EVALUATION REPORT

Mid-Term Evaluation

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

VOLUME II Annexes

Evaluation Branch
Division for Oversight Services

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The Maternal Health Thematic Fund Contribution to UNFPA Support to Maternal Health

Mid-Term Evaluation: Volume II Annexes

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ABSF	Association Burkinabé des Sage Femmes
ACDI	Agence Canadienne de Développement International
AFD	Agence Français de Développement
AHS	Academy of Health Sciences
AMDD	Adverting Maternal Death and Disability
ANC	Antenatal Care
AOP	Annual Operational Plan
APRO	Asia and the Pacific Regional Office
AusAid	Australian Agency for International Development
AWP	Annual Work Plan
BEmONC	Basic Emergency Obstetric and Newborn Care
BRIC	Brazil, Russia, India, China
CAP	Consolidated Appeal Process
CARE	CARE International in Cambodia
CARMMA	Campagne pour l'Accélération de la Réduction de la Mortalité Maternelle en Afrique/ Campaign on Accelerated Reduction of Maternal, New Born and Child Mortality
CBD	Community Based Distribution
CCA	Common Country Assessment
CDHS	Cambodia Demographic and Health Survey
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CFA	Country Fistula Advisor
CHAI	Clinton Health Access Initiative
CHEW	Community Health Extension Worker
CHPS	Community-Based Health Planning and Services
CHT	College of Health Science and Technologies
CIDA	Canadian International Development Agency
CMA	Country Midwife Advisor
CMC	Cambodia Midwifery Council
CO	Country office
CP	Country Programme
CPAP	Country Programme Action Plan
CPN	Consultation Prénatale
CPR	Contraceptive Prevalence Rate
CS / C-Section	Caesarean Section
CSO	Civil Society Organizations
CSPS	Centre de Santé et de Promotion Sociale
DHD	District Health Department
DHS	Demographic Health Survey
DOP	Department of Organization and Personnel
DOS	Division of Oversight Services
DP	Development Partner
DRH (french)	Direction des ressources humaines
DRH	Department for Reproductive Health
DSME	Direction de la Santé de la Mère et de l'Enfant
ECO	Ethiopian country office
EMA	Ethiopian Midwifery Association
EmOC	Emergency Obstetric Care
EmONC	Emergency Obstetric and Newborn Care
ENSP	École Nationale de Santé Publique
ESOG	Ethiopian Society of Obstetricians and Gynecologists

EU	European Union
FACE	Funding Authorization Certificate of Expenditure
FGM	Female Genital Mutilation
FGM/C	Female Genital Mutilation/Cutting
FMoH	Federal Ministry of Health
GAVI	Global Alliance for Vaccine and Immunization
GBV	Gender-Based Violence
GDP	Gross Domestic Product
GHS	Ghana Health Service
GNC	General Nursing Council
GNI	Gross National Income
GP	Global Programme
GPRHCS	Programme Global pour la Sécurisation en Produits de Santé de la Reproduction/Global Programme for Reproductive Health Commodity Security
GRMA	Ghana Registered Midwives' Association
H4+	UNAIDS, UNFPA, UNICEF, WB, WHO
HACT	Harmonized Approach to Cash Transfers
HEF	Health Equity Fund
HIS	Health Information System
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HMIS	Health Management Information System
HQ	Headquarter
HR	Human Resources
HRD	Human Resource Development
HRH	Human Resources for Health
HSDP	Health Sector Development Programme
HSSP	Health Sector Support Programme
ICM	International Confederation of Midwives
ICMA	International Country Midwifery Advisor
ICPD	International Conference on Population and Development
ICRH	International Centre for Reproductive Health
IDWG	Institutional Development Working Group
IEOS	Integrated Emergency Obstetric and Surgery
IFC	Individual, Family, Community
IFIRP	*Instituts de* formation interrégionaux des paramédicaux
IHP	International Health Partnership
IMR	Infant Mortality Rate
IP	Implementing Partner
IRSS	Institut de Recherche en Sciences de la Santé
IUD	Intrauterine Devices
JANS	Joint Assessment of National Strategies
JICA	Japan International Cooperation Agency
KfW	Kreditanstalt fuer Wiederaufbau (German Development Bank)
L&D	Labor & Delivery
Lao PDR	Lao People Democratic Republic
LSIS	Lao Social Indicator Survey
M&E	Monitoring and Evaluation
MAF	Millennium Development Goals Acceleration Framework
MARP	Most at Risk Population
MAZ	Midwives Association of Zambia
MBB	Marginal Budgeting for Bottlenecks
MCH	Maternal and Child Health

MDG	Millennium Development Goal
MH	Maternal Health
MHTE	Maternal Health Thematic Evaluation*/Évaluation Thématique Santé Maternelle*
MHTF	Maternal Health Thematic Fund/ *Fonds Thématique* d'Affectation Spéciale pour la *Santé Maternelle*
MMR (french)	Maternité à Moindre Risque
MMR	Maternal Mortality Ratio
MNCH	Maternal, Newborn and Child Health
MNH	Maternal Newborn Health
MoE	Ministry of Education
MoEYS	Ministry of Education, Youth and Sports
MOH	Ministry of Health
MPSC	Medical Product Supply Centre
MWH	Maternity Waiting Home
n	Respondents of the question of the online survey
N	Total sample of country offices selected for the online survey
NGO	Non-Government Organization
NHIS	National Health Insurance Scheme
NMNCHC	National Maternal Newborn Child Health Centre
NPC	National Population Council
NPO	National Programme Officer
NRHP	National Reproductive Health Programme
OMS	Organisation mondiale de la santé
ONG	Organisation non gouvernementale
PDR	People Democratic Republic
PEER	Participatory Ethnographic Evaluation and Research
PF	Planification Familiale
PHD	Provincial Health Department
PIB	Produit intérieur brut
PMNCH	Partnership for Maternal, Newborn and Child Health
PMO	Provincial Medical Officer
PMP	Performance Monitoring Plan
PMTCT	Preventing Mother-to-Child Transmission
PNC	Postnatal Care
PNDS	Plan National de Développement Sanitaire
PSI	Population Services International
PSoN	Provincial Schools of Nursing
PTA	Plan de Travail Annuel
PTME	Prévention de la transmission mère-enfant
RCMA	Regional Coordination Mechanism Advisor
RHCS	Reproductive Health Commodity Security
RHTF	Reproductive Health Thematic Fund
RMNCH	Reproductive Maternal Newborn and Child Health
RO	Regional Office
SBA	Skilled Birth Attendant
SCADD	Stratégie de croissance accélérée et de Développement Durable
SF	Sage-femme
SF/ME	Sagefemme Maïeuticien d'État
SIDA	Swedish International Development Cooperation Agency
SIDA (french)	Syndrome de l'immunodéficience acquise
SM	Safe Motherhood
SMAG	Safe Motherhood Action Group

SNIS	Système National d'Information Sanitaire
SNNPR	Southern Nations, Nationalities and Peoples Region
SONU	Soins obstétricaux et néonataux d'urgence
SONUB	Soins Obstétricaux et Néonataux d'Urgence de Base
SONUC	Soins Obstétricaux et Néonataux d'Urgence de Complémentaires
SPSR	Sécurité des Produits de Santé Reproductive
SR	Santé reproductive
SRA	Santé de la reproduction des adolescents
SRAJ	Santé de la Reproduction des Adolescents et des Jeunes
STI	Sexually Transmitted Infection
SWAA	Society for Women and AIDS Action
SWAp	Sector-Wide Approach
TBA	Traditional Birth Attendant
TD	Technical Division
TFR	Total Fertility Rate
TL	Team Leader
TNA	Training Needs Assessment
ToR	Terms of Reference
TTF	Thematic Trust Fund
TV	Television
TVET	Technical and Vocational Education and Training
TWG	Technical Working Group
UBW	Unified Budget and Work plan
UN	United Nations
UNAIDS	United Nations Programme on AIDS
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNESCO	United Nations Education, Social and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children Emergency Fund
UNV	United Nations Volunteers
US	United States
US$	US-Dollar
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
VIH	Virus de l'immunodéficience humaine
VSO	Voluntary Services Overseas
WAHA	Women and Health Alliance
WB	World Bank
WHO	World Health Organization
ZUNO	Zambian Union of Nurses Organization

1. The global context of maternal health

1.1 The global maternal health situation

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

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

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

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

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

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

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

[1] WHO, Unicef, UNFPA and the WB estimates - Trends in maternal mortality: 1990 to 2010
[2] WHO, Unicef, UNFPA and the WB estimates - Trends in maternal mortality: 1990 to 2010
[3] WHO, Unicef, UNFPA and the WB estimates - Trends in maternal mortality: 1990 to 2010
[4] UNFPA (2010): *How universal is access to reproductive health – a review of evidence*, September 2010 (http://www.unfpa.org/webdav/site/global/shared/documents/publications/2010/universal_rh.pdf)

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

1.2 The global maternal health response

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

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

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

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

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

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

[6] "Countdown to 2015: Tracking progress in maternal, newborn & child survival" at http://www.who.int/child_adolescent_health/documents/9789280642841/en/index.html

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

2. Evaluation methodology

2.1 Evaluation process

The four phases of this assignment were:

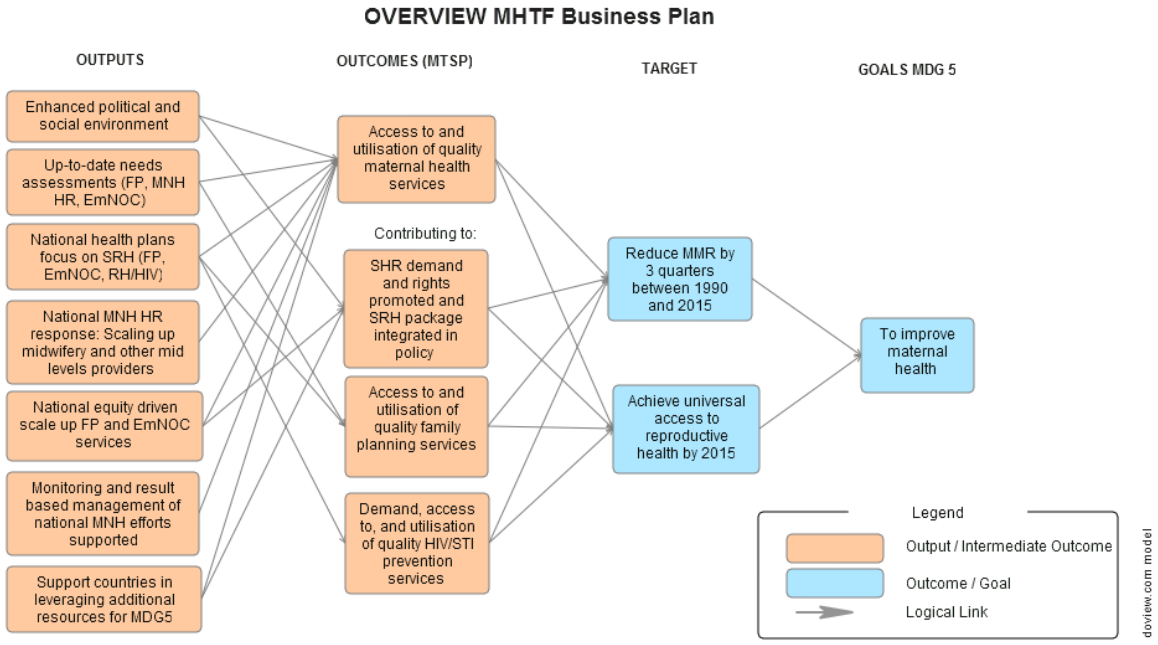
- The Extended Desk Phase, which was itself divided into two parts:
  - *Part one ("structuring stage")* involved the detailed structuring and design of the evaluation, the development of clear evaluation questions and their operationalization using judgment criteria and indicators.
  - *Part two* of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

[7] Countdown to 2015: assessment of official development assistance to maternal, newborn, and child health, 2003–08, Lancet 2010; 376: 1485–96

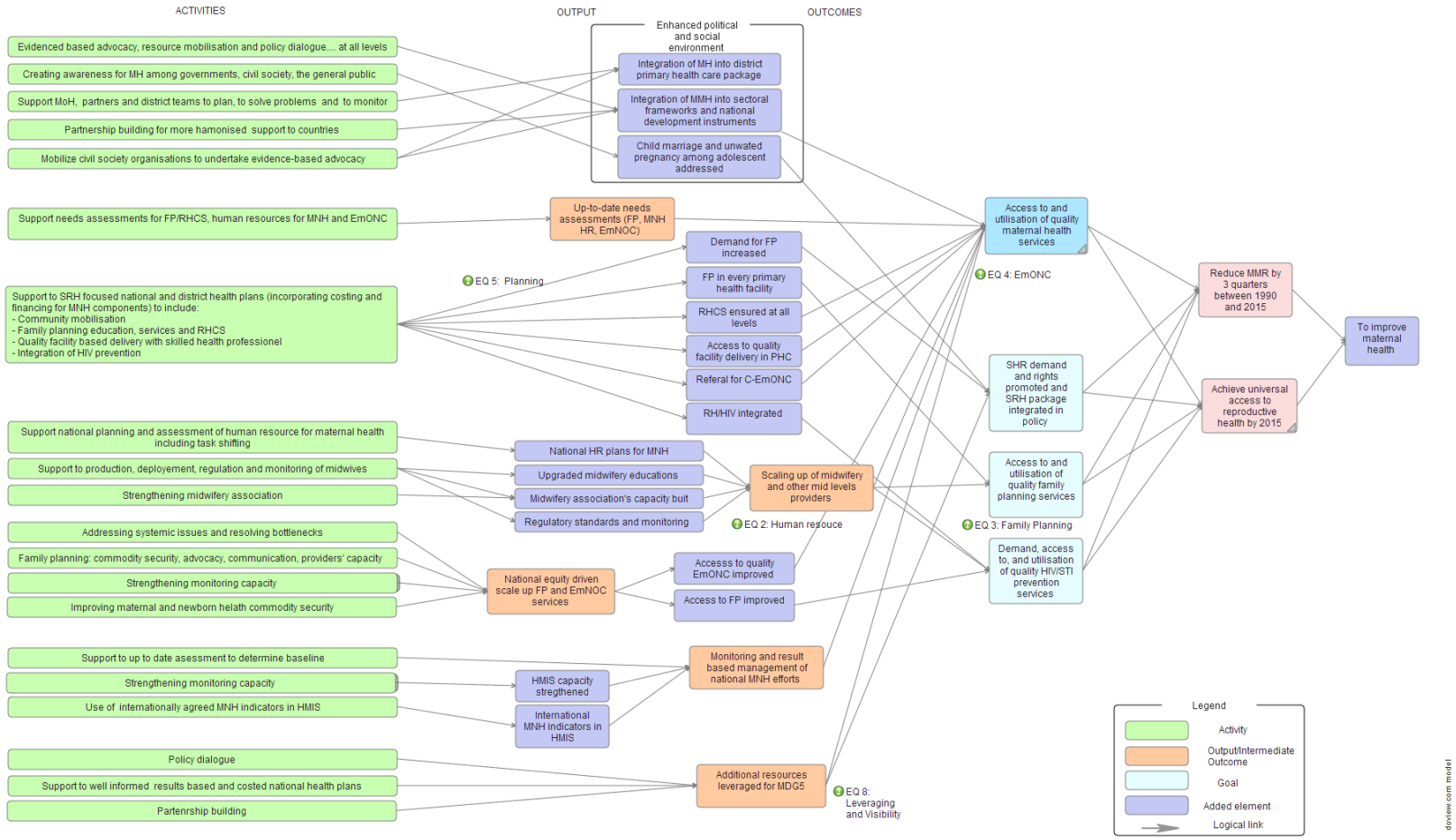
2.2 Overview of the MHTF Business Plan and effects diagram

The following figures present the overview of the MHTF Business Plan and the effects diagram.

Overview MHTF Business Plan (faithful)



Effect diagram for MHTF Business Plan 2008 – 2011 (logically reconstructed)



2.3 Sampling of case study countries

Table 1: Sampling of case study countries: Grouping of desk phase countries that have made large improvements in reducing maternal mortality; 2000 – 2011

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

Table 2: Sampling of case study countries: Grouping of desk phase countries that have made relatively small improvements in reducing maternal mortality, 2000 – 2011

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

3. Work plan

Figure 1: Work plan of evaluation

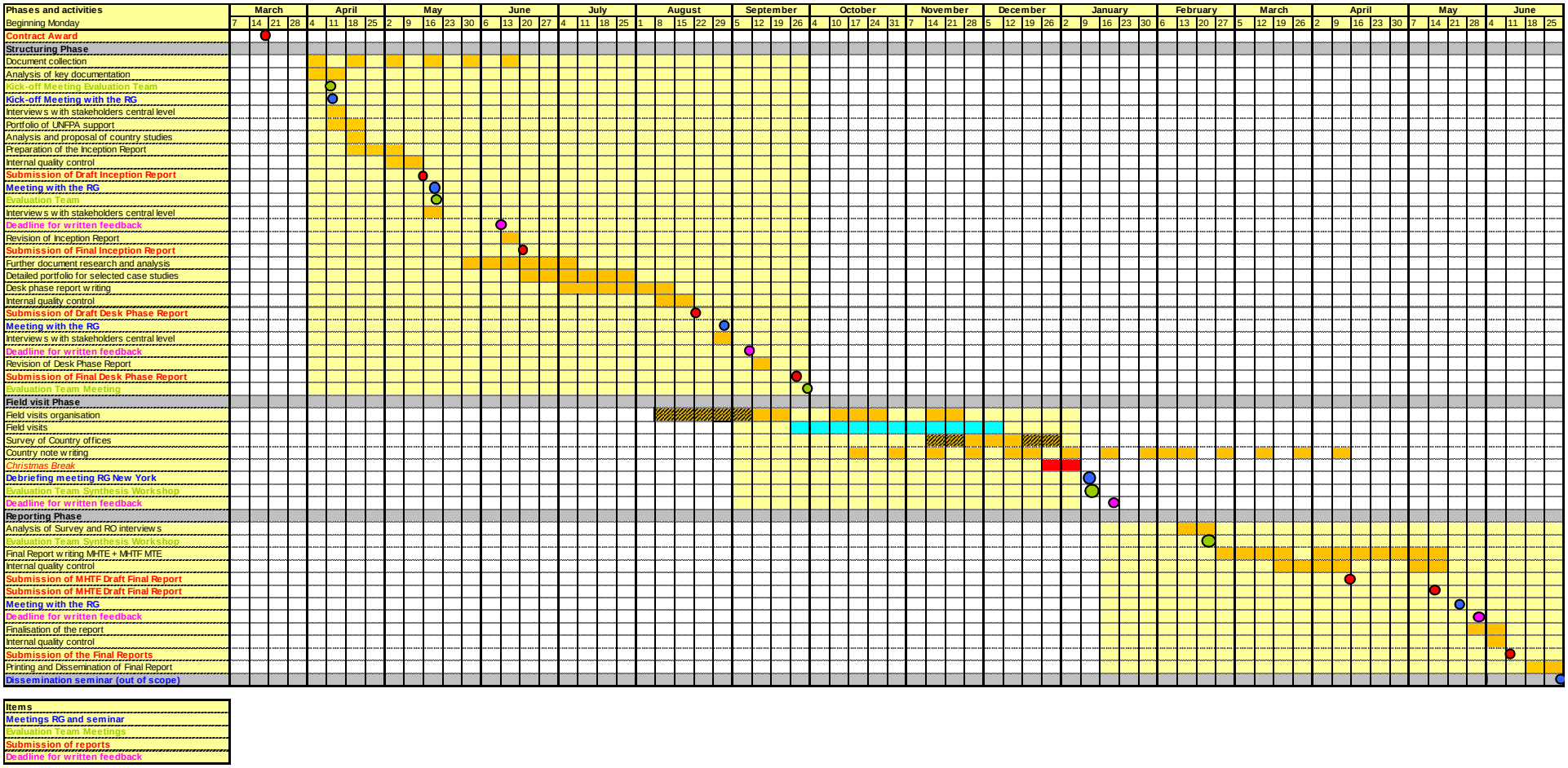
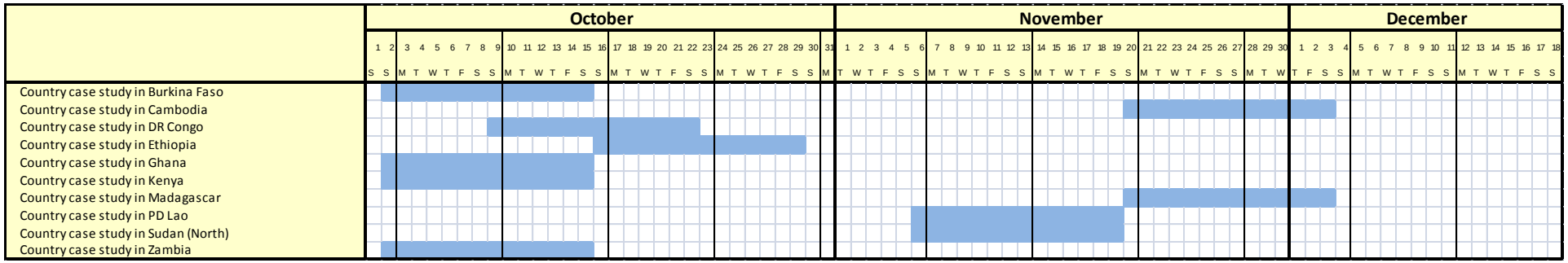


Figure 2: Work plan of country case studies



4. Data collection tools applied

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

Issues to assess	Data Sources (documents, stakeholders)											Key assumptions (no need to state the obvious)	Likelihood that assumption is fulfilled (High, Medium, Low)
	UNFPA HQ	UNFPA Regional Offices	Country Offices	IPs	Government Coordinating Authority (Gov)	Programme Component Manager – SRH (Gov)	Gov (others)	H4+ (WHO, UNICEF, World Bank, UNAIDS)	Other UN Agencies (UNDAF)	Other Donors	Project Visits (all stakeholders)		
JC 1.1.Correspondence between levels of UNFPA SRH / MH support and maternal health needs of vulnerable groups across partner countries													
What qualitative criteria does UNFPA / do regional offices consider when deciding on the resource distribution for MNH between countries?		IP DC [1]	IN[2]									• Resource allocation process is documented in regional offices	High
To what extent have MNH commitments of partner donors influenced UNFPA's own level of commitment to MNH in high needs countries?		IP DC [3]	IN					IN				• Documentation of coordination process between UNFPA and other donors is available	Medium
To whate extent did population size influence the distribution of resources among MNH high needs countries?	IP DC	IP DC											High
JC 1.2. (Increased) availability of accurate and sufficiently disaggregated data for targeting most disadvantaged / vulnerable groups													
To what extent do UNFPA/ IP monitoring tools include indicators to capture the specific situation of the most vulnerable?			IN DC	IN DC	IN DC	IN DC							High
To what extent do UNFPA COs utilize information from needs assessments other than the CCAs?			IN DC										High
Has UNFPA identified and targeted "vulnerable													High

Table 4: Data collection result matrix per country

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

Table 5: Format for interview reports

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

Table 6: Format for focus group reports

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

5. Presentation of results of online survey for MHTF

5.1 Introduction

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

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

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

The survey has focused in particular on the following issues:

- Maternal health related support country offices have received from regional offices
- Maternal health related support country offices have received from UNFPA headquarters
- The organizational capacity of country offices with regard to maternal health

For those countries that have received funds from the Maternal Health Thematic Fund (MHTF), the survey also contains several questions that would provide information on the added value of the MHTF in the three areas mentioned above.

