution. The level of integration of P&D issues in sectoral policies lacks the necessary depth of analysis. Youth, despite being a key priority, is not an exception. Ministries still identify needs based on very partial sources such as youth associations, instead of referring to or obtaining key disaggregated data such as youth unemployment by region and the specific level of education of the unemployed. This not only affects negatively the youth population, but also impedes alignment with the needs of the economy,[84] thus impacting on the whole country.

d) *Integration of P&D at all levels: Decentralization.*

The country programme aimed at P&D integration “at all levels”. However, the level of integration of P&D issues at central level has not yet translated into a change of attitude vis-à-vis planning or acquisition of knowledge at decentralized levels. Awareness of the importance of P&D issues can be observed in the discourse of MINEPAT at decentralized levels (not in other sectoral decentralized services). However, there is very little understanding on the implications for planning or policy making. In addition, the decentralized administration is poorly informed about the data available at the central level. Finally, the lack of data at department, *arrondissement* and commune level has so far made impossible the analyses beyond the level of the region. Also it should be added that the role of INS in the framework of decentralization is still not clear.

OUTPUT 2:

The technical capacity of national counterpart staff in charge of integrated management information systems in the area of population and development is strengthened

Ascertaining the level of achievement of output 2 entails the analysis of a number of sub-areas. The

[83] On a positive note, historically it was possible to find demographers only in MINEPAT, whereas today there are some contracted in the Ministry of Finance. This can be interpreted as a small indication of progress in terms of awareness of the need of demographic data for planning, but it is still very marginal.

[84] An illustrative example is the opportunity missed when the exploitation of petroleum from Chad required the hiring of foreigners in a country devastated by unemployment. An understanding of the level of education of youth and foresight planning could have avoided this situation in many engineering positions.

evaluation team presents an assessment of effectiveness covering the following areas:

a. Support to the strengthening of the government statistical system;

b. Administrative sources: civil registry, health and educational sources; support to the government in the development & implementation of an updated statistical data system;

c. 3rd General Population and Housing Census: support to the implementation, analysis and dissemination;

d. EDS IV (Demographic and Health Survey) and MICS III (Multiple Indicator Cluster Survey): support to their implementation, analysis and dissemination;

e. Support to follow up of International conferences on P&D and annual production of P&D report.

a) Support to the strengthening of the government statistical system

The visa system of INS is a key element for effective harmonization, credibility and comparability of statistics, yet it comes more as a guiding principle than a systematically enforced requirement. The reinforcement of its application has been an important contribution of UNFPA, who has taken advantage of its position and relation with key line ministries such as MINSANTÉ or MINPROFF to create awareness about the significance and importance of the aforementioned visa. Although systematic good practice regarding visa procedures is still a work in progress, the determined stand of UNFPA and its insistence has already proven useful in ensuring the appropriate incorporation of the INS for specific processes (e.g., concerning the emergency obstetric care).

The National Strategy for the Development of Statistics has been successfully drafted, distributed and validated by the different relevant ministries with the support of UNFPA. Once this important step has been taken, the most demanding challenge will be the effective implementation of the strategy.

UNFPA has contributed, when possible, to encourage the coordination of two different institutions, INS and BUCREP. They both have important responsibilities vis-à-vis national statistics, and are separated (yet with overlaps) with two different general directors, two different cultures and two different stages of development (BUCREP is recently created). The actions implemented by UNFPA include the promotion of joint preparation of Population Day, joint training sessions related to the census and REDATAM,[85] joint analysis of some results from the census, and ad hoc secondment of staff from INS to BUCREP for data collection.

DevInfo[86] has become operational in Cameroon with joint support from UNFPA and UNICEF. This collaboration increases the effectiveness, with additional benefits (originally not planned by UNFPA) such as the project to include Cameroon data in the India DevInfo website for world access. Presently INS is migrating data to REDATAM from different surveys, and UNFPA has given additional support to INS for the migration of 1987 census data. Whereas this can be considered an achieved result in the terms of its formulation in the CPAP, it should be noted that the dependency of the INS on data from the line ministries and the difficulties of the latter to provide this data makes REDATAM a constrained source. Other limitations are related to the disorganization of data in numerous cases and the difficulties of retrieval of information in time for the database.

b) Administrative sources: civil registry, health and educational sources; support to the Government in the development and implementation of an updated statistical data system.

The availability and reliability of these sources are important for the statistical system of the country.

[85] REDATAM creates and processes hierarchical databases from censuses, surveys, vital statistics and other sources for local, regional and national analyses.

[86] DevInfo is a database system endorsed by the United Nations Development Group for monitoring human development. It is a tool for organizing, storing and presenting data in a uniform way to facilitate data sharing at the country level across government departments, UN agencies and development partners.

Administrative sources are a regular provision of data much needed for routine planning and studies, while ad hoc surveys do not offer the same frequency and scope. This result was achieved at a much more limited scale than originally planned. In particular, no work was performed on health and educational sources, and the support given within the civil registry sources (mainly marriages, births, deaths) was limited to only capital cities, which affects representativeness.

c) Third general population and housing census: support to the implementation, analysis and dissemination.

Effectiveness of the census requires consideration of four important but somewhat contradictory aspects. The census would not have been possible without UNFPA support and while it is technically acceptable, there is room for improvement. However, there are doubts about the census's credibility in the perception of public and media, and finally the appropriate exploitation and usage of census data is still uncertain.

On the first point, UNFPA has been valued as the only donor fully committed to support the census. It can be safely said that, as widely recognized by the main government partners, without UNFPA support, the census would not have taken place and would have most likely be of lesser quality. Therefore, analysis of its quality, delays, limitations, etc., should include consideration of this general achievement. Some major contributions to enhanced effectiveness of the census were the key support to BUCREP through long-term technical assistance during 2005-2010. Also, the constant personal presence of the UNFPA representative ensured that obstacles to the census were overcome.

On the second point, the positive influence of UNFPA on the design of the questionnaires must be stressed. In a context of a difficult trade-off between the tendency of every ministry to try to include questions addressing information of their interest and, on the other hand, a balanced number of issues to be covered in the questionnaires (which have to be workable), UNFPA has been instrumental on limiting their scope to those aspects most relevant for the country.

Apart from the serious delays mentioned in the efficiency section, the typical technical, logistical and financial limitations that affect any major endeavour in a developing country have also affected the census process. Within these limitations, the census data can be considered of a reasonably good quality: more disaggregated than the previous existing data, more complete, better exploited, offering more opportunities for analysis and, all in all, sufficiently reliable.[87] It presents a level of precision that suffices for planning estimations and policy making purposes.

The third point, in contrast with the reasonable adequacy of the census data from a technical point of view, is the widespread perception among public opinion and journalists that the census data is not reliable.[88] This is linked to the political sensitivity of the census and the ensuing suspicions that were exacerbated by the extended and not satisfactorily explained delays. Furthermore, there also seem to be implausible results, although the data is actually coherent. This perception constitutes a problem in itself, as it casts doubts on the credibility of the census results.

The fourth point, it is still too early to assess the usage of the data. In April 2010, there was a partial publication of results, and some results are still not fully published. No information has been released yet as regards what data will be published, when, with what disaggregation level and through which procedure. This puts in jeopardy the effective and timely usage of data for planning purposes. So far, the demands for information from line ministries are not abundant, which tentatively points to lack of interest or lack of awareness resulting from this lack of effective communication.

[87] Different technical experts from different leading statistics institutions in the country - without vested interests- confirm the technical acceptability of the data, i.e. IFORD, INS and independent experts. It is also illustrative that IFORD has declined its participation in the census in Equatorial Guinea as they considered that the methodology was inadequate and that it could harm the prestige of the institution; in contrast, they have participated in the census in Cameroon wholeheartedly.

[88] See annex 10: note on the journalist's focus group discussion.

d) *EDS IV (Demographic and health survey) and MICS III (Multiple indicator cluster survey): support to their implementation, analysis and dissemination.*

The support of UNFPA has been perceived as crucial by the INS. The technical support provided in areas such as reproductive health has been paramount indeed, addressing a specific gap of INS through utilising the core expertise of UNFPA. Furthermore the leadership in funding and the help with logistics has proven essential for the implementation of the EDS. The analysis of the EDS also remains to be done, which impedes a full assessment of effectiveness at this stage.[89]

e) *Support to follow up of international conferences on P&D and annual production of P&D report.*

UNFPA has supported the Cameroon government following up the ICPD + 15 agenda. UNFPA has produced a report and conveyed information on P&D to the sectoral ministries. This information has been useful to identify shortcomings which were validated by ministries and civil society representatives. The report not only informs about the status of the country against the benchmarks, but it permits the comparison with other countries and the additional psychological motivation of being competitive and to do better. In spite of the intentions of MINEPAT-UNFPA, this exercise has not yet been followed up by commitments towards action plans in the sectoral ministries.

Summary of findings:

Whereas integration of P&D issues is being achieved in MINEPAT at general level, there is no real integration into sectoral planning and policies. Additionally, the integration of P&D issues has not yet reached decentralized levels of government. UNFPA has been a key contributor to obtaining better data in Cameroon. However, the ability to transform data into real information that is usable for planning purposes has not yet been achieved and remains a key challenge to real effectiveness.

4.2.4 Sustainability

Question 8: To what extent are the benefits likely to continue beyond program termination? Has UNFPA been able to support its partners and the beneficiaries in developing capacities, mechanisms to ensure the durability of effects? Were the activities, outputs designed taking into account a reasonable hand over to local partners?

The main positive factors regarding sustainability of UNFPA support have been the careful mutual consultation approach that has taken place during the programming phase. The proximity and responsiveness of UNFPA to government demands have secured a high level of ownership.

Another important positive element is the continuous support to key actors such as MINEPAT or INS that allows long-term strategies across successive programming cycles as well as the provision of a critical mass of services. In this regard, it is worth mentioning the opportunity created by the establishment of the BUCREP. Cameroon has an institution fully dedicated to the census, as opposed to an ad hoc one, which allows for greater sustainability of the investments in training, equipment, etc.. It also ensures a better usage of already acquired assets for the census.[90]

Also contributing to an enhanced sustainability is the gradual increase of attention given to the P&D component within UNFPA (in relation with previous cycles and in comparison with the other two focus areas). This attention is also reflected by a progressive recognition of P&D issues as basic elements for planning in the UN system at large.

However the P&D focus area is facing two major challenges: the lack of an exit strategy both in the overall CPAP and in specific AWPs, and the absence of a capacity development strategy. For the latter, the capacity development section of this report (see chapter 5) details the problems encountered in the P&D component (which are also present in the other focus areas of the

[89] At the time of writing the EDS has not yet been finished, and therefore its effectiveness can only be projected.

[90] E.g. it will not be necessary to do again the cartography or the questionnaires, but update or improve, which has benefits in terms of sustainability and efficiency.

programme). For instance, the proliferation of isolated training to BUCREP or INS has helped to solve specific challenges, but has not resulted in stronger institutions or departments.

Concerning an exit strategy, the design of the programme does not explicitly incorporate a clear end with a timing and with a strategy for hand-over to the government before withdrawal of UNFPA. This can lead to the perception that UNFPA support has not been planned with an end point, and risks creating perverse incentives that discourage the effort on the part of the local partners to take ownership. Examples of this effect can be found in the roles of the national experts that are considered as assets to solve day-to–day situations and even coordination or monitoring roles, instead of being used to develop the necessary coordination or monitoring capacity within the department in a structured way including a termination/handover stage.

It appears that the country will still be dependent on external resources for the production of reliable data, both regular administrative data and surveys. As a result, UNFPA should anticipate a situation in which direct support or advocacy to obtain support from donors will still constitute an important part of its efforts in the P&D component.

Summary of findings:

The most important factor regarding sustainability of UNFPA support has been the careful mutual consultation approach that has secured a high level of ownership. Additionally, the continuous support to the same partners along different cycles allows for the design of long-term strategies conducive to sustainability. However the CO faces two major challenges: the lack of an exit strategy (both in the overall CPAP and in the specific AWPs) and the lack of a capacity development strategy. Finally, in the present framework of economic crisis, budget limitations and competing priorities, the country will still be dependent on external resources. In this context, direct financial support or advocacy to obtain support from donors will still constitute an important part of the efforts of UNFPA in the coming years.

4.3 Gender, culture and human rights

4.3.1 Relevance

Evaluation Question 9: To what extent is UNFPA support to Gender (i) adapted to the needs of the population (ii) and in line with the priorities set by the international and national policy frameworks?

The focus on gender-related issues used to be a subcomponent of the Population and Development focus area (in the fourth country programme) but its profile has been heightened in the fifth country programme and is now a specific component, which is appropriate given the magnitude of the issues at hand.

a) Gender-based violence and denial of rights

Improving how women's rights are taken into account by policy-makers, preventing gender-based violence (GBV) and particularly violence against women, and developing access to basic services for girls and women are issues that need specific attention in Cameroon. This has been shown by numerous studies, including those produced with the support of UNFPA in recent years.[91] It is particularly crucial in the northern regions, where women experience violence, deprivation of rights, early and forced marriages and sexual relations, excision and low access to schooling. The well-known consequences on health (physical and mental) and wellbeing (including on social status) justify the interventions of UNFPA including in the south-west and the east regions. Indeed, GBV, for example, is prevalent in the south-west where UNFPA has supported the Ministry for the Promotion of Women and the Family (MINPROFF) to reduce the incidence of female genital mutilation (in Mamfé).

The issues that are faced by Cameroonian women are also faced by girls and women from refugee

[91] For example : République du Cameroun, Ministère de la Promotion de la Femme et de la Famille. *Etat de lieux des violences basées sur le genre au Cameroun.* UNFPA. Décembre 2010.

populations. They, too, live in situations in which inequity and harmful practices are the norm but where precarious living conditions exacerbate those issues and make it more difficult to tackle them.

The range of situations that can create a negative environment for women in particular is vast. The situation is complicated further by a national legal framework not sufficiently in line with the various international conventions and declarations that Cameroon has ratified in the past. There still are legal loopholes that mean women's rights are denied. For example, the legal age of marriage is lower for women (fifteen) than for men (eighteen), a wife has virtually no succession rights, the husband is the actual administrator of his wife's (or wives') estate, and there is no disposition for divorce by mutual agreement. Some regions are more prone to these situations than others, and certain forms of inequality or violence against women are more prevalent in the south-west provinces (female genital mutilation), and the northern provinces (north and far north regions), where early and forced marriage as well as restricted access to education, especially among Muslim populations, is the norm.[92]

b) Alignment with national and international agendas

MINPROFF, has acted in a number of ways including the institution of gender-focal points in all ministries and para-public institutions (which have received training from UNFPA and others[93]) and the organization of special celebrations throughout the country such as the "Fight against Female Genital Mutilation Day". However, considerable challenges remain. The positive step of the institution of gender focal points at the ministerial level has not been effective as the focal points face difficulties in both consolidating their positions in those ministries and understanding fully what their role should be. Consequently, UNFPA has delivered training as well as provided communication and information material to enable them to better advocate for their role and the importance of streamlining gender issues in sectoral policies.

Planned UNFPA-supported interventions are well aligned with national and international agendas, policies, plans, and programs regarding gender rights, prevention of abuse and discrimination against women, promotion of equal access to basic services. Particular attention is paid to the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) and with the 1995 Beijing Declaration and Platform for Action (Fourth World Conference on Women) which listed all the areas where the rights of women and girls need to be asserted and promoted. The UNFPA gender component does meet the demands of those agendas, including the possibility for women to receive legal support (CEDAW) and the participation of women's NGOs (Beijing), as demonstrated by UNFPA's interventions in Cameroon (ACAFEJ, FESADE, OFSAD, for example).

Summary of findings:

Gender-related unresolved issues abound in Cameroon and the level of response, at the national level, remains low. Gender rights, and more particularly the rights of women and girl are still baffled on a regular basis. UNFPA has aligned with and promotes national and international agendas. It has given this area of work more emphasis with its fifth country programme, as gender has become a component in its own right. It addresses gender-related issues that are particularly highly prevalent in regions where it provides support.

Evaluation Question 10: Are planned interventions adequately designed to reach the stated goals?

The field-based activities implemented by UNFPA tackle issues at stake in policies and strategies that UNFPA has helped design and develop. This includes activities that fit regional contexts and respond to challenges that are difficult to address for socio-cultural reasons. For example, the "causeries éducatives" (educational talks) and ensuing "cliniques juridiques" (or legal clinics) address the following sensitive issues: premature sexual relations and marriage, deprivation of inheritance rights for women,

[92] As noted by studies and clearly communicated to informants by community leaders in the north and far north (see for example reports from "causeries éducatives" and "cliniques socio-juridiques" organized with the support of UNPFA in 2009 and 2010 in those two regions – data from gender component's annual reports for 2009 and 2010).

[93] UNDP, UNWomen, CIDA.

gender-based violence, the necessity of registering births (as included among the strategies of the CPAP), the detection and treatment of obstetrical fistulae, etc.

UNFPA concentrates its efforts on women and female adolescents, which seems relevant given the fact that Cameroon's society is mostly patriarchal and that reports demonstrate discrimination, violence and abuse frequently affecting women and girls in Cameroon. Forms and episodes of violence affecting men have also been discussed during "causeries éducatives", as detailed in reports from these collective, community-based conversations but are less prevalent, and have far less serious consequences on their victims.

The efforts of UNFPA are also appropriately focused on refugees in Cameroon (from Chad and the Central African Republic). They are concentrated in northern and eastern regions and come from societies where patterns of discrimination are similar to those in place in local populations. There are up to 40,000 refugees in transit camps in the far north and activities have been conducted on awareness on gender rights, HIV-Aids, reproductive health and family planning.

However, despite gender-related issues being taken into account in UNFPA programming documents and comprising a separate component of the country programme, the budget allocated for the implementation of gender activities component remains insignificant. The total budget allocated for gender activities is 2 million USD out of a total country programme budget of 17.75 million.

Summary of findings:

UNFPA relevantly addresses a host of sensitive issues among local and refugee populations. However, it has only a modest budget to conduct its activities in the gender component.

4.3.2 Efficiency to date

Evaluation Question 11: How appropriately and adequately are the available resources (funds and staff) used to carry out activities?

As noted in the reproductive health section, the administrative and financial management of the programme incurs long administrative lead-times and delays which impede a fuller implementation of the planned activities. This was particularly true in 2008 when the AWP for gender was not signed until May (which coincide to a period of recruitment of a new Assistant-Representative). In subsequent years there has been some progress and AWPs were signed earlier (in March in 2009, February in 2010 and March-April in 2011).

The presence of sub-regional offices of UNFPA in both the north and the east regions brings continuity to, and enables follow-up of, activities conducted at the field level. The good integration of staff into the local institutional fabric, its dynamism and creativity, enhances the efficiency of processes and the effectiveness of implementation. However, it is still difficult for the local stakeholders to obtain information on the AWPs as this has to come from the central level and information is not automatically sent to its Delegations.

The far north region, though theoretically covered by the sub-regional office based in Garoua, does not receive enough support from that office due to distances, bureaucracy and complicated logistics for transportation (bad roads, requirement for authorization by the central representation, the necessary mobilization of the *Brigade d'Intervention Rapide*, etc). These restrictions limit the implementation of activities, which is unfortunate given the identified needs. It also prevents follow-up of activities in this important region, as identified by the situation analysis.

The presence of national experts (paid for by UNFPA) yet positioned at the regional level (gender at DRPROFF in the east and youth at the DRJEUNES in the north) provide valuable support to these delegations. However, they do not seem to be in a position to expedite the implementation of the programme from an administrative and financial standpoint. This, in part, is due to their role and daily activities involving much substitution of the delegation work.

The transfer of the UNFPA-funded gender expert from Garoua to Bertoua was certainly unfortunate for the northern region, but it is a definite plus for the

eastern region. The expert implements technical support, avoiding substitution of the MINPROFF delegation work, while providing added value to that work through the development of strategic and monitoring tools, and through continuous interaction with the delegate. That is not the case of all UNFPA-funded national experts, who are often too absorbed by their daily delegation duties such as providing "logistical support" (as labelled by one expert), that is, planning of activities and preparation of reports while leaving technical work to the delegation. That type of situation is, unfortunately, a very common feature of technical assistance programs.

Summary of findings:

Long administrative lead-times hinder the full completion of the planned programme of activities. However, the presence of sub-regional offices and of sectoral experts located in regional delegations help mitigate this, especially in the case of the gender expert transferred from Garoua to Bertoua.

Evaluation Question 12: To what extent were activities with local organizations managed in a manner to ensure the delivery of high quality outputs?

NGOs mobilized by the programme are aligned to the needs of the programme.[94] However, their mobilization, when it occurs, is not predictable, or regularly, only taking place annually. Most associations with which the evaluation team met had not been solicited to contribute to actual activities and were rarely asked to participate at the programme's annual planning stage. Some associations who participated at the AWPs 2010 discussion meeting were not called to implement activities. Only ACAFEJ, the Women's Legal Network, seems to be solicited on a regular basis, mostly for "causeries éducatives" and legal clinics. They also have participated in the identification of women with obstetrical fistulae as part of the SRH component's implementation. Some associations, that are mentioned as being important in documents prepared with UNFPA support,[95] such as the *Association de Lutte contre les Violences Faites aux Femmes* (ALVF), have not been mobilized and were not mentioned by the interviewees.

Contrary to other UN agencies, UNFPA does not engage into partnership agreements with those organizations. The intention is to ensure ownership and sustainability at the national level. As a result, the CO misses an opportunity to build a continuum of a working relationship between the government and NGOs.

In the case of Youth associations, one can see that there is a privileged partnership established between the UNFPA and AFRIYAN (who describe themselves as the "Youth branch of the UNFPA"). UNFPA had a crucial contribution to the creation of this network. On the other hand, other Youth organizations do experience difficulties to be heard and to effectively collaborate with the UNFPA programme, even though some of them are solicited to contribute to its planning. ACAFEJ, which has participated in the programme's implementation, notes that the lack of planning and preparation forces them to be reactive and stresses how this is detrimental to their own organization and efficiency. There is a clear lack of continuity in the planning of activities where NGOs and associations are solicited for implementation (as shown by table 11).

Summary of findings:

Absence of planning and continuity affects the implementation of the Gender focus area of the fifth country programme. This is clearly visible with the use of national NGOs and CSOs, which perform very valuable and sensitive work at the ground level, but whose participation lack continuity, follow-up and monitoring.

4.3.3 Effectiveness to date

Evaluation Question 13: To what extent were the excepted outputs of the CPAP achieved or are likely to be achieved?

94 As discussed during two focus groups that gathered with (i) women's associations (ACAFEJ, CAMNAFAW , FESADE, OFSAD), and (ii) youth associations (AESEC, AFRIYAN, CAMNAFAW, CAMNOSOP – NEPAD Youth Club, GODUCOMER – Femmes et Filles du Cameroun, Presse Jeune, UNYA).

95 *République du Cameroun, Ministère de la Promotion de la Femme et de la Famille. Etat de lieux des violences basées sur le genre au Cameroun. UNFPA. Décembre 2010.*

The activities identified in the CPAP for the gender component are being implemented and the objectives are reached. They broadly aim at developing capacity in order to integrate or mainstream equality, gender, cultural and human rights agendas into development policies, strategies and programs or projects and to develop capacity to prevent gender-based violence (GBV) and to provide support to victims.

In order to assess the effectiveness of the support of UNFPA in the Gender component, a general reference is outcome 3 of the CPAP "A favourable social and legal environment to promote gender equality and equity and to reduce sexual and gender-based violence", and its two ensuing outputs, which are analysed below.

OUTPUT 1:

The capacity of national staff is strengthened in order to mainstream gender, culture and human rights issues in social development policy and programme formulation, implementation, monitoring and evaluation.

a) Support to institutional capacity development and creation of a policy framework

Since the beginning of the fifth country programme, UNFPA has become a prime sponsor of the MINPROFF's activities and has supported the institutional development of the response to adverse conditions and situations affecting women and girls. It has done so through the initiation of and support to the development of the National Policy on Gender (2010-2020),[96] which includes an action plan. The National Policy on Gender was developed with active support from UNFPA (which was the originator of the concept) with externally contracted consulting services (provided by UNDP) and the support of NGOs and traditional leaders. The introduction of the idea of such a strategic framework came from UNFPA staff who had drawn experiences from the fact that the proposed National Strategy for the Promotion of Women (which was receiving support from other donors) was not making progress fifteen years after the introduction of the idea. UNFPA managed to gain the confidence of the government to start work on the new strategic framework, which was completed in 2010. The document has been validated but not yet adopted. The completion of its translation into English by UNWOMEN is still pending.

It is not clear, however, what type of resources are being allocated to the National Policy on Gender, with MINPROFF negotiating with the Ministry of Finance for an appropriate budget allocation. Advancement is not optimistic with the budget of MINPROFF shrinking very seriously from 7 billion FCFA (Central African Francs) in 2009 to over 5 billion in 2010 and less than 3.5 billion in 2011.[97]

UNFPA has advocated for the introduction of gender-related issues into policy making in all sectors, particularly through the production of situation analyses on gender-related issues in Cameroon.[98] The CO has supported the production of guidelines on how to better streamline gender-related issues and their address into policies and planning.[99] UNFPA also organized a seminar focusing on the integration of gender into policy making and strategic planning in October 2010 (the Secretary Generals from all ministries were invited).

In order to support the gender agenda, gender focal points have been created in most line ministries. UNFPA, among others, has provided support to the implementation of those new positions, particularly through the provision of training and advocacy material to focal points, and the organization, in September 2010, of a seminar aiming at better determining the role and terms of reference of gender focal points.[100]

Finally, UNFPA promotes the integration of gender-related issues in higher-education. In particular, UNFPA

[96] *République du Cameroun. Ministère de la Promotion de la Femme et de la Famille. Document de Politique Nationale Genre 2011-2020.* Not dated.
[97] Communication by the MINPROFF.
[98] *République du Cameroun. Ministère de la Promotion de la Femme et de la Famille. UNFPA. Etat des lieux de la prise en compte du genre dans les politiques, programmes et projets du Cameroun. Décembre 2010.*
[99] *République du Cameroun. Ministère de la Promotion de la Femme et de la Famille. UNFPA. Guide d'intégration du genre dans les politiques, stratégies, programmes et projets de développement. Décembre 2010.*
[100] *République du Cameroun. Ministère de la Promotion de la Femme et de la Famille. Composante Genre, Culture et Droits Humains. CMR5G11A. Rapport annuel 2010. 5ème Programme de Coopération UNFPA-Cameroun: 2008-2012.* Not dated.

supported the University of Yaoundé I in the creation of a Masters degree on gender studies in 2009.

However, there is no clear monitoring and evaluation system in place (see chapter 6), at the moment, to follow-up on activities performed. This is also true at the institutional level.

OUTPUT 2:

The capacity of ministries, NGOs and community networks are strengthened to prevent gender-based violence and treat victims of such violence

Within this output, UNFPA provides support in three main areas:

a) the development of knowledge

b) the development of an institutional capacity and response

c) the development of local, ground-level capacities and responses

a) Support to the development of a knowledge basis

UNFPA has put emphasis on the development of knowledge regarding the issues raised. In order to understand the magnitude and the variety of situations of abuse and violence women are confronted to, UNFPA has sponsored studies[101], which provide a very valuable situation analysis along with recommendations as to what could and should be done to deal with the issues identified. They also identify major stakeholders with which to partner in order to bring about change, which include local institutions and leaders.

To tackle the issues identified in these and other studies, and in accordance with the objectives stated in the CPAP, UNFPA provided support to the design of a National Strategy to Fight Gender-Based Violence[102] in 2010. It is a comprehensive document that considers GBV in detail, and provides what seems to be an adequate strategy. However, it lacks a truly operational plan (including a monitoring and evaluation plan) and it is not clear who is in charge of coordinating, monitoring and evaluating its implementation and how, even though MINPROFF seems like the logical choice.

b) Support to the development of an institutional capacity and response

In order to support the strategy, and particularly, to ensure the harmonization and coordination of the response, UNFPA ensures the dissemination of the knowledge basis and has provided sensitization, through seminars, for personnel from a variety of ministries involved in the issues. Seminars were organized for cadres from government services and partners (e.g., police, gendarmerie, health, women and family affairs, NGOs). At the regional level, as seen in the north, these government services come together to coordinate on the response to abuse and violence.

c) Support to local capacities and responses

Community leaders and peer-educators for youth (approximately 200 of them since 2008) have also benefited from sensitization and training on gender rights, the prevention of violence, reproductive health rights (including family planning), through seminars. They have also been equipped with materials. These have targeted implementation areas, in the far north for example, where there is traditional resistance to address gender-related issues. Peer-educators, who the evaluation team feel are courageous young people, are actively communicating messages at their community level, particularly through the organization of community-based or collective discussions – ”causeries éducatives”.

Important work, on the sensitization on gender rights, including Gender Based Violence, is being conducted

[101] *République du Cameroun. Ministère de la Promotion de la Femme et de la Famille. UNFPA. Etat des lieux des Violences Basées sur le Genre au Cameroun. Décembre 2010.*

[102] *République du Cameroun. Ministère de la Promotion de la Femme et de la Famille. Stratégie Nationale de Lutte contre les Violences Basées sur le Genre.* Not dated.

Table 11: Participation of "causeries éducatives" and "cliniques juridiques"

		No. of causeries and clinics held	Regions covered	No. of participants/direct beneficiaries			
				Women	Men	Totals	at Legal clinics
2008	No activity		None			None	None
	ACAFEJ		east, north	1,388	277	1,665	103
2009	(19 Oct. – 9 Nov.)	25	north	83%	17%		89 W 14 M
	ACAFEJ		east	2,550	450	3,000	116
	(Dec.)	67		85%	15%		96 W 26 M
	Afidi Nnam		center	671	299	970	66
2010	(Dec.)			69%	31%		57 W 9 M
	Totals	92		4,609	1,026	5,635	285
TOTALS	%			82%	18%		

Source: Various Gender component annual and VSBC activity reports.

through the organization of "causeries éducatives" and "cliniques juridiques" (legal clinics) by NGOs that receive UNFPA funding, which take place approximately one session per year. Thousands of women in 4 regions (east, center, north, far north) have attended, as well as men. The work performed by such organizations as the Cameroonian Association of Female Lawyers (ACAFEJ) and the NGO Afidi Nnam ("Village Hope"), plays an important role in communicating valuable information to women who otherwise would never receive such information. Legal counsel is provided in follow-up through "cliniques juridiques" but are attended by, about 5-6 persons only, compared with 20 to up to 300 people attending causeries.[103] While women represent generally up to 80-85% of attendants (see table 11) in the central region, men accounted for 30% (out of the almost 1,000 participants). Activities have so far been held in 2009 (in the north and far north) and in 2010 (in the east and central region). UNHCR and the Red Cross have also contributed by identifying participants to these clinics from refugee populations in the north, far north and east regions. Afidi Nnam has also conducted similar activities in the central region. Causeries were also delivered to refugees in the far north, north and east.

Material support has also been provided to the National Referral Centre on violence against women *(Centre d'Accueil de la Femme en Détresse or CAFD, in Yaoundé V)* – which includes psycho-social and economic support (through IGAs jump-started with micro-credit). Women from Yaoundé and from distant regions come to this center to seek support. They usually have been victim of violence, exclusion, marginalization. They also benefit from training and financial support for the start of IGAs.

Finally, UNFPA has provided support to the sensitization of the general population on gender-related issues through the broadcast of radio programs. Training was provided in 2010 to 10 radio stations in the east and 10 in the north and far north. In the central and southern regions, radio broadcasts are supported by UNICEF. Programs had to be reviewed by MINPROFF and approved by the MINCOM. In the north, for example, 7 out of 10 radio stations subsequently broadcast programs on gender-related issues. A total of 210 broadcasts were performed in 2010.[104]

The discussion of effects of the various domains of activity reviewed in the present section is presented in the answer to the next evaluation question.

[103] According to data reported in: République du Cameroun. Ministère de la Promotion de la Femme et de la Famille. Composante Genre, Culture et Droits Humains. CMR5G11A. *Rapport annuel 2010*. 5ème Programme de Coopération UNFPA-Cameroun : 2008-2012. Not dated.

[104] République du Cameroun. Ministère de la Promotion de la Femme et de la Famille. Composante Genre, Culture et Droits Humains. CMR5G11A. *Rapport annuel 2010.* 5ème Programme de Coopération UNFPA-Cameroun : 2008-2012. Broadcast of programs not dated.

Summary of findings:

UNFPA support has allowed the expansion of knowledge on gender-related issues in Cameroon and the development of key policy frameworks (such as the National Policy on Gender or the National Strategy to fight GBV). UNFPA has provided training and sensitization to hundreds of community leaders, of community-based workers, peer educators and social workers. These, in turn, have reached tens of thousands of people, with support from NGOs and CSOs involved in "Causeries éducatives" and "legal clinics". Support has also been given, yet with limited effectiveness, to the creation of a national referral center for women victims of violence. The dissemination of information on gender-related issues has also been spurred by the broadcast of local radio programmes sponsored by UNFPA and welcomed by national authorities. However, the lack of funding and of mainstreaming of gender-based policies, indicate a persistent low level of institutionalization of the response to the discrimination of women and female adolescents in Cameroon.

Evaluation Question 14: To what extent were the targeted groups of beneficiaries reached by UNFPA support and are these beneficiaries taking advantage of benefits from the intervention?

At the institutional (central) level, policies, strategies and guidelines have been produced, yet it is not evident whether gender-related issues have really been streamlined into policy making and strategic planning including allocation of resources. Awareness on gender issues is clear at the MINPROFF staff level, but it is not the case at other Ministries. The effectiveness of gender focal points in sectoral ministries can be questioned as they have had difficulties in being accepted or in understanding their role and implementing their terms of reference. Similarly, a recent study has shown that "gender-sensitive budgeting" introduced in all ministries does not have a significant impact on their own planning and practices.[105] There is also insufficient understanding of gender as, when asked how gender-related issues are mainstreamed into their policies and activities; the Ministry of Youth Affairs (MINJEUNES) has noted that 70% of the Ministry's staff is female. While the feminization of the ministry's staff is welcome news, it is by no means a sufficient and adequate response to the issues at stake.

Overall, the consideration given to gender rights and the prevention and adequate treatment of gender-based violence is not the norm yet, as also concluded by the 2010 UNDP study on the consideration given to gender issues in 9 ministries. The inclusion or mainstreaming of gender-related issues in the responses to the challenges identified in the national policy and strategic frameworks remains weak. This was exemplified by a study[106], conducted with the support of UNFPA, which has shown that the main areas of policy-making and main strategic documents lack a clear understanding of these issues. This is the case for "Vision 2035" and the DSCE. While it has been improved in PRSP, it is not yet satisfactory. The main conclusion of that recent study is that there is a major lack of capacity at the institutional level to take gender-related issues into account and to introduce them into policy-making and planning.

Action is still lagging behind intentions or even plans, with many policies and strategies, and sometimes laws, being developed, and even approved, but not sanctioned by decrees of implementation or not operationalized. This is also a finding for the Reproductive Health section. In order to help mitigate these institutional limitations, work is underway with the support of UNFPA at the regional level where the sub-regional offices are able to collaborate with various stakeholders, including in major areas of government (police, the legal system, education, MINPROFF, the health sector and others). UNFPA has also supported the development of guidelines to help

[105] Ministère de l'Economie, de la Planification et de l'Aménagement du Territoire. UNIFEM. PNUD. *Suivi du Développement Humain National et Régional (volet Genre). Etat des lieux de la prise en compte du Genre dans les budgets de 09 Ministères pilotes au Cameroun.* Etude faite par Mme Handjou Noubou Chantal et M. Somnga II. Juillet-septembre 2010.

[106] République du Cameroun. Ministère de la Promotion de la Femme et de la Famille. UNFPA. *Etat des lieux de la prise en compte du genre dans les politiques, programmes et projets du Cameroun.* Décembre 2010.

mainstream gender-related issues into policy-making and strategies.[107] It is a recent document (published in December of 2010) therefore it is too soon to measure its effects on the mainstreaming of gender-related issues into policy making and strategic planning.

Behaviour change and mitigation strategies are complex endeavours in gender relations. In response, and in line with the previously mentioned national strategy, UNFPA supports the sensitization of populations, and more particularly of its leaders, through Behaviour Change Communication (BCC) and mitigation strategies. This includes creating constituencies of institutional partners, from both government and non-governmental levels (traditional and religious leaders, NGOs/CSOs, representatives from governmental institutions at the regional level), to discuss and elaborate strategies in view of terminating harmful practices and/or mitigating their impact.

This is the case for the support provided by UNFPA to institutions that provide services to disadvantaged women (CPFF) and youth (Multifunctional Centers for the Promotion of the Youth - CMPJ) where material is being used to provide beneficiaries with messages about Sexual and Reproductive Health. In the area of Awareness to Reproductive Health, it has been noted that peer-educators are very articulate, even at a young age, and seem to be able to provide valuable information to their peers. However, they face resistance from older members of the population, especially the community leaders, who are not inclined to listen to the youth. Despite this, they have succeeded in attracting the support of parents who have generally found the discussions very informative. Nevertheless, the number of CMPJ and CPFF groups that benefit from such support is limited to a small number (mostly at the regional capital level), and has, therefore, had a fairly limited impact on the entire population. CMPJs and CPFF only cover about 1/3 of the 360 "*arrondissements*", or administrative districts. One possible limitation to the breadth of the activities performed at CMPJ and CPFF is that these institutions serve mostly destitute or marginalized populations (women that are rejected by their families for example or young people who have dropped out of school) and thus are unable to maximise the benefits of the training.

CMPJ and CPFF provide support to income-generating activities (IGA or AGR), as does UNFPA in various other aspects of its programme. In this particular case, the objective is twofold: (i) lure excisors away from the business of Female Genital Mutilation (FGM) and (ii) support women whose obstetrical fistula has been surgically repaired to regain economic and social footing. Small grants or micro-credit are provided to these women (once they have completed a training) to establish their business. The Delegate for the MINPROFF in the far north indicated that 30 women whose fistula had been repaired had received 2.5 million FCFA in all (or approximately 83,000 FCFA per women on average) after completing training and receiving support from counsellors who had come from the CPFF.[108] IGA are also available for marginalized women and youth both members of (CMPJ) who also provide consistent training over several months.

Work conducted with radio stations has allowed the production and broadcasting of programs on gender-related issues. However, not all programs produced have been broadcasted (7 out of 10 in the north for example). There seems to be less interest among commercial radios than there are among community-based or public stations for the follow-up and re-broadcasting of the programs produced. Nevertheless, in Abong Mbang, Community Radio Metoung FM 98.0 has actively supported gender-based issues and family planning issues, producing more programs on its own and mainstreams them through broadcasts.

The effects of "causeries éducatives" and legal clinics on beneficiary populations are not clear as regards awareness on gender rights, HIV-Aids, reproductive health and family planning issues. The evaluators assess that they have reached out to tens of thousands of people so far, which is no small achievement, but measuring the actual effect is quite difficult. As a result of "causeries", clinics, and seminars, there seems to be a higher awareness regarding gender-related is-

[107] République du Cameroun. Ministère de la Promotion de la Femme et de la Famille. UNFPA. *Guide d'intégration du genre dans les politiques, stratégies, programmes et projets de développement.* Décembre 2010.
[108] However, an amount of 15,000 FCFA was mentioned by other interviewees for women who had been suffering from a fistula

sues, and in particular discrimination and violence based on gender. The response of traditional, religious and administrative authorities is a positive sign for the future, as seen in the south west. But there still is resistance to change and the weight of tradition is very significant. This was witnessed, for example, during a meeting held by the evaluation team with refugees (30 men and 25 women in two separate groups) from the Central African Republic in Bazzama (east); it was also reported by peer-educators.

Similarly, it is difficult to measure change brought about by the building up of a local community of stakeholders against GBV, as in the case of genital mutilations. There is anecdotal indication of some effects, for example, leaders involved in the activities sponsored by UNFPA now counsel community members on violence and sometimes even refer them to the judicial system. In Mamfé, where UNFPA has provided strategic support to the creation of the FGM local committee, local leaders are now eager to denounce violence against women, particularly as regards female genital mutilation. This activity has also involved the use of income-generating activities (IGAs) to promote an economic incentive for practitioners to change their source of income. However, it is not clear whether these IGA have actually achieved their intended purpose of luring excisors away from their lucrative activity.

As regards the effects of the radio programmes, there are signs of a more active response to issues related to violence against women, about their rights, genital mutilations, and the support that they can receive (healthcare, legal support). However it is not possible to measure precisely what the actual impact on the population of those broadcast is, and what their coverage has been. Radio Aurore, in Bertoua, for example, estimates that it has an 80% market share according to a recent survey but they do not know how many people actually listen to the radio. It should also be reiterated that most people living in rural areas do not possess radio sets or listen to radio broadcasts. According to the 2004 DHS only 27.7% of rural populations listened to the radio at least once a week and 68.6% of that population had no exposure to any form of media (77.8% in the far north region). In Cameroon, about half of the population lives in rural areas but radio programs seem to reach mainly the urban population. Moreover, the difference between women's and men's exposure to media was very significant, with 45% of women having no exposure at all (all country) vs. 18% for men (2004 DHS).

Overall, there is an indication that some change is being achieved. There is now a debate, at the national and more importantly at the local level, about gender-based violence and gender rights, as noted by some of our informants. Until recently, populations who would not have referred to these issues, at the present, talk about them more freely, even in areas such as the north and far north or the south-west where they remain a sensitive theme (particularly premature marriages and births, girls' schooling, in particular). Radio stations tackle the issues, and so do other media (television, newspapers). Thousands of citizens have received direct information on the seriousness of the gender-related violence, for example, including many community leaders. However, young peer-educators trained with UNFPA support report that older people, including leaders, resist the introduction of new ideas and behaviours. Therefore it is difficult to measure the actual magnitude of the effects in the population on their practices through the change notified by interviewees. Establishing the exact extent of change would require a more thorough investigation and the use social science methodologies and longitudinal studies.

Summary of findings:

A substantial work has been performed to support the integration of gender into policies and at the institutional (ministerial) level. However, it has had fairly little effects, so far. Considerable work has been done with community leaders, and with the population through the action of community health workers, peer-educators, and social workers trained and sensitized, and with the support of NGOs and CSOs. This has helped disseminating information and promoting behaviour change. Awareness has most certainly increased and there are signs that people start to ware about gender and gender-related issues. Yet, it is still insufficient and resistance against change prevails in many instances.

4.3.4 Sustainability

Question 15: To what extent are the benefits likely to continue beyond program termination? Has UNFPA been able to support its partners and the beneficiaries in developing capacities and mechanisms to ensure the durability of effects? Were the activities and outputs designed taking into account a reasonable hand-over to local partners?

UNFPA has provided support to the elaboration of a national gender policy and strategy. However, like many other such documents, including legal policies, final approval by the government is subject to delays and important documents are not translated into legal mandates and action. The same comment applies to the National Strategy to Fight Gender-Based Violence. Furthermore, contrary to the situation observed with the SRH component, coordination of partners, including UN agencies, is poor. As a result, it is difficult to assess how mainstreaming of gender-related issues will remain a priority at the government level beyond the production of documents. UNFPA supports the establishment of UN Women in Cameroon, with human and logistical resources, but it is still a very young endeavour.

MINPROFF has a very small and rapidly shrinking budget (as discussed earlier), limiting the operations of its regional delegations with approximately 500,000 FCFA in annual operational budget. All activities performed by the central structure of MINPROFF are funded by donors, with government funds only paying for investments (such as infrastructure support), and the activities of MINPROFF would be severely limited without the support of donors. This is not sustainable and ensuring that gender-related issues become a central concern for policy making in Cameroon requires considerable progress. Although Cameroon signed international conventions and commitments, its legal framework is not evolving accordingly. UNFPA has sponsored the production of studies and situation analyses (of women in Cameroon) including documents drawn from the census.

Support to women through communication for behaviour change and sensitization, including legal support, is a very valuable strategy. The low level of male participation (maximum 30% of attendees in the central region) in those activities is a weakness. Moreover, there is a need for continuity in order to reinforce messages and highlight its importance to every citizen and to the country in general (as stated in the national strategy to fight gender-based violence). The various national strategies and plans need to be operationalized if they are to have any meaningful impact. Monitoring & evaluation of policies and strategies is not clearly articulated (or even absent), which constitutes a major weakness for their successful implementation.

Moreover, as noted earlier, the mainstreaming of gender issues in all ministries and their budgets is still insufficient. This means that the consideration given to gender rights and the prevention and adequate treatment of gender-based violence is not yet the norm. The weak mainstreaming of gender-related issues at the institutional level still constitutes a serious barrier to the implementation of national policies and strategies. UNFPA is helping to improve that situation, particularly at the regional level through the sub-regional offices of UNFPA which are able to organize collaborative work involving various stakeholders, including major areas of government involved in those issues (police, the legal system, education, MINPROFF, the health sector and others).

At the national level, all 3 education ministries[109] have integrated gender-related curricula or activities (such as “gender clubs” at the high school level and the opening of a “gender and development” master at the University of Yaoundé I). This could help lay the ground for a better understanding and integration of gender-related issues into policy making and strategic planning for social and economic development.

Income-generating activities (IGA) are an important component of strategies provided by both the government (MINPROFF) and UNFPA to help disadvantaged and marginalized women and the youth to regain social and economic ground. IGA have their own benefits, in social terms: they reintroduce the destitute or the marginalized (such as women who were suffering from social and economic exclusion due to an obstetrical fistula) into the social and economic fabric of society. It provides

them with a sense of purpose, or helps rebuild their sense of purpose, but also helps restore their dignity, and that is very valuable. However, experience, both in Cameroon and in other countries, shows that IGA are not easy endeavours and are not always self-sustainable economically, which is acknowledged by UNFPA and government officials. Reasons are that: people who benefit from them have little or no education and are not trained in high-value or cutting-edge techniques and businesses where they could easily find a niche as this would require many more resources. Those groups of people are concentrated in areas where there are high levels of competition (weaving, growing and/or selling of agricultural products and food, woodworking, electricity, cooking), as confirmed by several interviewees. The low level of micro-credit reimbursement is a testimony to that low level of sustainability (although there was anecdotal evidence of a better reimbursement rate in the northern provinces). However, some of the beneficiaries interviewed (in the north for example) say that the trained youth have found work, which is encouraging. Providing training in the area of Information and Communications Technology (ICT) may be seen as having more potential for the future given the current fast transformation of administrative and management techniques.

Long-term benefits will primarily be achieved through continuous efforts to disseminate information, to communicate for behaviour change, and sensitize political, traditional, religious or other leaders, for the recognition of basic human rights, including those of the most vulnerable, especially women and girls. There are some signs of change in those areas, as exemplified by the fact that some radio stations, such as Community Radio Metoung in Abong Mbang, have now included programming on gender issues on a regular basis, with significant time allocation, on their own initiative after receiving training sponsored by UNFPA.

The DHS 2010 (EDS IV), whose first results are due at the end of 2011, should provide valuable data on a variety of gender-related indicators – access to basic services (healthcare and schooling), gender-based violence (including genital mutilations and home-based violence), contraceptive prevalence – as well as on a range of health-related indicators where discrimination against women can be identified.

Summary of findings:

The lack of attention, resources and the weak mainstreaming of gender-related issues limit considerably the prospect for long-term effects of activities performed at the institutional level. At the population level, some of the actions undertaken will have fairly short-lived effects as in the case of income-generating activities, at least from an economic reinsertion point of view, but the sensitization of community leaders and of populations, through a variety of means should have longer-lasting and self-sustainable effects, locally.

[109] Ministry of Basic Education, Ministry of Secondary Education, Ministry of Higher Education.

CHAPTER 5

Strategic Positioning

5.1 Corporate strategic alignment

Question 16: To what extent is UNFPA support to Cameroon aligned with the Fund's strategic plan dimensions: capacity development, support to disadvantaged and vulnerable groups, and South-South cooperation as appropriate to the Cameroon context?

a) Disadvantaged and vulnerable groups

There is a marked focus on vulnerable groups by UNFPA-sponsored activities in general, and this is particularly clear in the Reproductive Health and Gender components. Some of the informants who are implementing partners at the regional level have pointed to the fact that one of the main achievements of UNFPA is precisely that it reaches out to the most vulnerable sections of the population; this is confirmed by the evaluation team's assessment. The fifth programme provides support to a range of vulnerable sub-groups. These include, in particular, women rejected by their families or their environment (women with fistula and women who have been victim of violence including genital mutilation); women who are not able to exert their basic rights (as in the case of inheritance); young girls who are forced into early marriage and sexual activity; as well as refugee populations (from Chad and the Central African Republic).

There are limitations to the effectiveness and the breadth of those activities. For example, poorest sections of the population are still not reached when it comes to the affordability of health services. Cost-sharing or payment schemes promoted with UNFPA support (gynecological or obstetrical "forfaits", or fixed costs, including the pre-positioning of kits in the northern regions) have succeeded in rendering those services

Among the main strategies and activities targeting the most vulnerable:

- "Causeries éducatives" and legal clinics for women and men in order to: promote Sexual Reproductive Health (SRH) and Family Planning, legal rights, access to basic services, awareness about the risks of early pregnancy (which leads to complications including obstetrical fistula);
- Support provided to CMPJ and CPFF. These centers mostly cater for women and young people in marginalized situations, have been excluded from their environment, have dropped out of school (youth), or have been victims of stigma;
- The surgical repair of obstetrical fistulae, which affects mainly poor women and is an aggravating factor of their poverty;
- Sensitization of populations, including traditional and religious leaders, to the effects of gender-based violence (example of excision in Mamfé);
- Support to women victims of violence through psycho-social and income-generating activities and support provided to the CAFD (*Centre d'Accueil des Femmes en Détresse* located in Yaoundé) serving women from remote areas of the country;
- Support provided to populations affected by humanitarian crises (refugees from the Central African Republic and Chad and to populations affected by outbreaks of cholera in the northern regions), through the provision of SRH products and services (such as dignity and obstetrical kits, contraceptives, etc.).

more affordable for the poorest, especially in rural areas where the economy is mainly based on subsistence farming. There is some progress through the involvement of municipal authorities (for example in Betaré Oya in the east where 20% of the cost of delivery is covered by the municipality, or in Lagdo in the north where the mayor has agreed to pay for an ambulance driver), but this remains insufficient.

In a highly patriarchal society, promoting gender rights allows women and girls to improve their status, and some positive results have been achieved, with women and girls starting to make a stand for themselves and claiming their rights (to inheritance for example). It is still difficult, however, to measure the effects of activities performed over a period of two and a half years. Promoting change is a long-term endeavour, particularly for populations and individuals that do not have economic power, suffer from exclusion and stigma, lack access to basic services and cannot exert their basic rights.

b) Capacity development

The development of capacities is central in UNFPA implementation of its fifth country programme in Cameroon. It does so through significant levels of support to central government institutions (Ministries of Health, Planning, Women and Promotion of Family, BUCREP), referral institutions (such as the Center for Women in Danger in Yaoundé), and to institutions of the regional or peripheral level.

Support is provided in a variety of forms. These include technical assistance (TA) to the central level to contribute to the development of national strategic sectoral frameworks and policies, such as: the Policy on Gender, the National Strategy to Fight Gender-Based Violence, the CARMMA. Technical assistance is also meant to influence the broader national frameworks – e.g., DSCE, Vision 2035. Similarly, TA is provided by short and long-term experts hired by UNFPA at both the central and the regional level. Gender and SRH experts are located in the DSF (MINSANTE) and in regional delegations. However, this TA has, at times, a limited effect, as it is drawn into substitution activities. UNFPA staff and some of the Technical Assistance experts know that this is not the objective of this type of assistance, but avoiding substitution, depends on personalities and on their environment. For example, the gender expert who was in the north and is now working at the MINPROFF delegation in the east provides very valuable technical and strategic contributions, with a clear understanding from her counterpart of her intended role.

At the central institutional level, and throughout the five regions covered by the programme, capacity development is also achieved through training. This includes technical training to staff at INS, BUCREP, DADM and to health personnel in at least 26 health districts (with some beneficiaries from beyond the area of intervention) as well as at the regional hospital and regional health delegations. The training has also involved training of trainers, which is an important factor to create spill-over effects and sustainability. This capacity - development has shown results, with beneficiaries being able to better care for pregnant and delivering women and for their infants. However, the short time period allocated to Emergency Obstetric and Neonatal Care (EmONC) training – now reduced to 11 days – limits the technical impact of this type of training. Furthermore, the lack of resources for supervision combined with other factors (such as the very small number of patients in many health facilities especially in rural areas, the stock shortages, the lack of funding among others) hinders the sustainability of the results achieved. In the P&D component, capacities have increased at BUCREP but this is not as clear in INS and DADM.

Training is also provided to VSBC (community-based health workers or auxiliaries) and to peer-educators from the youth population. Topics covered in the training include SRH, FP, and life skills. The trained individuals are then expected to share their knowledge and discussion material with the general population and their peers. This capacity development is also achieved at the more general level of the population through the sensitization and communication for behaviour change (legal clinics have reached thousands) provided by trained educators and NGOs. Counselling (including counselling provided at the health facility level) also enables the sharing of knowledge with patients and the general population. Radio programs, sponsored by UNFPA, also participate in communicating key messages which can develop the understanding of listeners

on difficult issues where stigma, pre-conceived ideas, prejudice and harmful habits/practices are common. Information provided through all these channels allows the empowerment of beneficiaries and, more particularly, of women. They can better negotiate their sexual and reproductive life, advocate their rights, and become financially more self-sufficient.

c) South-south cooperation

South-south cooperation has been historically defined[110] as the conscious and systematic exchange of resources, technology, and knowledge between developing countries. The Strategic Plan of UNFPA puts emphasis on South-South Cooperation as a means to address with more guarantees the challenges related to development. However, the CPAP in Cameroon has not given priority to the promotion of this approach.

Despite the general absence of a systematic South-South strategy, some isolated opportunities have been seized. The Director of Statistics in Rwanda visited Cameroon to observe the process of operationalization of DevInfo and migration of data from REDATAM. Additionally, individuals trained in Cameroon have also been employed in Addis Ababa to train other trainers. Furthermore, the National Strategy for the Development of Statistics has been requested by representatives of the Republic of the Congo to be used as a reference for their own strategy. Another illustration of the potential of that regional cooperation is the experience of IFORD, which has benefited from exchanges and experiences with Ivory Coast and Niger and relatively frequent collaborations with the countries in the region.

5.2 Systemic strategic alignment (UNCT)

Evaluation Question 17: to what extent does UNFPA capitalize upon complementarities and avoids duplication with the UN country team?

The UN in Cameroon is characterized by its large country team, composed of 18 resident and 5 non-resident agencies. This large number of agencies accounts for a fragmented UN system, and the difficulty to speak with one voice. The UNCT is also characterized by a long tradition of bilateral communication between each agency and the Cameroonian government, and by vertical programming which allows for very little horizontal communication among agencies.

At the central level (Ministries and agencies in Yaoundé), there is no actual global coordination mechanism among UN agencies beyond the UNDAF elaboration process, which should only represent a starting point in the search for complementarities. Positive experiences have nonetheless occurred in the recent past for which UNFPA has played an active (and sometimes leading) role.