This section presents the results of the online survey related to the MHTF without further interpretation. The analysis of the results and their interpretation has been integrated into the main report (volume 1) with respective references to this document.

The response rate of the survey was 100 percent.

5.2 Overview of respondents

The sample of 55 countries has been selected during a multiple phase process where numerous selection criteria have been defined and which is presented in more detail in Volume 1 under the Methodology section.

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

Table 7: Regional offices and country offices

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

In the course of the analysis of the survey data, a breakdown of several questions has been made according to geographical regions but also to sub-regions. This has been considered relevant due to the assignment of considerable funds via sub-regional offices to country offices. However, sub-regional offices do not provide specific technical assistance to COs and have therefore not been included as separate entities within the questions of the survey.

The table below presents an overview of respondent countries per region and sub-region.

[8] The list of countries per region is not exhaustive but limited to the countries participating in the survey.

Table 8: Sub-regions and country offices

	Bangkok	Dakar	Johannesburg
1	Afghanistan	Benin	Angola
2	Bangladesh	Burkina Faso	Botswana
3	Bhutan	Cameroon	Burundi
4	Cambodia	Central African Republic	Comoros
5	India	Chad	Eritrea
6	Indonesia	Congo (Brazzaville)	Ethiopia
7	Lao PDR	Cote d'Ivoire	Kenya
8	Pakistan	Djibouti	Lesotho
9	Timor Leste	DRC	Madagascar
10	Nepal	Equatorial Guinea	Malawi
11		Gambia	Mozambique
	Cairo		
12		Ghana	Nigeria
1	Somalia	Guinea	Rwanda
2	Sudan	Guinea-Bissau	Sierra Leone
3	Yemen	Liberia	South Africa
16		Mali	Swaziland
	Panama		
17		Mauritania	Tanzania
1	Bolivia	Niger	Uganda
2	Haiti	Senegal	Zambia
20		Togo	Zimbabwe

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

Table 9: Starting years of funding by MHTF

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

	NON-MHTF
1	Angola
2	Bhutan
3	Bolivia
4	Botswana
5	Comoros
6	Equatorial Guinea
7	Gambia
8	India
9	Indonesia
10	Lesotho
11	South Africa
12	Swaziland
13	Tanzania
14	Togo
15	Zimbabwe

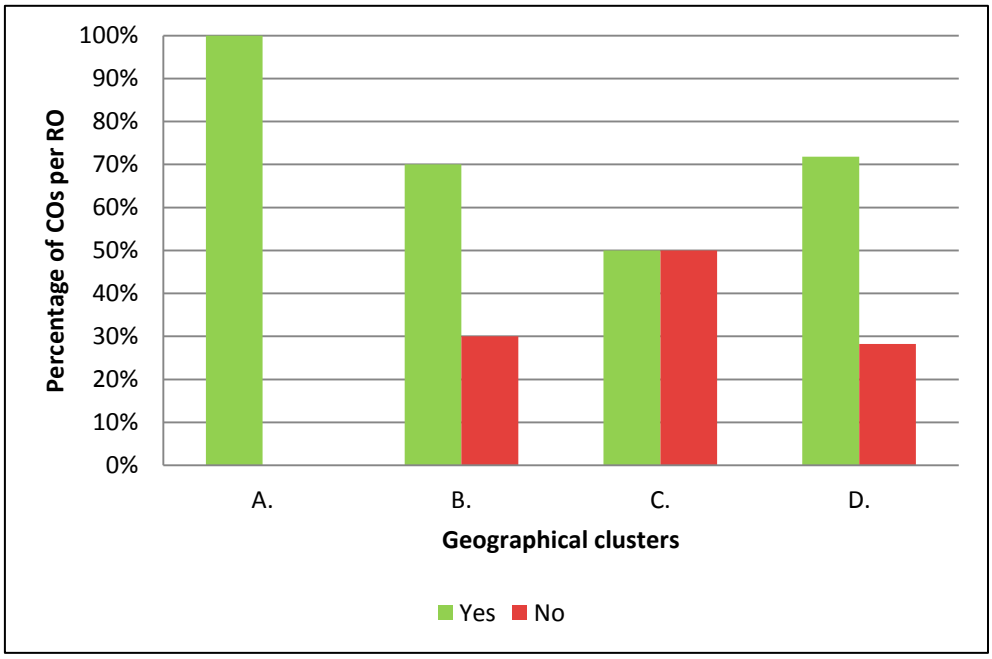
5.3 Results of MHTF questions

Question 26: Has your country office received funding from the Maternal Health Thematic Fund?

Legend on geographical clusters for analysis:

A. Country offices of RO Arab States
B. Country offices of RO Asia & Pacific
C. Country offices of RO Sub-Saharan Africa
D. Country offices of RO Latin America & the Caribbean[9]

Figure 3: Funding for CO from MHTF, clustered by regional offices (in % of CO per RO)

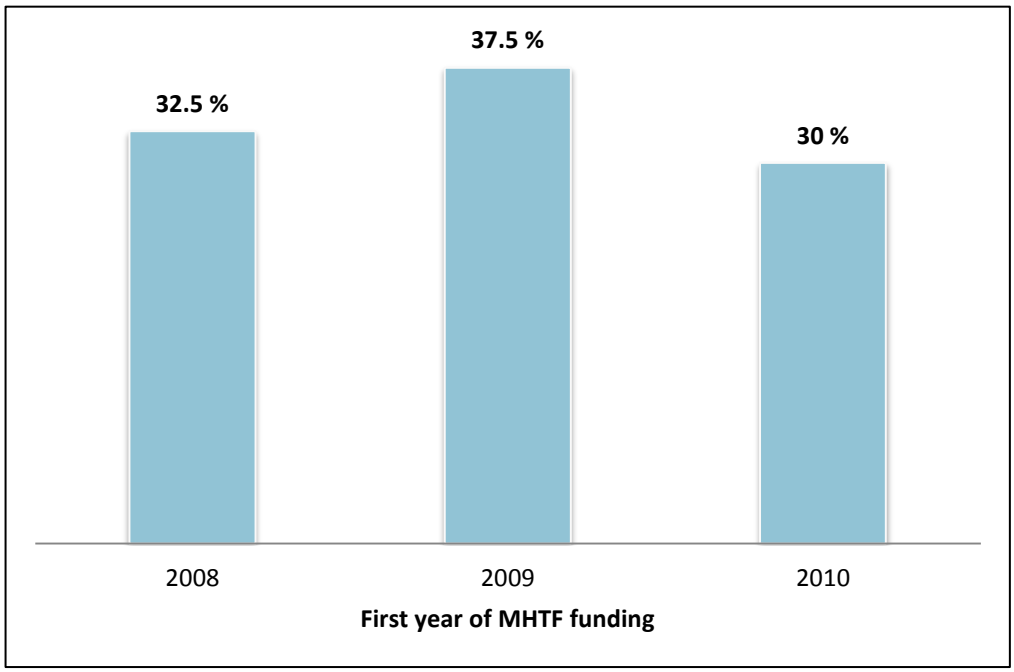


Notes	N=55, n=55
Comment	Within the respondent group of 55 countries around 73 percent have been recipient countries of the MHTF whereas the remaining 27 percent have not benefitted from the MHTF during the evaluation period from 2000-2011.

[9] Only one respondent

Question 27: The first year in which your country office has received funding from the MHTF?

Figure 4: **Starting years of MHTF funding (in % of all recipient countries so far)**



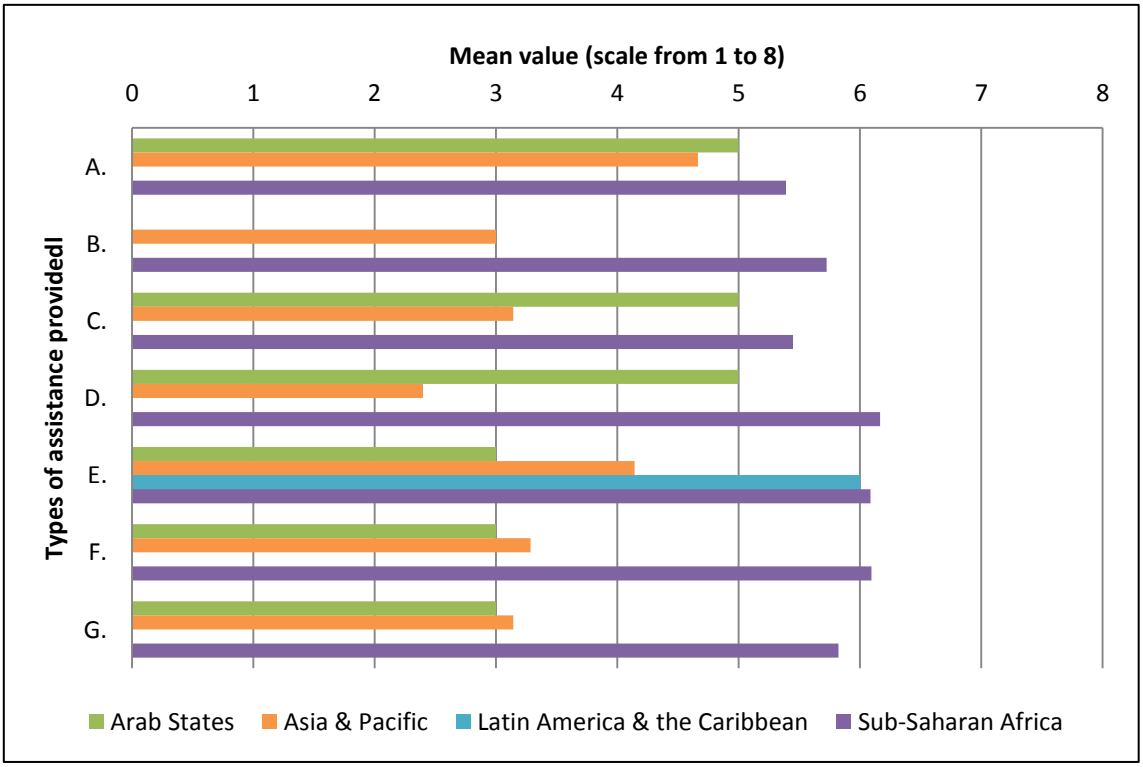
Notes	N=40 (Countries receiving MHTF funding so far), n=40
Comment	The share of countries starting to receive MHTF funds has been relatively balanced in the years 2008, 2009 and 2010 with around 30-40 percent equaling around 12-15 countries out of the respondent group who joined the MHTF recipient group every year.

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

Legend on "Types of assistance provided":

A. Standardized workshops on topics proposed by the regional office
B. "On-demand", customized workshops, addressing a topic of your choosing
C. In-country technical support (other than workshops) by regional office staff (direct technical support)
D. In-country technical support (other than workshops) by external consultant that had been recruited by regional office (facilitation of technical support)
E. Provision of guidance documents on issues related to maternal health or maternal health programming
F. Technical support over phone/ skype/ e-mail
G. Technical cooperation and exchange with another country office (only if facilitated by regional office)

Figure 5: Mean values for improvement of assistance from regional level, clustered by regions (rated on a scale with 1 lowest to 8 highest)



Legend on “Types of assistance provided”:

A. Standardized workshops on topics proposed by the regional office
B. “On-demand”, customized workshops, addressing a topic of your choosing
C. In-country technical support (other than workshops) by regional office staff (direct technical support)
D. In-country technical support (other than workshops) by external consultant that had been recruited by regional office (facilitation of technical support)
E. Provision of guidance documents on issues related to maternal health or maternal health programming
F. Technical support and support over phone/ skype/ e-mail
G. Technical cooperation and exchange with another country office (only if facilitated by RO)

Legend on “Clusters”:

Not applicable = for types of assistance which were not provided

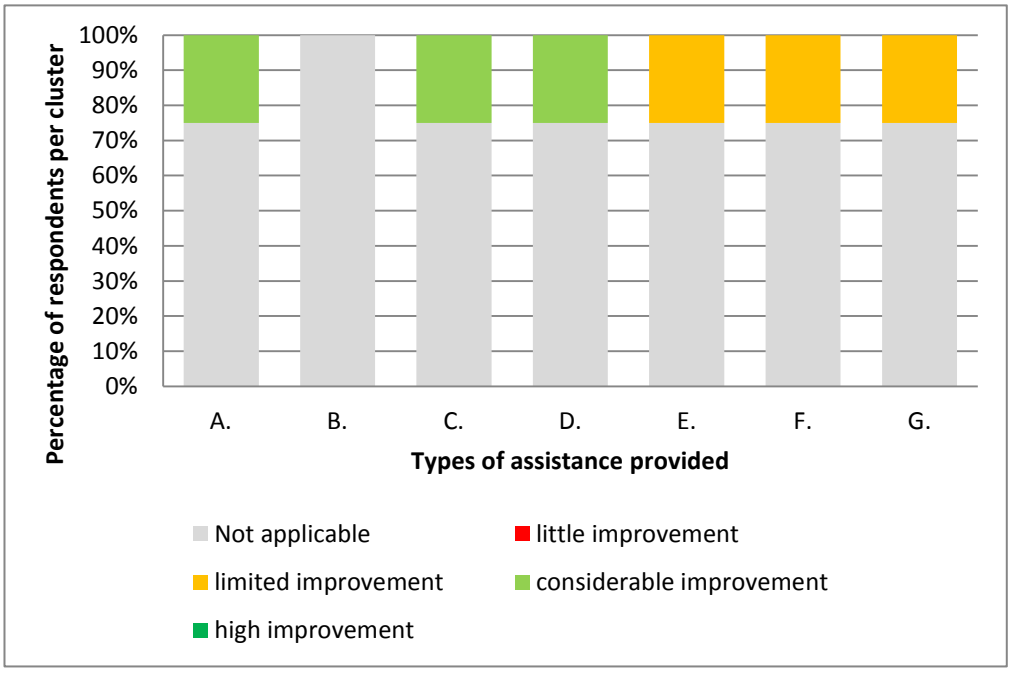
Scale value 1 and 2 = little improvement

Scale value 3 and 4 = limited improvement

Scale value 5 and 6 = considerable improvement

Scale value 7 and 8 = high improvement

Figure 6: Clustered analysis (in %) for improvement of assistance from regional level for the Arab States region (rated on a scale with 1 lowest to 8 highest)



Legend on “Types of assistance provided”:

A. Standardized workshops on topics proposed by the regional office
B. “On-demand”, customized workshops, addressing a topic of your choosing
C. In-country technical support (other than workshops) by regional office staff (direct technical support)
D. In-country technical support (other than workshops) by external consultant that had been recruited by regional office (facilitation of technical support)
E. Provision of guidance documents on issues related to maternal health or maternal health programming
F. Technical support and support over phone/ skype/ e-mail
G. Technical cooperation and exchange with another country office (only if facilitated by RO)

Legend on “Clusters”:

Not applicable = for types of assistance which were not provided

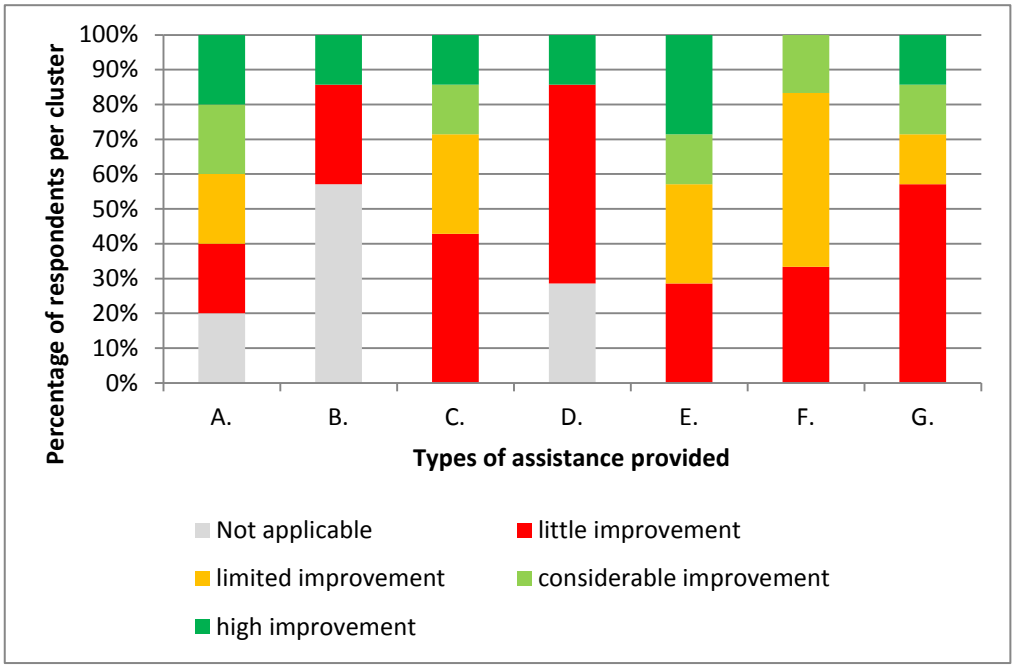
Scale value 1 and 2 = little improvement

Scale value 3 and 4 = limited improvement

Scale value 5 and 6 = considerable improvement

Scale value 7 and 8 = high improvement

Figure 7: Clustered analysis for improvement of assistance from regional level for the Asia & Pacific region (rated on a scale with 1 lowest to 8 highest)



Legend on “Types of assistance provided”:

A. Standardized workshops on topics proposed by the regional office
B. “On-demand”, customized workshops, addressing a topic of your choosing
C. In-country technical support (other than workshops) by regional office staff (direct technical support)
D. In-country technical support (other than workshops) by external consultant that had been recruited by regional office (facilitation of technical support)
E. Provision of guidance documents on issues related to maternal health or maternal health programming
F. Technical support and support over phone/ skype/ e-mail
G. Technical cooperation and exchange with another country office (only if facilitated by RO)