UNCT technical groups on HIV-AIDS, Emergency or Gender are examples of good exchange of information and sharing of good practices among agencies. In the case of the Gender technical group, the sharing of roles between UNFPA and UN Women proved to be smooth and effective: UNFPA left the leadership of the Gender technical group to UN Women, while taking the leadership on the subgroup on gender based violence (in which UN Women acts as coordinator). Following on its key contribution to the development of the national policy on Gender, UNFPA has played a key role in the setting up of a coordination unit within the MINPROFF, which regroups all UN agencies.

The CARMMA initiative is also a good example of recent steps taken towards better coordination among UN agencies, under the leadership of UNFPA. Although each participating agency has its own budget and management procedures, they have been able to identify common objectives (set in the CARMMA roadmap), a common strategy and a joint action plan for 2011-2012. In the dialogue with Cameroonian national authorities, UNFPA speaks on behalf of the UN system as a whole.

The UNCT in Cameroon has also entrusted UNFPA with the leadership of the consultation process regarding the coming UNDAF programming cycle (2013-2017). Besides meetings of the “groupe programme” in charge of the review of the UNDAF, UNFPA participates

[110] United Nations General Assembly in 1978.

actively in its sub-group "Urgence" which supported the government in reviewing and adopting a new national contingency plan.

At the local level, coordination among UN agencies is more advanced. In the north region, for example, monthly coordination meetings involve all UN agencies present in the region. However, unlike in the east region, coordination in the north is mainly limited to exchange of information and has not led yet to the establishment of a joint action plan.

In the east region, the UNCT is striving towards the objective of "delivering as one." Located in the same compound in Bertoua, the 5 UN agencies present in the region (UNHCR, WFP, UNDP, UNFPA and, more recently, UNICEF) call themselves a "mini One UN". Although each agency works within its own mandate, they intervene jointly in the humanitarian field. Besides exchanging information on their respective action plans, the agencies often carry out joint activities. UNHCR and UNFPA have thus carried out several common training activities, aiming at the development of capacities in the refugee settlement areas. UNDP has also utilized UNFPA expertise (i.e., the gender expert seconded by UNFPA in the provincial delegation of MINPROFF in the east) to ensure gender mainstreaming in its local development programme.

Summary of findings:

The activities of UNFPA in Cameroon are well-aligned with the principles of UNFPA Strategic Plan (2008-2013) as far as disadvantaged and vulnerable groups are concerned, with young girls and women receiving particular attention. However, support to the development of national capacities shows mixed results, with support for training showing the greatest added value. South-South cooperation has not been systematized, and there is no such strategy within the framework of the country programme. The country office has made a key contribution to improving inter-agency coordination and its contribution has helped address issues arising from a large and fragmented UN country team.

5.3 Responsiveness

Evaluation Question 18: To what extent has the CO been able to respond to changes in national needs, including national priorities, or to shifts caused by crisis or major political changes? What was the quality of the response?

The UNFPA response capacity is one of its most appreciated features among development partners in Cameroon. The good response capacity of UNFPA rests first in its speed. In the humanitarian field, UNFPA shows a great capacity to react swiftly to emergency situations. After the floods in Maga (far north region) in 2010 – which was followed by a cholera outbreak – UNFPA was immediately able to distribute 2,000 kits (dignity kits, delivery kits as well as C-section kits) which had been previously pre-positioned by the CO.

UNFPA has proved to be very flexible, with a constant adaptation to evolving national needs and priorities. In the north and the east regions, for example, frequent meetings between UNFPA regional offices and the provincial delegations of the MINSANTE have allowed UNFPA to improve the content and format of its trainings in EmONC, while adapting them to the specific requirements of its beneficiaries.

UNFPA also shows a good response capacity in seizing opportunities for new and/or pilot initiatives within the framework of its mandate areas. This is best exemplified by the pilot initiative of the pre-positioning of obstetrical kits in the three northern regions of Cameroon (north, far north and Adamawa),[111] managed by AfD and financed under the C2D funding mechanism. Participating in this initiative was a good opportunity for UNFPA to further support the improvement of women's access to quality EmONC services while demonstrating its specific expertise in the field of Reproductive Health. UNFPA made a significant contribution to the design of the initiative and now plays a key role in the implementation and the management of the project. Similarly, its participation in the design of other creative cost-sharing or payment schemes (such as gynaecologi-

[111] Although the Adamawa is not one of the five provinces covered by UNFPA's programmes in Cameroon, it is covered by the C2D pilot initiative.

cal or obstetrical fixed-priced pre-defined packages of care) demonstrates the capacity of the CO to adapt and respond to specific local needs.

The two regional sub-offices of UNFPA have proven instrumental in UNFPA flexibility and quick capacity of response. The two sub-offices allow for a closer monitoring of changes affecting the context of intervention. They also allow for a shortened decision chain from the identification of new needs and challenges to the implementation of activities. Proximity with other development partners also fosters the identification of possible synergies and the ability to seize opportunities for new local collaborations.

In most cases, the response of UNFPA is well-aligned with the priorities and objectives set in its strategic plan as well as in the CPAP. However, demands originating locally have led to responses which have no clear strategic justifications. The provision of vehicles to remote health centers in the far north and the east provinces, for example, although justified by transportation difficulties, is not always linked to the core activities of UNFPA. In the east province, as a response to a demand expressed by the UNHCR, UNFPA provided a refugee camp with beds although this does not fall under its mandate. The provision of a wide variety of equipment, materials and consumables (such as soaps, compresses, gloves, etc.) to the district hospital in Abong Mbang, whereby UNFPA responded positively to almost every demand for assistance, is not consistent with the mandate of UNFPA. More generally, UNFPA does not apply clear selection criteria to the numerous (and almost limitless) demands stemming from the field, to the detriment of the overall logic and quality of its response.

Summary of findings:

The CO is highly responsive to demands from partners and to changing priorities. It also takes advantage of opportunities to develop new initiatives within its mandate areas. The good capacity of response of the CO owes a lot to the two regional sub-offices. Overall, the quality of the responses is good, although some of them lack clear strategic justification and appear to fall outside of the mandate of UNFPA.

5.4 Added value

Question 19: To what extent would the results observed within the focus areas have been achieved without UNFPA support? What are the main UNFPA comparative strengths?

In each of its three focus areas, UNFPA has made good use of its comparative strengths, thus bringing added value to the global external aid benefitting Cameroon. One of those comparative strengths consists in the UNFPA recognized technical expertise. It allows the CO to act as a facilitator, or a broker, playing an intermediary role between a donor (providing funds) and the national counterpart looking for sources of financing with a view to achieving its development objectives. UNFPA mostly acted as a facilitator in the field of Reproductive Health. The African Development Bank has entrusted UNFPA with the implementation and management of the PASR (Project for the National Programme of Reproductive Health) in the center and south regions. UNFPA is also managing the pilot initiative of the pre-positioning of obstetrical kits in the three northern provinces financed by AfD. The CO is also supporting the creation of 4 (out of a total of 8) midwifery schools, funded by AfD.

UNFPA proved to have a specific ability in policy dialogue, and particularly in placing sensitive themes on the national agenda. According to all development partners, the CARMMA initiative, for example, would not have been possible in Cameroon without UNFPA effective advocacy activities, which helped place the reduction of maternal mortality on top of Cameroon's development agenda. Its proximity to some key ministerial departments (such as the DSF in MINSANTE), through its own staff (many of whom have worked in line ministries before) and through its field sub-offices, accounts for this capacity to engage in sensitive issues. This has enabled UNFPA to make progress on complex agendas, some of which had been untouched for many years, as in the case of the gender policy.

The added value of UNFPA lies in the fact that it is the only development partner active in some areas. For example, UNFPA is the only agency addressing the issue of obstetrical fistula. UNFPA has also been the

only development partner to provide the Cameroonian government with support in the organization, the implementation, and the exploitation of the results of the census. Although the comparative strengths of UNFPA do not rest in its financial and material support to Cameroon (for obvious budgetary reasons), its partners and beneficiaries (especially at the local level) often tend to link its added value to tangible, small scale, concrete actions. This raises the issue of the discrepancy between the actual added value of UNFPA and the way it is perceived in the country.

Summary of findings:

The added value of UNFPA as a development partner is high, particularly where UNFPA has acted as a facilitator. Its ability and commitment to place sensitive themes on the national agenda, such as the reduction of maternal mortality or the MGF, is also well-recognized by partners and beneficiaries. However, the added value of UNFPA remains often misperceived and wrongly associated with its material and financial support only.

CHAPTER 6

Monitoring and Evaluation System of the Country Programme

Rationale and main objectives of this analysis

UNFPA is according a growing importance to the quality of its country programme monitoring and evaluation (M&E) and the necessity to equip its country offices with an effective M&E system as well the development of mechanisms and control-tools to ensure that country programmes' results frameworks provide appropriate indicators, realistic outputs and accurate baselines. Indeed, the absence of a proper M&E system impacts negatively the country programme action plans and their associated results frameworks. This, in turn, impairs the quality – and therefore the credibility and usefulness – of evaluations at UNFPA.

Monitoring is the indispensable complement to all *evaluation activities* as it should provide: (i) information as regards progress in the programme implementation and (ii) the set of indicators against which evaluators shall assess the programme's performance.

Conceptual approach to the analysis of the country programme M&E system

Although an M&E system ultimately integrates all the above-mentioned dimensions, each of them calls on a different methodological approach. The first four dimensions are the standard M&E components of any international organization working in development. The fifth aspect corresponds to the nature of the work of UNFPA, based on partnerships with the Government and aims at assessing the contribution of the CO to develop the M&E capacity of government partners.

6.1 Monitoring and evaluation system in the country office

a) Monitoring of inputs and activities

The monitoring of inputs and activities constitutes the main part of compliance monitoring. It refers to a large part of the routine tasks of the staff of the CO. This aspect includes follow-up of: budget expenditure and activities.

The performance of the CO concerning the follow up of inputs and activities can be considered satisfactory in its fundamental aspects, even though there is insufficient understanding of activities from an integrated or programmatic level and insufficient consciousness of time-bound schedules.

The analysis of the M&E system of a country programme comprises five different aspects:

- Monitoring of inputs and activities
- Monitoring of outputs and outcomes (results-oriented monitoring)
- Monitoring of assumptions and risks
- Integration of evaluations into the M&E system
  and
- Support to national partners in their M&E system and capacity

The most salient aspects of input and activities monitoring are:

- Most of the monitoring at this level revolves around the AWPs. Financial reports follow ATLAS procedures, and activity reports are produced regularly without noticeable problems.

- Meetings with the participation of UNFPA and Government staff take place regularly with ad hoc meetings organized every time there is a need for one.

- Most activities are monitored "on paper," with insufficient field monitoring. Field monitoring occur more often in regions where UNFPA has regional experts.

- National experts, embedded in partner ministries, play an important role vis-à-vis reporting quality and coordination aspects.

b) Monitoring of outputs and outcomes (results-oriented monitoring)

Monitoring of outputs and outcomes is intimately linked to a results-oriented monitoring approach, which, in turn, constitutes the cornerstone of results-based management. Our analysis puts special emphasis on this aspect, both for its indisputable importance vis-à-vis the improvement of strategies and results and for the strategic relevance it is acquiring at corporative level within UNFPA.[112]

The outputs and outcomes monitoring system is based on the M&E framework contained in the CPAP, which is then referred to in each AWP.

Overall, monitoring of outputs and outcomes in the CO shows important weaknesses and require urgent corrective actions given their consequences both at the CO and corporate levels. The main problems impeding a results-oriented monitoring system are the lack of a results-oriented culture (the focus is largely placed on activities) and the absence of a linked management information system. As a consequence, the CO does not have access to information related to results achieved, which impedes an evidence-based reflection on the strategies used and their improvement and detracts from learning processes and from an adequate visibility of the programme (including communication on results).

Lack of a results-oriented monitoring culture

One of the main bottlenecks related to the implementation of a results-oriented monitoring system is not of a technical nature, but rather, is linked to the culture. Although some individuals understand the value of results-oriented monitoring in CO, the institution has not yet embraced it. This lack of corporate emphasis on results-oriented monitoring is the main reason why evaluators observe an inadequate formulation of outputs and a poor formulation of indicators (see Annex 7 which presents an analysis of the quality of indicators on the CPAP results framework).

Some positive aspects vis-à-vis a future set-up of a results-oriented monitoring system

In a framework showing a lack of results-oriented monitoring system, the evaluators have seen that some positive aspects are already in place in the event that the CO should take a step forward towards monitoring for results. The most important are:

- There are already spaces created between UNFPA and government partners for truly participatory approaches to formulation, monitoring and review;

- The representative and some members of staff are aware of the importance of results-oriented monitoring for management purposes and, beyond, its value as a corporate requirement;

- There exists individual capacity and potential in the CO staff to implement results-oriented monitoring. The main bottleneck in this respect is related to lack of culture and clear demands, as well as the absence of incentives for an effective implementation of results-oriented monitoring;

[112] See paragraphs 27, 87 and 88 in Strategic Plan and Results-Based Management Policy; UNFPA, 2010.

Reasons for the lack of a functional results-oriented M&E system:	
Weak formulation of outputs	Outputs are often formulated at a level of effects that does not correspond to the level of deliverables remaining under the realistic control of the UNFPA CO. The excessive ambition in the formulation of these outputs leads to a general attitude of interpreting them as a vaguely desirable objective instead of a real, immediate objective that must be obtained and that serves as a reference for accountability in terms of services and results of the CO.
Weak formulation of indicators	The indicators in the CPAP of insufficient quality which, in turn, impedes their effective usage as a tool for indicative measurement. In general terms, the identified indicators lack a baseline, and the targets are defined in vague terms which impede a clear interpretation of progress. In addition, most are not specific or only partially relevant to measure success (see point 1.4.2 Limitations encountered). Many of the existing indicators could constitute a good basis to obtain the needed indicators if they were properly refined and if their deficiencies were addressed. However, whereas partially developed indicators constitute a good basis for developing finalised SMART indicators, they do not serve an effective monitoring purpose until they are defined in their minimum required aspects (baseline, clear target, specificity, relevance). There have been partial attempts in the CO to address this process, but these attempts were not finalised. As a consequence, indicators are not operational as a tool to monitor the degree of achievement of results (which should be their main function). The impossibility of measuring the degree of achievement of results impedes the objective analysis on which strategies work best, which ones need to be revised and, therefore, affect directly the correct design of exit strategies.
Lack of an Information Management System associated to the M&E system	In very basic terms, a good functioning system determines: who should collect what information, who should send it to whom, with what frequency and format, and for what purpose. As a result, if the quality of outputs and indicators improved, this would not be sufficient to use them as long as an effective monitoring system is not in place. In this context, the existence of a results framework (whether it is of good or poor quality) in the CPAP shall remain a "dormant" document without a practical application for management purposes. The lack of information management system associated with an M&E system hampers the ability of the CO to show the achievement of changes linked to its support (which is a requirement of the Strategic Plan of UNFPA).[113]
Lack of corporate real emphasis on results-oriented monitoring	In spite of the emphasis given to results-oriented monitoring in the Strategic Plan of UNFPA and strategic declarations, there has been little real attention to results in day-to-day requirements from headquarters and management practices. Most requirements still focus on budget expenditure and activity implementation. Thus, in a context of lack of results-oriented monitoring culture and lack of effective demands for, and related tools to collect this type of information, the CO staff performs monitoring tasks exclusively directed at activities and inputs.

- National experts have already tried to create awareness about the importance of results-oriented concepts and have included some aspects into new reporting formats. These attempts are still isolated and very partial, yet they could be used as a starting point towards a more comprehensive approach to results-oriented monitoring.

c) Monitoring of assumptions and risks[114]

Monitoring of risks and assumptions constitutes a key element for risk management in a context where many factors are outside the direct control of UNFPA. It is also important from a corporate point of view as expressed in the current Strategic Plan which considers the improvement of risk management as an element to be

113 See paragraph 88 of UNFPA Strategic Plan 2008-2011.

114 Assumptions are those external factors that are necessary in order to achieve outputs and outcomes of the programme. Risks are external factors that could put in jeopardy the achievement of outputs and outcomes of the programme. *External* is understood as out of the direct control of UNFPA, which enhances the importance of their proper monitoring so as to enable readiness and early reactions.

taken into account for the strengthening of results-based management.[115]

It can be considered that the CO caries out an appropriate monitoring of risks and assumptions. The identification of external factors is regularly done through constant contacts between the Representative and different partners as well as through regular meetings between the CO staff and partners.

Three aspects contribute to the good level of information on risks and assumptions in the CO:

- The proximity that UNFPA Representative and staff keep with their counterparts and their good relation and communication;
- The positive perception of UNFPA as an added value counterpart by its partners;
- The high level of understanding that the CO Representative and staff show on the socio-economic and political issues in the country.

However, these strengths do not apply to the follow-up of risks and assumptions in the context of decentralization, which remains weak.

In general terms, the main weakness in monitoring of risks and assumptions lie in its lack of formalization. There are no specific tool and as a result, no structured management and follow-up, little possibility of sharing information in a timely and systematic manner and of building an institutional memory.

d) Integration of evaluations into the M&E system

The CO does not have a planned process to integrate evaluations in the M&E system – i.e, no evaluation plan is in place for the current programming cycle. In this respect, the complementarity between evaluations and the internal M&E system of the CO is not formalized and opportunities for synergies are missed. While the CO offered excellent support to the current evaluation exercise and facilitated the work of the evaluators and their access to information, the CO has not yet identified specific aspects or even regions for which they could be requesting specific evaluation. For the CO, evaluations seem to be used as a general coverage, but they do not include tailor-made analysis that could be part of the evaluation reports with a particular added value to the CO. In this regard, the CO has not invited the suggestions of key counterparts on relevant issues that could be included on evaluations.

There is also too much proximity between the MTR (December 2010) and the current evaluation, especially considering that this evaluation is implemented before the programming cycle is fully finished (which leads to inefficient use of resources, both financial and human, invested in those exercises to the CO).

6.2 Support to national partners in their M&E system and capacity

The support to national partners in M&E tasks is an obligation as per both UNFPA Strategic Plan and the CPAP.

At programmatic level, UNFPA has contributed and continues supporting its partners in the improvement of their national data collection systems. The interventions of the CO encompass important actions such as: the support to the implementation and analysis of the census and EDS or the support to the national statistics system. As explained in the sections dedicated to the P&D component, these interventions are part of a process that is still on-going.

In terms of monitoring mechanisms, there have been attempts to support the partner institutions in the improvement of their systems. However, these attempts have been partial and designed/implemented without the necessary continuity. In this context, the lack of an explicit capacity development strategy for monitoring impedes the needed critical mass of training, accompaniment, systems set-up and follow up that would be to necessary to build an M&E system that incorporate results-oriented information, which is crucial for evidence-based decision making.

[115] See paragraph 87 in the Strategic Plan.

CHAPTER 7

Conclusions and Recommendations

7.1 Conclusions

Conclusions and recommendations are organized in three clusters: strategic and programmatic levels as well as related to the Monitoring & Evaluation System of the Country Programme.

7.1.1 Strategic level

CONCLUSION 1:

The support of UNFPA to Cameroon is well aligned with the Fund Strategic Plan as far as disadvantaged and vulnerable groups are concerned. Support to capacity development shows mixed results. The use of South-South cooperation is not systematized.

The activities of UNFPA in Cameroon are clearly focused on disadvantaged and vulnerable groups, among which *young girls* and *women* receive particular attention, with tangible results as regards the promotion of gender rights. Such results are less visible when it comes to reaching out to *the poor*, for whom the affordability of health services remains a major challenge.

The country office actively supports capacity development at all levels: central government institutions, referral institutions, regional and peripheral institutions (health facilities). When provided through technical assistance, this support has often led to substitution effects, in particular in the field of reproductive health, with experts hired by UNFPA performing core administrative tasks of the supported institutions. Support to capacity development through training — be it technical training or training of trainers — has proved more effective, showing actual results in terms of empowerment of beneficiaries.

CONCLUSION 2:

UNFPA is contributing to the improvement of the coordination of a particularly large and fragmented UNCT, both at the central and the regional levels. Its contribution is particularly useful when UNFPA takes the lead of the coordination process.

Apart from isolate initiatives, the country office has not engaged in South-South cooperation. UNFPA has not systematized the use of South-South cooperation as an aid modality, neither has it designed any South-South strategy within the framework of its country programme. In the context of a fragmented UN system which lacks a coordination mechanism at the central level, UNFPA has played a key role in the good functioning of the different UNCT technical groups in which it takes part (HIV-AIDS, Emergency and Gender). UNFPA has also contributed to an improved coordination of UN agencies at central level. It has supported the setting up of a coordination unit (within the MINPROFF) regrouping all UN agencies. In the east region, UNFPA is a key actor of the UNCT, already working as a "mini One UN".

On some occasions, the leadership of UNFPA has been key to the improvement of the coordination within the UNCT: this was particularly the case within the CARMMA initiative and with the consultation process of the coming UNDAF (2013-2017).

CONCLUSION 3:

The country office is able to provide a quick and flexible response, notably thanks to its two regional sub-offices (which intervene exclusively on SRH and gender). Overall, the quality of the response is good, although it suffers at times from insufficient "filtering" of demands stemming from the field.

The response capacity of UNFPA is highly appreciated both by its development partners and its beneficiaries. The country office is indeed able to provide a quick response, particularly in the case of emergency situations, in the humanitarian field. UNFPA also shows great flexibility in adapting its interventions to evolving national needs and priorities and in seizing opportunities of new initiatives within its mandate areas. The two regional sub-offices (in the north and in the east) have proved instrumental in UNFPA's flexibility and quick capacity of response.

CONCLUSION 4:

UNFPA has demonstrated added value in its three focus areas. However the added value of UNFPA is not always correctly perceived by partners and beneficiaries.

The overall quality of the response is good, i.e., the CO responds in a satisfactory manner to the identified needs. However, demands expressed locally often lead to responses which have no clear strategic justification. The regional sub-offices do not systematically filter demands stemming from the field, and the absence of clear selection criteria is detrimental to the relevance and coherence of sub-regional offices' responses.

UNFPA has demonstrated real added value in its three focus areas. Its recognized technical expertise has allowed UNFPA to act as a facilitator, playing an effective intermediary role between donors and the national counterpart, particularly in the reproductive health component.

The country office also adds value in engaging actively and effectively in policy dialogue, and particularly in placing sensitive themes on the national agenda such as fistula. Gender-based violence or Female Genital Mutilation started to be more actively tackled by the Cameroonian government thanks to UNFPA's advocacy work.

In some cases, the added value of UNFPA lies in the fact that it is the only development partner to intervene; this is particularly true for the issue of the reparation of obstetric fistulae or in the support to the organization of the census.

Although the added value of UNFPA should not be boiled down to its financial and material support, this confusion is often made by its partners and beneficiaries. They often consider that the UNFPA added value mainly consists in its small scale and material support.

CONCLUSION 5:

There are two major challenges to the sustainability of the CO interventions: the lack of an exit strategy and the absence of a capacity development strategy.

In general terms UNFPA has put significant care into avoiding substitution actions that detract from capacity development (yet, as mentioned in the previous chapter, substitution has not been completely avoided in the field of SRH). However, the lack of an exit strategy both in the CPAP and in the AWPs creates a general feeling of expected continuity and constitutes factor of dependency. The team notes that the nature and the time span of AWPs do not facilitate the incorporation of a fully-fledged exit strategy. In addition, the efforts to deliver trainings or to share knowledge have not been conveyed within an overall Capacity Development Strategy covering the five-year programming cycle.

CONCLUSION 6:

UNFPA shows an excessive dependence on specific individual staff members.

In 2008, at beginning of the fifth programme cycle, the CO encountered serious difficulties affecting in both communication and work (in particular in the P&D component) as well as in some initiatives (e.g., the Gender policy). The arrival of the new UNFPA representative unblocked the situation. However, this positive outcome should not hide a more structural problem which sees UNFPA being very dependent on its personnel's individual attitude and approach, notably among its key staff, which constitutes a significant institutional weakness.

7.1.2 Programmatic level

Conclusions related to reproductive health and gender

CONCLUSION 7:

Tackling SRH issues is evidently relevant given their magnitude in Cameroon. However, the approach is somewhat too vertical, and there is a definite opportunity for the integration of SRH into the development of the general healthcare system in Cameroon.

High levels of neonatal and maternal mortality are markers of the general state of the population's health and of the healthcare system. This justifies a specific response. Hence the introduction of MDG 5 among the poverty reduction framework designed at the beginning of the new millennium, and the addition, in 2005, of new targets specifically focusing on sexual and reproductive health.[116] Such an approach, though, as in any vertical response to a specific health issue, may end up consuming resources that could have, in part, been used to develop the general healthcare system. That development is crucial to be able to face the range of challenges met.

CONCLUSION 8:

Although there are clear indications of tangible effects subsequent to the interventions sponsored or directly funded by UNFPA in Reproductive Health and Gender, measuring their actual magnitude is difficult.

It is difficult to conclude on the actual magnitude of the effects produced by the fifth country programme as regards to reproductive health indicators. There are good indications of an increased quality of attention to pregnant and delivering women, with a lesser degree of certainty for neonatal health since women usually do not stay in maternity wards after they have given birth. The quantity of births attended in health districts which receive direct support from the fifth programme has certainly increased recently. However, it is not possible to conclude on the extent to which the improvement in quality is responsible for this. Indeed, work undertaken to sensitize the population to resort to health services, through "causeries éducatives" and other means (radio programmes for example), is likely to have also contributed to that effect.

It is equally too early to conclude on the actual effects of the obstetrical kit pre-positioning scheme in the northern regions since its implementation has only started in June 2011. The monitoring and evaluation of that initiative will be essential, especially as it is supposed to cover the whole country should its results prove positive.

Measuring the effects of actions undertaken (on women's and children's rights, on the prevention of violence, on discriminations, on economic autonomy or psychosocial restoration) is difficult within the present evaluation, especially in areas where practices, even if harmful, are engrained in culture and centuries of habits. However, there are positive signs, such as the multiplication of women associations (at least 3,000 are accounted for by public authorities) and the growing interest for and discussions on themes covered by the programme in the media and at the community level, including with the involvement of traditional leaders. But there are also signs of limited effects, as in the case of income generating activities which are usually not economically viable. Gender-sensitive budgeting and the streamlining of gender issues in public policy and strategic planning does not show very tangible signs despite the presence of gender focal points at the higher institutional level. In any event, these efforts are valid and relevant. Measuring effects is crucial to fine-tune strategies and adapt activities; however, this is not possible in the absence of effective and systematic monitoring.

[116] Taux de prévalence contraceptive, taux de natalité parmi les adolescentes, accès aux soins prénatals, besoins de planification familiale non couverts.

CONCLUSION 9:

There is a lack of continuity in some areas of intervention of UNFPA, particularly as regards sensitization and community-level work.

In some areas of intervention, particularly as regards field work, there is a clear lack of continuity in the implementation of the gender component, especially as regards the sensitization aspect of activities targeting the general population. So far, only three rounds of "causeries éducatives" and "legal clinics" have been organized during the implementation of the fifth programme. The central region has benefited only once (in December 2010) for a total of about 1,000 people. The east has seen two sessions, one in 2009 another in 2010 (both in December), the north and far north only one, in 2009. Although public funds do contribute to the organization of more sessions, this effort remains insufficient, and it is difficult to ascertain that such a limited activity will have long term positive effects at the national level. Furthermore, the strategic importance of this activity is greatly diminished by its implementation modality: implementing NGOs are indeed not well integrated into the planning and resource mobilization process.

A similar comment can be made for the radio programs that have been sponsored by UNFPA. There is a need for more continuity and follow up on activities/interventions. Behaviour change, in general, is indeed a long-term endeavour which requires continuous efforts and follow-up. Monitoring and evaluation of these important activities are also lacking, which diminishes the capacity for the programme to understand the magnitude of the effects produced, to draw lessons from what is being done, and, consequently, to adapt its strategies accordingly.

CONCLUSION 10:

the UNFPA fifth country programme has supported the introduction of creative ways to enhance financial accessibility to and sustainability of reproductive health services.

UNFPA has played a leading role in supporting the introduction of financing schemes to improve access of pregnant and delivering women and of their new-borns to HR services. Innovative ideas to diversify and consolidate healthcare financing are numerous and UNFPA is opened to creative ways of doing business in those important areas. This covers fixed-priced packages of care ("forfaits") associated or not with the pre-positioning of delivery kits. The distribution of kits has also allowed the subsidization of delivery for a (limited) number of poor women. Solutions adopted so far probably increase up-front or face-price affordability. However, they do not seem to extend that affordability to a large proportion of the poor, particularly in rural areas. In the case of pre-positioned kits, costs charged to women remain high, although they are now given the possibility to pay after the intervention is completed.

CONCLUSION 11:

The sustainability of capacity development at the health facility level is jeopardized by a number of limiting factors (lack of resources, low volume of activity, poor state of facilities, etc.). In particular, the lack of monitoring, especially of facilitating supervision, is a major concern.

A considerable number of healthcare workers have been trained by the programme in SONEU and other capacities. This has had a positive effect on the capacity of health personnel to perform higher quality services. It has also has contributed to the increase in the number of patients resorting to health facilities. However, the sustainability of these efforts is at risk, since health facilities lack resources (they are under-staffed, poorly equipped, notably with regard to electricity, water, pharmaceuticals and other essential basic materials and consumables). The low volume of activity hinders the capacity of trained personnel to perform their newly acquired skills on a sufficiently regular basis to maintain them up-to-date and to improve through practice. The lack of supervision or monitoring, particularly of facilitating supervision, is also a major concern, as it prevents from ensuring that techniques are correctly implemented and that quality is maintained. Supervision and monitoring are also needed to identify the type of equipment, materials and other inputs that are missing and need to be provided in order to maintain and enhance quality of services.

CONCLUSION 12:

At decentralized level, the fifth country programme works mostly with rural populations; large urban centers are not covered.

Socio-economic and health indicators are notoriously worse in rural areas. The fifth programme concentrates most of its ground-level work, particularly in SRH, on 26 health districts, with, at most, mid-sized urban centers. However, approximately 50% of the Cameroonian population now lives in urban centers, and that proportion is growing. Many, in those centers, dwell in poor conditions, in slums (such as the "Briquetterie" district in Yaoundé), where their access to services is not much better than in rural areas and where the lack of information and sensitization is the norm.

Conclusions related to population and development (P&D)

CONCLUSION 13:

Whereas integration of P&D issues is being achieved in MINEPAT at general level, there is no real integration into sectoral planning and policies.

Integration of P&D issues has been progressively achieved both in strategy documents and in MINEPAT at central level. However, the level of integration of P&D issues in sectoral policies is at best superficial, without an analysis of the links between population data and resulting alternative scenarios or of the causes and consequences of planning with/without P&D data at sectoral level. This is especially unfortunate since sectoral policies are the key vehicle for the government to effectively transform the economic and social sectors, the environment for the private sector and, ultimately, the lives of the citizens.

CONCLUSION 14:

UNFPA has played a crucial role supporting Cameroon in obtaining better quality P&D data. However, the ability to transform data into real information which is then usable for planning purposes has not yet been achieved.

Obtaining reliable P&D data in Cameroon is a challenge that has consumed a large part of the resources of UNFPA and the Government. Whereas this is a crucial objective, insufficient attention has been placed on the transformation of data into real information that can be understood and used effectively by policy planners. This affects all kind of data, from census data, to any survey or study done in the country.

CONCLUSION 15:

The integration of P&D issues has not reached decentralized levels of Government

In spite of the decentralization process in Cameroon and the upcoming new responsibilities for the municipalities, those responsible at the local level are not aware of the importance of data for planning and management. This gap affects the implementation of activities and limits their benefits for the citizens. UNFPA has focused its efforts at central level, with only marginal effects on decentralized actors or policies.

7.1.3 Conclusions related to the monitoring & evaluation system

CONCLUSION 16:

The quality of the M&E system of the CO varies with the monitoring of outputs and outcomes being the weakest dimension in spite of its key importance at both CO and corporate level.

Monitoring of inputs and activities is satisfactory. Monitoring of risks and assumptions is done in a regular and effective manner although it is neither systematic nor formalized. Results-oriented monitoring, on the other hand, is non-operational. Evaluations are positively supported but not integrated in the M&E system of the CO and remain underutilized.

Presently, results-oriented monitoring is non-operational in CO. This is due to the absence of a results-oriented monitoring culture, i.e., a lack of understanding by most staff of the rationale and concrete benefits of a

results-oriented effort. It is also the consequence of (i) the absence of a functional results-oriented M&E system, which in turn is fundamentally due to a weak formulation of outputs and indicators; (ii) the non-existence of an information management system associated with the M&E system and (iii) the absence of a corporate demand for, and associated tools and guidance) on results-oriented monitoring.

CONCLUSION 17:

The immediate consequence of a non-operational results-oriented M&E system is a CO unable to measure the degree of achievement of the programme results.

The CO cannot be held accountable in an objective manner on its performance and is unable to learn which approaches work. Other aspects affected by the lack of a results-oriented M&E system are the scarcity of tangible information to be used to give appropriate visibility to the performance of UNFPA. Although some partial attempts have been undertaken to improve the results-oriented M&E system, those have been insufficient, particularly when taking into account that this is a core aspect of the management in a CO.

7.2 Recommendations

Recommendations are listed in a priority order (1: high; 2: medium) and are presented with the mention of their respective targeted audiences.

7.2.1 Strategic level

Recommendation 1	Priority	Audience
Create conditions for sustainable effects: elaborate and integrate an exit strategy at both programming and implementation levels and develop a capacity development strategy for the entire programming cycle (based on conclusion # 5)	Priority 1	Country Office

In consultation with its partners, UNFPA should include an exit strategy both in the CPAP and in AWPs to create conditions for sustainability of benefits and limit the substitution effect (stepping in for the government in a number of areas creates dependency). This is particularly true for technical assistance (TA) provided through national experts. The CO should integrate from the outset issues such as: how long are they supposed to stay? what are their precise objectives? etc.. Activity plans for TAs and notably a clearer understanding of their terms of reference and timeframe for action will help them perform their duties and avoid substitution effects.

Associating exit strategies with the drawing of lessons from the implementation of the programme would also help better design the next country programme (and CPAP) and avoid the rather confusing strategic framework currently attached to the fifth programme.

In addition, measures should be put in place to develop the capacities of strategic partners or to share knowledge (such as: delivering trainings, workshops, providing long and short-term technical assistance, positioning national and/or international expert) within an overall capacity development strategy for a five year time period. The capacity development strategy should complement the CPAP in view of obtaining long-lasting effects.

Recommendation 2	Priority	Audience
UNFPA should reinforce its institutionalization at country level, thus lessening its dependency on individual staff members (based on conclusion # 6)	Priority 1	ARO/ Country Office

The effective functioning of a country office should not be dependent on the personal commitment and approach of its management, in particular the representative. Whereas this evaluation team agrees that staff personalities necessarily affect a programme, fundamental aspects such as the relationship with the counterparts in the construction of programmes should be much more defined by the institution itself. Less dependent on individual staff members or management styles, the organization could better ensure continuity of approaches in time of staff (representative and/or senior staff) turnover.

The **African Regional Office (ARO)** should support and create conditions to strengthen the CO institutional capacity. Possible actions to be considered are: (1) recruitment of a deputy representative and (2) attention to ensuring an adequate mix of expertise, both national and international, at the level of the technical staff.

The **CO should** (1) build-in and institutionalise a consistent strategy vis-a-vis the main partners and (2) maintain a coherent line of implementation within UNFPA mandate and approved country programme.

Recommendation 3	Priority	Audience
Incorporate the decentralization process to the support strategy of UNFPA in Cameroon (based on conclusion # 15)	Priority 2	Country Office

Until now, the UNFPA support to P&D has been concentrated at central level. The decentralization process in Cameroon calls for specific support at decentralized levels in order to achieve enhanced effectiveness. This support could consider the following three aspects:

Direct role of UNFPA in decentralization. Unless the integration of P&D issues in policy happen at all levels, it will remain superficial to a large extent. The decentralization process affects the interaction of the state with individuals, and the availability of data at local level constitutes an imperative for the fairness of services and to achieve the satisfaction of citizens. The current amount of human resources and budget in the CO does not match the commitment of UNFPA to support integration of P&D issues "at all levels" in Cameroon. A larger allocation of budget for the support of decentralisation would be the ideal solution. In the meantime, UNFPA could start with some initial interventions in those strategies considered to provide the highest added value. Possible actions to be considered are:

(i) Concentration on the identification of needs in order to lobby for the support of other donors and raise awareness about the importance of decentralization, its governance implications and public service improvement implications;

(ii) Provision of capacity development to councils;

(iii) Courses on local demography, integration of local data in local planning and local policy design;

(iv) Ensuring that the census information is channelled in a usable way to municipal level, that key actors at the decentralized level are informed beforehand about what types of data should be available and its utilisation.

The role of the INS in the decentralization process. The CO should aim at promoting reflection in INS about its role in the decentralization process. The need for a coordinated system for statistics requires an analysis of the implications of decentralization for INS, in particular the risk of top-down decisions made on non-technical criteria. Aspects to be considered are: the insufficient number of statisticians at municipal level; the expected increase in the need for data at department, arrondissement or commune level; the need to prioritize some local surveys; the needs of the INS to be able to oversee effectively the decentralization process, etc.

Methodological guide for Integration of P&D issues. The CO should take into account the decentralization process and decentralized levels when distributing and accompanying the implementation of the guide.

7.2.2 Programmatic level

Recommendations related to reproductive health:

Recommendation 4	Priority	Audience
Integrate the development of an effective response to sexual reproductive health challenges into the development of the general healthcare system (based on conclusion # 7)	Priority 1	Country Office

Verticality may be counterproductive from a general healthcare system point of view. While vertical programs do respond to *specific* public health issues/diseases, these issues become more complex and intertwined (see for

example HIV with TB or SRH with HIV). Therefore, they require more coordinated and integrated responses. UNFPA should learn from the experience accumulated in both vertical and general approaches, particularly as it now has specialists in both a vertical and horizontal approach to tackling reproductive health issues. It can do so through the H4+ group, for example, and through sector-wide approaches; e.g.; through the creation of a SWAP in Cameroon. The next country programme should take integration and cross-fertilization into account as foreseen in the CARMMA (third axis: « interventions sur le système de santé » or actions on the healthcare system) and SRH could play a catalytic role, while UNFPA has the capacity to play a leading role (as shown throughout the implementation of the fifth country programme).

Integrating, as much as possible, activities targeting the development of the healthcare system's response to needs in SHR into those aiming at developing the general healthcare system's functionalities should become a priority of the next UNFPA programming cycle. For example, the production, communication and use of reliable reproductive health data should be inscribed into the development of the global health management and information system (HMIS) instead of being developed in parallel. In particular, the elaboration of SRH and FP indicators and data collection should be used to develop the whole system (not just SRH/FP monitoring) and indicators covering that area could serve as pilots for a better, more functional system.

This recommendation (using SRH/FP to build up the healthcare system) also applies, to the building of a referral/counter-referral system, which is an essential part of SRH interventions and is currently very weak.

Recommendation 5	Priority	Audience
Create the conditions for sustainable effects: help the healthcare system develop its own capacity in "facilitating supervision" (based on conclusion # 11)	Priority 1	Country Office

The development of "facilitating supervision" will need to be emphasized in the next programming cycle. This is needed to ensure that techniques taught are correctly implemented and trainees are provided with complementary practical information if needed. This does not immediately address the issue of the limited number of interventions (important to maintain quality in medical practice), but contributes to maintaining a minimal level (critical in the long run) to increase that volume. At some point, however, the question of staffing, particularly in rural integrated health centers and district medical centers, will also become an issue. Developing the use of "facilitating supervision" will also help moderate the effects of shortage of time and resources that can be dedicated to training. Supervision should be primarily conducted by Equipes Cadre de District (ECDs) and, occasionally, by regional and central staff.

Recommendation 6	Priority	Audience
Design a more continuous and organized strategy on obstetrical fistulae (based on conclusion # 4).	Priority 2	Country Office

As regards obstetrical fistulae, a more regular and comprehensive action needs to be designed and implemented. The prevalence of this extremely debilitating and punitive condition is not well known yet and a specific study might be needed in order to better analyze the magnitude of the problem in Cameroon. Thanks to better prevention, care and treatment, it is likely that the incidence of fistulae will go down. But there will still be a large number of women suffering from the condition and who will not be able to get appropriate care, notably because of the stigma, which prevents them from referring themselves, and because of the huge financial cost to them. UNPFA alone will probably not be able to address the problem in all its dimensions, but it can band partners together in order to obtain a significant impact.

Recommendations related to gender:

Recommendation 7	Priority	Audience
A comprehensive strategy addressing female genital mutilation could offer excellent results and constitute a flagship action for UNFPA in Cameroon (based on conclusion # 9 and # 12)	Priority 2	Country Office

Female genital mutilation (FGM) constitutes an unacceptable practice that is still causing tremendous suffering and female degradation in Cameroon. The practice falls into the core of human rights concerns and of UNFPA mandate.

A comprehensive strategy addressing female genital mutilation can offer several advantages: not only would it yield invaluable individual benefits for those directly affected, but it would also offer the rare possibility of eradication (in specific areas) without an excessive demand on resources. Additionally, the high profile of the subject among human rights issues combined with the possibility of eradication would help UNFPA and MINPROFF obtaining great and tangible visibility.

Some key aspects for a comprehensive strategy are:

(i) Any strategy needs to be maintained during a mid-term period and needs to address both the supply and demand sides;

(ii) Once a critical mass of persons in the community have changed their perception on the practice, eradication becomes increasingly easy, (the social pressure that once was a cultural barrier to eliminate the practice becomes pressure to abhor it);

(iii) Although the programme in Yaoundé (Briquetterie neighbourhood) presents a number of difficulties (such as the heterogeneity of the community which is mirrored by the diversity of practices; the illegal status of many potential beneficiaries), it also offers great opportunities such as: higher needs of the potential beneficiaries (which facilitates entry points in the community; the easiness of monitoring and direct action; and the special visibility attached to an action that takes place in the capital;

(iv) In Mamfé, there is an opportunity due to the existence and commitment of an already formed local committee (relying on key community leaders) and the work already performed (including identification of "exciseuses" in some communities) in 26 villages, which constitutes a solid basis in view of the establishment of a full-fledged programme.

UNFPA can build on the valuable study of the situation of female genital mutilation in Cameroon that it has sponsored (2010) and support the operationalization of the 1998 strategy on FGMs. Similarly to what is proposed for the eradication of obstetrical fistulae, it should build a constituency of partners, public and private, including civil society organizations, around the government (MINPROFF, MINSANTE and others) in order to create a momentum towards the progressive eradication of these practices.

Recommendations applying to both the SRH and gender components:

Recommendation 8	Priority	Audience
Expand work to large urban centers –where a sizable proportion of the population does not have access to basic services (based on conclusion # 12)	Priority 1	Country Office

Half of the Cameroonian population lives in urban areas. Although socio-economic and health indicators are (on average) better in urban areas (as compared to the national level), large portions of the population – particularly those freshly arrived from urban areas and other countries of the sub-region – lack access to basic services. Given the growing number of the population living in those areas, it would be advisable to include them (at least some of their health districts) in the next country programme. The CO should first undertake a specific analysis of the situation in those districts in order to calibrate the type of response to be put in place, in line with national policies and strategies. However resources are limited and should not be spread too thin, hence UNFPA should work with its partners in order to create and co-finance pilot projects that could be implemented in some of the least privileged urban centres or peri-urban areas. This could, for example, include the "Briquetterie" in Yaoundé which host a diverse population (coming from different regions as well as from neighbouring countries).

Given the experience accumulated by UNFPA in rural areas, priority should still be given to them in the next programme, especially since a lot remains to be done

in order to bridge the gap between urban and rural populations. In SRH, emphasis should be placed on linking rural areas with facilities at the health district level (health district hospitals) and at the regional referral level (regional hospitals and facilities). This, in turn, imply that referral and counter-referral capabilities must be built and rendered permanent, which is a challenge in health districts with bad road systems and long distances. The CO has already undertaken to develop the linkage between rural areas and more affluent and better equipped facilities; this should be pursued and reinforced and it requires securing the availability of basic inputs at the rural health facility level.

This, in turn, affects interventions to enhance women's rights (their access to services and capacity to exert control over their sexual and reproductive life). Therefore interventions within the gender component, (notably on promoting women's and youth's knowledge on their rights and on SRH-related issues, through "causeries" and "legal clinics") need to be expanded to the rural level where this information currently does not reach populations, particularly the poor (who constitute the vast majority in those areas).

Recommendation 9	Priority	Audience
Documenting and ensuring continuity in sensitization and on behaviour change communication activities (based on conclusion # 9)	Priority 2	Country Office

There is a need for more continuous action in the activities in behaviour change communication or sensitization (through "causeries" or community-based discussions, and through legal clinics). Only few sessions have been organized so far. Impact, through this type of intervention, can only be achieved in the long run given the hardship in change habits, behaviours, practices. Therefore, repetition, follow up, use of multiple channels (including the various types of media), advocating for a national conversation, is essential. The constituency of partners and stakeholders needs to be expanded and a true coordinating mechanism, under the helm of the government, has to be implemented and made functional. Implementing a more expansive behaviour change framework will also need: (i) the operationalization of the various national strategies and plans that have been designed in the recent past (including the gender policy that UNFPA has helped craft) and (ii) an effective M&E system the absence of which constitutes a current major weakness in view of the successful implementation of those policies and strategies.

Recommendations related to population and development (P&D):

Recommendation 10	Priority	Audience
Focus the support of UNFPA on sectoral ministries and policies. (based on conclusion # 13)	Priority 1	Country Office

A vast proportion of the support of UNFPA in the P&D component has been allocated to MINEPAT with only secondary attention given to sectoral ministries. After achieving significant progress with MINEPAT, sectoral policies should now be at the core of the strategy of the CO. This shall not mean abandoning MINEPAT – a key actor in planning and a fundamental partner for UNFPA which should be supported in its important coordination role. However, the ambition to have real impact on the lives of the citizens calls for the direct engagement with sectoral decision-makers, in sectoral policies, and with concrete applications in sectoral planning.

The CO needs to move the focus from the planning institutions to policy making ones and, when determining which sectoral ministry/policy should be supported, it should consider any ministry dealing with strategies affecting the socioeconomic situation of the country.

In a framework of limited resources, prioritisation should be defined by the CO depending on perceived will to collaborate, capacity to implement and monitor or their relative strategic significance. In this respect, the evaluators suggest the Ministry of Secondary Education of Cameroon (MINESEC) as a strategic priority since (i) its target population is the key segment of those aged between 12 and 18 years old and (ii) its staff has suitable capacity to achieve significant progress. It is important to note that any support strategy should go beyond isolated actions and include mid-term accompaniment.

Recommendation 11	Priority	Audience
Concentrate the support of UNFPA on the transformation of data into usable information for planning (based on conclusion # 14 and #15)	Priority 2	Country Office

One of the main challenges in Cameroon is the ability to transform data into usable information for planning. The general commitment by UNFPA to avoid playing a substitution role to Government should not impede the identification of specific areas in which it can play a leading role in view of decisive initial push and prompt government activity.

One of these areas is the production of high-quality studies offering in-depth analysis on strategic sectors. Such studies should illustrate different scenarios and their likely consequences, offer cost-benefit estimations and present the links between investments and possible outcomes in a way that allows decision makers to compare different policies in an evidence-based fashion. As long as this level of analysis remains beyond local capacity, bringing outside expertise would provide a concrete example of overcoming the challenge of converting data into real information in a strategic sector. Showing how a certain depth of analysis can offer tangible benefits in planning and outcomes could facilitate the government taking ownership of the idea once the benefits of efforts in this area are exposed. In this respect, this strategy should be considered as an opportunity to change a paradigm in Cameroon's planning culture and constitute a breakthrough in the process of effective integration of P&D issues and hard data in the other sectors.

Critical factors that are required in this first study would be to ensure depth of analysis and its practical application for planning. Given the present under-utilization of data, almost any key sector in Cameroon is amenable to this approach (education, employment, agriculture or energy). The choice of sector should take into consideration obvious criteria such as the political will of the specific sectoral ministry, the capacity to follow up on the planning stage, the strategic relevance for the country and – taking into account the desired "demonstration effect" - the relative straightforwardness of the chosen study, hence demonstrating the feasibility of the approach for other sectors and studies.

Additionally, it is of fundamental importance to transform data into useable information for planning in terms of the link between demographic and economic growth: its long-term trend and how to channel the opportunities it offers (and how to minimize its risks). This analysis work would be essential to guide the government work and also to provide a base of evidence for UN/UNFPA strategic decisions in the country. Another area of attention - as well as opportunity – for UNFPA is offered by the recently finished census. Support and accompaniment in the task of interpreting the data and its incorporation into planning should be a core concern of the Government and UNFPA.

Recommendation 12	Priority	Audience
Capitalize on lessons learned for the next census (based on conclusion # 14)	Priority 2	Country Office

Among the many aspects from the previous census experience that can be capitalized upon, four deserve special consideration:

1. Start the process for the new census as soon as possible. Capitalize upon the momentum and anticipate those aspects that can already begin, e.g., preparatory tasks, engagement of funds, etc.

2. Review the previous census experience before starting a new one. Learning from past experience seems logical, yet is not always done. It is suggested that the main actors gather to review the previous experience before starting the new census cycle.

3. Take advantage of the existence of BUCREP. It is important to take advantage of the creation of a body that is specifically dedicated to the census. It represents an opportunity for institutional learning and sustainability of capacity development related to the census. Specifically, it is important to revise previous flaws related to the establishment of BUCREP and build upon its strengths.

4. Perception of the census quality is almost as important as its actual technical quality and should be proactively addressed. In this respect, creating awareness on basic technical aspects among the citizens will require significant resources. Organizing a seminar with key journalists to explain and show basic technical aspects of the census comes as less resource-intensive and necessary investment. The effect would not only be positive for the journalists themselves, allowing them to work more accurately and preventing unjustified criticism of the census, but it would also have an indirect effect on the population at large (given the role of journalists to convey information to the public at large).

In the case of unexpected problems with potential damaging impact on public perception of the census (e.g., delays in the release of information) the CO should make it a priority to inform the media (on reasons for delay and timeline) so that delays are not equated with lack of transparency and reliability.

Recommendations related to the M&E system:

Recommendation 13	Priority	Audience
Prioritize appropriate allocation of resources to allow for the establishment of an effective results-oriented monitoring system (based on conclusion # 16)	Priority 1	Executive Directors Office and CO

The application of results-based management (RBM) and the core importance of results-oriented monitoring to achieve RBM are explicitly recognized, in the UNFPA Strategic Plan, in the Business Plan and in the RBM policy of UNFPA. They also acknowledge the need to produce demonstrable changes, increase the use of evidence and credible information on results and the need to invest in staff capacity to make those priorities effective.[117]The resources currently allocated to this purpose do not correspond to the formal recognition of this corporate priority.

In this context, **UNFPA headquarters should**:

- Ensure a sufficient allocation of resources (notably a team at headquarter level) to allow the establishment of a corporate results-oriented monitoring system;

The CO should undertake the following actions:

- Prioritize the hiring of an M&E officer fully dedicated to the set-up, supervision and accompaniment of a results-oriented monitoring system which although it needs the contribution of every staff, can only function – if one person is responsible for its implementation and promotion within the CO.

Recommendation 14	Priority	Audience
Address the quality of the results-oriented monitoring tools so that they become operational. (based on conclusion # 17)	Priority 1	Programme Division and CO

The **Programme Division (PD) should support the COs** in the creation of a results-oriented monitoring system. In particular:

- Ensure a realistic formulation of outputs and of SMART indicators and baselines that allow a measurement of progress towards results. The methodology for this process should be provided and **supervised by PD**. It requires technical expertise on formulation of indicators, and, at CO level, it should involve CO staff and counterparts throughout the whole formulation process. These indicators should also be referred to in the AWPs.

- **PD** should initiate the process of design of an information management system based on results associated with the indicators identified for the results-oriented M&E system and which should be implemented in **COs.** In particular, this system should:

(i) define what kind of information should be collected, who should collect it, with what frequency, who this information should be communicated to, for what purpose, etc.;

[117] See paragraphs 87, 88 and 118 of the Strategic Plan and paragraphs 1 and 6 of the RBM in UNFPA.

(ii) establish a system for the registration and management of indicators (indicator fiches) and;

(iii) design the most appropriate IT platform for the office needs, taking into account platforms developed by other agencies. UNICEF and UNDP, have already initiated this process (namely: the enhanced results-based management platform of UNDP), and their experience can be extremely useful for the UNFPA process.

Terms of Reference (Summary)

UNFPA Country Programme Evaluation – Cameroon

1. Introduction

UNFPA 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 programs to reduce poverty and to ensure that every pregnancy is wanted, every birth is safe, every young person is free of HIV/AIDS, and every girl and woman is treated with dignity and respect. As defined in its Strategic Plan 2008 – 2011, the work of UNFPA focuses on the three areas: population and development; reproductive health and rights; gender equality.

The goals of UNFPA are:

- population and development: To ensure a systematic use of population dynamics analysis in order to guide increased investments in reproductive health and HIV/AIDS; gender equality; youth development, in view of improving quality of life, sustainable development and poverty reduction;
- reproductive health and rights: To improve quality of life by way of universal access to reproductive health by 2015 and universal access to comprehensive HIV prevention by 2010;
- gender equality: To advance gender equality and empowerment of women and adolescent girls to exercise their human rights, particularly their reproductive rights, and live free of discrimination and violence.

The role of the Evaluation Branch at the Division for Oversight Services (DOS) is: (1) to provide substantive support to the Executive director's accountability function to the executive board and wider public; (2) to support greater the UNFPA country offices accountability to stakeholders and partners at the country level; (3) to serve as a means of quality assurance for the UNFPA interventions at the country level; (4) to contribute to learning at corporate, regional and country levels.

DOS Evaluation Branch plans to conduct a country programme evaluation in Cameroon during 2011.

2. Background and context

Cameroon is one of the countries selected to pilot the methodology on country programme evaluations in 2011. The financial budget of UNFPA programme in Cameroon for the programming cycle under evaluation, 2008 – 2012 stay close to around US$ 17.75 million.

The Cameron country programme document and action plan covering the period from 2008 - 2012 focus on the following areas: reproductive health; population and development and gender equality.

UNFPA has a diversified portfolio in terms of areas of intervention and a number of Annual Work Plans have been agreed with national partners encompassing a set of interventions on the focus areas of UNFPA.

3. Overall purpose and objectives of the exercise

The overall purpose of the exercise is to produce an independent and useful evaluation report covering the period 2008 – 2011, with the aim of delivering a final evaluation report in a timely manner to contribute to a new country programme which will be prepared by the UNFPA country office and national stakeholders.

The specific objectives of the UNFPA Country programme evaluation in cameroon are:

1. To provide an independent evaluation of the progress or lack thereof, towards the expected outcomes envisaged in the UNFPA programming documents. Where appropriate, the evaluation will also highlight unexpected results (positive or negative) and missed opportunities;

2. To assess the monitoring and evaluation system of the country programme.

3. To provide an analysis of how UNFPA has positioned itself to add value in response to national needs and changes in the national development context;

4. To present key findings, draw key lessons, and provide a set of clear and forward-looking options leading to strategic and actionable recommendations for the next Programming cycle.