Legend on “Clusters”:

Not applicable = for types of assistance which were not provided

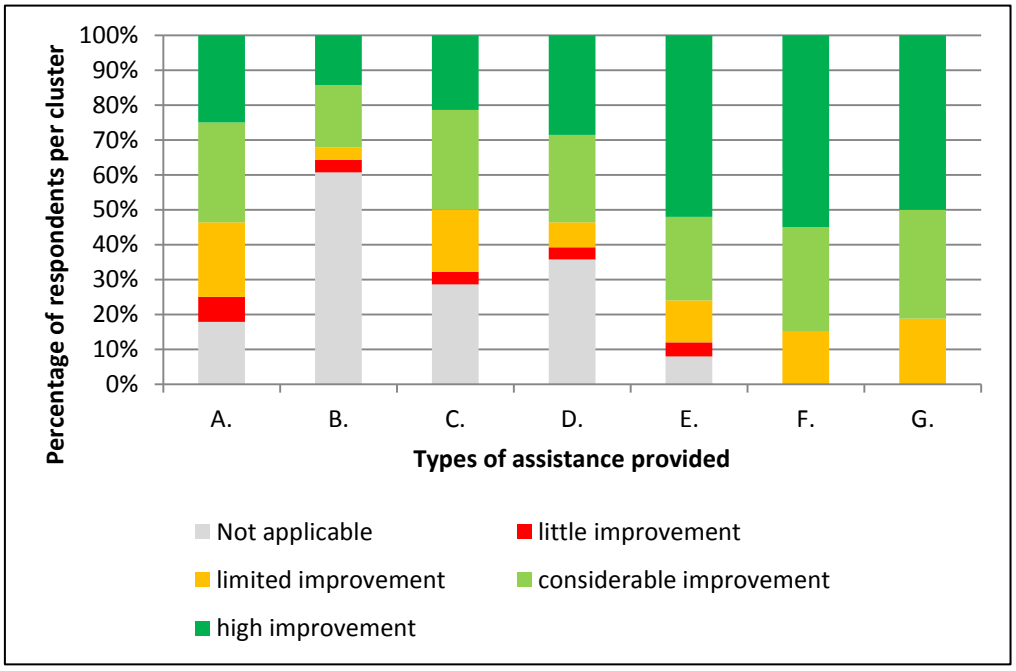
Scale value 1 and 2 = little improvement

Scale value 3 and 4 = limited improvement

Scale value 5 and 6 = considerable improvement

Scale value 7 and 8 = high improvement

Figure 8: Clustered analysis for improvement of assistance from regional level for the Sub-Saharan Africa region (rated on a scale with 1 lowest to 8 highest)



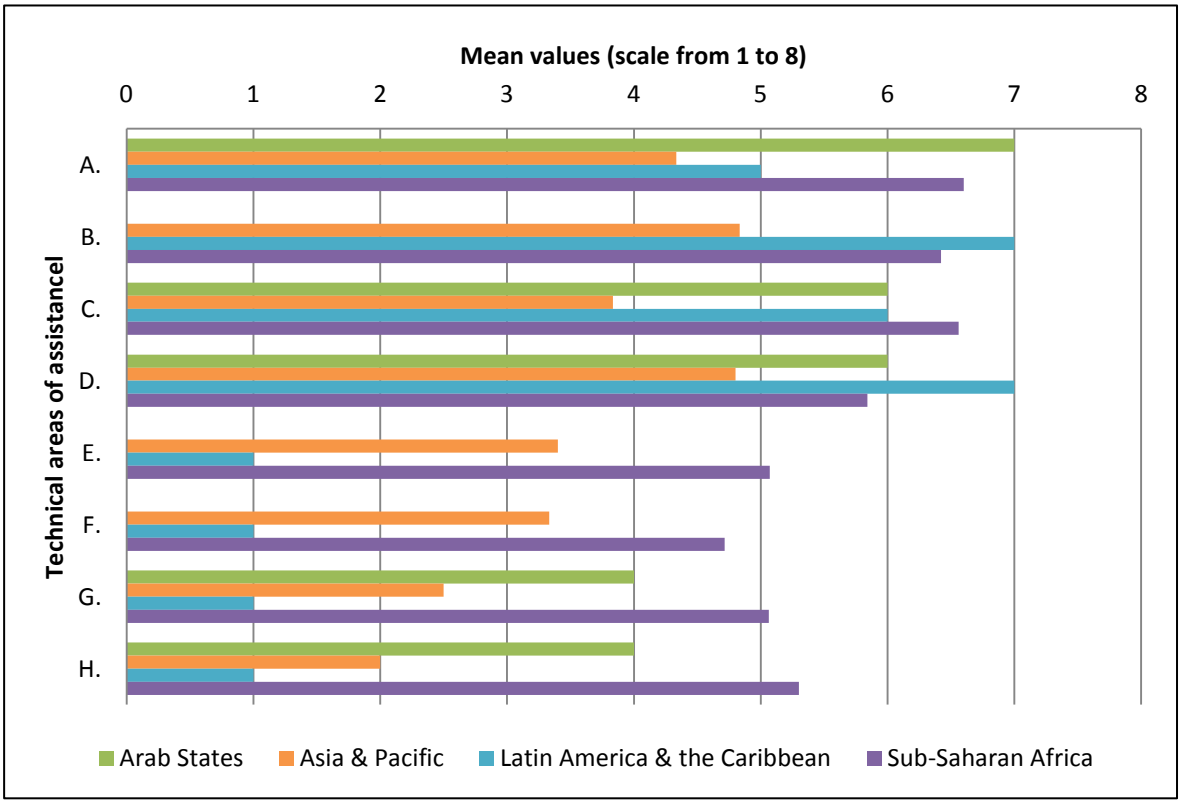
Notes	N=40, n=40

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

Legend on "technical areas":

A. Obstetric fistula, including prevention and treatment
B. Emergency Obstetric and Newborn Care (EmONC)
C. Family planning & reproductive health commodity security
D. Midwifery
E. Human resources for health (other than midwifery)
F. Sexually transmitted infections and reproductive tract infections
G. Integration of maternal health with the Population and Development component
H. Integration of maternal health with the Gender component

Figure 9: Mean values for improvement of assistance in technical areas from regional level, clustered by regions (rated on a scale with 1 lowest to 8 highest)



Legend on “technical areas”:

A. Obstetric fistula, including prevention and treatment
B. Emergency Obstetric and Newborn Care (EmONC)
C. Family planning & reproductive health commodity security
D. Midwifery
E. Human resources for health (other than midwifery)
F. Sexually transmitted infections and reproductive tract infections
G. Integration of maternal health with the Population and Development component
H. Integration of maternal health with the Gender component

Legend on “Clusters”:

Not applicable = for types of assistance which were not provided

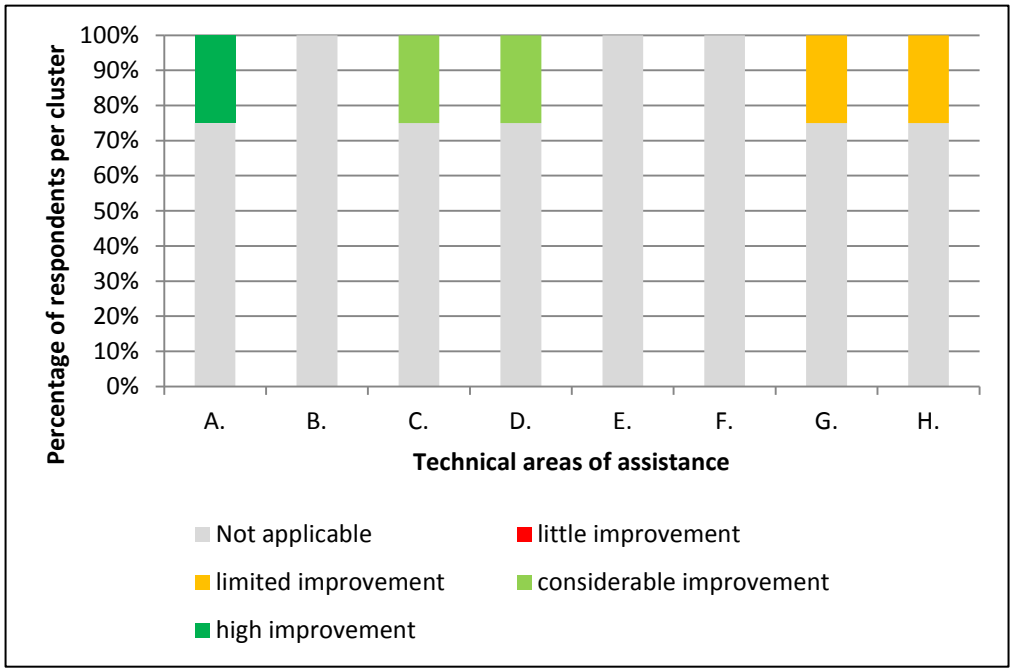
Scale value 1 and 2 = little improvement

Scale value 3 and 4 = limited improvement

Scale value 5 and 6 = considerable improvement

Scale value 7 and 8 = high improvement

Figure 10: Clustered analysis for improvement of assistance in technical areas from regional level for the region Arab States (rated on a scale with 1 lowest to 8 highest)



Legend on “technical areas”:

A. Obstetric fistula, including prevention and treatment
B. Emergency Obstetric and Newborn Care (EmONC)
C. Family planning & reproductive health commodity security
D. Midwifery
E. Human resources for health (other than midwifery)
F. Sexually transmitted infections and reproductive tract infections
G. Integration of maternal health with the Population and Development component

Integration of maternal health with the Gender component

Legend on “Clusters”:

Not applicable = for types of assistance which were not provided

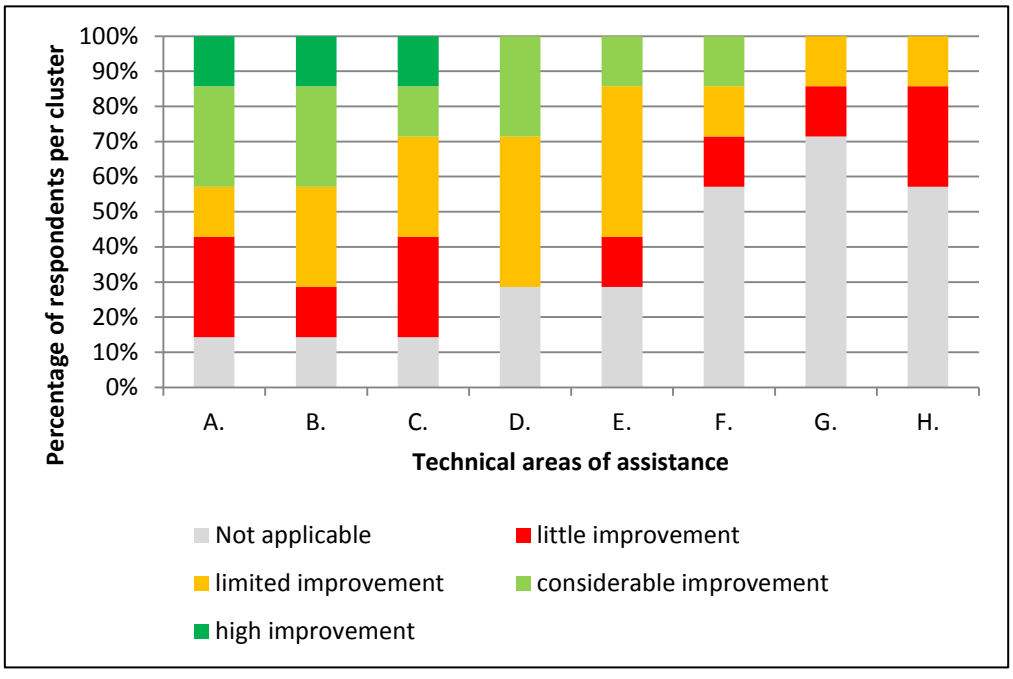
Scale value 1 and 2 = little improvement

Scale value 3 and 4 = limited improvement

Scale value 5 and 6 = considerable improvement

Scale value 7 and 8 = high improvement

Figure 11: Clustered analysis for improvement of assistance in technical areas from regional level for the Asia & Pacific region (rated on a scale with 1 lowest to 8 highest)



Legend on “technical areas”:

A. Obstetric fistula, including prevention and treatment
B. Emergency Obstetric and Newborn Care (EmONC)
C. Family planning & reproductive health commodity security
D. Midwifery
E. Human resources for health (other than midwifery)
F. Sexually transmitted infections and reproductive tract infections
G. Integration of maternal health with the Population and Development component
H. Integration of maternal health with the Gender component

Legend on “Clusters”:

Not applicable = for types of assistance which were not provided

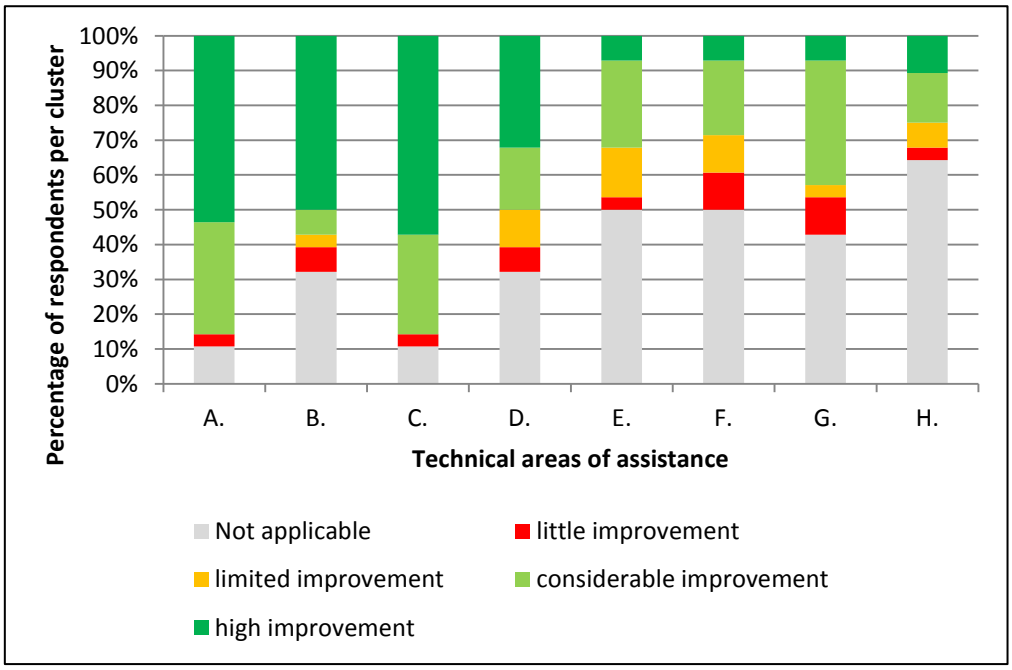
Scale value 1 and 2 = little improvement

Scale value 3 and 4 = limited improvement

Scale value 5 and 6 = considerable improvement

Scale value 7 and 8 = high improvement

Figure 12: Clustered analysis for improvement of assistance in technical areas from regional level for the Sub-Saharan Africa region (rated on a scale with 1 lowest to 8 highest)



Notes	N=40, n=40

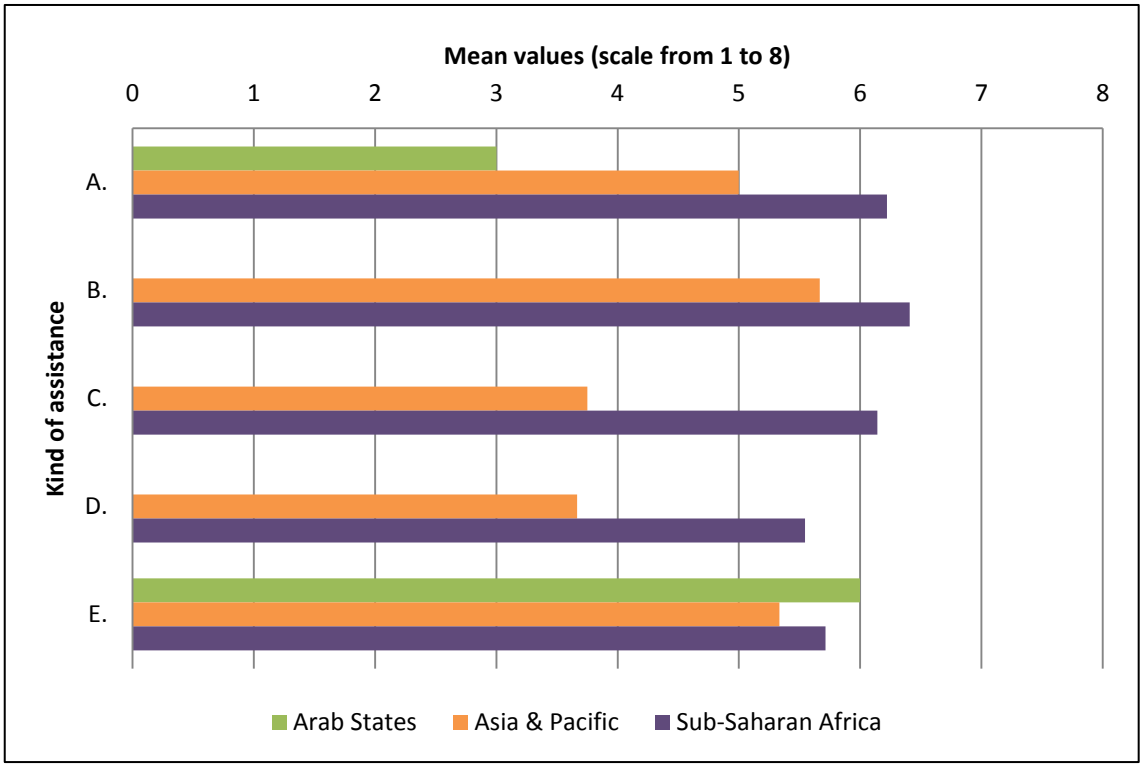
Question 30: On a scale of 1 to 8, please indicate to what extent the launch of the MHTF has improved the usefulness of the assistance that you have received from the regional level of UNFPA in the different areas of programme planning and management; with (1) for "no improvement at all" and (8) for "a lot of improvement".

(Note: for thematic areas in which you have not received any support, please select "Not applicable")

Legend on "Kind of support":

A. Development of country programmes (CPDs / CPAPs)
B. Annual programme planning in maternal health
C. Budgeting and financial management
D. Monitoring
E. Evaluation

Figure 13: Mean values for improvement of assistance in programme planning and management from regional level, clustered by regions (rated on a scale with 1 lowest to 8 highest)



Note: The Latin America & the Caribbean region did not receive any of these kinds of assistance in programme planning and management.

Legend on “Clusters”:

Not applicable = for types of assistance which were not provided

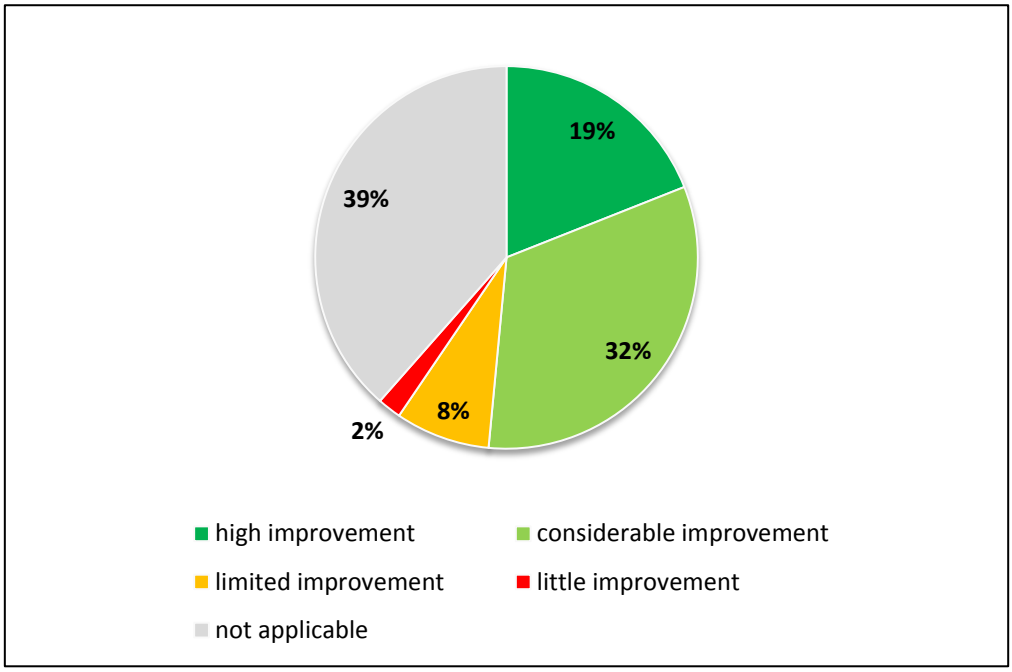
Scale value 1 and 2 = little improvement

Scale value 3 and 4 = limited improvement

Scale value 5 and 6 = considerable improvement

Scale value 7 and 8 = high improvement

Figure 14: Clustered analysis for improvement of assistance in programme planning and management from regional level (rated on a scale with 1 lowest to 8 highest), all respondents (in %), all types of support



Notes	N=40, n=40

Question 31: On a scale of 1 to 8, please rate how satisfied you have been with support from regional office since the launch of the MHTF; with 1 being "highly dissatisfied"; and 8 being "highly satisfied".