The evaluation outcomes will entail a review of the UNFPA ongoing programme portfolio. This includes an assessment of:

- achieved outcomes and/or progress in achieving outcomes within each focus areas;

- factors influencing results (UNFPA positioning and capacities and partnerships);

- the strategic alignment with the strategic plan 2008-13 of UNFPA and with UNDAF will be considered;

- the crosscutting linkages and their relationship to MDGs in particular MDG 5 – improve maternal health (targets: a) reduce by three-quarters the maternal mortality ratio; b) achieve universal access to reproductive health).

4. Evaluation questions and criteria

The analysis of results will identify challenges and strategies for future interventions. A core set of criteria shown below will be applied in assessing the results (indicative evaluation questions identified below to be finalized during the evaluation desk phase):

Results by focus area

- **Relevance of UNFPA programmes:** How relevant are UNFPA programmes to the priority needs of the country? Has UNFPA applied the right strategy within the specific political, economic and social context of Cameroon? What have been the eventual critical gaps in UNFPA programming?

- **Effectiveness:** Has UNFPA programme accomplished its intended objectives and planned results? What are the strengths and weaknesses of the programme? What are the unexpected results it yielded? Should it continue in the same direction or should its main tenets be reviewed for the up-coming cycle?

- **Efficiency:** How well did UNFPA use its resources (human and financial) in achieving its contribution? What could be done to ensure a more efficient use of resources in the specific country context?

- **Sustainability:** Is the UNFPA programme incorporating adequate exit strategies and capacity development measures to ensure sustainability of the results over time? Are conditions and mechanisms in place so that the benefits of UNFPA interventions are sustained and owned by national stakeholders after the interventions in all three mandate areas completed?

Strategic positioning of UNFPA

The evaluation will assess the strategic positioning of UNFPA both from the perspective of organisation and the development priorities in Cameroon. This will entail, i) an analysis of the place and niche of UNFPA

within the development and policy space in Cameroon; ii) the strategies used by UNFPA in Cameroon to strengthen the position of UNFPA in the development space and create a position for the organization in its core focus areas; iii) finally, from the perspective of the planned results for Cameroon, the assessment will evaluate the policy support and advocacy initiatives of UNFPA programme vis-à-vis other stakeholders.

The evaluation will analyse a core set of criteria related to the strategic positioning of UNFPA, as shown below (indicative evaluation questions identified below to be finalized in the desk phase and methodology component of the exercise):

- **Alignment:** to what extent is the country programme aligned with UNFPA Strategic Plan? How is the UNFPA CO aligned with the UN strategic framework? How has UNFPA been effectively working together with other UN partners in Cameroon?

- **Responsiveness:** To what extend did UNFPA anticipate and respond to significant changes in the national development context within its 3 core focus areas? What were the missed opportunities in UNFPA programming?

- **Added Value:** The extent to which the UNFPA country programme adds benefits to what would have resulted from other development actors' interventions only.

5. Evaluation methods and approaches

Data Collection
In terms of data collection, the evaluation will use a multiple method approach that will include document reviews, group and individual interviews and field visits as appropriate.

Validation
The Evaluation Team will use a variety of methods to ensure that the data is valid, including triangulation.

Stakeholders' Involvement
An inclusive approach, involving a broad range of partners and stakeholders, will be taken. The evaluation will have a process of stakeholders mapping in order to identify both UNFPA direct partners as well as stakeholders who do not work directly with UNFPA, yet play a key role in a relevant outcome or thematic area in the national context. These stakeholders may include representatives from the Government, civil-society organizations, the private-sector, UN organizations, other multilateral organizations, bilateral donors, and most importantly, the beneficiaries of the programme.

6. Evaluation process

The process will be divided in four phases, each including several steps.

Phase 1: Preparation and desk phase
Desk review – Based on the preparatory work by the DOS evaluation branch in collaboration with the CO (identification, collection and mapping of relevant documentation and other data), the evaluation team will analyze, inter alia, national documents and documents related to the programme of UNFPA over the period being examined: 2008 - 2011.

Stakeholder mapping – The evaluation team will prepare a basic mapping of stakeholders relevant to the evaluation. The mapping exercise will include state and civil-society stakeholders and go beyond the partners of UNFPA and will also indicate the relationships between different sets of stakeholders.

Development of a concrete plan in conducting this evaluation in consultation with the CO staff, including selection of data collection methods, selection of interventions for field visits and addressing logistical issues.

Output: Desk Report – A short desk report will be prepared by the team. The report will present the evaluation design, which encompasses the stakeholders mapping, evaluation questions and methods to be used, information sources and plan for data collection, including selection of project/field sites for visits, and design for data analysis.

Phase 2: Data collection phase
A mission of three weeks to the country will be undertaken line with the desk report to:

- *Clarify the understanding of Cameroon development challenges* with the Government and other key stakeholders. Understand the perspective of key stakeholders on the role of UNFPA in addressing development challenges within UNFPA mandate.

- *Deepen the understanding of UNFPA programme and activities* with the CO staff; this includes visit to significant projects/sites as identified in the desk report *Identify and collect further documentation*, as required.

At the exit meeting of the mission, the evaluation team will provide a debriefing of the preliminary findings to the CO, take initial comments and validate the preliminary thoughts.

Phase 3: Drafting the Evaluation Report
The information collected will be analyzed and the *draft evaluation report* will be prepared by the evaluation team within 4 weeks after the departure of the team from the country. The draft report will be submitted by the Team Leader to the methodology expert who will review the report to ensure that the report complies with the Terms-of-Reference, the desk report and the methodology guidelines.

Review – Once the draft report has undergone quality assurance, it will be subject to a formal review process. This process entails: a review by UNFPA CO, and the Government contra parte focusing on factual errors and/or omissions and/or errors in interpretation. The Team Leader has the overall responsibility to address these comments in the finalization of the report.

Phase 4: Follow-up
Management Response – the country office will prepare a management response to the evaluation recommendations.

Communication and dissemination – The evaluation report will be widely distributed to stakeholders in the country and at UNFPA headquarters. The evaluation report will be made available to UNFPA Executive Board by the time of approving a new country programme document. The report and the management response will be published on the UNFPA website.

Ethical code of conduct for UNEG/ UNFPA evaluations

Evaluations of UNFPA-supported activities need to be independent, impartial and rigorous. Each evaluation should clearly contribute to learning and accountability. Hence evaluators must have personal and professional integrity and be guided by propriety in the conduct of their business.

Evaluation team/evaluators:

1. To avoid **conflict of interest** and undue pressure, evaluators need to be **independent,** implying that members of an evaluation team must not have been directly responsible for the policy/programming-setting, design, or overall management of the subject of evaluation, nor expect to be in the near future.

   Evaluators must have no vested interest and have the full freedom to conduct impartially their evaluative work, without potential negative effects on their career development. They must be able to express their opinion in a free manner.

2. Should protect the anonymity and **confidentiality of individual informants**. They should provide maximum notice, minimize demands on time, and: respect people's right not to engage. Evaluators must respect people's right to provide information in confidence, and must ensure that sensitive information cannot be traced to its source. Evaluators are **not expected to evaluate individuals**, and must balance an evaluation of management functions with this general principle.

3. Evaluations sometimes uncover evidence of wrongdoing. Such cases must be reported discreetly to the appropriate investigative body.

4. Should be **sensitive to beliefs, manners and customs** and act with integrity and honesty in their relations with all stakeholders. In line with the UN Universal Declaration of Human Rights, evaluators must be sensitive to and **address issues of discrimination and gender equality**. They should avoid offending the dignity and self-respect of those persons

with whom they come in contact in the course of the evaluation. Knowing that evaluation might negatively affect the interests of some stakeholders, evaluators should conduct the evaluation and communicate its purpose and results in a way that clearly respects the stakeholders' dignity and self-worth.

5. They are responsible for the clear, accurate and fair written and/or oral presentation of study limitations, evidence based findings, conclusions and recommendations.

For details on the ethics and independence in evaluation, please see
UNEG Ethical Guidelines and Norms for Evaluation in the UN System
http://www.unevaluation.org/search/index.jsp?q=UNEG+Ethical+Guidelines
http://www.unevaluation.org/papersandpubs/documentdetail.jsp?doc_id=21

ANNEX 2: EVALUATION MATRIX

COMPONENT 1: ANALYSIS BY FOCUS AREAS

CRITERIA/ SUBCRITERIA	EVALUATION QUESTIONS	WHAT TO CHECK	DATA SOURCES	DATA COLLECTION METHODS
REPRODUCTIVE HEALTH				
RELEVANCE				
	Are the objectives of the SRH Component of the 2008-2012 CPAP (i) adapted to the needs of the population (ii) and in line with the priorities set by the international and national policy frameworks ? To which extent are interventions planned as a result of the CPAP 2008-2012 adequately designed to reach the stated goals.	Objectives of ICPD, Beijing Action Platform (Conférence Mondiale sur les Femmes), UNDAF and UNFPA Medium-term strategic plan are reflected in UNFPA programming documents. Aspects that should be covered by those policies, plans, programs, and need to be checked more specifically : • underserved and marginalized/poor populations receive special attention;- regional disparities are taken into account in programming (with emphasis on underperforming regions) – in particular, ethno-cultural diversity is taken into account in programming and activities funded; • reproductive health services and rights are emphasized and streamlined in health policies (including universal health coverage plans, HIV/AIDS and STI strategic plans); • reproductive health services for refugee populations (mostly from RCA) are incorporated in UNFPA-supported/funded activities, plans, programs; • support to/development of health services (safe pregnancy and birth giving) – availability of emergency care, of qualified personnel, of medical products, of safe blood, of functional equipment. Critical size of samples (for example the number of beneficiaries in training activities, literacy activities) is sufficient to bring about change and positive spill–overs. Pilot programs and projects/activities are useful for developing wider-range programs and policies. Activities planned and conducted use evidence-based and tested strategies and interventions.	Politique Nationale de Santé 2001-2015/Stratégie Sectorielle Santé ; Ministère de la Santé Publique Ministère du Travail et de la Sécurité Sociale (politique nationale – lois et décrets – en matière de couverture universelle des soins) All sub-sectoral/disease-specific strategic programs or directorates (particularly HIV/AIDS – STIs, DSME, DOS, DLME, DPHL/M, DEP) and directors Population Council Plan de contingences pour les réfugiés (de RCA particulièrement)	Gathering and reading of all strategic plans (covering time-periods relevant to the evaluation) in order to identify policies and strategies targeting or facilitating RH rights and accessibility. Interviews of key informants in various sectors (social and development sectors) – at government (secretary generals of line ministries, department-level directors of the ministries of Santé, Travail et Sécurité Sociale, Promotion de la Femme et de la Famille, Jeunesse, Justice), UN agencies locally involved in RH issues (UNFPA, WHO, UN Women, UNDP)

COMPONENT 1: ANALYSIS BY FOCUS AREAS (continued)

CRITERIA/ SUBCRITERIA	EVALUATION QUESTIONS	WHAT TO CHECK	DATA SOURCES	DATA COLLECTION METHODS
EFFICIENCY				
Organizational and Programmatic efficiency	How appropriately and adequately are the available resources (funds and staff) used to carry out activities? To what extent were activities managed in a manner to ensure the delivery of high quality outputs?	Beneficiaries of the support UNFPA receive the resources that were planned, to the level foreseen and in a timely manner. Resources (human, financial and otherwise) provided by the program are adequate vis-à-vis the objectives set by the CPAP. Administrative and financial procedures allow for smooth, accountable and responsive management of financial and human resources. The programming does not outstretch the administrative capacities of the Cameroon office.	UNFPA (including finance/ administrative departments) Partners Beneficiaries	Annual reports from partner Ministries, and implementing partners, audit reports and monitoring reports Interviews with ministry-level/secretariat general-level staff to review the coordination and complementarity features of the program's implementation (MSP, MINEPAT, MINJEUN, MINESEC, MINEDUB, MINCOM, Ministère des Armées, etc.) Review of financial documents at the UNFPA (from projects' documentation) and interviews with administrative and financial staff. Beneficiaries of funding (including NGOs, SCOs)

(continued)

ANNEX 2: EVALUATION MATRIX/Component 1: Analysis by Focus Areas (continued)

CRITERIA/ SUBCRITERIA	EVALUATION QUESTIONS	WHAT TO CHECK	DATA SOURCES	DATA COLLECTION METHODS
EFFECTIVENESS				
Degree of achievement of the outcomes	To what extent were the excepted outputs of the CPAP achieved?	Completion or degree of completion of outputs/results planned in the CPAP. Likelihood that intended outputs will be produced and outcomes will be achieved by the end of the current programming cycle (CPAP). Coverage of prenatal, assisted birth and postnatal care (% of health facilities with functional services – availability of trained personnel, of functional equipment, of pharmaceutical and other products). • Frequency of prenatal/postnatal care visits. • % of births assisted by appropriately trained personnel. • Inclusion of FP activities in the PMA (minimal package of activities in primary care facilities) and in post-partum/ post-abortum care. • Availability of reference/counter-reference services (surtout évacuations sanitaires d'urgence dans le cas des femmes en couche). • Financial accessibility of services to women. • Maternal death rate in health facilities providing birth services • % of C-sections. • Fatality rate of C-sections. • % of use of contraceptive methods. • Availability of contraceptive methods to both men and women. • Policies and methods used to promote family planning. • Maternal mortality rate. • Access to detection (voluntary testing) and counseling services (HIV/AIDS and other STI/Ds). • Prevalence of HIV/AIDS among 15-49 y-old and distribution M/F, urban/rural. • ARV coverage. • Access to PMTCT (rate of use, follow up). • Support to IEC for HIV/AIDS prevention. *Notes:* *ICPD indicators will be covered* *For all indicators rural/urban distinctions will have to be established whenever possible.*	UNFPA UNICEF INS Ministère de la Santé Publique DHS 2004 (and 2011 if available) Institute for Health Metrics and Evaluation Rapports d'activité annuels des ministères partenaires, du FNUAP (rapports d'activité annuels des plans de travail annuels), des partenaires d'exécution (rapports trimestriels et audits annuels), évaluation annuelle de l'UNDAF, rapports de visites techniques et de gestion,	Confrontation of results to expectations (in CPAP and AWPs) – use of M&E of CPAP indicators. Elaboration of situation analysis tables, based on M&E templates and complemented with ad hoc templates to further analyze the data.

COMPONENT 1: ANALYSIS BY FOCUS AREAS (continued)

CRITERIA/ SUBCRITERIA	EVALUATION QUESTIONS	WHAT TO CHECK	DATA SOURCES	DATA COLLECTION METHODS
Depth and breadth of the outcomes	To what extent were the targeted groups of beneficiaries reached by UNFPA support? Are these beneficiaries taking advantage of benefits from the intervention supported?	Marginalised populations (poor women in both rural and urban settings, women affected by HIV/AIDS, young girls) have been specially targeted and have seen significant changes in their situation as a result of those interventions. Degree of geographical and demographic coverage of the activities implemented (and more specifically: all provinces and health districts targeted by the interventions have effectively and equally benefitted from the interventions).	Projects' and activities' quarterly and annual reports (including evaluations) UNDAF, UNFPA annual reports and evaluations Beneficiaries (most importantly those in the field) Other informants (provincial and district-level health directorates/authorities)	Gathering of data from reports, from field visits to beneficiaries (both institutional and individuals – focus groups) Extrapolation of analysis from previous criterium, using data from quarterly and annual reports, as well as interviews of informants, particularly at the regional and district levels, but also of UNFPA, and other partners.
Unintended effects	What kind of spill-over effects (negative or positive) can be identified that were not expected?	For example: policies or interventions that were promoted or implemented in one part of the country or at one level of government have inspired others to replicate because they were favorably impressed by outcomes brought about by these policies or interventions	All the above mentioned (interviews, documentation, press/media)	Same as above mentioned.
SUSTAINABILITY				
Design for sustainability	To what extent are the benefits likely to continue beyond program termination? Were the activities, outputs designed taking into account a reasonable handover to local partners?	Potential risks and opportunities are identified in planning documents and in activity reports and response; coping strategies are designed and implemented as a result. Exit strategies are incorporated in the planning of interventions supported/funded by the UNFPA and are followed through. Implementers and beneficiaries have become owners of the programs, interventions and outputs produced by these programs. Lessons learned from previous evaluations (program, project supported or funded) are integrated into policies, strategic and operational planning (at national level, as well as at UNFPA level).	CPAP, AWPs, Projects/interventions' design/programming documents Policies'/Programs'/projects' evaluation reports Previous UNFPA Cameroon evaluations UNFPA reports Beneficiaries (both institutional and individual)	Review of documents to identify management strategies of risks and opportunities (including SWOT analyses), and of exit strategies. Complementary interviews, particularly with beneficiaries (organizations funded or supported and individuals – through semi-directed interviews and focus groups)

(continued)

ANNEX 2: EVALUATION MATRIX/Component 1: Analysis by Focus Areas (continued)

CRITERIA/ SUBCRITERIA	EVALUATION QUESTIONS	WHAT TO CHECK	DATA SOURCES	DATA COLLECTION METHODS
SUSTAINABILITY				
National capacity development	To what extent has UNFPA been able to support its partners and the beneficiaries in developing capacity development strategies, mechanisms that ensure the durability of outcomes and outputs?	• Resources mobilized (both internally at the UNFPA office and through the CPAP's funding) have allowed the increase, development, facilitation of : • Inclusion and prominence of SRH (including FP) in health policies and planning. • Adequate allocation of Government budgets and other public resources to SRH activities/interventions. • Planned continuation of support by donors plan to the SRH/Women's health agenda in the foreseeable future. • Existence of multi-year plans to support the development and strengthening of SRH-related interventions in the health sector and in other sectors (social security notably). • A critical mass of government officials trained on SRH-related issues. • All health districts have the minimal standard coverage of health services and functional emergency care facilities. • Safe blood banks are available and functional, or planned in the near future, covering the whole territory • Medical schools' curricula include specific training on routine and emergency care and support for pregnant women and on neonatal care. • Government's and other partners' commitment to UNFPA-supported or funded activities (e.g. disbursement of their share of funding). • Low turnover of personnel at the government level. • Monitoring and evaluation systems in place to follow up on outcomes and outputs achieved or pursued by the interventions supported by the CPAP.	Line ministries (particularly policy and strategic planning documents) UNFPA Other agencies NGOs/CSOs – beneficiaries The Camerounese media	Mostly through interviews and review of policy/strategic planning documents at government sectoral levels and at the UNFPA Cameroun office. Test of the perception from beneficiaries of the willingness of national authorities and partners to keep pursuing the intended goals and to review and adapt policies in order to increase effects and reach.

COMPONENT 1: ANALYSIS BY FOCUS AREAS (continued)

CRITERIA/ SUBCRITERIA	EVALUATION QUESTIONS	WHAT TO CHECK	DATA SOURCES	DATA COLLECTION METHODS
GENDER EQUALITY				
RELEVANCE				
	Are the objectives of the Gender Component of the 2008-2012 CPAP (i) adapted to the needs of the population (ii) and in line with the priorities set by the international and national policy frameworks?	Planned UNFPA-supported/funded interventions are aligned with national and international agendas, plans, programs, and policies regarding gender rights, prevention of abuse and discrimination against women, promotion of equal access to basic services, • Aspects that should be covered by those policies, plans, programs, and need to be checked more specifically: • Underserved and marginalized/poor women receive special attention. • Regional disparities are taken into account in programming (with emphasis on underperforming regions) – in particular Ethno-cultural diversity is taken into account in programming and relevant activities are funded. • Gender rights of refugee populations (mostly from RCA) are taken into account in UNFPA-supported/funded activities, plans, programs. • Pilot programs and projects/activities are useful in developing wider-range programs and policies. • Activities planned and conducted use evidence-based and tested strategies and interventions.	SDRP Politique Nationale de Population Politique Nationale de la Jeunesse Sectoral plans and programs Line ministries UNFPA UNICEF Population Council UN Women	Gathering and reading of all strategic plans (covering time-periods relevant to the evaluation) in order to identify policies and strategies targeting or facilitating gender equality, women's rights, prevention of abuse, etc. Interviews of key informants in various sectors (social and development sectors) – at government (secretary generals of line ministries, department-level directors of the ministries of Santé, Travail et Sécurité Sociale, Promotion de la Femme et de la Famille, Jeunesse, Justice), UN agencies locally involved in gender rights issues (UNFPA, WHO, UN Women, UNDP)

(continued)

ANNEX 2: EVALUATION MATRIX/Component 1: Analysis by Focus Areas (continued)

CRITERIA/ SUBCRITERIA	EVALUATION QUESTIONS	WHAT TO CHECK	DATA SOURCES	DATA COLLECTION METHODS
EFFICIENCY				
Organizational and programmatic efficiency	How appropriately and adequately are the available resources (funds and staff) used to carry out activities? To what extent were activities managed in a manner to ensure the delivery of high quality outputs?	Beneficiaries of the UNFPA support receive the resources that were planned, to the level foreseen and in a timely manner. Resources (human, financial and otherwise) provided by the program are adequate vis à vis the objectives set by the CPAP. Administrative and financial procedures allow for smooth, accountable and responsive management of financial and human resources. The programming does not outstretch the administrative capacities of the Cameroon office. The UNFPA Cameroon Office is able to coordinate with and be complementary of other partners (government, international, non-governmental, etc.)	UNFPA (including finance/ administrative departments) Beneficiaries Partners, particularly other donors and Ministries in charge of coordination (Planification, Promotion de la Femme et de la Famille) Institutional beneficiaries	Review of financial documents at the UNFPA (from projects' documentation) complemented by interviews Interviews with ministry-level/secretariat general-level staff to review the coordination and complementarity features of the program's implementation (MINEPAT, MINJEUN, MSP, MINEDUC, MINCOM, MINJUSTICE, Ministère des Armées, etc.)
EFFECTIVENESS				
Degree of achievement of the outcomes	To what extent were the excepted outputs of the CPAP achieved?	Completion or degree of completion of and outputs/results planned in the CPAP: • % of girls schooled at primary, secondary and higher levels (with distinction between rural and urban settings) • % of girls and boys married, at various age brackets (prior to 15, 15-19, 20-25 years) with distinction rural/urban • Literacy rates (reading and writing) among various age brackets, females vs males, rural vs urban, etc. • Birth rates for age brackets(prior to 15, 15-19 and 20-24 years) • Female genital mutilation • Forced sexual relations • Child labor • Access of females to health care services vs access of males (ex. access to ARVs) • Participation of women in political processes/representation of women's interests in politics and policies • Situation analysis of violence against women (evolution of indicators/qualitative information) Likelihood that intended outputs will be produced and outcomes will be achieved by the end of the current programming cycle (CPAP).	DHS/EDS 2004 (and hopefully preliminary results of DHS/EDS 2011) Population Council UNFPA UNICEF UNESCO OIT/ILO United Nations Development Fund for Women (UNIFEM) Ministère de la Santé Publique Ministère du Travail et de la Sécurité Sociale Ministère de l'Education INS	Confrontation of results to expectations (in CPAP and AWPs) – use of M&E of CPAP indicators Elaboration of situation analysis tables, based on M&E templates and complemented with ad hoc templates to further analyze the data.

COMPONENT 1: ANALYSIS BY FOCUS AREAS (continued)

CRITERIA/ SUBCRITERIA	EVALUATION QUESTIONS	WHAT TO CHECK	DATA SOURCES	DATA COLLECTION METHODS
Depth and breadth of the outcomes	To what extent were the targeted groups of beneficiaries reached by UNFPA support? Are these beneficiaries taking advantage of benefits from the intervention supported?	Marginalised populations (poor women and youth in both rural and urban settings, women and youth affected by HIV/AIDS, young girls), have been specially targeted and have seen significant changes in their situation as a result of those interventions. Degree of geographical and demographic coverage of the activities implemented (and more specifically: all provinces and health districts targeted by the interventions have effectively and equally benefitted from the interventions).	Projects' and activities' quarterly and annual reports (including evaluations) UNDAF, UNFPA annual reports and evaluations Beneficiaries (most importantly those in the field) Other informants (provincial and district-level health directorates/authorities)	Gathering of data from reports, from field visits to beneficiaries (both institutional and individuals – focus groups) Extrapolation of analysis from previous criterium, using data from quarterly and annual reports, as well as interviews of informants, particularly at the regional and district levels, but also of UNFPA, and other partners.
Unintended effects	What kind of spill-over effects (negative or positive) can be identified that were not expected?	For example: policies or interventions that were promoted or implemented in one part of the country or at one level of government have inspired others to replicate because they were favorably impressed by outcomes brought about by these policies or interventions	All the above mentioned (interviews, documentation, press/media)	Same as above mentioned.
SUSTAINABILITY				
Design for sustainability	To what extent are the benefits likely to continue beyond program termination? Were the activities, outputs designed taking into account a reasonable handover to local partners?	Potential risks and opportunities are identified in planning documents and in activity reports and response/coping strategies are designed and implemented as a result. Exit strategies are incorporated in the planning of interventions supported/funded by the UNFPA and are followed through. Implementers and beneficiaries have become owners of the programs, interventions and outputs produced by these. Lessons learned from previous evaluations (program, project supported or funded) are integrated into policies, strategic and operational planning (at national level, as well as at UNFPA level)	CPAP, AWPs, Projects/interventions' design/programming documents Policies'/Programs'/projects' evaluation reports Previous UNFPA Cameroon evaluations UNFPA reports Beneficiaries (both institutional and individual)	Review of documents to identify management strategies of risks and opportunities (including SWOT analyses), and of exit strategies. Complementary interviews, particularly with beneficiaries (organizations funded or supported and individuals – through semi-directed interviews and focus groups)

(continued)

ANNEX 2: EVALUATION MATRIX/Component 1: Analysis by Focus Areas (continued)

CRITERIA/ SUBCRITERIA	EVALUATION QUESTIONS	WHAT TO CHECK	DATA SOURCES	DATA COLLECTION METHODS
National capacity development	To which extent has the UNFPA been able to support its partners and the beneficiaries in developing national capacities strategies, mechanisms that ensure the durability of outcomes and outputs ?	Resources mobilized (both internally at the UNFPA office and through the CPAP's funding) have allowed the increase, development, facilitation of : • Adequate allocation of Government budgets and other public resources to gender-related activities/interventions; • Focus on girls (and gender in general) in policies (education and health more prominently - • Targeting of girls in education policies; • Existence of multi-year plans to support gender equity, fight against gender-based discriminations; • A critical mass of government officials trained on gender-related issues. • Monitoring and evaluation systems in place to follow up on outcomes and outputs achieved or pursued by the interventions supported by the CPAP.	Line ministries (policy and strategic planning documents) UNFPA Other agencies NGOs/CSOs – beneficiaries The Camerounese media	Mostly through interviews and review of policy/strategic planning documents at government sectoral levels and at the UNFPA Cameroun office. Test of the perception from beneficiaries of the willingness of national authorities and partners to keep pursuing the intended goals and to review and adapt policies in order to increase effects and reach.
POPULATION AND DEVELOPMENT				
RELEVANCE				
Relevance of the objectives	To what extent are the objectives of the CPAP in Cameroon aligned to the objectives in the DSCE & Vision-2035 documents and responding to the national priorities?	Analyze and compare CPAP, DSCE & Vision 2035 documents Is the strategy balanced and appropriate vis-à-vis national vs. provincial needs? Analyze and compare CPAP implementation, DSCE & Vision 2035 documents with emphasis on national vs. local allocation of initiatives and effects	UNFPA, MINEPAT. Provincial level coordination bodies CPAP, DSCE & Vision 2035 documents	Documents analysis: CPAP, DSCE & Vision 2035 documents. Interviews with UNFPA staff, and MINEPAT at national and provincial level.
	Is the design of the strategy appropriate vis-à-vis the needs as expressed in the DSCE & Vision 2035?	Analyze and compare CPAP implementation and DSCE & Vision 2035 documents	UNFPA, MINEPAT. Provincial level coordination bodies CPAP, DSCE & Vision 2035 documents	Documents analysis: CPAP, DSCE & Vision 2035 documents. Interviews with UNFPA staff, and MINEPAT at national and provincial level.

COMPONENT 1: ANALYSIS BY FOCUS AREAS (continued)

CRITERIA/ SUBCRITERIA	EVALUATION QUESTIONS	WHAT TO CHECK	DATA SOURCES	DATA COLLECTION METHODS
EFFICIENCY				
Organizational and Programmatic efficiency	How appropriately and adequately are the available resources (funds and staff) used to carry out activities for the achievement of the outputs? To what extent were activities managed in a manner to ensure the delivery of high quality outputs?	Are the resources sufficient? Disbursed in a timely manner? Allocated in coherence with strategic priorities?	UNFPA staff, Counterparts staff (coordination bodies) UNFPA administration and implementing counterparts. CPAP, AWPs and ATLAS as references	Analysis of organization charts and interviews with UNFPA and counterparts, mainly coordination bodies
EFFECTIVENESS				
Degree of achievement of the outcomes	To what extent are population elements taken into account in poverty reduction strategies and in policies, plans and programs at all levels?	Analyze development policies, plans and programs at all levels to see if population elements are mentioned or have been considered	Development and poverty reduction strategies, policies, plans and programs. UNFPA MINEPAT at national and provincial level MINPROFF; MINSANTE MINTRAVAIL; MINEDUC	Documents analysis & interviews
	To what extent were the excepted outputs of the CPAP achieved?	**Output 1.** Strengthened technical and institutional capacities of national counterparts in order to integrate in the development policies, strategies, plans and programs at all levels elements of population, reproductive health, gender, culture and human rights. **Output 2.** Strengthened technical capacities of the national staff in charge of integrated management information systems in the field of population and development Analyze the different sub-outputs related to Outputs 1 & 2 and assess their level of achievement and their contribution to the two planned outputs and in turn, the contribution of the two planned outputs to the outcome	MINEPAT (DADM mainly) INS BUCREP	Documents analysis & interviews

(continued)

ANNEX 2: EVALUATION MATRIX/Component 1: Analysis by Focus Areas (continued)

CRITERIA/ SUBCRITERIA	EVALUATION QUESTIONS	WHAT TO CHECK	DATA SOURCES	DATA COLLECTION METHODS
Depth and breadth of the outcomes	Is the achievement of the outputs followed by their effective use at national and provincial level?	Analyze effectiveness of use at national and provincial level	MINEPAT at national and provincial level INS, BUCREP and their counterparts/clients at national and provincial level	Documents analysis & interviews at national and provincial level
	Is the achievement of the outputs followed by a benefit at national and provincial level?	Analyze real and perceived benefits at national and provincial level		
Unintended effects	Are there any unplanned positive or negative effects stemming from the outcomes or the implementation process?	Analyze unplanned effects, both positive and negative	UNFPA and every main stakeholder including other donors	Documents analysis & interviews at national and provincial level
SUSTAINABILITY				
Design for sustainability	To what extent are the benefits likely to continue beyond program termination?	In view of the nature of the outputs/outcomes, assess the sustainability of the benefits taking into account local capacity, ownership, resources, level of support/commitment, etc	MINEPAT at national and provincial level INS, BUCREP and their counterparts/clients at national and provincial level	Documents analysis & interviews at national and provincial level
	Were the activities, outputs designed taking into account a reasonable handover to local partners?	Assess the design itself including implementation elements if relevant, and use as references the perceptions of the main counterparts and their effective initiatives taken or planned in relation with the activities, outputs and outcomes		
National capacity development	To what extent have local capacities at national and provincial level been strengthened?	Analyze both explicit capacity-building and indirect capacity-building that may occur as an unintended effect resulting from the interaction with UNFPA or implementation of the program, etc. Assess in particular the quantity and quality of human capital, financial resources, ownership and priority given to the continuation or development of the initiatives	MINEPAT at national and provincial level INS, BUCREP and their counterparts/clients at national and provincial level	

ANNEX 2: EVALUATION MATRIX/Component 2: Analysis of the Strategic Positioning

STRATEGIC ALIGNMENT				
Corporate dimension (Strategic Plan) Systemic dimension (UN System)	Are the objectives of the CPAP in Cameroon aligned with UNFPA strategic plan dimensions (capacity development, disadvantaged and vulnerable groups, youth and south south cooperation as appropriate to the Cameroon context) and objectives? To what extent is the country programme as currently implemented in line with the UNDAF? Are there any mismatches? If so, what measures have been adopted to reverse the situation? To what extent does UNFPA capitalize upon complementarities and avoids duplication with the UN country team?	Analyze and compare CPAP, UNDAF and UNFPA strategic plan AND actual implementation Identify complementarities or reasons for isolated work; Identify mechanisms used and their effect; Analyze any difficulties that have arisen, if any.	CPAP, UNDAF and UNFPA strategic plan UNFPA operational management,	Documents analysis: CPAP, UNDAF and UNFPA strategic plan Interviews with UNFPA and other agencies staff + RC office Documents analysis & interviews
RESPONSIVENESS				
	To what extent has the CO been able to respond to changes in national needs, including national priorities, or to shifts caused by crisis or major political changes? What was the quality of the response? Has the response capacity of the CO had any repercussions in terms of major deviations in planned resource allocations and in terms of maintaining the coherence of the country programme as set forth in then CPAP?	Extent to which the CO has been able to respond as well as the quality of the response, including: (1) the speed and timeliness of the response; (2) the appropriateness of the response i.e. was it adequate to the magnitude of the demands?; (3) the balance between short-term responsiveness and long-term development objectives. Flexibility in redirecting funds, adapting objectives and planning to changes in contexts and circumstances. Deviation of mandate and resources allocation	Implementing partners and beneficiaries (most importantly those in the field)	Interviews to government partners, developing partners and beneficiaries Focus group

(continued)

ANNEX 2: EVALUATION MATRIX/Component 2: Analysis of the Strategic Positioning (continued)

CRITERIA/ SUBCRITERIA	EVALUATION QUESTIONS	WHAT TO CHECK	DATA SOURCES	DATA COLLECTION METHODS
ADDED VALUE				
	To what extent observed results within the 3 focus areas would not have been achieved without the support UNFPA? To what extent has UNFPA support produced an unintended substitution effect at national level?	What are the main UNFPA comparative strengths in the country – particularly in comparison to other UN agencies working in similar areas i.e. UNICEF, UN Women, WHO and UNDP? Are comparatives strengths a result of UNFPA corporate features or are they explained by CO's specific aptitudes? What is the main UNFPA added value as perceived by national stakeholders? Why UNFPA as opposed to another agency? Check exiting national capacities and interest for working on the same issues.	Programing documents and implementation progress reports	Doc review Interviews to government partners, developing partners and beneficiaries Focus group Interviews to NGOs, academia, private sector

ANNEX 3

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Documents reviewed and consulted

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Organizational analysis INS

Organizational analysis BUCREP

Analysis national strategies for development Cameroon GTZ

BTI Cameroon Country Report

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ANNEX 4

People Met/Consulted

UNFPA

First name, Family name	Position	Institution
Alain Sibenaler	Representative	UNFPA Country Office
Alain Jean Mah	Expert Planification Suivi/Evaluation Sante Reproductive	MINSANTE Regional Delegation, Bertoua (east)
Angéelique Hongla	AR Gender (Gender)	UNFPA Country Office
Nicole Eteki	AR - Reproductive Health	UNFPA Country Office
Joseph-René Boum	Programme Officer – east (Bertoua)	UNFPA Regional sub-Office (eastern region)
Rostand Njiki	Programme Officer – north (Garoua)	UNFPA Regional sub-Office (northern region)
Diane Matanye	Administrative assistant	UNFPA sub-office, Garoua
Roger Seukap	Programme Officer	UNFPA Country Office
Donald Boulemou Onembote	Expert National Jeunesse Est	UNFPA Country Office
Emmanuel Singeh	Admin/Finance Assistant	UNFPA
Felix Kouam	Natality expert (Population and Development)	Country Office-MINEPAT
Olive Bonga	Communication expert	UNFPA Country Office
Rose Njeck	Former Assistant Rep. (Population and Development)	UNFPA Country Office
Thérèse Flora Tchatchoua	Experte Genre	UNFPA Country Office
Yaovi Fanidji	International Programme Officer	UNFPA Country Office
Martine Ritouandi	SRH focal point	UNFPA / Regional Delegation MINSANTE (Maroua)
Dr Yap		UNFPA country office
Mme Rachel Penda	Responsable du suivi et mise en oeuvre du projet BAD dans la region du Sud Experte nationale de gestion du projet BAD	UNFPA
Ernest Essomba	Responsable du suivi et mise en oeuvre du projet BAD dans la region du Centre Expert national de gestion du projet BAD	UNFPA
Souleimanou Youssoufa	Expert National Suivi-Evaluation en appui à la composante SR (M&E expert in support of the SRH component)	UNFPA / DSF (Department of family health) / MSP (MINSANTE)

Central Government

First name, Family name	Position	Institution
Abbièri Ebayah	APSF/MINPROFF	MINPROFF
Abdulaye	Ministre Deleguée	MINEPAT
Abena Ondoa née Obama Marie-Thérèse	Ministre de la Jeunesse	MINPROFF
Adoum Garoua	Minister	Ministry of Youth Affairs
André Mama Fouda	Ministre de la Santé	Ministry of Public Health
Alima Sidonie	C/ZEP	MINPROFF
Caliu Abessolo Asseko	12/ MINPROFF	MINPROFF
Damien Enguene Pierre	C/CECO	MINPROFF
Darie Nga	UNW- UNFPA	MINPROFF
Eliane Ngomo Essomba	CS/EA/DPSF	MINPROFF
Evina Louison	Cadre/ CC	MINPROFF
Gabriel Nloga	Chief of Communication	Ministry of Youth Affairs (MINJEUNE)
Jean-Pierre Nsoa	SDPEFA/ Technical coordinator	MINPROFF
Leon Tchonko Wessidjam	C/SPS	MINPROFF
Mama Nchare	Director of Education	Ministry of Youth Affairs
Mathias Mvolo	CT1 MINPROFF	MINPROFF
Mgo Mgoa Pauline	Chargee d'etudes assistance n1	MINEPAT- DADM
Minsoko Ndongo	Chief of Cooperation	Ministry of Youth Affairs
Nso Akrey E	AAF-UNFPA	MINPROFF
Oswald Ayuketah	Technical Adviser	Ministry of Youth Affairs
Paul Ngah Claude	Chief for Economic Development of Youth	Ministry of Youth Affairs
Saibon Nassourou	General Secretary de la Jeunesse	MINPROFF
Solange Abe Onana	C/SPEF/CC	MINPROFF
Tousile Sadiamia	CEA/CS	MINPROFF
Wespa Koukréo Maipa	CS/PG	MINPROFF
Prof. Robinson E. Mbu	Director, Department of Family Health	MINSANTE
Dr Seidou Moluh	Sub-director for Reproductive Health – Department of Family Health	MINSANTE
Dr Martine Bayé Lukong	Technical advisor (conseiller technique n°3)	MINSANTE
Dr Jean Yves Redon	Conseiller technique du MSP	MINSANTE
Jean Bosco Elat	Secrétaire permanent (National Programme Coordinator)	CNLS (Conseil National de la Lutte contre le SIDA – National AIDS Control Committee)
Thérèse Nkoa	Chef de service de la sécurité transfusionnelle (Director of blood transfusion safety)	MINSANTE / DLM (Direction de la maladie – Department of disease control)
Prof. Fru F. Angwafo III	Secretary General	MINSANTE

Annex 4: Regional Government and Peripheral Institutions (continued)

First name, Family name	Position	Institution
Tamsser	Delegué Regional du Ministère	MINPROFF Regional Delegation
Fritz Dikosso-Sémé	Secretary General	Services du Gouverneur de la Région du Nord (Regional Government – north)
Bernard Docgne	Délégué régional de l'Ouest MINEPAT	MINEPAT Regional Delegation Bafoussam
Eliane Zangone	Chef de service policy nac. De population	MINEPAT Regional Delegation
Ellon	Délégué régional du MinProff pour le littoral	MINPROFF Regional Delegation
Emilienne Mangue	Conseiller de jeunesse et animations	MINJEUN Regional Delegation
Jacques Fritz	Délégué regional Douala	MINEPAT Regional Delegation
Joseph Tamche	Director General INS	MINEPAT-INS (Institut National de la Statistique) Agence du Littoral
Kighe-Free MnKuwiyayen Abel	Demographer and Regional Delegate MINEPAT	MINEPAT- INS Regional Delegation north-west (Bamenda)
Ngalim Julius Takwa	Regional Delegate MINJEUN	MINJEUN Regional Delegation north-west (Bamenda)
Paul Tasong	Permanent secretary	MINEPAT Regional Delegation
Same Mbou Samuel	Délégué Régional de la jeunesse pour le Littoral	MINJEUN Regional Delegation
Zafack Martin	Head of Agency	INS Delegation north-west (Bamenda)
8 people		Regional Delegation of Public Health – north
Dr Jean Pierre Essinai Mbuda	CSSA Betaré Oya	Equipe cadre de district (DS de Bétare Oya)
Jean Essono Nzoue	CBAAF	Equipe cadre de district (DS de Bétare Oya)
Théophile Mikolou Ndjessie	Equipe cadre de district	Equipe cadre de district (DS de Bétare Oya)
Joel Nbuena	PR COSA Bétaré Oya	Equipe cadre de district (DS de Bétare Oya)
Rigobert Ngongang	S General HO	Equipe cadre de district (DS de Bétare Oya)
Baba Zakari	P COGEDI	Equipe cadre de district (DS de Bétare Oya)
Abouraman Liman Mahamat	CCSI De Naokayo	Equipe cadre de district (DS de Bétare Oya)
Kantou Romain	Economist	Equipe cadre de district (DS de Bétare Oya)
Jean Pierre Dttou	Représentant	Equipe cadre de district (DS de Bétare Oya)
Philippe Nawara	CBS	Equipe cadre de district (DS de Bétare Oya)
Brice Donfack Temgoua	Equipe KIME Hospital	Equipe cadre de district (DS de Bétare Oya)

First name, Family name	Position	Institution
Yvette Nougayo MJ	IDE hospital Bétaré Oya	Equipe cadre de district (DS de Bétare Oya)
B. Ngakam N Cakanou	IDC Hospital Bétare Oya	Equipe cadre de district (DS de Bétare Oya)
Mendonga Honorine	AS Hospital Bétaré Oya	Equipe cadre de district (DS de Bétare Oya)
Emmanuel Alain Goum	Maternal Health Specialist	Equipe Cadre Bertoua
Claude Gualbert Mempou	IDE Specialisé en Anesthésie Réanimation PEC des AVP et Femmes Enceintes	Equipe Cadre Bertoua
Germaine Selatsa	IDE Specialisé en Santé de la Reproduction	Equipe Cadre Bertoua
Suzanne Awana	IDE en Maternité ; Formateur en P.F.	Equipe Cadre Bertoua
Marie Yvonne Baina	Infirmière Principale	Equipe Cadre Bertoua
Marie Louise Essane	Infimière	Equipe Cadre Bertoua
Dr. Flavian Yélé Beaunet	Director	Regional Hospital, Bertoua
Dr Huguette Nguélé Méké	Directrice du service de Gynéco-obstétrique (head of OBGYN department)	Regional Hospital, Bertoua (east)
Bassiron Mamadou	Surveillant Général	Hôpital Régional de Garoua
Dr. Thomas Zra	Gynécologue Obstetricien	Hôpital Régional de Garoua
Dr. Massing J. Joseph		Hôpital Régional de Garoua
Mamadou Anidjo	Major Maternité	Hôpital Régional de Garoua
Dr. Tanke Dongmo Lezin	Chirurgien, Chef de Service Chirurgie	Hôpital Régional de Garoua
Alphonse Djallo	Point Focal SR	Délégation Régionale MINSANTE
Bichair Mahamat	Chef SAF/DRSP/N	Délégation Régionale MINSANTE
Lougga Bello	CEA/CSSE DRSPN	Délégation Régionale MINSANTE
Dr. Jean-Joseph Massina	Pédiatre Consultant	
Dr. Maha Danna	Expert National Chargé du Suivi – C2D Santé	
Dr. Elie Lama	CCSSE/DSRP/Nord	Délégation Régionale MINSANTE
Dr. Sepde Oumanon	Coordonateur	GTR
Dr. Salinou Sadou	Manager	CAPR/Nord
Dr. Nsom MBA Charles	Délégué	Ministry of Public Health, Delegation of the east
Kegne Benoit	Délégué Régional de l'Est	Délégation du Ministère de la Jeunesse
Nicole Moandgel	Chef de Bureau de la Participation des Jeunes	Délégation du Ministère de la Jeunesse
Monique Boandge	Chef de Personnel	Délégation du Ministère de la Jeunesse
Lucie Boundar	Chef du Courrier	Délégation du Ministère de la Jeunesse
Dr. Denis Nsame	Directeur	Hôpital du District d'Abong-Mbang
Mme Catherine Nkemomb	Infirmière Brevetée Accoucheuse	
Mme Marceline Assah	Infirmière Brevetée Accoucheuse	

Annex 4: Regional Government and Peripheral Institutions (continued)

First name, Family name	Position	Institution
Solange Abdoulaye Amoa	Delegate (head of regional delegation)	MINPROFF regional delegation – north
Samuel Yinyang	Delegate (head of regional delegation)	MINJEUNE regional delegation – north
Aliou Aïssatou	Chef de service vie associative	
Jude Kudiboja	Expert jeunesse	
Dr Théodore Désiré Dipanda	Head of health district Director of district hospital	Health District (and district hospital) of Lagdo (north)
Mme Edith Bissohong	Infirmière Diplômée d'Etat (IDE – prof. nurse)	District hospital of Lagdo (north)
Mme Manou Djakao	Aide soignante – responsable CPN	District hospital of Lagdo (north)
Mr André Godwé	Infirmier assistant	CSI de Djippordé (HD of Lagdo – north)
Mme Isabelle Djinbé	Chef du CMPJ	Centre Multifonctionnelle de Promotion de la Jeunesse – Garoua (north)
Mahamat Salé	Delegate, head of delegation	MINPROFF Regional Delegation, Maroua (far north)
Dr Rebecca Djao	Delegate, head of delegation	MINSANTE Regional Delegation, Maroua (far north)
Martin Kami Bouba	Delegate, head of delegation	MINJEUNE Regional Delegation, Maroua (far north)
Dr Jean-Jacques Bissémou	Gynéco-obstétricien, interim Head of district hospital	District Hospital, Mokolo (far north)
Mr Serge Lono-Dydy	Chef de centre (head of center)	CSI de Mokolo-I, Bertoua
Mme Honorine Moankong	Infirmière	
Siméone Bieloa	Infirmière Brevetée Généraliste	
Mme Sandrine Françoise Mentouga	Infirmière (maternité)	
Mme Félicité Bobdjal	Infirmière (maternité)	
Mme Solange Edwige Metindi	Delegate (head of Delegation)	MINPROFF Regional Delegation (Bertoua)
Simon Semboung	Chef de centre (head of center)	CSI de Bazzama (east)
Mohamadou Rabiou	Commis / agent de santé communautaire	
Anie Lizette Ambazza	Journalist	Magic FM
Irène Sidonie Ndjabun	Independent journalist	"La nouvelle expression"
Jocelyne NdouJou-Mouliom	Journalist	Cameroon Tribune
Patricia Ngo Ngouela	Journalist	Mutations
Rosaligue N. NGanzi	Journalist	Repères
Serge Henri Kamegni	Journalist	Cameroon Tribune
Dr Patricia Mouné Etotoké	Directeur Programmes de Santé Publique	CENAME (Centrale Nationale d'Approvisionnement en Médicaments et Consommables Médicaux Essentiels)
Mme Luzette Ndongo Zinga	Directrice	Centre de Promotion de la Femme et de la Famille (Yaoundé V) Centre d'Accueil de la Femme en Détresse / MINPROFF
Mme Victorine Kenfack	Conseiller pédagogique	
Meme Marguerite Akamou Owona	Assistante sociale principale	

First name, Family name	Position	Institution
Elisabeth Chantal Odette Oyié	Infirmière Brevetée Accoucheuse	Centre de Santé Intégré confessionnel Nkol-Bikon (Bertoua)
Geneviève Ngah Onana	Infirmière Brevetée Généraliste	
Rodrigue Lakoa	Médecin généraliste (physician)	
Prof. François-Xavier Mbopi-Kéou	Director, National Public Health Laboratory	MINSANTE

International Organizations and Bilateral Agencies

Arsene Enyegue		UNHCR
Cathie Danielle		UNHCR
Florette Lobé	Senior Field Monitor	PAM / WFP
Gaston Sorgho	Sector Lead Human Development	World Bank
Helene Solange Bilounga	SERCOM	UNHCR
Jean Jacques Ebène (and 3 more people)	Chef de Bureau de terrain	UNHCR, north
Joseph Claude Amougou		PAM
Kassaimon Daimon		UNHCR
Louis Nduwimana	Specialiste de Programme	PNUD
Fatta Kourouma Mamadi	Chef de la Sous Delegation	UNHCR
Mengue Nadine		PNUD
Nhake Marthe C		PNUD
Nzoa Gervais		PNUD
Philippe Onanaa	Protection Assistant	UNHCR
Arlette Mvondo	Chargée de Programme	UN Women
Jacky Amprou	Chargé de Mission	AFD
Dieudonné Takouo	Director of the Department of north-south cooperation and Multilateral Organisations	DGCOOP
Albert Mendy	Programme Specialist Education	UNESCO
Aida Haile Mariam	Representative	UNHCR
Dr Mamadou Sakho	Représentant Cameroun	UNAIDS
Mme Ora Musu Clemens-Hope	Représentante Cameroun	UNICEF
Dr Gerd Eppel	Conseiller technique principal	GIZ
Sibylle Herzig	SRH programme officer)	GIZ
Dr Charlotte Faty-Ndiaye	Représentante Cameroun	WHO
Dr Pascal Milingué	Responsable VIH	
Mr Jean-Marie Esso	Coordonateur Cellule d'Exécution de Projet	PASR / BAD (Projet d'Appui à la Santé de la Reproduction – African Development Bank)
Mr Jean-Jacques Mengbwa	Chargé de communication du projet Focal point UNESCO & UNFPA	
Faustin Tsimi	Chef de departement de gestion des catastrophes NDMT/RDRT/ERDAC Chef de projet Opération d'Assistance aux Réfugiés – Langui	Croix Rouge Camerounaise

Annex 4: International Organizations and Bilateral Agencies (continued)

First name, Family name	Position	Institution
Justine Melingui	Infirmière Diplômée d'Etat - (IDE – professional nurse) / major au BHC du camp de réfugiés Langui	Croix Rouge Camerounaise
Dr. Dominique Landreau	Conseiller Technique pour les Délégués Régionaux de la Santé du Nord, Ext. Nord et …	C2D

Civil Society Organizations

First name, Family name	Position	Institution
Atabong Maurin	Member	Committee Against Female Genital Mutilation (CAFG) Mamfé
Martin Etta	Chief Publicity officer	Committee Against Female Genital Mutilation (CAFG) Mamfé
Chief Osamge	President of the local committee for the fight MGF	Committee Against Female Genital Mutilation (CAFG) Mamfé
Etce Richard	Journalist, trained advocate	Committee Against Female Genital Mutilation (CAFG) Mamfé
Mary	Member (and victim)	Committee Against Female Genital Mutilation (CAFG) Mamfé
Obi Joseph	Journalist	Committee Against Female Genital Mutilation (CAFG) Mamfé
Obi Mareon	Regional Delegate of MINPROFF	Committee Against Female Genital Mutilation Mamfé (and MINPROFF regional delegation)
Pauline Agbo Besem	Zone coordinator	Committee Against Female Genital Mutilation (CAFG) Mamfé
Susanne Ekem	Treasurer	Committee Against Female Genital Mutilation (CAFG) Mamfé
Tabaitah Eyuk	Director Woman Empowerment Center Training (Centre promotion Femme CPF)	Committee Against Female Genital Mutilation Mamfé (and MINPROFF-CPF)
Tambe Frida	Ex-practitioner and Member	Committee Against Female Genital Mutilation (CAFG) Mamfé
Emmanuel N. Ngappe	Executive Director	Civil Society Organization
Mounlom Damaris	Coordinator	FESADE (ONG Femmes-Santé-Développement en Afrique sub-Saharienne/ Women-Health-Development in sub-Saharan Africa)
Patricia Sanguen	Technical Assistant	OFSAD
Rosalie Nkonpa	Secretary General	OFSAD
Tolevi Kenfack	President	Civil Society Organization
Altimatou Moussa		UNYA
Brice Saha Foudjo		UNYA
Dhou Moulion Lamarre		AFRIYAN
Ebong Parfait		UNYA
Eric Guemne		CAMNAFAW
Fanson Bari Bongmpiy		Pro-Nepad Youth
Girault Duvalier Ndamcheu	Program Officer	Presse Jeune

Civil Society Organizations (continued)

First name, Family name	Position	Institution
Idrisson Mondpe Chare		AFRIYAN
Olga Tiyon		Goducamer Communications
Patrice Meteunou		AIESEC-Yde
Salomon Mfouapon		AFRIYAN
Thierry Kanmi		UNYA
Fanny Ango	Presidente	Association Camerounaise des Femmes Juristes
Giscard Bounga	Animateur de Radio	Radio Aurore
3 women	Members of association	Association des Femmes Catholiques de Lagdo Centre (north)
Mme Ascadjam – épouse Bakari	Présidente régionale	Réseau des associations féminines de l'Extrême Nord
Djessi Ndine Alaine	Présidente nationale Présidente de la cour d'appel	ACAFEJ (Association Camerounaise des Femmes Juristes)
Damaris Mounlorn	Coordinatrice	ONG Femmes-Santé-Développement en Afrique sub-Saharienne (FESADE)
		CAMNAFAW (Cameroonian National Association for Family Welfare)
		OFSAD (Organisation des Femmes pour la Santé la Sécurité Alimentaire et le Développement)

Final Beneficiaries

Anatole Etondi		CPFF, Bertoua
Arnold Betala	Pair Educateur	RAJEDES, Bertoua
Benjamin Ndowe	Pair Educateur	Mandjou - PE – ADESPROH, Bertoua
Doriane Kwedi	Pair Educateur	ASAD, Bertoua
Florence Ngaikpu		ADPSPRON, Bertoua
Freddy Edimo		CMPJ, Bertoua
Gerard Yenoka		ADESPROH, Bertoua
Linguine Beme	Pair Educateur	RAJEDES, Bertoua
Messina Messina		CPFF, Bertoua
Toukourou Mohamed		ADES PROH, Bertoua
Vanessa Mayezam	Pair Educateur	CMPJ, Bertoua
Amina	17 year old girl	CMPJ, Garoua (north)
Fatoumé	16 year old girl	
Koubakoué	19 year old boy	
Yasmine	17 year old girl	
Djaitouma Djoumba	Around 16 year old	Benefited from surgical repair of obstetrical fistula
2 Group discussions with 50 refuges		

ANNEX 5: UNFPA Portfolio – List of Atlas Projects (2008-2010)