(Note: if you have not received any support from regional level since the launch of MHTF, select "N/A")

Legend on "Clusters":

Not applicable = if no support was received

Scale value 1 and 2 = highly dissatisfied

Scale value 3 and 4 = dissatisfied

Scale value 5 and 6 = satisfied

Scale value 7 and 8 = highly satisfied

Figure 15: Satisfaction of respondents with support from regional offices (in %), clustered scale from 1 to 8

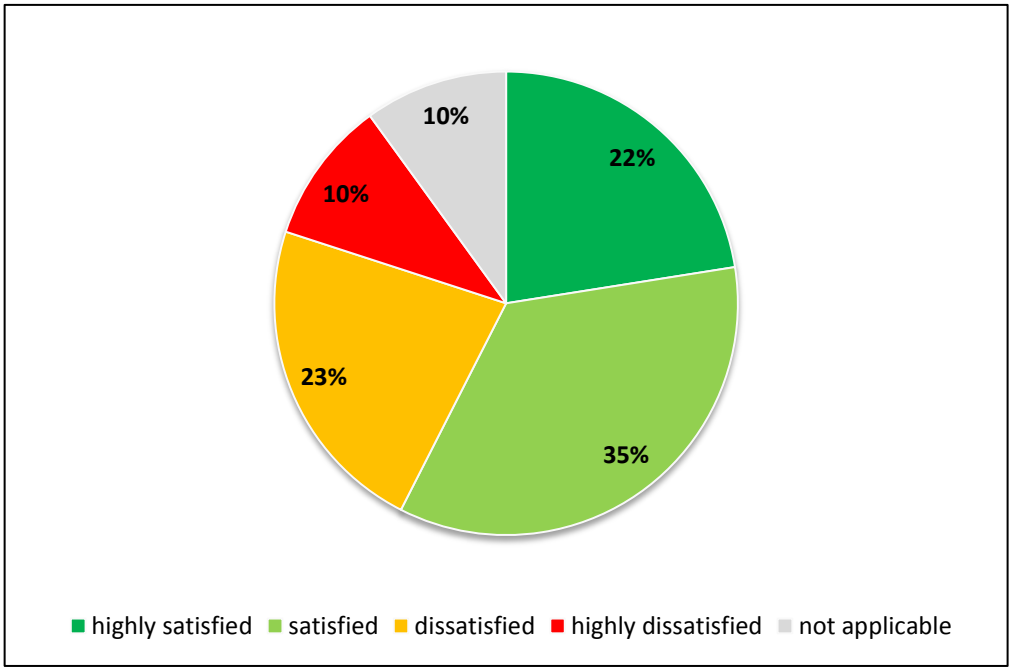
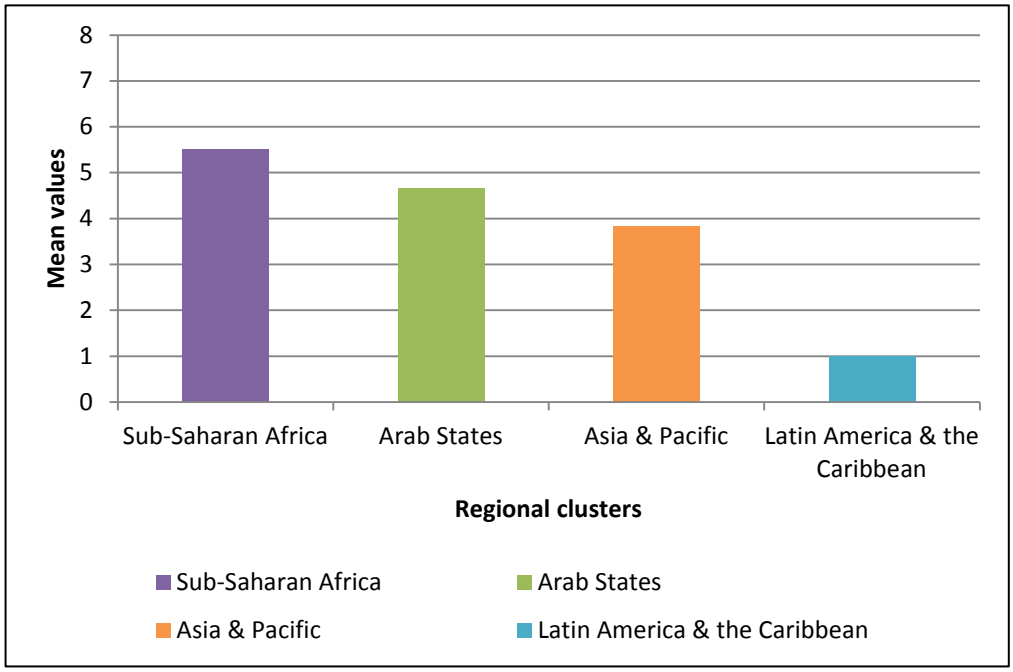


Figure 16: Mean values by regions for satisfaction of respondents with support from regional offices (in %), (scale from 1 to 8)



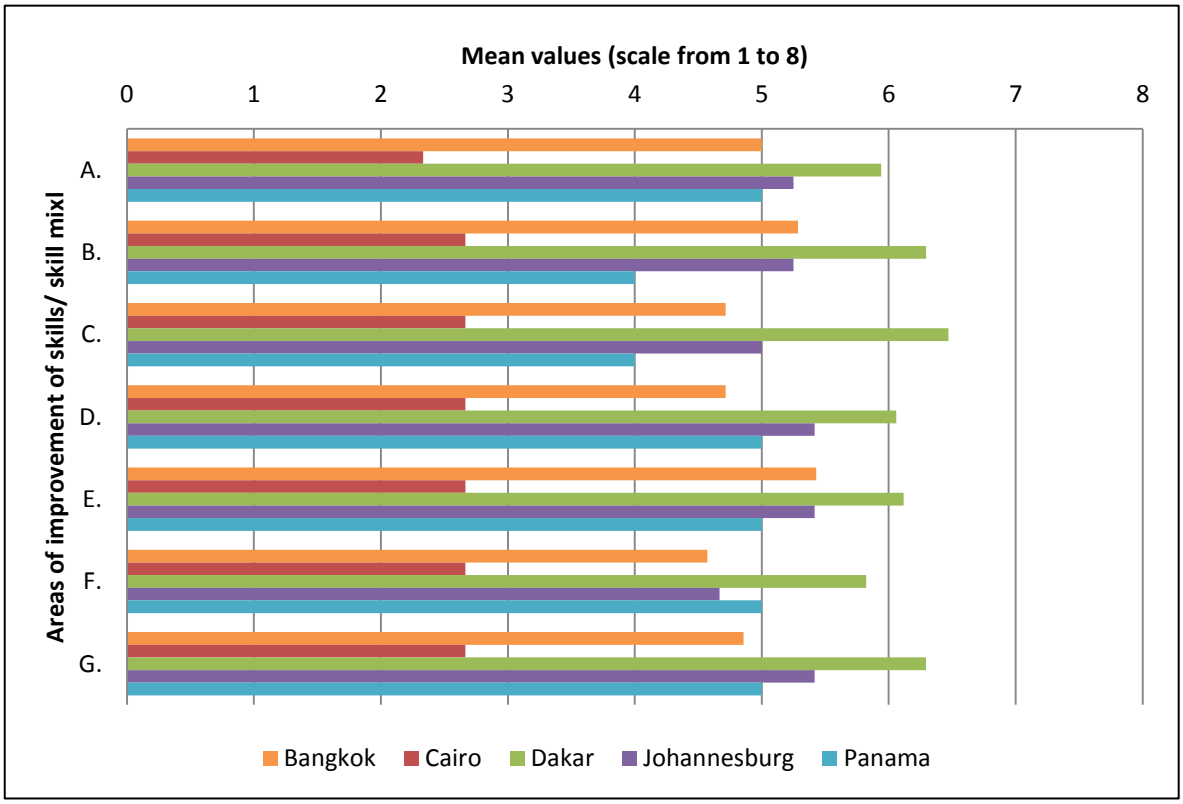
Notes	N=40, n=40

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

Legend for "different areas of improvement":

A. Because of the launch of the MHTF, the skill mix available in my country office to do effective policy advocacy for maternal health with our partners (Government & development partners) has....
B. Because of the launch of the MHTF, the skill mix available in my country office to establish UNFPA as the lead agency for policy advocacy to promote maternal health has...
C. Because of the launch of the MHTF, the skill mix available in my country office to establish UNFPA as the lead agency for evidence-based technical contributions to promote maternal health has...
D. Because of the launch of the MHTF, the skill mix available in my country office to make meaningful technical contributions (e.g. leading of technical working groups, provision of technical guidance on maternal health) in maternal health has…
E. Because of the launch of the MHTF, the skill mix available in my country office to kick-start new initiatives in maternal health (e.g. the introduction of new concepts or approaches) has...
F. Because of the launch of the MHTF, the skill mix available in my country office to appropriately monitor and evaluate our maternal health interventions has...
G. Because of the launch of the MHTF, the skill mix available in my country office to fulfill all of our responsibilities related to the overall maternal health component of the country programme has...

Figure 17: Mean values for improvement of types of skills/ skills mix in different areas since the start of MHTF, clustered by sub-regions (rated on a scale with 1 lowest to 8 highest)



Legend for “different areas of improvement of skills/ skill mix”:

A. Because of the launch of the MHTF, the skill mix available in my country office to do effective policy advocacy for maternal health with our partners (Government & development partners) has....
B. Because of the launch of the MHTF, the skill mix available in my country office to establish UNFPA as the lead agency for policy advocacy to promote maternal health has...
C. Because of the launch of the MHTF, the skill mix available in my country office to establish UNFPA as the lead agency for evidence-based technical contributions to promote maternal health has...
D. Because of the launch of the MHTF, the skill mix available in my country office to make meaningful technical contributions (e.g. leading of technical working groups, provision of technical guidance on maternal health) in maternal health has…
E. Because of the launch of the MHTF, the skill mix available in my country office to kick-start new initiatives in maternal health (e.g. the introduction of new concepts or approaches) has...
F. Because of the launch of the MHTF, the skill mix available in my country office to appropriately monitor and evaluate our maternal health interventions has...
G. Because of the launch of the MHTF, the skill mix available in my country office to fulfill all of our responsibilities related to the overall maternal health component of the country programme has...

Legend on “Clusters”:

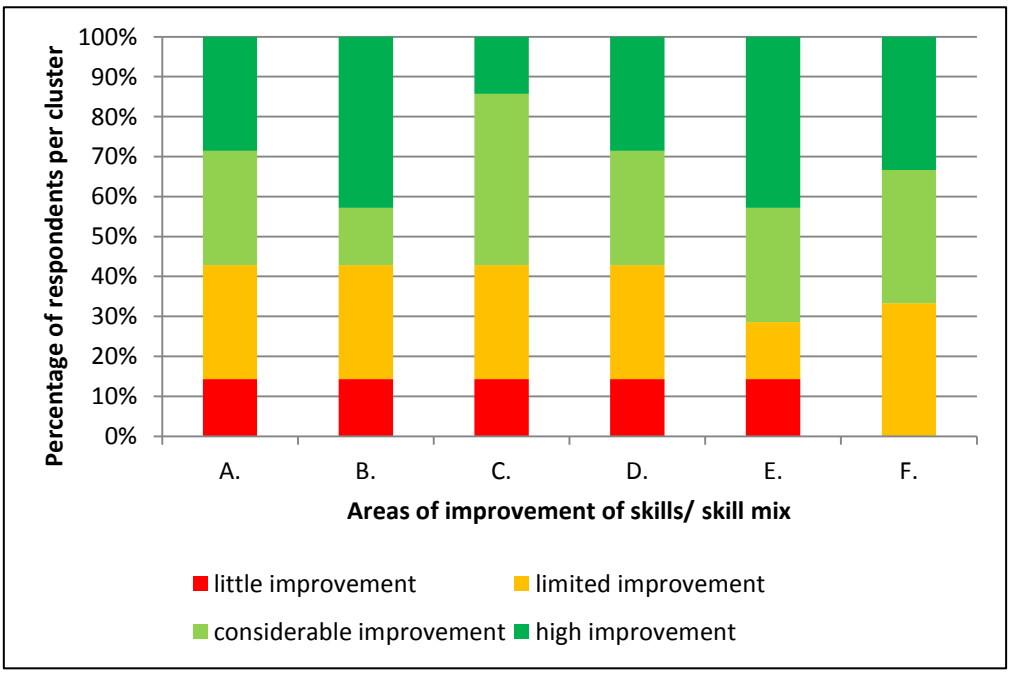
Scale value 1 and 2 = little improvement

Scale value 3 and 4 = limited improvement

Scale value 5 and 6 = considerable improvement

Scale value 7 and 8 = high improvement

Figure 18: Clustered analysis for improvement of types of skills/ skills mix in different areas since the start of MHTF for respondents of the sub-region Bangkok



Legend for “different areas of improvement of skills/ skill mix”:

A. Because of the launch of the MHTF, the skill mix available in my country office to do effective policy advocacy for maternal health with our partners (Government & development partners) has....
B. Because of the launch of the MHTF, the skill mix available in my country office to establish UNFPA as the lead agency for policy advocacy to promote maternal health has...
C. Because of the launch of the MHTF, the skill mix available in my country office to establish UNFPA as the lead agency for evidence-based technical contributions to promote maternal health has...
D. Because of the launch of the MHTF, the skill mix available in my country office to make meaningful technical contributions (e.g. leading of technical working groups, provision of technical guidance on maternal health) in maternal health has…
E. Because of the launch of the MHTF, the skill mix available in my country office to kick-start new initiatives in maternal health (e.g. the introduction of new concepts or approaches) has...
F. Because of the launch of the MHTF, the skill mix available in my country office to appropriately monitor and evaluate our maternal health interventions has...
G. Because of the launch of the MHTF, the skill mix available in my country office to fulfill all of our responsibilities related to the overall maternal health component of the country programme has...

Legend on “Clusters”:

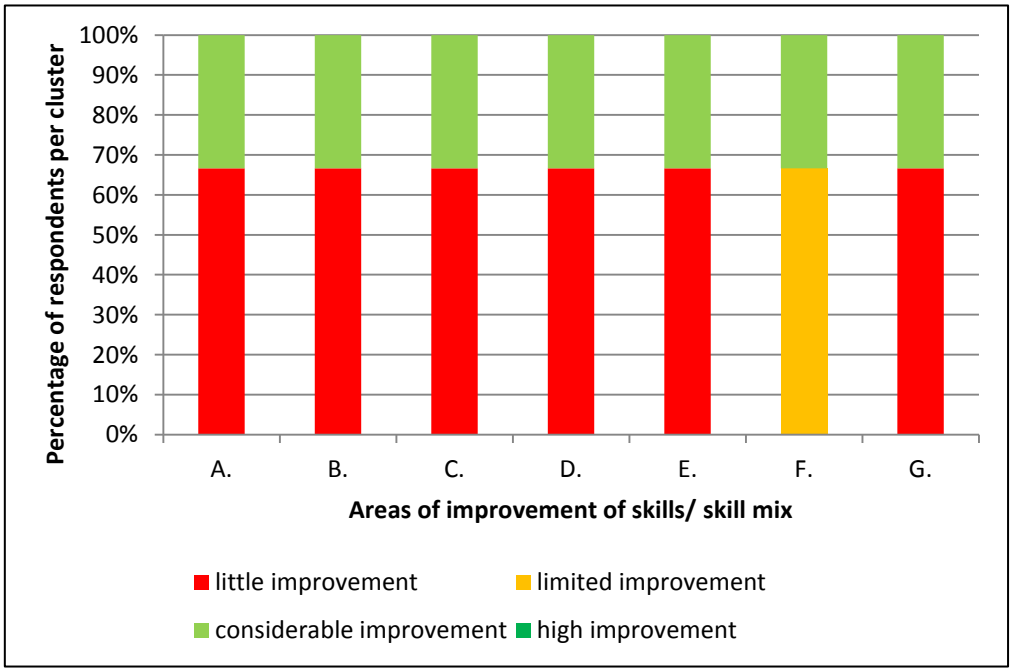
Scale value 1 and 2 = little improvement

Scale value 3 and 4 = limited improvement

Scale value 5 and 6 = considerable improvement

Scale value 7 and 8 = high improvement

Figure 19: Clustered analysis for improvement of types of skills/ skills mix in different areas since the start of MHTF for respondents of the Arab States region



Legend for “different areas of improvement of skills/ skill mix”:

A. Because of the launch of the MHTF, the skill mix available in my country office to do effective policy advocacy for maternal health with our partners (Government & development partners) has....
B. Because of the launch of the MHTF, the skill mix available in my country office to establish UNFPA as the lead agency for policy advocacy to promote maternal health has...
C. Because of the launch of the MHTF, the skill mix available in my country office to establish UNFPA as the lead agency for evidence-based technical contributions to promote maternal health has...
D. Because of the launch of the MHTF, the skill mix available in my country office to make meaningful technical contributions (e.g. leading of technical working groups, provision of technical guidance on maternal health) in maternal health has…
E. Because of the launch of the MHTF, the skill mix available in my country office to kick-start new initiatives in maternal health (e.g. the introduction of new concepts or approaches) has...
F. Because of the launch of the MHTF, the skill mix available in my country office to appropriately monitor and evaluate our maternal health interventions has...
G. Because of the launch of the MHTF, the skill mix available in my country office to fulfill all of our responsibilities related to the overall maternal health component of the country programme has...

Legend on “Clusters”:

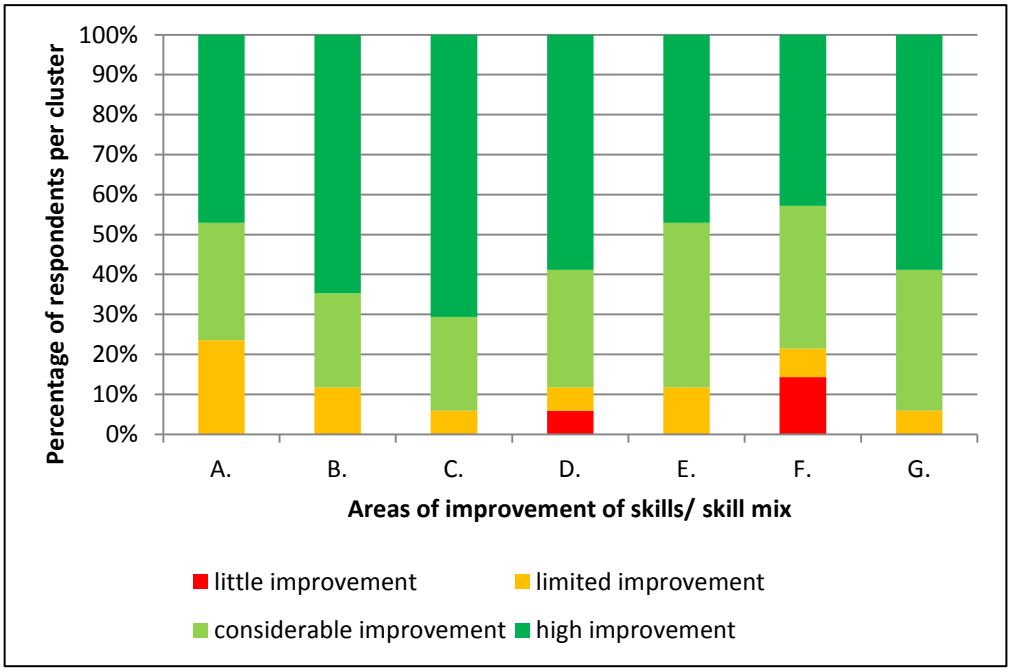
Scale value 1 and 2 = little improvement

Scale value 3 and 4 = limited improvement

Scale value 5 and 6 = considerable improvement

Scale value 7 and 8 = high improvement

Figure 20: Clustered analysis for improvement of types of skills/ skills mix in different areas since the start of MHTF for respondents covered by the sub-regional office in Dakar



Legend for “different areas of improvement of skills/ skill mix”:

A. Because of the launch of the MHTF, the skill mix available in my country office to do effective policy advocacy for maternal health with our partners (Government & development partners) has....
B. Because of the launch of the MHTF, the skill mix available in my country office to establish UNFPA as the lead agency for policy advocacy to promote maternal health has...
C. Because of the launch of the MHTF, the skill mix available in my country office to establish UNFPA as the lead agency for evidence-based technical contributions to promote maternal health has...
D. Because of the launch of the MHTF, the skill mix available in my country office to make meaningful technical contributions (e.g. leading of technical working groups, provision of technical guidance on maternal health) in maternal health has…
E. Because of the launch of the MHTF, the skill mix available in my country office to kick-start new initiatives in maternal health (e.g. the introduction of new concepts or approaches) has...
F. Because of the launch of the MHTF, the skill mix available in my country office to appropriately monitor and evaluate our maternal health interventions has...
G. Because of the launch of the MHTF, the skill mix available in my country office to fulfill all of our responsibilities related to the overall maternal health component of the country programme has...

Legend on “Clusters”:

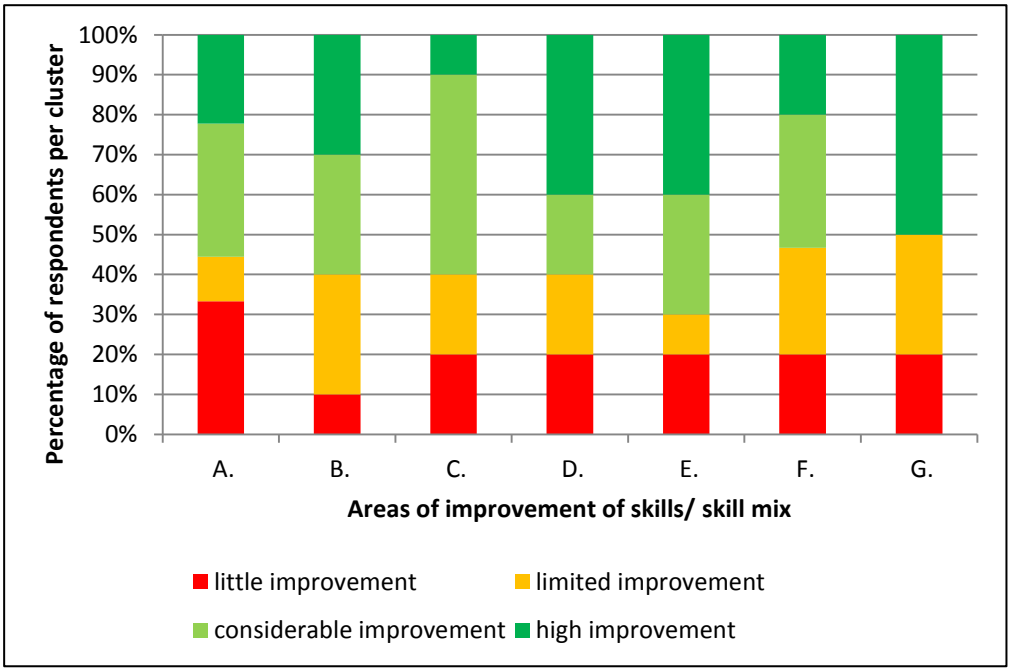
Scale value 1 and 2 = little improvement

Scale value 3 and 4 = limited improvement

Scale value 5 and 6 = considerable improvement

Scale value 7 and 8 = high improvement

Figure 21: Clustered analysis for improvement of types of skills/ skills mix in different areas since the start of MHTF for respondents covered by the sub-regional office in Johannesburg



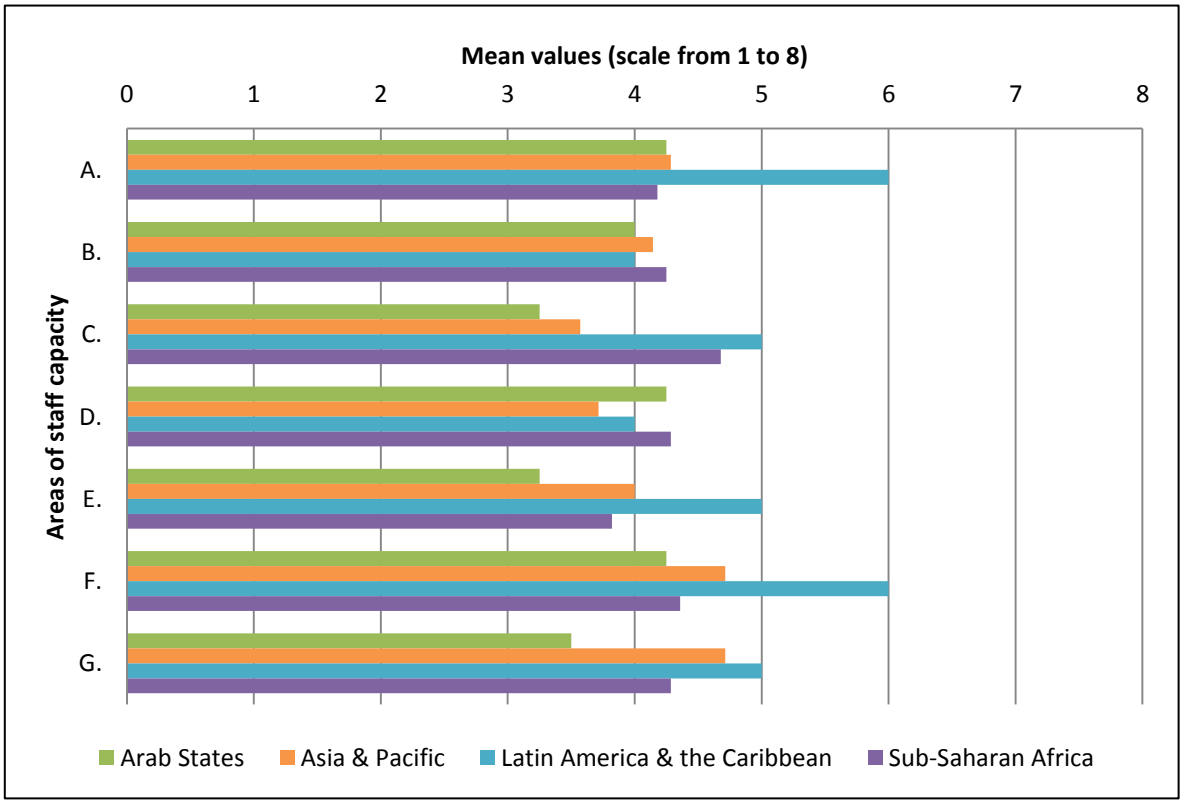
Notes	N=40, n=40

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

Legend for "Areas of staff capacity":

A. With regard to staff capacity for effective policy advocacy for maternal health with our partners (Government & development partners)...
B. With regard to staff capacity to make technical contributions in training of human resources for health...
C. With regard to staff capacity to make technical contributions in raining of midwifes...
D. With regard to staff capacity to make technical contributions in addressing regulatory and policy-related issues in human resources for health
E. With regard to staff capacity to make meaningful technical contributions (e.g. leading of technical working groups, provision of technical guidance on maternal health)....
F. With regard to staff capacity to appropriately monitor and evaluate our maternal health interventions...
G. With regard to staff capacity to fulfill all of our responsibilities related to the overall maternal health component of the country programme...

Figure 22: Mean values for remaining staffing gaps after launch of MHTF, clustered by regions (rated on a scale with 1 lowest to 8 highest)



Notes	N=40, n=40

Question 30: If you would like to give us any other feedback regarding UNFPA work in maternal health, please feel free to provide it here. (open question referring to both, MHTE and MHTF)	
Presentation of results	Results are available to the evaluators only due to confidentiality and have been taken into account for the analysis presented in the final report (Volume 1).

6. Overview: Evaluation questions

Evaluation question 1: *To what extent is MHTF support adequately focused on addressing the reproductive and maternal health needs of the vulnerable groups among countries and within countries?*	
Judgment criteria	1.1. MHTF countries selection processes support the role of MHTF as strategic instrument to improve maternal health among the most vulnerable populations
	1.2. MHTF supported national assessments yield sufficient and disaggregated data for needs orientation planning, programming and monitoring targeting the most vulnerable groups (including underserved groups)
	1.3. National policies and sub national level sexual reproductive health (SRH)/ maternal health planning and programming priorities the most vulnerable groups and underserved areas
Evaluation question 2: *To what extent has the MHTF contributed towards strengthening human resources planning and availability (particularly midwives) for maternal health and newborn health?*	
Judgment criteria	2.1. Partner countries midwifery education upgraded based upon International Confederation of Midwives (ICM) essential competencies through MHTF support
	2.2. Strategies and policies developed to ensure the quality of midwifery services provision in partner countries through MHTF support
	2.3. Midwifery associations able to advocate and support scaling up of midwifery services through MHTF support
Evaluation question 3: *To what extent has the MHTF contributed towards scaling-up and increased access and use of family planning?*	
Judgment criteria	3.1. Creation of enabling environment to facilitate scale-up of quality family planning services in priority countries through MHTF support
	3.2. Demand increased for family planning services in MHTF priority countries, particularly among the vulnerable groups, through MHTF support.
Evaluation question 4: *To what extent has the MHTF contributed towards scaling-up and utilization of EmONC services in priority countries?*	
Judgment criteria	4.1. Creation of enabling environment that facilitates scale-up of EmONC services through MHTF support
	4.2. Utilization and access of EmONC services improved through MHTF support
Evaluation question 5:	

To what extent has the MHTF contributed to improve planning, programming and monitoring to ensure that maternal and reproductive health are priority areas in partner countries?	
Judgment criteria	5.1. Improved positioning of maternal and reproductive health in national strategies and policies through MHTF support
	5.2. National plans consider sustainable funding mechanisms for sexual and reproductive health/ maternal health through MHTF support
	5.3. National and sub-national health plans include clear monitoring and evaluation frameworks for family planning, skilled care in pregnancy and child birth, EmONC, obstetric fistula and reproductive health/ HIV linkages
Evaluation question 6: *To what extent have the MHTF management mechanisms and internal coordination processes at all levels (global, regional and countries) contributed to the overall performance of the MHTF in fulfilling its mission?*	
Judgment criteria	6.1. Coordination of the MHTF contribution within the overall UNFPA support to maternal health
	6.2. Instruments and mechanisms developed by the MHTF to strengthen country office capacities to manage the fund at global and regional level
	6.3. Monitoring and evaluation of the MHTF supported proposals including financial monitoring
Evaluation question 7: *To what extent has the MHTF enhanced and taken advantage of synergies with other UNFPA thematic funds e.g. the Global Programme on Reproductive Health Commodity Security (GPRHCS), the Campaign to End Fistula, the UNFPA-ICM10 Midwives Programme and HIV-PMTCT11 in order to support maternal health improvements?*	
Judgment criteria	7.1. Integration of the components of the Campaign to End Fistula into maternal health programmes after the integration in MHTF
	7.2. Joint and coordinated planning at country level with GPRHCS
	7.3. Integration of Midwives Programme strategic directions in MHTF plans in countries
	7.4. Harmonized MHTF integration strategies and mechanisms at global and regional level
	7.5. MHTF plans integrate HIV activities in synergy with core funds, Unified Budget and Work plan (UBW) and other resources
Evaluation question 8: *To what extent did the MHTF increase the visibility of UNFPA sexual and reproductive health/ maternal health support and help the organization to leverage additional resources for maternal health at global, regional and national level?*	
Judgment criteria	8.1. (MHTF-facilitated) presence of UNFPA in global and regional maternal health initiatives

[10] International Confederation of Midwives
[11] Preventing Mother-to-Child Transmission

	8.2. Effect of MHTF on (increased) external financial commitments to UNFPA/ MHTF for maternal health support (at global, regional, country level)
	8.3. Effect of MHTF on (increased) financial commitments of partner governments to sexual and reproductive health/ maternal health

7. Evaluation findings matrices for MHTF

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

Findings from desk study
Needs orientation of UNFPA maternal health support is not immediately apparent. There is no or little correspondence between the allocation of UNFPA maternal health support among countries and the prevalence and severity of maternal health needs in the countries. At country level, the Common Country Assessment of the UNDAF which is the formal basis for all UN programming at country level often only provides very limited data and information on maternal health; and on the groups most affected by maternal health threats. UNFPA country programmes also generally do not identify the specific vulnerable groups of women and mothers that UNFPA is targeting with its maternal health support. There is no or little correspondence between the allocation of UNFPA maternal health support among countries and the prevalence and severity of maternal health needs in the countries. An internal UNFPA report (UNFPA, 2011) found no correlation between the reproductive health status in UNFPA programme countries and the levels of UNFPA investment in reproductive health[12]. This is possible because the specific criteria[13]; and the different steps in UNFPA resource allocation (among country groups) and resource distribution system (within each of the three country groups) renders the influence of the quantitative allocation criteria that represent measure of maternal health needs relatively indirect. The resource allocation system merely considers, to what extent a country has reached a series of 8 relatively high thresholds, when assigning it to one of the needs-based country groups[14]. The allocation system does therefore not systematically consider how far the different countries in each group are away from reaching the agreed thresholds. This could in principle result in a situation where the aggregated needs in the high needs group (Group A) are so high that the additional resources that UNFPA allocates to this group are not sufficient to give these countries the intended higher share of support in comparison to the medium need countries in Group B. Also, the Resource Distribution System that is responsible for distributing resources within each of the groups gives considerable leeway to HQ and the regional offices to base the distribution of resources on

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

[13] I.e., the set of 8 maternal health and sexual and reproductive health indicators and the associated targets

[14] I.e. the "high needs group" (Group A); the "medium needs group" (Group B), or the "low needs group" (Group C).

considerations other than maternal health related criteria. These include overall socio-economic quantitative criteria (GNI per capita, for example); but also additional qualitative criteria[15]. No information exists at this time to assess to what extent reduced funding to certain high need countries was a result of strategic considerations among maternal health partner organizations (e.g. H4+) that assigned UNFPA a strategically important but less costly role (JC1.1).

The needs orientation of UNFPA support at country level is also not immediately apparent. UN agencies, including UNFPA, are preparing their country programmes for each country in a joint process, working out the United Nations Development Assistance Framework (UNDAF). The UNDAF is developed on the basis of a common needs assessment of all UN agencies, the so-called Common Country Assessment (CCA). UNFPA is responsible for the sufficient consideration of maternal health issues in the CCA as well as later in the UNDAF. However, the extent to which past CCAs have identified the specific maternal health needs was often limited. A number of assessments limited themselves to very basic data and often left out specific information on maternal health/reproductive health. A small number carried out a thorough assessment of reproductive health/maternal health based on the latest data. Niger and Sudan are relatively positive examples of CCAs that meet the UNFPA and UN requirements. Almost all CCA were lacking sufficiently disaggregated data for targeting most disadvantaged and vulnerable groups. Many CCAs were based on old or estimated data and therefore could not capture the country health-related situation at that moment[16]. Only about half of the examined CCAs contained a specific chapter on maternal health/reproductive health in which maternal health related statistics as well as qualitative data were provided. Some CCAs at least identify maternal health/reproductive health as an important issue and give explicitly information on it in a summarized way. Six out of the 22 assessed CCAs, however, did not provide any specific information on the issue of maternal health/reproductive health but limited themselves to the presentation of general health issues. Only eight out of 22 CCAs contained an analysis of root causes for poor maternal health. Some countries carried out an analysis but only mention immediate causes such as the concrete reasons for maternal deaths, e.g. hemorrhage, obstructed labor, abortion, etc. and ignore the structural root causes or just cover the health sector in general disregarding maternal health/reproductive health issues[17] (JC1.2).

Needs orientation of planning and design of UNFPA supported interventions was also weak. Along with the annual work plans (AWP), UNFPA country programme action plans (CPAPs) are the basis for the implementation of the Fund country programmes. Thus, CPAPs should identify maternal health needs and constraints of (most) vulnerable and disadvantaged groups and develop specific and customized strategies. However, the quality of the CPAPs differs significantly regarding these issues. Whereas some CPAPs identify and name the most vulnerable groups, explain the rationales for identifying these groups as most vulnerable and align their reproductive health strategies with the specific groups, other CPAPs do not provide any disaggregation of the vulnerable groups at all and either refer to vulnerable groups as a whole or do a very superficial breakdown by sex and age (women, men, young people). Positive examples are the CPAPs of Ivory Coast, Ethiopia and Nepal, which initially identify the most vulnerable groups and then align the reproductive health strategies with their needs and constraints. Moreover, Nepal is the only case that provides a specification of vulnerable groups by their social status regarding the caste system in the country. Many CPAPs, however, rather focus on HIV than on maternal health issues and thus specify groups primarily by their vulnerability to HIV (JC1.3).

[15] Such as “Degree of political support to the ICPD agenda”, “Absorptive capacity” or the “Humanitarian response, transition and recovery situation in each country”.

[16] Usually the assessments rely on the national Demographic and Health Surveys (DHS); other sources are the Ministry of Health and international organizations (WHO, UNICEF). Many CCAs fall back on the main indicators of MDG5. As a consequence the indicators MMR, skilled birth attendance and contraceptive prevalence can be found in almost all CCAs where they usually are the crucial quantitative basis for further analysis of maternal health/reproductive health. In some cases further official MDG5 indicators, like antenatal care and adolescent birth rate are used. Only few CCAs bring in additional indicators such as Caesarean rate, FGM or obstetric care. The strong focus on MDGs can also be seen in the structure of some CCAs, which follows the classification of the eight MDGs.

[17] It is not clear at this point, to what extent UNFPA, and in particular UNFPA country offices have had access to reliable and accurate data from regular monitoring at the activity and output level.