			2008		2009		2010	
	Project ID	Project Title	Budget	Expenditure	Budget	Expenditure	Budget	Expenditure
REGULAR RESOURCES	CMR5A11A	Support to the 5th Country Programme	910,000.00	938,581.61	792,000.00	820,892.38	895,090.00	997,832.99
	CMR5A11B	Support to Programme Coordination	20,860.00	22,083.34	0.00	2,961.51		
	CMR5G11A	Gender Mainstreaming in policies			88,494.00	81,407.36	213,176.00	211,434.18
	CMR5G41A	Reduction of Gender Based Violence	215,665.00	65,162.62	282,763.64	364,439.14	194,443.00	178,595.86
	CMR5G41C	Reduction of Gender Based Violence			211,310.00	99,809.31	0.00	7,750.66
	CMRM0809	CMR BSB Management	740,738.00	742,160.26	704,115.00	649,473.51	745,057.00	714,206.64
	CMR5P11A	Strengthening of national capacities to integrate the issues of POP/DEV in development planning policies.	65,878.00	4,128.99	172,748.00	154,380.34	247,918.47	208,847.37
	CMR5P31A	Strengthening of technical capacities of national counterpart staff in charge of integrating management information systems in the area of population and development.	206,850.00	130,358.75	333,388.00	268,858.31	119,692.00	116,864.62
	CMR5P31B	Data base on Population and Development			527,830.00	524,105.23	339,467.00	334,437.36
	CMR5P32A	Strengthening of technical capacities of national counterpart staff in charge of integrating management information systems in the area of population and development.	385,000.00	85,743.11	7,572.00	735.93	0.00	-446.03
	CMR5R101	Humanitarian Response	200,000.00	23,217.60				
	CMR5R11A	National Capacity to reduce maternal morbidity and mortality.			259,361.00	390,120.36	442,870.00	408,441.46
	CMR5R21A	Strengthening of technical capacities of health care clinics, ministries and community networks to manage the healthcare system, to respond to humanities crisis, humanitarian response and resources mobilization.			670,022.00	541,229.76	682,641.00	632,853.00
	CMR5R21B	Reproductive Heath			123,866.53	13,914.87		
	CMR5R22A	National Capacity to reduce maternal morbidity and mortality strengthened.	1,539,541.00	752,708.76	34,046.88	31,092.37	0.00	-2,848.38
	CMR5R22B	National Capacity to reduce maternal morbidity and mortality strengthened.	0.00	203.07	3,095.00	0.00		
	CMR5R24A	National Capacity to reduce maternal mortality strengthened.	160,898.00	42,533.77	18,503.99	17,895.14		

ANNEX 5: UNFPA Portfolio – List of Atlas Projects (2008-2010) (continued)

			2008		2009		2010	
	Project ID	Project Title	Budget	Expenditure	Budget	Expenditure	Budget	Expenditure
	CMR5R51A	Strengthening of national health care centres to promote behavior change for improved reproductive health, including the prevention of sexually transmitted infections and HIV.	250,357.00	41,736.02	777,411.00	654,157.40	1,048,321.00	1,006,312.50
Total RR			**4,695,787.00**	**2,848,617.90**	**5,006,527.04**	**4,615,472.92**	**4,928,675.47**	**4,814,282.23**
OTHER RESOURCES	CMR5R11A	National Capacity to reduce maternal morbidity and mortality strengthened.			298,849.04	-4,455.41	355,276.65	170,989.16
	CMR5R21A	Strengthening of technical capacities of health care clinics, ministries and community networks to manage the healthcare system, to respond to humanities crisis, humanitarian response and resources mobilization.	82,040.00	46,154.23	378,359.31	279,965.41	574,184.73	296,668.10
	CMR5R21B	Reproductive Heath	233,509.00	10,154.77	0.00	113,287.23		
	CMR5R22B	National Capacity to reduce maternal mortality strengthened.	883,989.00	253,093.53	125,377.01	112,725.60	0.00	-433.17
	CMR5R23A	National Capacity to reduce maternal mortality strengthened.	217,928.00	0.00				
	CMR5R51A	Strengthening of national health care centres to promote behavior change for improved reproductive health, including the prevention of sexually transmitted infections and HIV.			290,992.11	233,984.67	110,779.05	69,476.21
Total OR			**1,417,466.00**	**309,402.53**	**1,093,577.47**	**735,507.50**	**1,040,240.43**	**536,700.30**
Total			**6,113,253.00**	**3,158,020.43**	**6,100,104.51**	**5,350,980.42**	**5,968,915.90**	**5,350,982.53**

(continued)

ANNEX 6: Stakeholders Mapping

Fund Type	Donors	Implementing Agency	Other Partners	Beneficiaries
GENDER				
Strategic Plan Outcome: Gender equality and women/young girls rights integrated in national policies (3.1)				
CPAP Output: National staff capacity strengthened to mainstream gender in social policy and program formulation, implementation, monitoring and evaluation (3.1)				
CMR5G11A – Gender Mainstreaming in Policies				
REGULAR RESOURCES		Ministère de la Promotion de la Femme et de la Famille – MINPROFF	MINEPAT, MINJEUN, MINJUSTICE, MINDEF, MINSANTÉ, MINFOPRA, MINAS, MINRESI, MINESUP, INS, DGSN, SED, EMIA	
Strategic Plan Outcome: Responses to Gender-based violence, expanded through improved policies, protection, legal and prevention systems (3.4)				
CPAP Output: Social Sector Ministries and Civil Society Capacities strengthened to prevent gender-based violence (3.2) (2010 -2009) National staff capacity strengthened to mainstream gender in social policy and program formulation, implementation, monitoring and evaluation (3.1) (2008)				
CMR5G41A: Reduction of Gender Based Violence				
REGULAR RESOURCES		Ministère de la Promotion de la Femme et de la Famille – MINPROFF	Ministère de l'Economie, de la Planification et l'Aménagement du Territorire - MINEPAT, Ministère de la Jeunesse - MINJEUN, Ministère de la Justice - MINJUSTICE, Ministère de la Defense -MINDEF, Ministère de la Santé Publique - MINSANTÉ, Ministère de l'Administration Territoriale et de la Decentralisation - MINATD, Ministère de la Recherche Scientifique -MINRESI, Ministère de l'Enseignment Superieur - Minesup, Institut National de la Statisque - INS, Institut de Formation et de recherches demographiques - IFORD, Bureau Central des recensements et des etudes de populations - BUCREP, Delegation Generale a la Surete National - DGSN, Associations et ONG, Autorites Religieuses et Traditionnelles	
CPAP Output: Social Sector Ministries and Civil Society Capacities strengthened to prevent gender-based violence (3.2) (2010 -2009)				
CMR5G41C: Reduction of Gender Based Violence				
REGULAR RESOURCES				
POPULATION AND DEVELOPMENT				
Strategic Plan Outcome: Population Dynamics and interlinkages with gender, SRH and HIV/AIDS incorporated in policies (1.1)				
CPAP Output: National counterparts capacities strengthened to integrate population, SRH, gender and rights in political strategies, plans and development programs at all levels (2.1) (2008, 2009 & 2010)				

CMR5P11A – Strengthening of National Capacities to Integrate the Issues of Pop/Dev in Development Planning Policies			
REGULAR RESOURCES	Ministère de l'Economie, de la Planification et l'Aménagement du Territoire/Direction Générale de la Planification et de l'Aménagement du Territoire/Division des Analyses Démographiques et des Migrations - MINEPAT/DGPAT/DADM	Départements Ministériels/Universités/INS, BUCREP, IFORD, UNFPA	
Strategic Plan Outcome: Data on PD, gender, SRH and HIV/AIDS as basis to develop/monitor policies (1.3)			
CPAP Output: National counterpart capacities in charge of integrated information systems reinforced (2.2) (2009 & 2010)			
CPAP Output: National counterparts capacities strengthened to integrate population, SRH, gender and rights in political strategies, plans and development programs at all levels (2.1) (2008)			
CMR5P31A – Strengthening of Technical Capacities of National Counterpart Staff in charge of Integrating Management Information Systems in the Area of Population and Development			
REGULAR RESOURCES	Ministère de l'Economie, de la Planification et l'Aménagement du Territoire/Institut National de la Statistique - MNEPAT/INS	MINSANTÉ, MINEDUB, MINESEC, MINATAD, MINPROFFF, BUCREP, ISSEA, IFORD	
CPAP Output: National counterparts capacities strengthened to integrate population, SRH, gender and rights in political strategies, plans and development programs at all levels (2.1) (2010)			
CMR5P31B – Data Base on Population and Development			
REGULAR RESOURCES	Ministère de l'Economie, de la Planification et l'Aménagement du Territoire/Bureau Central des Recensement et des Etudes de Population - MINEPAT/BUCREP		
CPAP Output: National counterpart capacities in charge of integrated information systems reinforced (2.2) (2009)			
CMR5P32A - Strengthening of Technical Capacities of National Counterpart Staff in charge of Integrating Management Information Systems in the Area of Population and Development			
	Ministère de l'Economie, de la Planification et l'Aménagement du Territoire/Bureau Central des Recensements et des Etudes de Population	INS, MINSANTÉ, IFORD, INS, DADM, UNFPA	
REPRODUCTIVE HEALTH			
Strategic Plan Outcome: SRH integrated in public policies of development with monitoring (2.1)			
CMR5R101 – Humanitarian Response			
REGULAR RESOURCES			
CPAP Output: 1.1 National Capacities strengthened to reduce morbidity and maternal mortality (2009, 2010)			

(continued)

ANNEX 6: Stakeholders Mapping (continued)

POPULATION AND DEVELOPMENT				
CMR5R11A – National Capacity to Reduce Maternal Morbidity and Mortality				
REGULAR RESOURCES	Cameroon	Ministère de la Santé Publique	Ministère de la Jeunesse, BAD, Facultés de Médecines, Sociétés Savantes, ONG et Associations Locales	
	Italy			
Strategic Plan Outcome: Access and Use of Maternal Health Services Increased (2.2)				
CPAP Output: Health structures strengthened for solving SRH problems and resources mobilization (1.3) (2009, 2010)				
CMR5R21A – Strengthening of Technical Capacities of Health Care Clinics, Ministries and Community Networks to manage the Healthcare System, to Respond to Humanities Crisis, Humanitarian Response and Resources Mobilization				
OTHER RESOURCES	Japan	Ministère de la Santé Publique/Direction de la Santé Familiale	MINJEUN, MINPROFF, MINAS, MINESEC, MINESUP, MINATD, MINCOM, BAD, ONG et Associations locales.	
	Multi donors			
	Cameroon			
REGULAR RESOURCES				
	OCHA			
CPAP Output: Reduction of maternal mortality and morbidity (1.1)				
CMR5R21B – Reproductive Health				
OTHER RESOURCES	Spain - Cataluna			
REGULAR RESOURCES				
OTHER RESOURCES				
CPAP Output: Health structures strengthened for solving RH problems and resources mobilization (1.3); Reduction of maternal mortality and morbidity (1.1) Social mobilization and adoption of conducive behaviour to RH, including prevention of STD-HIV/AIDS (1.2) (2008)				
CMR5R22A - National Capacity to Reduce Maternal Morbidity and Mortality Strengthened				
REGULAR RESOURCES		Ministère de la Santé Publique	Ministère de la Promotion de la Femme et de la Famille, Ministère de l'Education de base, Ministère des Enseignements Secondaires, CENAME, IFORD, ONG et Associations Locales	

POPULATION AND DEVELOPMENT				
CPAP Output: Health structures strengthened for solving RH problems and resources mobilization (1.3) Reduction of maternal mortality and morbidity (1.1) Social mobilization and adoption of conducive behaviour to RH, including prevention of STD-HIV/AIDS (1.2) (2008)				
CMR5R22B - National Capacity to Reduce Maternal Morbidity and Mortality Strengthened				
OTHER RESOURCES	Cameroon			
		Ministère de la Santé Publique	CEP/PAPNSR/BAD, IFORD, ONG et Associations Locales	
CPAP Output: Health structures strengthened for solving RH problems and resources mobilization (1.3) Reduction of maternal mortality and morbidity (1.1) Social mobilization and adoption of conducive behaviour to RH, including prevention of STD-HIV/AIDS (1.2) (2008)				
CMR5R23A – National Capacity to Reduce Maternal Mortality Strengthened				
OTHER RESOURCES	Spain - Cataluna	Ministère de la Santé Publique	Ministère de la Promotion de la Femme et de la Famille, Ministère de l'Administration Territoriale et de la Décentralisation, Ministère de la Communication, IFORD, BAD, Fondation Chantal Biya, ONG et Associations Locales.	
CPAP Output: Health structures strengthened for solving RH problems and resources mobilization (1.3) (2008)				
CMR5R24A – National Capacity to Reduce Maternal Mortality Strengthened				
		Ministère de la Santé Publique	Ministère de la Communication, IFORD, ONG et Associations Locales	
Strategic Plan Outcome: Access of young people to SRH, HIV and gender violence prevention services (2.5)				
CPAP Output: Social mobilization and adoption of conducive behaviour to RH, including prevention of STD-HIV/AIDS (1.2) (2010, 2009)				
CMR5R51A – Strengthening of National Health Care Centres to Promote Behaviour Change for Improved Reproductive Health, Including the Prevention of Sexually Transmitted Infections and HIV				
OTHER RESOURCES	Cameroon	Ministère de la Santé Publique	Ministère de la Jeunesse, Ministère des Enseignements Secondaires, Ministère de l'Education de Base, Ministère de la Promotion de la Femme et de la Famille, ONG et Associations Locales	
OTHER RESOURCES	Multi donors			
	Japan			

(continued)

ANNEX 7: CPAP Indicator Quality Assessment Grid (CPAP 2008-2011)

		Indicator	Baseline	Target	Relevant	Specific	Operational				
							Baseline available	Endline available	Target available	Means of verification	Values collected and reported
POPULATION AND DEVELOPMENT											
UNDAF: By 2012, the implementation, monitoring and evaluating of macroeconomic policies and programmes promoting development and poverty reduction through the creation and equitable distribution of wealth is improved at national and provincial levels.											
Outcome	Population issues are taken into account in poverty reduction strategies and in sectoral policies, plans and programmes at all levels	Number of strategies, plans and programmes that integrate population, gender, culture, human rights and development	N/A	4	1	0	0	0	0	1	0
		Percentage of basic social indicators to monitor plans and programmes available in an integrated database	N/A	60%	1	0	0	0	1	1	0
Output	**Output 1:** The technical and institutional capacity of national counterparts is strengthened to integrate population, reproductive health, gender, culture and human rights issues into development policies, strategies, plans and programmes at all levels	Percentage of policies and sectoral strategies that integrate issues of population and development, RH, Gender and human Rights	N/A	60%	1	0	0	0	1	1	0
	Output 2: The technical capacity of national counterpart staff in charge of integrated management information systems in the area of population and development is strengthened.	National population report including issues on reproductive health and gender, is published every two years.	1	3	1	0	1	1	1	1	0

		Indicator	Baseline	Target	Relevant	Specific	Operational				
							Baseline available	Endline available	Target available	Means of verification	Values collected and reported
REPRODUCTIVE HEALTH											
UNDAF: By 2012, policies and social programmes, including human rights and gender equality to promote social well-being, are elaborated, strengthened, implemented, monitored and evaluated to achieve the Millennium Development Goals.											
Outcome	Increased utilization of high quality reproductive health services	Attendance rate of Health centers	N/A	10%	0	0	0	0	1	0	0
		Contraceptive prevalence rate for modern methods	13%	25%	1	1	1	0	1	1	0
		Percentage of targeted youth having used high quality adolescent sexual and reproductive health	N/A	At least 50%	1	1	0	0	1	1	0
		Percentage rate of reproductive health needs and gender-based violence needs of populations affected by humanitarian crises are met	N/A	25%	1	0	0	0	1	1	0
		Percentage of C-sections	2.0%	At least 3%	1	1	1	1	1	1	0
Output 1	National Capacity to reduce maternal morbidity and mortality is strengthened	Percentage of Health centres in intervention areas of the programme providing PM of Reproductive Health including SONU	5%	At least 50% of health centres involved in the intervention	1	1	1	1	1	1	1

(continued)

ANNEX 7: CPAP Indicator Quality Assessment Grid (CPAP 2008-2011) (continued)

		Indicator	Baseline	Target	Relevant	Specific	Operational				
							Baseline available	Endline available	Target available	Means of verification	Values collected and reported
Output 1 (continued)		Percentage of women with obstetric complications including obstetric fistula attending health centres in intervention areas that offer emergency obstetric care	OC:NA	At least 50% of obstetric complica-tions visiting health centres	1	1	0	1	0	1	0
			OF: less than 1%		1	1	1	1	1	1	0
		Number of Health centres in the intervention zones providing minimum health care and complete health care services	N/A	100 health centres in the interven-tion zone	1	0	0	1	1	1	0
		Contraceptive prevalence in the intervention areas of the programme	ND	Increase 5% to 10% vis a vis current prevalence rate	1	1	1	0	1	0	0
		Intra-hospital mortality	NA	Reduction to at least 50% in the supported health districts	0	0	0	0	1	1	0
Output 2	The capacity of national service providers and community leaders to promote behaviour change for improved reproductive health, including the prevention of sexually transmitted infections and HIV, is strengthened	Percentage of pregnant women and young people aged 15-24 have undergone voluntary testing for HIV	ND	25% of pregnant women	1	1	0	0	1	1	0
			ND	10% of youth	1	1	0	0	1	1	0

ANNEX 7: CPAP Indicator Quality Assessment Grid (CPAP 2008-2011) (continued)

		Indicator	Baseline	Target	Relevant	Specific	Operational				
							Baseline available	Endline available	Target available	Means of verification	Values collected and reported
Output 2 (continued)		Number of villages located more than 5 km from a health centre equipped with a community-based service outpost and providing promotional services towards fight for prevention of sexually transmitted diseases and HIV.	ND	25% of villages located 5km from a health centre	1	1	0	0	1	1	0
		Number of primary and secondary schools delivering Family Life Education and Education in Population	15	30 secondary schools	1	1	1	0	1	1	0
		Proportion of adolescents/ youths in the intervention areas having visited Repro-ductive Health and CMPJ	ND	10 primary schools	1	1	0	0	1	1	0
				10% of A/J	1	1	0	0	1	1	0
Output 3	The capacity of health services, national institutions and communities is strengthened in health system management, including crisis preparedness, humanitarian response and resource mobilization.	Proportion of health districts supported by the programme include a development plan for social health, for financing a system of referral/ evacuation and treatment of obstetric complications and of a functional SIG.	11	25 health districts	1	1	1	0	1	1	
		UNFPA contingency plan based on national policies and periodically revised UN system policy	1	5 updated	0	0	1	0	1	1	0
		Percentage of outreach in Reproductive health service on displaced population in the zones of intervention	Less than 1%	10%	1	0	1	0	1	0	0

(continued)

ANNEX 7: CPAP Indicator Quality Assessment Grid (CPAP 2008-2011) (continued)

		Indicator	Baseline	Target	Relevant	Specific	Operational				
							Baseline available	Endline available	Target available	Means of verification	Values collected and reported
GENDER											
UNDAF: By 2012, policies and social programmes, including human rights and gender equality to promote social well-being, are elaborated, strengthened, implemented, monitored and evaluated to achieve the Millennium Development Goals.											
Outcome	A favourable social and legal environment to promote gender equality and equity and to reduce sexual and gender-based violence	Revised DSRP includes Gender issues		DSRP revised and available	1	0	1	0	0	1	0
Output 1	The capacity of national staff is strengthened in order to mainstream gender, culture and human rights issues in social development policy and programme	At least 3 sectoral strategies documents integrate gender issues	1	3	1	0	1	0	1	1	0
Output 2	The capacity of ministries, NGOs and community networks strengthened to prevent gender based violence and treat victims of such violence	Number of institutions and decentralized structures providing support to victims of gender-based violence	0	100%	1	0	0	0	1	1	0

		Quality Aseessment Criteria						
				Operational				
		Relevant	Specific	Baseline Available	Endline Available	Target Available	Means of Verification	Values Collected and Reported
#	# of yes (1)	24	14	12	6	25	24	1
	# of no (0)	3	13	15	21	2	3	26
	TOTAL	27	27	27	27	27	27	27
%	# of yes (1)	89%	52%	44%	22%	93%	89%	4%
	# of no (0)	11%	48%	56%	78%	7%	11%	96%
	TOTAL	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

ANNEX 8

Interview Guides

COUNTERPARTS - Example DADM/MINEPAT
INTERVIEW GUIDE

1. Human connection

- Spend a few minutes to understand sincerely how the interviewee is today. Are we coming in the middle of a hard day or a happy one for our interviewee? Is he/she really busy and we should make the interview shorter than agreed?
- Explain briefly something about yourself, where do you come from, other interviews you are doing that also frame this present interview, etc. (Inform yourself previously about etiquette and cultural formalities).
- Thank for the time dedicated to this interview.

2. Inform the interviewee of the objective and context of the interview

- Clarify briefly what the evaluator‘s work is about.
- Confirm the time available for the interview.
- How the information of the interview will be used.
- Inform of confidentiality of the information collected.
- Explain what is the objective of the interview (context). (This not only shows due respect, but it is also useful for the evaluator, as helps the interview answer in a more relevant manner.)

3. Opening general questions: refining our understanding of the interviewee's role

- Before addressing the objectives of the interview guide, the evaluator needs to ensure that he/she understands the role of the interviewee vis-à-vis the organization, the program, etc., so as to adjust the questions and address them in the most effective way.
  - What is the exact role of DADM within MINEPAT vis-à-vis P&D issues? Is there some other division I should be speaking with?
  - What is your role vis-à-vis P&D and UNFPA support?

4. Core interview: objectives of the Interview Guide transformed into questions

- Understand the organization
  - Brief description of the role of the organization.
  - Do they integrate Population aspects in their planning? How? What? To what purpose?
  - How do they interact with Line ministries i.e. Minsanté, Minproff, Minedu, Minstravail, INS, Bucrep, etc?
  - Any challenges in doing so? (Knowledge on how to do it, staff, methodology, interest, lack of support from leaders)
  - Any training received on integration of Population elements in their policies?
  - What population sources they use to obtain their data? Are they easily accessible? Satisfactory?
  - Where is support needed with most priority?

- **Understand the program from the DADM/ MINEPAT perspective**
  - Brief description of the program in your own words (Actions developed by DADM/ MINEPAT with UNFPA in 2008-2012)
  - Satisfied/unsatisfied with the program as a whole?
  - What was their involvement in the design of the programme.
  - Points they consider the most successful/useful in the program. Why.
  - Points that have been the most challenging. Why.

- **Understand the program in detail. By outcome, output (INDICATORS in CPAP), activity group.**
  - Main changes between previous programme and present one.
  - What indicators they use to feel satisfied/ unsatisfied with the programme?
  - If they use their own indicators, try to understand their logic and meaning.
  - In any case, afterwards take CPAP indicators and review them together: are they meaningful? Are they being achieved? Why?
  - Any change in Cameroon or in policies during these years that has affected the program?

- **M&E focus**
  - How do you organize yourselves to follow up the program_ Who does what?
  - Indicators in CPAP. Do you use these ones? Are they appropriate? Can we really access this information, how is it collected and sent to you?
  - Indicators that have not been as useful as they thought would be. Why. Suggestions for better ones.
  - Any aspect/data they don't have access to that would be helpful for they work.

- **Understanding UNFPA contribution**
  - Understand main objectives of DADM/ MINEPAT regarding P&D.
  - What has been the contribution of UNFPA regarding these objectives?
  - How were these contribution decided? Why these objectives prioritized?
  - Are there other donors/agencies also working with DADM/MINEPAT on P&D?
  - What is the main added value of UNFPA in the framework of DADM/MINEPAT's objectives? (compare with other donors).
  - What are the main limitations of UNFPA? What could they improve in your opinion?
  - Relation with UNFPA in implementation of program. Flexible, responsive (compared to other donors).

- Understanding DADM/MINEPAT needs, limitations and potential
  - In your opinion what are the aspects (vis-à-vis P&D) that DADM/MINPEAT is strongest at?
  - In your opinion what are the aspects (vis-à-vis P&D) that DADM/MINPEAT needs to strengthen with most priority? Why.
  - What is the best way for UNFPA to support you in that strengthening process? (or do you think that other donors are in a better position to help you with that. Why).

- **Sustainability**
  - Are the benefits in terms of outcomes/outputs sustainable beyond program completion?
  - Handover of activities, outputs and outputs to local partners.
  - To what extent have been strengthened local capacities at national and provincial level.

- **Looking at the FUTURE**
  - What are your ideas for the upcoming program in terms of strategies, main outputs, etc.?
  - Where do you think this evaluation could be more useful? (What kind of information or aspects should we put our emphasis on to serve you better).
  - Understand policy context regarding P&D, present and future priorities regarding P&D.
  - Any change you foresee in Cameroon or in political framework that should be taken into account for the design of the new program?

BENEFICIARY INSTITUTIONS INTERVIEW GUIDE

1. Human connection

- Spend a few minutes to understand sincerely how the interviewee is today. Are we coming in the middle of a hard day or a happy one for our interviewee? Is he/she really busy and we should make the interview shorter than agreed?
- Explain briefly something about yourself, where do you come from, other interviews you are doing that also frame this present interview, etc. (Inform yourself previously about etiquette and cultural formalities).
- Thank for the time dedicated to this interview.

2. Inform the interviewee of the objective and context of the interview

- Clarify briefly what the evaluator's work is about.
- Confirm the time available for the interview.
- How the information of the interview will be used.
- Inform of confidentiality of the information collected.
- Explain what is the objective of the interview (context). (This not only shows due respect, but it is also useful for the evaluator, as helps the interview answer in a more relevant manner.)

3. Opening general questions: refining our understanding of the interviewee's role

- Before addressing the objectives of the interview guide, the evaluator needs to ensure that he/she understands the role of the interviewee vis-à-vis the organization, the program, etc., so as to adjust the questions and address them in the most effective way.
    - What is the exact role of the beneficiary institution as far as P&D issues are concerned?
    - What is your role vis-à-vis P&D and UNFPA support?

4. Core interview: objectives of the Interview Guide transformed into questions

- **Understand the organization**
    - Brief description of the role of the organization.
    - Do they integrate Population aspects in their planning? How? What? To what purpose?
    - Any challenges in doing so? (Knowledge on how to do it, staff, methodology, interest, lack of support from leaders).
    - Any training received on integration of Population elements in their policies?
    - What population sources they use to obtain their data? Are they easily accessible? Satisfactory?
    - Where is support needed with most priority?

- **Understand the program from their perspective**
    - Brief description of the program in your own words (Any support received from UNFPA directly or indirectly).
    - Satisfied/unsatisfied with the program as a whole? (effectiveness) Indicators to say so?
    - What is the usefulness of the service for them?
    - What is the consequence for others (impact if they incorporate the service).
    - Points they consider the most successful/useful of the program. Why?
    - Points that have been the most challenging. Why?
    - Any change in Cameroon or in policies during these years that has affected the program?

- **Understanding UNFPA visibility**.
    - What has been the contribution of UNFPA regarding these objectives?
    - How were these contribution decided? Why these objectives prioritized?
    - Are there other donors/agencies also working on this objective?
    - What are the main limitations of UNFPA? What could they improve in your opinion?

- **Understanding the organization needs, limitations and potential**
  - In your opinion what are the aspects (vis-à-vis P&D) that the organization is strongest at?
  - In your opinion what are the aspects (vis-à-vis P&D) that the organization needs to strengthen with most priority? Why.
  - What is the best way for UNFPA to support you in that strengthening process? (or do you think that other donors are in a better position to help you with that. Why).