7.1.1 Judgment criterion 1.1: MHTF countries selection processes support the role of MHTF as strategic instrument to improve maternal health among the most vulnerable populations

Type of analysis	Findings
Findings from case study in **Burkina Faso**	*La sélection du Burkina Faso comme pays prioritaire pour bénéficier du MHTF s'inscrit dans la logique du groupe H4. Les interventions appuyées par le MHTF sont cohérentes avec la répartition des rôles entre les différentes agences*. Une coopération active entre les partenaires, qui forme maintenant le groupe H4+, existe au Burkina Faso depuis un certain nombre d'années avec comme conséquence un appui concerté pourvu au ministère de la santé. Le projet des partenaires H4+ dont le financement a récemment été approuvé par l'ACDI est une conséquence de la confiance des bailleurs de fonds dans la coordination de ces agences et des efforts du siège de l'UNFPA. L'équipe du MHTF au niveau global a joué un rôle clé en 2008 et 2009 dans le renforcement de l'approche H4 et dans le lancement des efforts dans les 25 premiers pays prioritaires du H4+ dont le Burkina Faso fait partie[18]. Les activités soutenues par le biais du MHTF correspondent aux fonctions définies dans le cadre global du H4 + telles que le soutien à une formation de qualité des sage femmes et à la mise en place de régulations de la profession ainsi que le renforcement des SONU à travers l'évaluation des besoins en SONU (initiée par l'UNFPA/MHTF, l'OMS et l'*Adverting Maternal Death and Disability* (AMDD) et réalisée en partenariat avec l'UNICEF, la Banque Mondiale et le gouvernement). Le MHTF a soutenu également la formation des prestataires des structures de référence en SONU complets qui est habituellement considéré comme du ressort de l'OMS[19].
Findings from case study in **Cambodia**	*In Cambodia, the alignment of the MHTF country selection process with the list of H4+ priority countries had not yet fully translated into improved coordination and cooperation among the H4+ partners at the time of the evaluation. However, H4+ was active with individual high-level advocacy events in 2010 with limited multipliers. None of the relevant EDPs saw H4+ as an important technical co-ordination mechanism, as they were already involved closely in many other mechanisms and initiatives and felt there was no need for another.* H4+ was constituted in Cambodia in 2009. There is division of labor among UN agencies in Cambodia that reflects the Memorandum of Understanding on the SG Joint Action Plan: UNFPA and WHO are responsible for maternal health, UNICEF and WHO are responsible for newborn health and UNFPA and UNICEF are responsible for family planning[20]. However, the 3 partners and World Bank had not met as H4 until June 2010, when they came together to support the preparation of the country delegation for the Women Deliver Conference in Washington DC, which had been funded by MHTF[21]. The country delegation consisted of senior parliamentarians, Government officials, civil society representatives and the UNFPA Representative. Because of the gathering, parliamentarians signed a petition requesting that the first lady become the national advocate for MCH, which she accepted. In mid-2011 in an effort to implement the Secretary General Joint Plan of Action for Women and Child Health and at the request of H4+, the UN Country Team also invited the First Lady to become the champion for the SG Joint Plan of Action. The project portfolio that MHTF introduced to Cambodia, including EmONC Assessment and EmONC Improvement Plan, closely corresponds to the core functions of UNFPA and has helped enhance UNFPA strategic position, but not necessarily as a H4+ member[22]. For example, there had been an effort to introduce a national EmONC assessment in 2003-2004, but efforts diminished due to the lack

[18] Entretiens avec l'équipe UNFPA et les partenaires techniques et financiers
[19] Voir détails dans la question d'évaluation n°4
[20] External Development Partner
[21] UNFPA Cambodia, Annual Joint Reporting for the Thematic Funds, Jan-Dec. 2010
[22] External Development Partner

	of interest of MoH. The EmONC Assessment tool was introduced to UNFPA Cambodia by MHTF (through the regional office), and was originally supposed to be funded by MHTF. However, with the growing interest of World Bank, UNICEF and WHO, agencies that regarded the tool as a strategic instrument to improve maternal health for poor and disadvantaged groups, it was agreed to jointly promote the National EmONC Assessment to MoH. AusAid funds were made available through UNFPA for a national assessment in early- to mid-2009, and HSSP II funding was made available for the development and implementation of the Improvement Plan (2010-2015).
Findings from case study in **Ethiopia**	*The MHTF is providing strategic support to the FMoH towards the MDG 5 goal, focusing on the weakest links in the current maternal and child health programmes: pregnancy, child birth and immediate postpartum period. It supports essential components of the health system performance: qualified human resources at all levels; drugs, supplies and equipment; and functioning referral systems.* UNFPA is the signatory to the H4 'Flagship Joint Programme on Improving Maternal and Newborn Health and Survival for 2010-2011[23], which aims to support the country in achieving MDG 5 and contribute to MDG 4 and 6 through support to the FMOH efforts for scaling up the implementation of evidence based high impact maternal health interventions through a continuum of care approach. UNFPA contributes to this endeavor with MHTF, SIDA and RHCS funds. On country level the guiding cooperation agreement is the joint action plan, which was signed by all H4 partners in country in September 2010. A joint costed work plan has been approved; monthly meetings are chaired by WHO and UNFPA contributes from MHTF, SIDA, and RHCS funds. The cooperation seems guided by the "traditional" division of labor and "added value" of each organization, only in very few instances activities in the Joint Plan are attributed to more than one organization. Family planning and Skilled Attendance at Birth are the areas assigned to UNFPA in the H4 plan. To alleviate the enormous shortage of midwives in Ethiopia, around US$ 4.6 million from the Maternal Health Trust Fund complement efforts initiated by the midwifery programme to address maternal health concerns one of which is this midwifery training. Based on the experience drawn from a previously supported tracer project in Tigray, the MHTF invests in human resource strengthening through supporting a three year mater degree course for non-physician-clinicians (Health officers) in Integrated Emergency Obstetric and Surgery (IEOS) to enable the expansion of comprehensive EmONC facilities.
Findings from case study in **Ghana**	*MHTF supports country office to reach out to poor and disadvantaged groups "vulnerable persons", including people with fistula and in areas of midwifery to support pregnant women in rural areas where there are not many facilities, and providing contraceptives. MHTF funded EmONC needs assessment will help to identify gaps that prevent the addressing of the needs of vulnerable groups through partnerships*. Based on its own selection criteria, MHTF HQ included Ghana in the first wave of 11 countries to be funded in 2008. That same year MHTF briefly supported the planning for resource teams to do regional trainings on updating the maternal death audit guidelines. This has also been done with the help of the WHO (but not as H4). A joint team of three people went to South Africa for a maternal audit study tour[24]. The UN Resident Coordinator was leading the process in 2009 to address the current bottlenecks facing national progress on MDG 5

[23] It targets 500 health centers and 50 Hospitals to provide the full package of basic and comprehensive emergency maternal and newborn care services including family planning and PMTCT. The total cost is estimated to be US$ 38,277,000. Of this, the implementing UN agencies – UNFPA, UNICEF, WHO and the World Bank have together put in US$ 19,152,000. The remaining US$ 19,105,000 is requested from the UNCT through a proposal.

24 Interview with UNFPA

	especially the issues surrounding human resource for health (HRH) within MDG Accelerated Framework (MAF). The Task Team also included WHO, UNFPA and UNICEF. The MAF development coincided with MHTF inception mission[25]. In 2009 which was the first year of MHTF full operation in Ghana, the country was strategically supported by MHTF in two areas identified by UNDAF/MAF: a) Midwifery to address HRH issues including needs assessment of training schools with in-depth assessment in the Northern Region which is the most deprived area and b) Fistula Programming that directly addresses issues of vulnerability among poor women. In the latter half of 2010 MHTF supported the planning of EmONC needs assessments in 5 of UNFPAs programme areas most of which is considered rural and remote and the survey was completed in 2011 but reports were still to be finalized (this has been taken up in Evaluation question 7 and further taken up in Evaluation question 16) at the time of this evaluation[26]. The new UNFPA Country Representative has helped operationalize HRH reviews in the hard to reach field areas (with MoH and MoFEP) and CARMMA Family Planning Week as the first order of the day[27].
Findings from case study in **Madagascar**	*The MHTF bases its strategic support on the evidence created by the EmONC survey in 2009. The specific vulnerability of remote rural populations (not only in geographical and physical aspects) was demonstrated and the MHTF in a joint decision with the MoH focuses its direct implementation on six regions with remote population, whilst at the same time addressing the whole Malagasy population during health campaigns.* The MHTF targets geographically the six regions that have been identified together with the MoH as having the greatest need to improve maternal health indicators. These regions include underserved populations in remote areas[28] and the regions in the south that are prone to natural disasters. Targeted vulnerable population groups include 'rural populations', those living in the 'zones enclaves', adolescents, women with fistulas, pregnant women, etc.[29]. The MHTF supports UNFPA core functions, such as community mobilization, institutional capacity building, technical skills and M&E functions upgrading and the H4 core functions.[30] The H4+ has an extended partnership in Madagascar; it includes donors, as far as they are still present in Madagascar and is chaired by UNFPA. This technical working group has developed an operational and costed plan for the MDG 4 and 5 for 2012 to 2015. It is based on needs assessments, including the 2009 EmONC survey and the 2008/2009 DHS and embedded in the national framework. The portfolio includes for example, HRH planning and capacity building, provision of equipment and consumables to enable application of new skills. The H4+ working group serves as a platform for the coordination of technical and financial partners. The current leadership position of UNFPA is explained firstly by being the initiator and secondly by having stronger technical representation (through the MHTF funded staff) in reproductive health than the partner organizations. The H4+ partners have currently a non-conflicting division of labor[31], which may change, once the political situation has improved and /or the strong international technical UNFPA representation is not anymore available.
Findings from case	*At the time of the evaluation, the MHTF had not yet provided an impetus for H4+ partners or other development partners to engage in a*

25 Interview with Government
26 MHTF Annual Report 2009
27 Interview with Government
28 as identified in the DHS 2008/2009 and the EmONC Survey 2010 (Evaluation des besoins en matière de SONU a Madagascar, 2010)
29 Thus de facto covering the whole country
30 See MHTF results framework
31 WB and WHO: only technical assistance UNICEF and UNFPA: EmONC training and equipment (in different regions)

study in **Sudan**	*harmonized approach for addressing maternal health issues in Sudan.* So far, the H4+ concept has not translated into any concrete cooperation between the global H4+ partners, as the concept has been introduced into Sudan only recently, promoted in particular by WHO[32].
Findings from case study in **Zambia**	*In Zambia, the alignment of the MHTF country selection process with the list of H4+ priority countries had not yet fully translated into improved coordination and cooperation among the H4+ partners at the time of the evaluation[33].* The H4+ group was constituted in Zambia in 2009. However, the group had not really convened any meetings under the H4+ label; and consists largely of UN agencies that had already cooperated as the UNDAF sub-group for health. Cohesion of this group is driven to a large extent by long-standing working relationships of national staff members that pre-date the H4+ concept. Consequently, UN partners started to apply the H4+ label to their cooperation, however, without consciously applying and following global guidance on the envisioned "division of labor" between H4+ partners at country level (see also Evaluation Question 2 on MHTE above). Instead, the cooperation was guided by the "traditional" division of labor and "added value" of each organization[34]. This situation notwithstanding, the Zambian H4+ group of UN-agencies has secured funding or has submitted a funding proposal for overall two "joint programmes" in the area of maternal health since the introduction of the H4+ concept to Zambia. One of these joint programmes[35] has received funding from CIDA[36]. It is conceptually linked to another joint programme on Maternal, Newborn and Child Health (MNCH) that has been submitted to the European Union for funding.
Findings from UNFPA **Regional/ Sub-regional office**s	The selection of countries is based on MMR, the total number of maternal deaths, the commitment of the governments, the capacity of country office to implement programmes and also the presence of other donors, how conducive is the environment, the existing resources available and the coordination of sectoral partnership. RO was consulted in selection. Criteria were pretty clear. COs developed proposals and work plans and RO gave a lot of input on the proposal and looked whether it is in line with the priorities and then send to HQ. In 2009 there were some specific areas that were not considered priorities for MHTF e.g. young people, community involvement. In 2010, it was agreed that some of these funds can be used for these issues that are important determinants for maternal deaths. Community involvement is very important and beyond the 3 pillars. In addition there are conditionalities from donors. RO has been involved in assessment, pre-funding assessment with an advisor from the HQ technical division and looked at country programme and national programme and national priorities to see how MHTF funding fits in. HQ decides how much money should be allocated to which country. The process is not transparent. Some countries receive disproportionate amount. [37]
Findings from **global level**	The selection of countries was done in consultation between the MHTF secretariat, senior management, and the regional offices.[38] It was felt that UNFPA resource allocation framework was not focused enough on needs to have impact. The MHTF was initiated to sharpen focus on maternal health. At the same time the H4 Joint statement, written by the MHTF coordinator, sought to 'harmonize approaches by UN agencies towards improving maternal and newborn health (maternal health) at country level and jointly raise the

[32] For more information, see Evaluation Question 2 on the Maternal Health Thematic Evaluation
[33] Improved coordination and synergies among H4+ partners in MHTF countries had been one rationale of UNFPA globally for focusing MHTF support on H4+ priority countries.
[34] Interviews with H4+ partners (including UNFPA)
35 The programme for "Accelerating Progress Towards Maternal, Neonatal and Child Morbidity and Mortality Reduction in Zambia"
36 In the amount of US$ 9,991,500
[37] Interviews with UNFPA regional offices
[38] Terms of Reference - Maternal Health Thematic Fund - Inception Mission in Lao PDR - 2010

	necessary resources'. The focus on maternal and newborn health was further emphasized during the Women Deliver conference in June 2010 and with the UN Secretary General 'global strategy for women and children health' that was launched in 2010[39]. At global level H4 has been initiated as collaboration between WHO, UNFPA, UNICEF and the World Bank initially and UNAIDS joined later. It had a slow beginning but the momentum has increased and it has a growing recognition as 'a viable option to channel funds for joint action'. The coordination is done on a rotating basis by all the agencies, UNFPA/MHTF had been an active coordinator. The different agencies try to make people work together at country level but it depends upon people. The different agencies have different mandates that are complementary and they try not to overlap[40]. At country level MHTF flexible funding allows to facilitate the H4+ group collaboration through organizing meeting or other events.

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

Type of analysis	Findings
Findings from case study in **Burkina Faso**	*L'évaluation des besoins en SONU a le potentiel d'être utilisée pour une planification de l'amélioration des services SONU ciblant les groupes les plus vulnérables si l'analyse prend en compte des données des enquêtes nationales pour l'identification des groupes vulnérables et les moins desservis. Toutefois les données concernant les barrières d'accès parmi ces groupes n'ont pas été explorées.* L'évaluation SONU est une revue des services de SR qui inclut l'offre de service aux femmes, aux nouveaux nés et aux enfants qui sont considérés comme groupes vulnérables. La synthèse de l'évaluation SONU disponible au moment de l'évaluation ne prend pas en compte l'accès des groupes les moins bien desservis. Toutefois les données existent (monographies par district) et une analyse pouvant permettre une désagrégation des données pour les groupes les plus vulnérables et les moins desservis est possible par district sur la base des données du recensement mais requiert un effort important[41]. Par contre l'évaluation SONU ne fournit pas d'informations relatives aux barrières d'accès aux services de SONU parmi les groupes les plus vulnérables qui ont souvent le plus de difficultés pour accéder à ces services[42].
Findings from case study in **Cambodia**	*MHTF was successful in leveraging funds for the National EmONC Assessment and the Improvement Plan as noted above. The assessment tool that MHTF provided was well received by MoH. The orientation, planning, design and execution of the assessment were highly consultative and participatory. The process is considered an example of the practical use of a technical research tool, knowledge transfer and sharing, inter-agency cooperation and Government participation. For this reason, the findings of the assessment, while very critical of public health facilities, were fully accepted by MoH and recommendations were rapidly scaled up to feed into the development and implementation of the EmONC Improvement Plan.* Introduction of MHTF EmONC assessment tool in Cambodia was fully supported by UNFPA Central Office, WHO and UNICEF in its in collaboration with Avert Maternal Deaths and Disability (AMDD) Programme of Columbia University. This tool, which includes maternal

[39] Interviews with UNFPA headquarters
[40] Development partners
[41] Entretiens avec les partenaires d'exécution
[42] Revue documentaire

	health indicators commonly known in Cambodia as the UN EmONC indicators, provided a framework and helped establish the quality and readiness of EmONC services in the country. The Assessment Report has been accepted by MoH as the first baseline study on the subject[43]. The National EmONC Assessment was conducted by the National Institute of Public health, with technical support from the National Maternal and Child Health Centre and the National Reproductive Health Programme (NMCHC). UNFPA staff, using at least in part MHTF resources, facilitated and coordinated the technical, administrative and logistical arrangements. AusAid, through UNFPA, supported the technical consultant on the design, data monitoring, data analysis, interpretation and report writing. The assessment was completed in 70 public hospitals, most at the district level and one-third of the Health Centers (230) as a sample of facilities used by the poorer sections of society in rural areas and 40 private hospitals that are well used by the general population and would serve as a point of comparison of services. All 24 provinces were represented in the sample. Provincial health directors, operational district directors, hospital directors, health center chiefs, doctors, midwives, nurses and technicians in each study site provided inputs into the study throughout the process. The National EmONC assessment identified several barriers related to availability, functioning and utilization of EmONC from the perspective of supply side. Many of the gaps discovered related to lack of quality assurance, readiness and care by the public health system. The assessment also flagged the critical barriers of user fees and the issues of affordability in what should be a free/low-cost health care service for the poor. All 10 UN EmONC indicators were included in the assessment, and the findings were compared to the established UN standard. NMCHC added two "poverty-related" indicators associated to intra-partum: 1.) very early neonatal death rate and 2.) Proportion of maternal deaths due to indirect causes (no standard set yet). The national assessment found that while the health infrastructure existed in general, there is a need for EmONC service expansion in some rural and many remote areas, and in others a serious upgrading of facilities is needed. The rapid agreement on the assessment report and the development and the implementation of the EmONC Improvement Plan were seen as widely participatory, and the first changes were implemented within 6-7 months of planning. This is surprising "*given the fact that the approval process can be very long and protracted in Cambodia. It shows the commitment of MoH to improve the quality of its health facilities.*[44]"
Findings from case study in **Ethiopia**	*The MHTF has supported several national assessments that survey the needs of the most vulnerable populations and address nationally (by the GoE) and internationally recognized priorities (by the development partners) - which in the case of the maternal health conform in Ethiopia.* The MHTF supported national assessments to provide evidence for unmet needs of most vulnerable groups such as pregnant women, poor women, adolescent girls, in remote or hard to reach areas, etc.: • National Baseline Assessment for Emergency Obstetric & Newborn Care Ethiopia 2008 • National Survey on Availability of Modern Contraceptives and Essential Life Saving Maternal/reproductive health Medicines in Service Delivery Points in Ethiopia, 2010, UNFPA • Ethiopia Young Adult Survey A Study In Seven Regions, 2010, UNFPA • Capacity Assessment in seven midwifery training institutions and the Ethiopian Midwifery Association, 2009 In addition to the abovementioned assessments, the MHTF utilizes reports from other development partners to guide its planning and implementation of programmes, such as:

[43] UNFPA Cambodia and NGO Partner
[44] UNFPA Cambodia

	• Capacity Gap and Cost Implications in Selected Universities and their Affiliated Hospitals Proposed to Start M.Sc. Programme in Integrated Emergency Surgery, 2008 • Situational assessment of anesthesia schools in Ethiopia 2010, WHO • Report On the National Situational Analysis of Pre-Service Midwifery Training In Ethiopia. WHO, 2008 The FMoH frequently joins assessment missions and proposes areas of research and utilizes the results for national programmes or strategy development.
Findings from case study in **Ghana**	*Evidence indicates that the Government of Ghana (GoG) has made maternal health a priority, especially the MHTF areas of family planning, midwifery and EmONC, and MoH/Ghana Health Service will be accountable for follow up on EmONC assessment findings.* The recent national EmONC assessment, funded in part by MHTF, will help to identify gaps that prevent the addressing of the needs of poor and disadvantaged groups and where the country really needs to focus its short and long term efforts (see Evaluation question 7 too). EmONC assessment recommendations when ready will be incorporated into MAF strategies. EmONC report will be submitted during the National Health Summit in November 2011.
Findings from case study in **Lao PDR**	*The MHTF supported EmONC assessment provided disaggregated information about EmONC services such as coverage of EmONC facilities as well as possibilities for facilities to exempt poor women. This information will be used as the basis for improved planning for vulnerable groups. Since many government partners at different levels were involved throughout the process that contributed to develop their capacity and their ownership of the results.* The national EmONC assessment undertaken in 2010 has been completed in 12 provinces with the technical support of AMDD and the MHTF funded SBA coordinator. Major funding is by MHTF and by UNICEF. The EmONC assessment highlighted the poor geographical distribution of EmONC facilities in the southern and northern provinces. It also included information on the their system of waiving maternity fees for poor women in EmONC facilities, as services fees are considered as important barriers to accessing health services. This is in line with the MOH orientations to provide free services or limit the cost of services for poor women[45]. The EmONC assessment process has involved many partners what contributed to developing the capacity of the MOH at different levels, as well as the University of Health Science and the National Institute of Public Health. The participation of the relevant hospital staff and health managers in the development of the EmONC improvement plan based on the findings of the assessment will certainly guarantee a real ownership of the plan. That also developed their capacity to analyses data and to draw plans to make EmONC services available for all in their area.
Findings from case study in **Madagascar**	*The MHTF supports assessments that consider or reveal needs of most vulnerable groups with the aim to support policy and programme planning of the MoH. The MoH is involved in the development and conducting of such surveys. The EmONC and the DHS surveys demonstrate their usefulness for identification of vulnerable groups addressed in programme planning of the MoH.* The EMONC survey (supported by the MHTF) in 2009 (published in 2010) evaluated nationwide nearly 300 health facilities performing more than 20 deliveries per month, and identified gaps in service delivery, ranging from lack of equipment, insufficient human resource skills to lack of basic infrastructure. Whilst the survey did not address specifically a vulnerable population group, it provides a mapping of the geographical distribution of services and their utilization[46]. Lack of access due to geographical French version still needed 24.02distance is considered a barrier for poor pregnant women in Madagascar. The survey has been the first of such scale ever done in Madagascar and mentioned by IPs and GPs as being the basis for the current planning of the scaling up of the midwifery and EmONC

[45] Emergency Obstetric and Newborn Needs Assessment in 12 selected provinces – Lap PDR - 2011

[46] The DHS of 2009, supported by UNFPA provides data regarding the vulnerable group of pregnant teenagers and one question on gender violence.

	services. The MHTF together with its partners plans or conducts already further needs assessments and surveys, such as a qualitative survey on youth and on gender based violence and a study on socio cultural barriers to health services. These surveys have been included into the H4+ operational plan, approved by the MoH, which is participating and /or leading the assessments as it strongly supports initiatives towards the MDG 4 and 5.
Findings from case study in **Sudan**	*The MHTF in Sudan has neither been used to increase the availability of data for planning, programming of UNFPA maternal health support, nor for monitoring of UNFPA target populations.* MHTF in Sudan has not supported needs assessments; many needs assessments had already been carried out before the MHTF was launched in Sudan[47].
Findings from case study in **Zambia**	In cooperation with other development partners[48], UNFPA has supported Zambia General Nursing Council (GNC), the country regulatory agency for nursing and midwifery, in conducting a comprehensive training needs assessment for nurses and midwives. However, this support is not clearly linked to MHTF, as the needs assessment was done before MHTF was officially launched in the country. Nonetheless, this needs assessment forms the basis for comprehensive revisions of training curricula for nurses and midwives, also under the leadership of the GNC that is supported by UNFPA, in terms of financial support for logistics and by providing technical input through the MHTF midwifery advisor and the fistula advisor[49].
Findings from **global level**	A memorandum of understanding was signed between the Columbia University Averting Maternal Death and Disability Programme (AMDD), UNICEF and UNFPA in 2008 for 4 years. In all the all the MHTF-supported countries AMDD has been the implementing partner of the MHTF in order to build capacity at regional and country level to undertake EmONC needs assessments and to plan EmONC services and human resource improvement[50].

7.1.3 Judgment criterion 1.3: National policies and sub national level sexual and reproductive health / maternal health planning and programming priorities the most vulnerable groups and underserved areas

Type of analysis	Findings
Findings from case study in **Burkina Faso**	*Le projet d'étendre l'offre de services SONU de base au niveau des chefs-lieux de communes a le potentiel d'accroitre l'accès des population plus isolées à la condition que cette mesure soit accompagnée d'un politique de ressources humaines visant à renforcer le déploiement et la rétention des sages-femmes en milieu rural.* Les résultats de l'évaluation SONU ont mis en avant l'insuffisance des SONU de base dans les districts et une des actions proposées est de transformer les CSPS des chefs-lieux de communes en CMA. Le programme sagefemme contribue à accroitre le nombre de

[47] Document review and interviews with UNFPA; Also, UNFPA office defines vulnerable groups broadly as women of reproductive age, between 15 and 49 years, and has targeted these age groups within the 5 focus states and 3 Darfur regions
[48] Health Sector Support Programme (HSSP) (USAID-funded) and the Clinton Foundation
[49] As explained above, UNFPA has not focused its support on specific vulnerable demographic groups, but has instead used geographic targeting of its three focal provinces.
[50] AMDD AWP 2009 and 2011. Memorandum of understanding between UNFPA, UNCEF and the Trustees of Columbia University in the City of New York – 2008.

	sage-femme et entre autre la disponibilité des sages-femmes dans les zones rurales. La transition avec le système actuel demandera une attention particulière car les sages-femmes ne sont pas habituellement nommées dans les zones rurales[51].
Findings from case study in **Cambodia**	*MHTF project portfolio targets the poor and disadvantaged by conviction and design, which aligns readily with UNDAF outcomes and the objectives of UNFPA Cambodia Country Programme III. MHTF is well regarded as a fund that is both flexible with regard to the situation on the ground and catalytic in expanding UNFPA support, in terms of geographic reach and capacity building in unexplored area of activities.* MoH perceives both the National EmONC Assessment and EmONC Improvement Plan as good examples of pro-poor intervention. Circumstances dictated that these two critical instruments are funded by external donors, AusAid and HSSP II respectively. MHTF had been budgeted for the expansion of the special reproductive health Equity Fund, which UNFPA had piloted in 5 ODs. However, in 2009, MoH decided to move towards Universal Coverage/Universal Package for Health Equity Funds (by 2015), which meant that existing efforts were to be funded from the HSSP pool in 2010/11. This led to under-utilization of MHTF resources in 2009-10. MHTF did fully contribute to the initial installation of five Maternity Waiting Homes (MWH) in two remote provinces that were operational in 2009, with 47 high-risk pregnant women coming from remote villages. By 2010, seven MWH had been established in four remote provinces, caring for 1,268 pregnant women with high-risk symptoms and 111 identified high-risk pregnant women from remote communities[52]. The first Guidelines for Establishing and Operating Maternal Waiting Homes were developed and approved by MoH, and information was disseminated in 2010. The guidelines provided clear, step-by-step guidance on how to set up, operate and expand MWH at a designated public health facility. In 2011, NGOs were beginning to support the building of maternity homes and are now required to follow the guidelines. Scholarships for enrolling students from remote districts as candidates for midwife pre-service training were under discussion at the time of the evaluation.
Findings from case study in **Ethiopia**	*Whilst national policies address most vulnerable population in hard to reach areas, and the newly trained cadres – supported by the MHTF – are supposed to fill gaps in those areas, the initiative to develop a national EmONC facility upgrading prioritized by pre-defined indicators seems to be lacking.* The MHTF works within the UNFPA country office and UNDAF frameworks and both are linked to the national priorities. Hence vulnerable groups are clearly identified by the partners, especially concerning the MDG 5 goal, pregnant women in hard to reach and underserved areas. For example the national baseline survey on EmONC[53] services contains indicators that address the equitable distribution and access of facilities. Whilst the MHTF is supporting the upgrading of skills for EmONC services, there is no obvious link between those facilities identified in areas of most need and the refurbishment, equipment provision and placement of the new cadre. Neither the EMONC survey nor the HRH strategies of the FMoH provide a list of prioritized areas, nor the indicators of what constitute 'most in need' for the health sector planning. The UNDAF 2012 to 2015 for example does not include a baseline and a target for upgrading EmONC services, and the Road Map for accelerating the reduction of Maternal and newborn morbidity and mortality in Ethiopia, 2011- 2015 still requires an implementation plan.

[51] Entretiens avec les partenaires d'exécution et les partenaires gouvernementaux

[52] UNFPA Cambodia MHTF Progress Report 2009, 2010

[53] The Ethiopian national baseline assessment on EmONC is a large facility-based survey that canvassed all hospitals and health centers (around 800 facilities) in the government and non-governmental sectors. The survey is important to provide baseline figures useful in tracking progress and monitoring national plans of action such as the Health Sector Development Programme I in the pursuit of achieving MDGs 4 and 5

Findings from case study in **Ghana**	*MHTF provides support to vulnerable women through UNFPA fistula awareness campaign that includes advocacy, repair and social re-entry especially in three Northern Regions, which is both rural and remote and where the need is acutely prevalent[54].The fistula programme has expanded into other regions that have districts with fistula prevalence and high MMR.* The MHTF is used to educate poor and rural communities that fistula is not caused because a woman has been bewitched, and to identify patients and bring them for repair[55]. After repair, MHTF programme rehabilitates beneficiaries through the Income Generation Activities (IGA) training done by the Non-Formal Education Division (NFED) of the Ministry of Education, Youth and Sports (MoEYS) establishing link between maternal health and the Livelihood Empowerment against Poverty Programme (LEAP). In the area of midwifery training and capacity building, MHTF supports deployment and retention of midwives in poor and rural areas of the Northern regions where there are few facilities and access is difficult[56]. As an incentive MHTF carefully selected a group of midwives serving in remote and hard to reach areas of Western and Central Regions and provided intensive 10 day life-saving skills on prevention and management of obstetric and neo-natal emergencies[57].
Findings from case study in **Lao PDR**	*MHTF contributes (as UNFPA does) to giving priority to remote areas candidates for attending the SBA training and EmONC training courses. Through funding technical assistance it also supported discussions about incentives to keep in the system midwives living in remote area as well as about free delivery for poor women.* The selection criteria for the SBA trainees (both community midwives and the 5 core modules for 1st level staff) take into consideration remoteness and the ethnicity of the candidate. In the case of the direct entry course the required schooling level is 8 instead of 10 for the applicants from remote or specific ethnic areas[58]. The EmONC training funded by MHTF has taken place in the 3 Southern provinces that are remote and poor provinces. The needs of the most vulnerable groups have been taken into consideration through the advocacy for setting up a system of incentives for remote area health care providers including midwives and for the policy for free assisted delivery services for poor women. The MHTF-financed SBA coordinator and the other reproductive health staff have taken an active part in the advocacy and the TWG discussions about the modalities.
Findings from case study in **Madagascar**	*The MHTF prioritizes and supports geographical and topical areas of concern that concur with the ones of the MoH, which is in line with the UNFPA Strategic Plan and the MHTF Business Plan.* The GoM prioritized in 2004 maternal and neonatal health and developed the National Road Map 2005-2015 which aims at increasing facility based deliveries. The underlying assumption was that accessible quality services attract clients. The MHTF supported EmONC survey identified gaps in resources, staffing and training in the surveyed health facilities which should be providing basic or advanced EmONC services, but do not. In supporting the MoH to upgrade the identified facilities (with skilled personnel, equipment and some refurbishment, free delivery kits, youth friendly services, community programmes, etc.), the MHTF aims reaching the identified target group (poor, pregnant, adolescents, men, community leaders, etc.) to increase the uptake of health services.[59] The MHTF has influenced the HR strategy of the MoH to enlarge the available cadre by general doctors and anesthetic nurses with training on treatment of

[54] MHTF Annual Report 2008, 2009 and 2010 (this issue will be taken up under EQ19)
[55] Interview with UNFPA
[56] Interview with Regional Health Service
[57] MHTF Annual Report, 2010
[58] Government partners interview
[59] Interviews with IP, DP, and MHTF/GPRHCS Joint Annual Reports 2009 and 2010

	obstetrical emergencies. The MoH also budgeted for 28 midwives in remote areas.
Findings from case study in **Sudan**	*At the time of the evaluation, MHTF funds had not been used to advocate for a more targeted reproductive health policy framework to address the maternal health needs of the most vulnerable groups and underserved areas in Sudan.* For the most part, MHTF resources have been used to support the reproductive health package that has been funded with core funds: support for pre service Village Midwifery trainings, school refurbishing if necessary for school to function, food for trainees, skills lab equipment, in service family planning trainings on how to counsel and how to use methods for care providers: health visitors, nurses, medical assistants and medical doctors. MHTF funds have also been used to complement core resources to deliver EmONC support through in service trainings, equipment and supplies, and refurbishing of operating theatres. MHTF further has supported the development of Obstetric Fistula repair capacity through training of physicians and construction of operating theatres and wards[60]. With its support of fistula repairs, the MHTF has addressed the maternal health needs of some of the most vulnerable women in Sudan, as obstetric fistula often is a cause for stigmatization and exclusion from families and communities. The MHTF has also financed the position of the International Consortium for Medical Abortion.
Findings from case study in **Zambia**	*MHTF-resources so far have not been used to influence Zambia maternal health policy agenda and regulatory framework.* Although a number of donor-supported national initiatives are underway nationally to reform the existing mechanisms for deployment and retention of health staff[61], UNFPA, i.e. the MHTF-financed advisors, have not been involved in these initiatives, at least in part due to a lack of adequate financial resources and staffing to support UNFPA involvement[62].

[60] Other activities that have been supported by the MHTF are noted below under Evaluation Question 2
[61] E.g., World Bank-led advocacy to influence policy to increase retention of midwives in remote areas
[62] Based on feedback in UNFPA interview. See also footnote 49.

7.2 Evaluation question 2: To what extent has the MHTF contributed towards strengthening human resources planning and availability (particularly midwives) for maternal and newborn health?

Findings from desk study

Background

The MHTF means to influence changes in policies, regulations, systems, practice and by trying to affect public opinion towards strengthening skilled birth attendance, particularly midwifery, by building sustainable capacity in the health workforce.

The MHTF places a particularly strong focus on institutionalizing midwifery, in part by assisting in the creation of supportive platforms and networks. The intention is to use these networks as a means to sustainably improve education and service delivery and to advance recognition of the key role of midwives in maternal health. Several MHTF countries have seen the gradual development of regulatory and legislative frameworks to ensure quality of care (judgment criterion 2.2) as stated in the MHTF Annual report 2010: "National curricula based on all seven essential midwifery competencies have been developed and implemented in 13 countries (Afghanistan, Benin, Burkina Faso, Cambodia, Côte d'Ivoire, Ethiopia, Ghana, Guyana, Haiti, Malawi, Sudan, Uganda and Zambia). In Ethiopia, which has received a significant amount of funding and technical assistance, the number of midwifery training institutions with revised curricula has increased dramatically from one to 23, with a concomitant increase in the number of midwifery graduates from 2,500 to 3,900 (a 56 percent increase)".

Midwifery associations have been either revived or newly formed in 17 of the supported countries[63]. Their role differs from country to country. The input necessary to strengthening these associations depends upon their management and functioning capacity. Whether they are functional needs to be explored further during the field phase (judgment criterion 2.3).

Gaps

- Although strengthening midwifery education is a strong component of the MHTF support, the way it is institutionalized varies between countries. The extent to which partner governments (and other development partners) are committed to ensure national level quality midwifery education to respond to national midwifery needs and the mechanisms for monitoring and ensuring quality midwifery education could not be made explicit from the available data and requires further study (judgment criterion 2.1).
- The need for additional midwives to meet public sector demand is much greater than UNFPA, even with its partners, will be able to train. For example, the country office in Ethiopia has estimated that "there is a need for additional 7,544 midwives within five years to meet public sector demand only, which implies that UNFPA together with partners need to train an additional 1,200 midwives annually".[64] The way the MHTF supports its programme countries in setting priorities for scale up is an issue to pursue during the field visit.
- The types of activities that the MHTF has supported requires adequate follow-up support mechanisms to reinforce the implementation of the developed policies, strategies and regulations in particular with regards to the quality of midwifery service provision but also to the deployment and retention of midwives within the health system. The latter often being an issue of concern in many countries.
- In some countries strong opposition from other medical associations that may encumber this implementation has to be taken into consideration.
- Although stressed in the Global Call of Action, less focus was put upon policies to address deployment and retention of midwives which is often an issue of concern in many countries particularly in remote areas

[63] MHTF Annual report 2010: Report on the Mid Term Review of UNFPA CPAP (2007 – 2011) (DRAFT) reproductive health Component, Yasmin Yusuf, Ethiopia, 2009
[64] Idem

7.2.1 Judgment criterion 2.1: Programme countries midwifery education upgraded based upon ICM essential competencies through MHTF support

Type of analysis	Findings
Findings from case study in **Burkina Faso**	*Le MHTF a joué un rôle prépondérant dans la mise à niveau des programmes de formation des sages-femmes sur la base des compétences ICM et des formations SONU et l'amélioration de la capacité des enseignants. Il a également permis d'introduire la PTME ainsi que les problématiques de SR liées aux jeunes, Toutefois si l'enseignement des écoles de formation de base a été renforcé grâce au MHTF, la capacité d'absorption de ces institutions n'est pas en relation avec l'augmentation des quotas de sages-femmes à former.* Le programme sage-femme a débuté le dernier trimestre 2008 avec le recrutement de la sage-femme conseillère pays, avec des financements suédois en 2008 et 2009. En 2009 il a été intégré au MHTF. Dans le cadre du programme sage-femme, l'UNFPA a entrepris la révision des curricula de formation des sages-femmes sur la base des compétences ICM (International Confederation of Midwives) et du curriculum régional de formation de l'Organisation Ouest Africaine de la Santé (OOAS) et a fourni un appui à la standardisation des compétences. Le MHTF a appuyé le renforcement des écoles de formation de base (école nationale de santé publique ENSP) par le biais d'équipements et par l'amélioration des compétences des enseignants et des encadreurs de stage, entre autre sur l'utilisation du partogramme, la prévention de la transmission mère-enfant (PTME) et du VIH, la santé reproductive des adolescents et des jeunes (SRAJ) ainsi que les techniques d'encadrement des stagiaires. Le MHTF a soutenu la DSME en organisant des séminaires avec des panels de professionnels[65] pour la révision des curricula de formation continue en SONU et sur les audits des décès maternels et un guide de supervision en santé maternelle et néonatale[66].Cette révision des curricula de formation sur la base des standards internationaux recommandés par l'OMS de même qu'une supervision de qualité permettra la mise à niveau des prestataires de santé en matière de SONU et une offre de soins améliorée. Afin de répondre à l'augmentation du nombre de sages-femmes et Maïeuticiens d'Etat (SF/ME) prévue dans la réforme mentionnée ci-dessus, les quotas de formation ont été augmentés ce qui met les Ecoles Nationales de Santé Publique (ENSP) en position difficile pour prendre en charge les élèves et la qualité de l'enseignement risque d'en pâtir. Les mesures d'accompagnement prennent en compte l'augmentation du personnel enseignant et d'encadrement dans les sites de stages, mais leur capacité reste à renforcer. D'autre part un suivi systématique pour l'application effective des compétences enseignées n'a pas été mis en place[67].
Findings from case study in **Cambodia**	*In 2009-10, MHTF provided support to UNFPA Cambodia to establish itself as the EmONC expert and to add value to the ongoing Midwifery Programme by providing in-service EmONC trainings and pre-service curriculum development as a strategic entry point as well as to help create an enabling environment for the midwifery profession. ICM competencies were being introduced in 2011, but the process was slow, and the ICM integrated curriculum has come under criticism due to poor adaptation. The support to the midwifery component was not as strong as in the past, when a Midwifery Advisor was in place.* The Midwifery Review (2006) and Midwifery Programme and Action Plan (2007-2010) was supported by German funding. In 2009, MHTF supported the EmONC Training Curriculum for midwives and doctors (as part of the support to the EmONC Improvement Plan). This was a standard EmONC training curriculum for midwives at health Centers and a Diploma/certificate course in EmONC for medical doctors/physicians (24 weeks) that was developed with the support of external technical assistance. In 2010, hands-on training and

[65] Des associations professionnelles telles que la Société des Gynécologues et Obstétriciens du Burkina (SGOB) étaient impliquées dans la révision des curricula
[66] Entretiens avec les partenaires d'exécution, les partenaires gouvernementaux et le personnel de l'UNFPA
[67] Entretiens avec les partenaires d'exécution.

	coaching, again facilitated by an international expert on EmONC Training Curricula, was conducted for 18 Midwives and 18 medical doctors to become Master Trainers. They in turn provided the first 12-week EmONC training course for 10 medical doctors.[68] The training took place in late 2010, to fulfill the urgent need for midwives with these skills at health facilities that had been selected for upgrade to either Comprehensive EmONC (with surgery) or Basic EmONC (without surgery). The essential competencies for midwifery services (ICM) were adapted to the Cambodian context through four consultation workshops prior to MHTF. ICM competencies and standards were introduced in service and pre-service training curricula in 2010-2011, with MHTF support and without pre-testing. There has been no post-test. No supervision guidelines had been developed at the time of this evaluation, but were planned for 2011, if technical support is available[69]. The first curriculum for Bachelor Degree in Midwifery was developed in 2010, with technical support from a qualified international expert. This degree was seen as highly useful for the Department of Human Resources Development to implement with appropriate training institutions. It is a major step towards assisting midwifery lecturers, as well as addressing the current shortage of these professionals[70]. In 2010, all five Regional Training Centers (RTCs) provided midwifery training to a total intake of 835 students (continuing the trend of increase from 335 in 2008 to 830 in 2009). Most of the students have been trained through the German Fund, but the equipment and training materials were provided by MHTF, as was the support for the midwifery teachers and the clinical practice in the four RTCs. The Refresher course for anesthetists (nurses or doctors) for emergency obstetric care was not implemented in 2009, due to non-existence of approved rates of long-term training. The Ministry of Economy and Finance did not initially approve the proposed rates. In 2010, the training was again not implemented as planned, due to a Government policy change banning all forms of payment of incentives to Government staff. The change negatively affected staff motivation, leading to further delays and suspension of the training[71]. Support to the development of the roles and functions of the Cambodian Midwives Council and Cambodian Midwives Association and how they create an enabling environment for their profession will be elaborated under judgment criteria 2.3.
Findings from case study in **Ethiopia**	*The MHTF (staff and/or fund) is supporting the midwifery education based upon ICM competencies, the standardization of curricula for all levels and the development of a monitoring and supervision tool for the FMoH. It is too early in the programme implementation to evaluate the results of the capacity development component, but the development of a tool for supervision is a very important step towards this.* To alleviate the shortage of midwives in Ethiopia[72], the MHTF complements efforts initiated by the midwifery programme through capacity development within the ICM strategic framework. Based on a capacity gap assessment of midwifery and anesthesia training schools[73], the MHTF[74] has expanded the existing midwifery training (based on SIDA funding through 2012) and supports the three levels of midwifery trainings in country: Now eleven universities are providing midwifery bachelor degree programs and 20 institutions are providing midwifery training at diploma level. The FMoH started in March 2011 accelerated midwifery training; this is a one year