- **Sustainability**
  - Are the benefits in terms of outcomes/outputs sustainable beyond program completion?
  - Handover of activities, outputs and outputs to local partners.
  - To what extent have been strengthened local capacities at national and provincial level.

- **Looking at the FUTURE**
  - What are your ideas for the upcoming program in terms of strategies, main outputs, etc?
  - Where do you think this evaluation could be more useful? (What kind of information or aspects should we put our emphasis on to serve you better).
  - Understand policy context regarding P&D, present and future priorities regarding P&D.
  - Any change you foresee in Cameroon or in political framework that should be taken into account for the design of the new program?

5. Wrap up

- If some aspect of the interview was unclear, confirm with interviewee before finishing. Confirm that nothing that the interviewee considers important has been missed: "Have I missed any important point?"
- Wrap up confirming any mutual follow-up obligations that have been agreed, e.g. if documents need to be sent and by when, if the evaluator needs to provide any feedback, etc.
- Mention when will the report be issued and who will receive it (even if it is another institution, in case they want to contact them).
- If relevant, ask the interviewee for suggestions/facilitation about what other key persons that could also be interviewed. Is there somebody else in your division you suggest I should be speaking with?
- Thanks again for the time dedicated to this interview.

ANNEX 9

Maternal Health Indicators

UNFPA STRATEGIC PLAN GOAL INDICATORS		Most Recent Statistic	Immediately Previous Statistic	Source	Disaggregated levels	Disaggregated levels:
1. ADOLESCENT FERTILITY RATE:						
RELATED CORE INDICATORS	**1.1 - Age at First Marriage:**					
	1.2 a- Education Enrolment (primary):	75,5% (2007)		ECAM3	6-11 years old	
	1.2 b- Education Enrolment: (secondary)	43% (2004)		DHS		
2. UNMET NEED FOR FAMILY PLANNING:						
RELATED CORE INDICATORS	**2.1 - Contraceptive Prevalence Rate: (modern methods)**	13.5% (2004)		DHS		
	2.2 - Infant Mortality Rates:	87 (2006)	74 (2004)	UNICEF/ DHS		
	2.3 - Child Mortality Rates	117 (2006)	87 (2004)	BUCEN-IDB/DHS	under 5 years	
	2.4 - Abortion Rate:					
3. MATERNAL MORTALITY RATIO:		669 (2004)		DHS		
RELATED CORE INDICATORS	**3.1 - Attended Deliveries:**	7.8% (2004) by doctor/ 61.7 by health prof.		DHS		
	3.2 - Antenatal Care:	60% (2004)		DHS		
	3.3 – C-Section Rate:					

ANNEX 9: MATERNAL HEALTH INDICATORS (continued)

UNFPA STRATEGIC PLAN GOAL INDICATORS		Most Recent Statistic	Immediate-ly Previous Statistic	Source	Disaggregated levels	Disaggregated levels:
4. HIV PREVALENCE:		5,5% (2004)		DHS	6,8 % women and 4,1% men	
RELATED CORE INDICATORS	**4.1 – HIV/AIDS Knowledge among 15-24 Year Olds:**	22% women- 32% men (2004)		DHS	15-49 years complete knowledge of HIV	
	4.2 - Condom Availability:					
	4.3 - Condom Use Prevalence among various Population Groups.	55% males – 40% females (2004)			Reported condom use with non regular partner	
5. GENDER-BASED VIOLENCE:						
RELATED CORE INDICATORS	**5.1a – Proportion of women who have suffered domestic psychological violence:**	53% (2004)		DHS		
	5.1 – Proportion of women who have suffered domestic sexual or physical violence:					
	5.2 – Proportion of women who have suffered sexual violence:					
	5.3 – Incidence rate of female genital mutilation:					

Fertility Rates						
Fertility rate desired						
Fertility rate observed	**4.4 (2008)**	6.2 (2004)		BUCEN-IDB and DHS		
Fertility rate observed rural	**6.1 (2004)**			DHS		
Fertility rate observed urban						

Comparative levels of reproductive and neonatal health indicators – Cameroon and neighbouring countries

	GNI / Cap (US $)			Rate of prenatal care visits (CPN) – at least 1 visit	CPN rate - 4 visits	Rate of skilled attended births	C-section rate	Contraceptive prevalence rate	ARV / PMTCT coverage rate	Estimated Maternal Mortality Rate (MMR) (per 100,000 births) (*)			Estimated neonatal mortality rate (per 1,000 live births (**)		
	1990	2000	2009	2000 - 2010	2000 - 2010	2000 - 2010	2000 - 2010	2000 - 2010	2009	1990	2000	2008	1990	2000	2009
Bénin	360	360	750	84%	61%	78%	3,6%	17%	46%	790	560	410	42	36	32
Cameroon	860	620	1 170	82%	60%	59%	2,0%	26% (***)	27%	680	660	600	36	37	37
Congo	890	580	1 830	86%	75%	86%	3,2%	44%	12%	460	590	580	32	34	36
Gabon	4 940	3 080	7 370	94%	63%	87%	5,6%	33%	30%	260	260	260	30	28	25
Nigeria	260	270	1 140	58%	45%	39%	1,8%	15%	22%	1 100	980	840	49	46	39
RCA	470	270	450	69%	-	53%	-	19%	34%	880	900	850	45	47	45
Tchad	250	180	610	39%	17%	21%	0,4%	3%	6%	1 300	1 300	1 200	45	45	46

(*) Data for Maternal Mortality Rate are given (in WHO statistics) in ranges (mid-point and confidence interval). Here, only the mid-point data is reported.
(**) The neonatal mortality rate is computed over 1,000 live births, before the age of 1 month.
(***) Data from DHS 2004 (EDS III). WHO statistics 2011 indicate a rate of 29%.
Source : WHO's World Health Statistics 2011 for health and family planning data, except for (***) and for GNI (from World Bank's statistics).

Per 100,000 births	1980	1990	2000	2008
Estimated MMR (with confidence/uncertainty interval)	810 (507–1254)	523 (308–845)	886 (549–1415)	705 (393–1155)
Estimates from WHO statistics	-	680	660	600

ANNEX 10

Results of the focus group discussion on the perception of journalists about UNFPA in Cameroon

I. Objective of the focus group

The organization of the media focus group was aimed at obtaining qualitative information on the perception of the press and individual journalists about UNFPA and programs implemented or supported by UNFPA.

II. Presentation of the information

The focus group addressed four major subjects. Each of them is presented as follows:

a) Subject of the discussion: brief description of the main issues addressed

b) Statements of the journalists: objective transcription of statements of the journalists.

c) Summary of the discussion: Key ideas that composed the participants discourse.

Whereas section b) shows the verbatim transcription of answers or spontaneous statements made by the journalists, section c) collates and summarises the main ideas contained in the participants' interventions.

III. Methodology

The focus group participants were chosen to try and ensure that media of different ideologies and financial sources would be present (pro-government, pro-opposition, independent). The emphasis was on the written press, but a radio station and a TV channel (who declined to attend) were also invited to enrich the group.

The diversity of the focus group was satisfactory, as it included the main media financed by the government (Cameroon Tribune) and a good representation of different privately-financed media (Repères, Mutations, La Nouvelle Expression, Magic FM).

Focus group participants	
Irène Sidonie Ndjabun	*Independent journalist and "La Nouvelle expression" (written press)*
Rosaligue N. NGanzi	*"Repères" (written press)*
Jocelyne NdouJou-Mouliom	*"Cameroon Tribune" (written press)*
Serge Henri Kamegni	*"Cameroon Tribune" (written press)*
Anie Lizette Ambazza	*"Magic FM" (radio station)*
Patricia Ngo Ngouela	*"Mutations"(written press)*

IV. Subjects addressed by the journalists and analysis

1. Perception of UNFPA among the media

a) Subject of discussion:

What is your impression of UNFPA, what is their business? How do you perceive the role of the agency?

b) Statements of the journalists:

- "UNFPA works for the well-being of women and children (Maternal Mortality)"
- "UNFPA works in reproductive health"
- "UNFPA has good programs, but when the government takes over to implement them, then things don't work out so well"
- "In some cases, UNFPA knows that ambulances -for example- are misused. The journalists denounce this and UNFPA does not do anything about it. Or in a trip to Bertoua, it is seen that the material delivered to the health posts has been badly neglected and UNFPA does not do anything. Maybe they lack the staff?"
- "When people read that UNFPA has given financial support to a hospital, they think why should they be paying for anything?
- "UNFPA is like the rest of the UN agencies, it does not have a specific image"

c) Summary of the discussion:

On the one hand, UNFPA is perceived mainly as a Reproductive Health agency. Other focus areas of Population & Development or Gender responsibilities are not mentioned. Additionally, UNFPA conveys a generally positive perception, which contrasts with a negative perception of the government to the extent that, when a program does not work well, the assumptio n of the journalists is rather that it is the government's fault and not UNFPA.

Another point to be taken into account is the possible counterproductive effect provoked by the publicity given to UNFPA's investments in the health system with regard to public entitlement to services.
The positive perception about UNFPA should also be put in the context of a general good perception of the UN agencies as a whole. Whereas some journalists showed during the exercise a distinct understanding of UNFPA vs. other UN agencies, others in the group would consider them as one UN agency without any particular feature.

2. Accessibility of UNFPA for journalists

a) Subject of discussion:

Is UNFPA accessible to journalists? Is the information produced by UNFPA easily usable by the journalists? Can UNFPA improve its accessibility?

b) Statements of the journalists:

- "UNFPA are always available for interviews. They never tell you to come back on the following week, but make themselves available very quickly"
- "If I ask information from them, they always send it to me"
- "The documents that UNFPA produce are usable by us journalists, they are not too technical"
- "The documents provided are sufficiently rich and clear to directly serve journalistic work"
- "If UNFPA could improve their strategy to make our work easier? They just need to keep doing what they already do: to remain available and to keep their sources open for us"
- "UNFPA´s approach to treat the media is very good"

c) Summary of the discussion:

There was **unambiguous consensus among all participants on the excellent accessibility of UNFPA**, both in terms of making themselves available and by a timely provision of requested information. This unanimity is even more valuable when taking into account that the focus group was composed by journalists belonging to media of different ideologies.

3. Perception of the 3rd general census among the media

a) Subject of discussion:

We understand that there has been some controversy about the census. Can you please explain to us what the controversy has been about?

b) Statements of the journalists:

- "The census has been criticized by all media in the country"
- "For the census the government has recruited not only cartographers, but also students that have been trained to collect information in three months. If the basis is wrong, then the census will also be wrong"
- "For the enumerators, the government has also taken anyone to do it, really anyone"
- "How can we get the results of the census after 5 years? This takes away any credibility from the census" (opinion agreed by all participants in the focus group).
- "The figures are known now, why are they not published? Nobody believes this is credible."
- "The methodology for the census has not been shown".
- "There are rumours that the figures are not good; for example Douala appears as less populated than Yaoundé! And all the staff from the Regional Delegation in Douala have been then transferred to Yaoundé".
- "They are using figures from 2005, making projections for 2010"

c) Summary of the discussion:

There were concerns regarding the credibility of the statistical representativeness of the census as well as the potential political use of the statistics. The lack of transparency with the origin of the delays or timely information on when can the results be known, etc, translates in a lack of credibility of the results, regardless of their degree of technical accuracy.

4. Remarks on the media as a channel for awareness messages

a) Subject of discussion:

In the context of awareness-raising messages (e.g. behaviour change on gender-based violence, promotion of the use of neonatal services, etc) what can/should be the role of the media. What type of media/strategy is more effective to convey messages to the public?

b) Statements of the journalists:

- "It is important to distinguish journalists from communicators. Journalists should not be used to send messages; their role is to report freely on the activities of UNFPA in the field. The journalists have to look for information by themselves, instead of becoming a UNFPA communication tool. UNFPA could resort to professional Communicators if they want to convey specific messages to the public".
- "In Cameroon there is not such regular data on audience figures etc. unless you conduct an ad hoc survey. The effect of a program is known by methods such as *vox populi,* meetings, government reactions or internet hits. The written press is not read by everyone, the price is already a barrier to the poorest. Community radio is very effective as it is not only widely listened to, but it goes beyond English and French, broadcasting in local languages"
- "Radios, and particularly community radios, are best suited for information and communication on such themes as GBV, obstetrical fistula and family planning"
- "Thanks to radio broadcasts, women are better informed of the importance of prenatal visiting, as well as of means of prevention of HIV-AIDS"

c) Summary of the discussion:

Journalists mistrust and resent agencies who try to use them to pass messages but they are receptive to information campaigns. Moreover journalists are in favour of trainings on UNFPA programme which would help them understand the development challenges. Community radio appears as an appropriate means for rural awareness as they are broadcasted not only in English or French but also in local languages. Radio appears as a particularly relevant media for raising awareness on such issues as: FGM, obstetrical fistula and family planning.

Analysis of UNFPA in the press

Introduction to the analysis

This analysis studies the relation between the press publications and the mandate and activities of UNFPA. It intends to reveal how UNFPA appears in press publications and what is the general image about UNFPA that the media sends to its readers.

The content of this annex constitutes an additional body of evidence to support the findings of this Evaluation.

1. Methodology of the analysis

The Country Office provided a Press Folder that constituted the *object of analysis*. This folder contained a sample of news that were collated during 2009 and part of 2010. The content of this sample of news was varied: some were related to the focus areas of UNFPA, others were connected with UN in general and others treated government decisions or issues in the country. The study covered **571 news items in total, of which 163** were taken into consideration for the final analysis which were related to UNFPA focus areas or activities.

The data collection method was the review of approximately 368 news items sampled from the 2009 set of news and 123 news items sampled from the 2010 set. Of these, 163 were taken into consideration for the final analysis which was related to UNFPA focus areas or activities. Additionally, the team also considered a compilation of approximately 60 news items related to the "International Women's Day" and news covering the publication of the Third population census in 2010.

Type	Name	Control
Radio	• Cameroon Radio Television (CRTV) • Radio Magic • Radio Reine • Radio Siantou	• Ministry of Communication • Private • Catholic church • Private
TV	• Cameroon Radio Television (CRTV) • Canal 2 • STV	• Ministry of Communication • Private • Private
Press	• Cameroon Tribune • Le messager • Mutations • The Herald • The Post • La Nouvelle Expression	• Ministry of Communication • Private, (Douala) • Private • Private, in English • Private, in English • Private

2. Descriptive phase

The news items were published during the period 2009-2010. The table below offers a general overview of media in Cameroon[118]:

The selection of daily newspapers and weekly magazines included:

• ***Cameroon Tribune:*** Its circulation and influence are the largest at national and local level. It is a public media outlet almost always aligned with the government message.

• ***La Nouvelle Expression:*** It has an important circulation at national and local level. Its influence is significant as it is a privately-owned media and sometimes this permits the influence of ideas belonging to a shadow cabinet.

[118] Any such list is subjective by definition. The purpose of this one is to offer a context for the reader who is not familiar with the media environment in Cameroon.

• ***Le Messager:*** It has a significant influence in Douala, the economic centre of the country. It is a privately-owned media that sometimes manifest disagreement with the government. For this reason it can sometimes create clashes in the public opinion.

• ***The Post:*** This has local circulation, mainly in the Littoral region, and is in English, which allows the coverage of English-speaking areas (south-west and north-west). It has a low national influence except in these English-speaking areas.

• ***Mutations:*** This media circulates mostly in the north of the country (Garoua). It has a low influence excepting Yaoundé and Garoua.

• ***Others:*** these include *Avenir* or *The North-West.*

Themes of study by UNFPA focus areas

Gender - We classified the news related to this component in four sub-groups:

1) Gender-based violence,
2) Female Genital Mutilation (FGM).
3) Gender mainstreaming and empowerment and
4) Others.

Reproductive Health - We classified this component in the following sub-groups:

1) Preservatives use and family planning (FP),
2) Obstetric Fistula,
3) Maternal and Child mortality,
4) CARMMA* initiative and
5) Others.

Population and Development - As the most important activity in the country has been related with the support of the census, we have designed two categories:

1) Census, and
2) Other.

* We included in this category events as the celebration of the International Women's Day.

Number of articles by media, component and sub-group:

Gender		
	Number	%
Gender-based violence	5	7.3%
Female Genital Mutilation	4	5.8%
Gender mainstreaming and empowerment	30	43.7%
Other*	30	43.7%
Total	69	100%

As we can see above, the frequency of the occurrence of news that talk about Gender mainstreaming and empowerment is much higher than other relevant gender sub-themes such as gender-based violence or female genital mutilation.

There is vast coverage of the efforts that the country is making to ensure Gender is given appropriate consideration, with activities such as the celebrations in the International Day of Woman.

Female Genital Mutilation remains a reality affecting Cameroonian women in some regions of the country, but the frequency of its occurrence in the news is very low. Only 5.8% of the news related to Gender covered this problem.

Reproductive Health		
	Number	%
Preservatives use and Family planning	11	22%
Obstetric fistula	6	12%
Maternal and child mortality	19	38%
CARMMA[119] initiative	4	8%
Other	10	20%
Total	50	100%

Maternal and child mortality is a theme frequently covered by the media. The tone of media reports indicates that the use of preservatives and other family planning

119 CARMMA: Campagne pour l'accélération de la réduction de la mortalité maternelle en Afrique. (Campaign for accelerated reduction of maternal mortality in Africa.)

strategies have been accepted by the media: there is a large number of news items that insisted on the use of female preservatives as a way to promote women's sovereignty and empowerment in the configuration of the families, even when it was not the central point among the discourse presented in them.

Population and Development		
	Number	**%**
Census	31	70.4%
Other	13	29.6%
Total	44	100%

* In this category there were two fundamental sub-themes: Youth and EDS/DHS.

The publication of the Third Census of Population and Habitat has been a point where media coverage has been comprehensive. This is explained by the political weight that this exercise has in the country and by the importance of the results for the upcoming elections this year.

3. Main findings

UNFPA was visible in the media in relation to Population & Development (P&D) themes but it did not have the same visibility when the news treated a sub-theme related with the other two core focus areas of its mandate (Gender and Reproductive Health).

The news studied indicated that the relations between the government and UNFPA are fluid. In general, it was observed that the national and public media (*Cameroon Tribune*) disseminated a positive image of the government and also of UNFPA.

UNFPA is perceived as a strategic partner for the Cameroonian government. It is mainly seen as a Reproductive Health and P&D agency. Their role as a partner in Gender support is much less clear. Also, as we will see in more detail below (Third Census of Population and Habitat), UNFPA has been perceived as a sponsor. In exceptional cases the contribution UNFPA has been questioned due to the delay in the presentation of the results and the questioning of the reliability of the results of the census.

UNFPA has been perceived as a polyvalent agency sometimes without a specific role further than a "UN agency for the population" or a "Reproductive Health Agency". This has induced the media into confusion and mistakes in the emission of positive messages. The type of mistakes that we find with relative frequency are confusions with the name of the organization, or confusions with the name of the Representative.

Census:

In relation to the census, UNFPA appeared virtually every time that the media presented the figures resulting from it in a positive way: "The Representative of the United Nations Fund for Population Activities (UNFPA) has described the results as scientific, rigorous and professional without reservation" (news from Mutations, 08/03-12/03 week of 2009). During the presentation of the census, UNFPA appeared positively as the funder of the operation and as a technical supporter when the INS institution encourages the application of the results into the development strategy of the country (*Le Messager*, 17/05 -21/05 week of 2009).
In this sample we can also identify a large number of news items that rejected the validity or timing of the presentation of census where UNFPA was also mentioned: the delay was explained as a political issue related to the next elections (*Le Messager*, 17/05 -21/05 week of 2009). During the period of analysis the census theme attracted significant political attention, which explains the relatively high number of news items about it.

Youth and gender:

When the media treated the subject of youth, for example during the *African youth Forum for Peace,* UNFPA was singled out as an ally. (*Cameroon Tribune* 19/04-23/04 week of 2009).

UNFPA appeared with the MINPROF in different news items addressing women's presence in the political and social life in the country. For example we can mention that UNFPA appeared with MINPROFF in *The ceremony of Gender objectives 2010* (*Cameroun Tribune*, 25/01-29/01) and in different publications referring the International Women's Day. Nevertheless we observed that UNFPA was not always mentioned when the media

treated other important advocacy themes as the participation of woman in the political life. For example, UNFPA was not mentioned in news about the "Mobilization for a female candidate" (Mutations, 22/03-26/06 week of 2009); the "Women for a better world" event (Le messager, 29/03-02/04 week of 2009); the presence of Women in Parliament (Cameroun Tribune, 29/03-02/04 week of 2009); or the integration of gender mainstreaming in the DSCE (Le messager, 05/04-09/04 week of 2009).

UNFPA has made a great effort to appear in events to support the government's actions especially in the reduction of the female genital mutilation (FGM), accompanying MINPROFF and the OMS (news from Mutations, 08/03-12/03 week of 2009). The Representative also appeared at different occasions with Synergies Africaines as a positive supportive partner to fight the practice of FGM. (Cameroun Tribune, 25/10-29/10 week of 2009)

On several occasions UNFPA was not mentioned with other organizations that were fighting against the practice of FGM. For example, UNFPA did not appear in such news in relation with the Cameroon National Association for Family Welfare (Camnafaw) or in the Family Planning movement of International Planned Parenthood Federation (IPPF) among others (Cameroun Tribune 12/04-16/04 week of 2009). We can also see examples of this in the Cameroun Tribune, when they emphasize the role of the UN agencies in general in order to reduce the increase of FGM rates without specifically mentioning UNFPA (Cameroun Tribune 07/02- 11/02 week of 2009).

The presence of UNFPA in news items talking about gender is constant but very general. We can deduce from this that the agency is perceived as a political ally of the government making gender topics more present in the life of the country. However when concrete actions are described to eradicate the discrimination of women in the political and social life of the country, the presence of UNFPA is not as clear.

Reproductive health:

UNFPA is mainly perceived as a Reproductive Health Agency according to the narrative of the news. This is thanks to the presence of the Representative supporting the actions from the government and the First Dame through Synergies Africaines. In contrast, when the news talked about the increase of the use of female condoms, UNFPA was rarely presented as a family planning actor. In this sample, we can find approximately twelve news items about preservatives and family planning and none of them mentioned UNFPA. Four news items from the sample talked about CARMMA and only one mentioned UNFPA (Cameroun Tribune, 25/10- 29/10 week of 2009).

UNFPA and other partners:

The media frequently does not distinguish between the activity of one or another UN agency. For example when the media talks about the revision of CEDAW (Cameroun Tribune, 31/05-04/06 of 2009), it presents the compromise of CEDAW in the country as a responsibility for the UN system in general without mentioning UN Women or UNFPA.

It is not usual to find reflected in the media a coordinated work between UNFPA and other international organizations. UNDP was the most mentioned partner, followed by UNICEF and UN Women.

Some of the civil society associations more frequently mentioned in the sample are ACAFEJ (Association of Women Lawyers of Cameroon), Assocasfiasar, SDF, RFAMPC, FCEM, Camnafaw, Synergies Africaines and ACMS (Association Camerounaise pour le marketing social), but their association with UNFPA is not reported. Only the alliance between Synergies Africaines and UNFPA has been presented by the media. CAFEJ, one of the most active organizations that is pro-gender in Cameroon is a frequent partner of UNFPA but this alliance has never been reported in the period analysed.

Positioning of UNFPA in Cameroon:

UNFPA has been considered an important actor by some governmental institutions, especially by MINEPAT, MINPROFF and MINSANTE. The presence of UNFPA in governmental events and initiatives, as for example the celebration of the International Women's Day or its presence during the publication of

the census results, gives us an indication of the perception of the responsiveness of UNFPA to national needs. The principal level of actuation of UNFPA in the country is at the political level, influencing policies and orientating government action. UNFPA has been perceived as a funder and also as a technical supporter. In some news that informed about the publication of the census, UNFPA was perceived as an essential actor for completing the process, always providing resources and technical assistance when it was required.

It is clear that UNFPA is perceived as making a significant effort to adapt its contribution to the national needs and the government initiatives. However its role in specific actions has not been well reflected by the media.

Only Population & Development shows UNFPA as providing added value because no other International partner has been helping the government with the census. UNFPA provides a visible technical assistance especially in Population & Development issues.

Summary

UNFPA is acknowledged in the country more as a good political partner. Its concrete actions are often not captured, with the exception of high profile interventions particularly such as the census. The media perceives UNFPA mostly as a Population & Development agency or a Reproductive Health promoter. It is not perceived as an actor supporting Gender. The media rarely differentiates the actions of UNFPA from the role of other UN agencies. When separated, UNFPA is perceived positively.

The image of UNFPA is not constant and it depends on the issues that attract the attention of the country. When the census was published, UNFPA was perceived as a Population & Development Agency. When the initiative CARMMA and the Synergies Africaines group started advocating for the reduction of maternal mortality, UNFPA was perceived as a Reproductive Health agency.

ANNEX 12

Progress of MDGs

	Goal	Achievements
1.	Eradicate extreme hunger and poverty	From 2001 to 2007, the national proportion of people living below the poverty line remained virtually stable 40.2% to 39.9% (1); 18% children underweight (Source: INS; CCA)
2.	Achieve Universal Primary Education	Between 2001 and 2007, the net primary school enrolment ratio increased slightly. Illiteracy among 15- to 24 year olds remained virtually unchanged, increasingly slightly from 82.3 % to 83.1% (1) Average rates conceal disparities at the province level (2)
3.	Promote Gender Equality and Empower Women	The situation of women has been improving in some areas, particularly in primary education where the girls/boys ratio rose from 0.83 to 0.89 between 2001 and 2007 (1). Female literacy increased between 1990 and 2000 from 74.1 to 77% (2). The proportion of women in the National Assembly has dropped from 11.8% in 1992 to 10.6% in 2002(2)
4.	Reduce Child Mortality Target: Reduce under-5 mortality by 2/5th to 75.8 per 1000 live births	Rate: 149 in 1990[120] to 131 deaths per in 2008 and significant further reduction is required to meet the MDG target.
5.	**Improve Maternal Health** **Target: Reduce maternal mortality by 1/5th to 350 deaths per 100 000 live births.**	**From 1990-2000 the maternal mortality rate was unchanged at 430 deaths (2) and 2008 estimate is 600 deaths[121].** **Proportion of deliveries with the assistance of qualified staff seems to be improving with an increase from 78.8 per cent in 1998 to 83.4 per cent in 2004 (1)**
6.	Combat HIV/AIDS, Malaria and other Diseases Target: Halt HIV spread and reduce prevalence by 9%; Control malaria and bring down incidence by 8%	From 1990 to 2000 the AIDS prevalence rate rose from 2 – 11% (2) Malaria 40% in 2004 to 15 % in 2005 (1)
7.	Ensure Environmental Sustainability i) Target: reduce proportion of population using solid fuels to 42.2% ii) Target: 72.1% population have access to drinking water	Recent usage estimates: 82 % population using solid fuels (1) Access to drinking water increased from 40.6 % in 2001 to 43.9% in 2007 (1), but in 2001 only 31.3% of rural households had access compared to 86.2% of urban households (2) Proportion of the population with access to a better public sanitation system increased from 8.5 % in 2001 to 31.7 % in 2007 (1)
8.	Develop a Global Partnership for Development Target: Devise and implement strategies enabling youth to find decent and useful jobs	Youth unemployment dropped in 2001 and 2007 from 14.3% to 8.2% (2)

Sources:
1. *Growth and Employment Strategy Paper, Republic of Cameroon (2009)*
2. *MDG Progress Report 2003*

[120] HDI 1990 data
[121] HDI 2010

UNFPA-Because everyone counts

United Nations Population Fund
Evaluation Branch,
Division for Oversight Services
605 Third Avenue
New York, NY 10158 U.S.A.

http://www.unfpa.org/public/home/about/Evaluation/EBIER/CPE