[68] Maternal Health Thematic Fund Cambodia, Progress Report 2009 and 2010
[69] External Development Partner
[70] Government Partner
[71] UNFPA Cambodia and NGO Partner
72 In collaboration with government and partner agencies, the UNFPA has estimated that there is a need for additional 8365 midwives within five years to meet public sector demand only, which implies that UNFPA together with partners need to train an additional 1,600 midwives annually. (HSDP IV, 2011)
73 Capacity Assessment in seven midwifery training institutions and the Ethiopian Midwifery Association, 2009
[74] The initial support has been from MHTF (40.000 in 2008). Additional resources from SIDA US$ 3.7 million for 2010-2012 could be mobilized on ECO level.

	programme for diploma level nurses. The first group of students will be deployed in health centers as of mid-2012. The level of support includes teaching and learning materials, mannequins, vehicles and upgrading tutor skills. Some curricula were developed by a task force organized by the FMOH, which includes JHPIEGO, UNFPA (through MHTF) and WHO. These curricula are in line with the seven ICM essential competencies and also the Ethiopian professional standards. Curricula differ per level. The Diploma curriculum was developed by the Technical Vocational Educational Training (TVET). Each university has its own curriculum content. In 2010 the task force tried to standardize curricula through as consultative process, but now the ICM has just released new midwifery education standards and the GoE has just come up with a new plan that all curriculum must be in modules, so the curricula will be reviewed and redesigned again by the task force. To ensure appropriateness of training and application of new skills, a further task force has been established by FMOH for supervision, is comprised of FMOH, WHO, UNFPA (through MHTF) and JHPIEGO. The plan is to monitor newly graduated students at their sites, find out if have equipment, and sufficient skills, make sure drugs and equipment they are trained on are there. JHPIEOG plans that Midwifery schools will conducted a quality assurance assessment using JHPIEGO tool and develop action plans and then proceed jointly with UNFPA to further upgrade the training skills[75].
Findings from case study in **Ghana**	*MHTF has collaborated with ICM to ensure that midwifery curricula for both, the Diploma Midwifery Programme and the new bachelor degree midwifery programme, created largely through UNFPA initiative, are aligned with ICM standards and essential competencies.* The integration of the MHTF supported Midwifery Programme in Ghana began in early 2009 and continued in 2010 and represents the first two years of full operation. The ICM sub-regional Project Office was established the same year in Accra and MHTF supported a detailed desk review and needs assessment and gap analysis to establish a baseline on prevailing standards of midwifery (pre-service and in-service) The needs assessment also revealed that prevailing legislative and regulatory environment existed in Ghana but lacked updating and that status of midwives association (s) needed to be assessed[76]. By late 2009, Ghana had updated pre-service national curricula based on WHO/ICM seven essential competencies and integrated them into training schools. In 2010 the country saw an increase of 400 midwifery graduates, adding to the 3000 that existed and 8000 needed by 2015. Nursing and Midwifery Council undertakes an established training curriculum review process every five years. MHTF support began shortly after a formal curriculum review had been completed; however, MHTF Ghana has made some revision recommendations which was taken on board and UNFPA Ghana will have active input for the next review process. MHTF spearheaded and supported the development of the curriculum for a four- year Bachelor of Science (BSc) degree at the Kwame Nkrumah University of Science and Technology. This new programme was approved by the National Accreditation Board and began the course in October 2011. It is intended to attract students and practicing midwives who might otherwise choose a nursing bachelor degree. UNFPA Ghana anticipates ongoing MHTF support for this programme[77]. There is government commitment to sustain all main activities of the BSc. degree that has been done through MHTF/UNFPA[78]. MHTF is not currently involved with the 18 month post graduate midwifery training for community health nurses, however the Country Midwifery Advisor has shared ICM assessment documents to help assess and standardize this curriculum content[79].

[75] Information from development partner
[76] MHTF Annual Report 2009
[77] Interview with ICM sub-regional Office, Accra
[78] Interview with Government
79 Interview with UNFPA

Findings from case study in **Lao PDR**	*ICM competencies were included in the community midwife education and MHTF has supported training institutions through training teachers and clinical preceptors, supervising them and providing teaching equipment. Despite this support the quality of practical training still requires additional time and support to reach acceptable standards.* The aim of the SBA plan 2008-2012 (coordinated by UNFPA) is to upgrade different types of health workers and to upgrade the training courses in order to reach the required standards. Towards this aim UNFPA with MHTF funds and other development partners have been strengthening the midwifery education capacity of the College of Health Science and Technologies (CHT) and the Provincial Schools of Nursing/Public Health (PSoN). Schools were equipped with teaching material with Luxemburg and MHTF funds and MHTF has been training teachers as well as clinical preceptors. The capacity of the preceptors however is an issue of concern as they do not have appropriate practice and their ability to coach trainees has still to be developed[80]. Standards for Midwifery Education and a national licensing examination for midwifes (based upon ICM competencies) were introduced with MHTF support for the first time in Lao PDR as part of the quality assurance mechanisms and regulatory systems. DOP wants to adopt similar mechanisms to assess the competencies of the other professional cadres. A system of supervision of the training institution has been set up, done by the SBA Coordinator and the Department of Organization and Personnel (DOP) as well as the teachers of the Vientiane Faculty of Nursing Sciences (funded by different sources) what contributes to increase the competence of the government partners[81].
Findings from case study in **Madagascar**	*The midwifery education in Madagascar has been supported by the MHTF on national level with the development of curricula which are now being utilized nationwide in six training institutions which have been provided with some training equipment by the MHTF. The updating of the curricula was important, as the previous ones focused on theoretical education rather than practical skills.* In 2010, the MHTF has supported the MoH, together with partners, in upgrading the national midwifery education. The basis was a review of the current education[82] and the EmONC survey in 2009. The MoH has adapted a new curriculum for EmONC, which was tested, validated and adapted to the context of Madagascar by the Liverpool School of Tropical Medicine, the Royal College of Obstetricians and Gynecologists and the WHO.[83] Technical support on monitoring and evaluation of this training was provided by Averting Maternal Death and Disability (AMDD) of the University of Columbia. Hundred sixty-seven providers and supervisors of the Ministry of Health, as well as teachers of six Interregional Training Institutes of Paramedical (IFIRP) were trained in EmONC using the new curriculum. The training institutions were provided mannequins and other training equipment, the facilities with posters depicting flow charts, medical pathways. The MoH jointly with the MHTF is developing a monitoring tool for supervisory visits that will focus on application of technical skills and not only on administrative procedures (documents filled in, equipment available, etc.) as was the case before. The monitoring tool will be tested in the six focus regions of the MHTF but is applicable countrywide as all training is now following the new national curriculum. The output of midwives of the training institutions has not changed in the last eight years, and an

80 UNFPA staff interview

81 Government partners interviews

82 La revue documentaire qui a pour objectif d'identifier les besoins et les écarts entre la formation et la pratique (gestion, déploiement, rétention, mobilité, plans de carrière, motivation, et supervision) de la profession sage-femme dans le secteur privé et public ainsi que le gap relatif au bon fonctionnement de l'association des sages-femmes.(MHTF/GPRHCS Annual Report 2009)

83 New curricula that include the ICM standards were developed by UNFPA and other partners for the short course (5d) on EMONC and the degree course for midwifery, which now includes EMONC as a compulsory module. (GP)

	increase is also not planned, as overall there seems to be a geographical distribution problem of midwives rather than a lack in numbers.[84]
Findings from case study in **Sudan**	*As in other technical areas, MHTF funds used for midwifery support merely complemented the funding of projects that had been launched primarily with UNFPA core funds. Although this type of complementary funding had been used to upgrade the training of technical health cadres, the corresponding curricula and trainings were not upgraded sufficiently to meet the international ICM standards for midwives or skilled birth attendants. At the time of the evaluation, the relatively recently posted ICMA had not yet been able to make a significant substantive contribution to help upgrade Sudan midwifery education.* As mentioned above, MHTF funds have been used to complement core funding, i.e., to fund individual budget items to implement projects that for the most part are being financed through core funds. This means that the added value of the MHTF has consisted in particular in the additional resources it has made available, i.e., to fund midwifery support that had been conceived of and started prior to the launch of the MHTF in Sudan. For example, MHTF funds had been used to complement UNFPA core funding directed at developing and implementing a 2 year training curricula for so-called midwifery technicians. These technicians were considered to be SBAs by the Sudanese Government, despite the fact that their training did not meet the corresponding global ICM definitions[85]. At the time of the evaluation, the MHTF had not funded the development of any follow-up mechanisms to assess the relevance of training content, trainers' capacities or the appropriate utilization of training equipment for the training of midwives. Although the MHTF-funded ICMA was posted at the Academy of Health Sciences (AHS)[86], the agency in charge of the curriculum review process, she had not yet been allowed to play an active role in this process[87]. However, she had begun to advocate for a stronger role for herself and the other (unpaid) midwife staff member of the AHS[88]. At the time of the evaluation, the ICMA was also in the process of drafting a proposal for recruiting United Nations volunteers (UNV) as midwife tutors and midwife supervisors in hospitals[89].
Findings from case study in **Zambia**	*UNFPA has used the MHTF and the MHTF-funded Country Midwife Advisor (CMA) to establish itself as a partner with acknowledged technical capacity in midwifery in a relevant technical midwifery forum in Zambia and has used its involvement to support a number of initiatives related to midwifery education and training.* MHTF has addressed in particular the following mechanisms that are linked, albeit indirectly, to securing long-term midwifery education funding in Zambia: Firstly, MHTF has started to support the development of organizational capacities in relevant professional associations and Government institutions: It is working with the regulatory agency for nursing and midwifery education in Zambia, the General Nursing Council (GNC). It has supported and still is supporting the creation of a professional midwifery association, i.e. the "Midwifery Association of Zambia", which, once fully established, could become an advocate for additional funding for midwifery training and deployment. In particular the support to the GNC has the potential to help improve regulation and oversight of midwifery education in

[84] EmONC Survey 2010 (L'évaluation des besoins en matière de SONU à Madagascar, 2010)
[85] The education level of the trainees also did not allow a more comprehensive training than the one offered (document review and interviews with UNFPA)
[86] The Academy of Health Sciences is the Sudanese Government agency in charge of overseeing and regulating the training of midwives and at the time of the evaluation was formally leading the curriculum review process on behalf of the Government.
[87] Reasons that contributed to this situation have likely been the low standing of midwifery as a profession in Sudan, which added to the difficulties of the ICMA, as a non-Sudanese professional from Sub-Saharan Africa, to advocate for midwifes in the challenging social and political context of Sudan
[88] Interviews with UNFPA
[89] Interviews with UNFPA

	Zambia in the medium- to long-term. In addition, MHTF has provided support for the development of the National Nursing and Midwifery Strategic Plan; and is supporting the development of a corresponding operational plan, to guide midwifery and nursing affairs between 2009 and 2013. Although none of these initiatives necessarily and directly translate into secure, long-term funding, they can provide an important basis for Zambia Government to solicit additional funding for midwifery training and education. Midwifery and nurses curricula have been standardized across Zambia since 1984; and the curricula have gone through a series of reviews prior to the launching of the ICM-UNFPA midwifery programme in Zambia (MHTF)[90]. After the launch of the ICM-UNFPA midwifery programme in June 2009, the GNC initiated another review of the nursing and midwifery curricula, among other things to add components on EmONC. UNFPA used MHTF funds and resources to support this review. Both the Country Midwife Advisor (CMA) and the Country Fistula Advisor (CFA) participated in the working group sessions. In addition the MHTF CMA worked with midwifery tutors to change the midwifery training programme from 12 to 18 to 24 months and to introduce a "direct entry" midwifery training programme[91].
Findings from **regional** level	The partnership with ICM, Sudan, Ethiopia, Madagascar, Burundi, Cote d'Ivoire and Burkina Faso did a midwifery needs assessment. Based on findings, with ICM technical support they began to liaise with country systems to design programs and activities that would impact midwifery programs within countries. Support started with curriculum design. Looking at country needs, curricula have ranged from basic certificate programs to diplomas and to bachelors and to masters programs. Several countries are moving toward plans to have masters programs because they want to create a range of midwives, for local sites as well as midwives who can assume advocacy positions at high levels. In the needs assessment reports, issues were raised about the lack of tutors, of teaching learning materials and of infrastructure. Another area of support in education has been in service training for existing midwives to update their knowledge. Training has ranged from EmONC, HIV/AIDS, Active Management of Third Stage of Labor (AMSTEL), family planning, Manual Vacuum Aspiration (MVA).

7.2.2 Judgment criterion 2.2: Strategies and policies developed to ensure the quality of midwifery services provision in programme countries through MHTF support

Type of analysis	Findings
Findings from case study in **Burkina Faso**	*L'analyse situationnelle de la profession SF/ME appuyé par le MHTF a informé permis de mieux la planification des services de santé maternelle. La sage-femme conseillère de pays financée par le MHTF mais surtout la chargée de programme SR de l'UNFPA, ont pris part dans les discussions visant à élaborer des mécanismes visant à promouvoir la nomination et la rétention des sages-femmes en zone rurale toutefois ces mécanismes ne sont pas encore inclus dans le plan de développement des ressources humaines. L'élaboration d'un guide de supervision intégrée incluant les standards définis avec la DSME est une première étape vers le renforcement de la qualité des services.* Une stratégie de décentralisation du recrutement du personnel de santé a été mise en œuvre depuis 2006. Cette stratégie permet le

[90] These reviews were led by Zambia General Nursing Council (GNC), the regulatory agency in charge of nurses and midwife education. Family planning and gender were formally introduced into the curricula in 2000; in 2004 the curricula were reviewed once more "to meet demands of the Zambian public and new trends in health care" (not specified which demands theses were).

[91] Prior to the introduction of this programme, all Zambian midwives first were required to be trained as nurses; and to practice and work as nurses for a number of years. The direct entry programme is meant offer a quicker way for midwives to receive training and to start practicing.

	recrutement et l'affectation du personnel dans la région dans laquelle il a postulé, permettant ainsi de le/la fidéliser dans sa zone avec en appui un mécanisme d'indemnisation favorisant les zones rurales. La sage-femme conseillère de pays (financée par le MHTF) mais surtout la chargée de programme SR/MMR ont pris part aux discussions d'élaboration de ces mécanismes lors du dialogue avec la DSME et à bien moindre mesure avec le Département des Ressources Humaines (DRH)[92]. Ce type d'appui, même si renforcé par le MHTF, a été initié avant l'introduction du MHTF car c'est un effort de longue haleine et requiert une certaine crédibilité auprès des partenaires du Ministère de la Santé. Un lien accru avec le DRH et une implication dans la finalisation du plan de développement des ressources humaines aurait le potentiel de garantir que les sages-femmes aient la place souhaitée par la DSME dans les systèmes de santé. Un plan des ressources humaines pour la santé est en train d'être développé et des efforts additionnels seront nécessaires pour que les aspects de déploiement et rétention des sages-femmes soient abordés (voir Question d'évaluation n°1). L'ICM et l'UNFPA avec l'appui financier et technique du MHTF ont réalisé une 'Analyse situationnelle de la profession de sage-femme et maïeuticien d'état (SF/ME)' en 2009, afin d'obtenir des données sur la formation de base des SF/ME, la cartographie des SF/ME dans les 13 régions du pays; les activités des organisations professionnelles de SF/ME et les conditions de travail des SF/ME dans les centres de santé. L'évaluation SONU également fournit des données précises sur la SR va permettre une planification plus spécifique et plus rationnelle. Un Guide national de supervision intégrée en santé maternelle et néonatale a été développé en 2009 et disséminé avec l'appui du MHTF. Il inclut les standards qui avaient mis à jour dans les curricula et donc est un document de référence important.
Findings from case study in **Cambodia**	*MHTF started operations in Cambodia in 2009, when UNFPA Cambodia was already half-way into the full-funded Midwifery Programme (2007-10). MHTF sought to influence quality through EmONC in-service curriculum development, in which it translated fragmented trainings into one coherent framework (as described in judgment criterion 2.1), added the coaching of midwives and developed a pre-service curriculum (as described in judgment criterion 2.3). However, the MHTF has so far not addressed the larger question of how to ensure the needs-based deployment of new midwives and the retention of those already employed. This remains a key challenge for the provision of midwifery services in Cambodia.* Since 2008, there has been a large increase in midwifery students, largely attributable to the three-year direct entry midwifery-training programme that is funded by the German Trust Fund and the Government Midwifery Incentive Programme. At the end of 2010, the MoH and UNFPA remained committed to achieve their target of having at least one midwife working at each Health Centre. In the coming years, the Ministry will increase coverage to at least two midwives per Health Centre. MHTF has not been called upon to do any quality assessment or to support the deployment retention of midwives, but there is anticipation on this front from the Fast Track Road Map. With the end of the German funding in 2010, support is being sought in four areas related Human Resources for Maternal Health in 2011[93]: • Participation in international and regional conferences • Support for training workshops on reproductive health/maternal health and midwifery • Support to midwifery training in 4 RTCs • Support to roles and functions of the Cambodian Midwives Council and Association. The standardization and quality assurance by the Cambodian Midwives Council is discussed under judgment criteria 2.3.
Findings from case	Quality of services is addressed by the MHTF through participation in the relevant technical working group, and support to the FMoH

[92] Entretiens avec l'équipe UNFPA – cf. la question d'évaluation n°4
[93] Updated Planned Activities and Budget Required for 2011 for reproductive health Component, Taken from Atlas Code

study in **Ethiopia**	supervisory framework development. The draft Road Map for Accelerating the Reduction of Maternal and Newborn Morbidity and Mortality in Ethiopia (2011) has as Objective 1 to increase skilled attendance during pregnancy, childbirth and postnatal period at all levels of the health care delivery system. It includes targets the target to train and deploy 8635 midwives and to staff all Health Centers by at least two midwives each by 2015. This Road Map though is neither costed nor does it have an implementation plan. The WHO, FMOH, ESOG, and UNFPA are all playing roles in trying to ensure that facilities are ready for the deployment of the cadres whose trainings have been supported by MHTF. Monitoring and assessment visits are underway now to identify how these facilities need to be strengthened prior to arrival of newly deployed health workers[94]. Deployment, retention and motivation is a prerogative of the FMoH, these issues of are not raised by the MHTF as firstly the new cadres and trainees will only take up their positions in 2012, and secondly the FMOH has bonded the midwives for 2-5 years. The nurse anesthetists and the IEOS will receive good salaries; the expectation is that bonding, better salaries, better status and improved equipment will suffice to retain staff. Concerning the midwifery training, a good example was set with the mentoring programme for the Gode Health Sciences College by the University of Gondar. All the tutors and instructors from Gode indicated that they learned quite a lot and changed some of their negative practices after the mentorship programme. The evaluation of the end – beneficiaries would be needed to determine the long term results of the intervention.
Findings from case study in **Ghana**	*The country office has a relationship with HR directorate of MoH, which has commended MHTF support in the capacity building of in-service midwives and training of pre-service midwives utilizing the 14 Regional Training Schools. MoH does not yet have a defined incentive plan as expected because UNFPA does not fund it.* ICM and UNFPA (HQ) jointly hosted the first Inception Forum for Country Midwife Advisors (CMA) and capacity building workshop in Accra. This 2009 workshop gave a strategic perspective in promoting and strengthening midwifery services at country level with a specific focus on midwifery education, regulation and strengthening midwifery association[95]. The CMA at UNFPA Ghana is fully funded by MHTF and there is a move to make this position more sustainable[96]. To assist the government in its efforts to strengthen pre-service midwifery training, a nationwide needs assessment of all 12 midwifery training schools was conducted in 2009 and an in-depth assessment of the infrastructure and curriculum (pre-service and in-service). As part of this, an in-depth assessment was done of the Bolgatanga Training School which is the most deprived midwifery institution and serves the UNFPA programme districts of the Northern Region. The Bolgatanga report was catalytic in making MoH and Ministry of Women and Children Affairs take high level action in re-equipping the school. The success of the Bolga Midwifery School project was showcased too and both schools were instrumental in that the EmONC assessment of 2011 identified the gaps and immediate improvement that was possible without waiting for the National Improvement Plan which would not be in place until 2012. MHTF Ghana also distributed medical equipment and anatomic models to the 14 schools in 2009. The CMA reported that in 6 of the schools visited as part of a review, the equipment and models were found to be useful as indicated by the higher passing rate of students. However, teachers met during this evaluation visit noted that some models were more utilized than others and there was a lack of comprehensive training of teachers[97]. ICM and MHTF hosted a workshop in 2011 with INTEL to discuss expanding capacity building

[94] ibid
[95] Interview with UNFPA
[96] Interview with UNFPA
[97] Interview with Regional Training School

	into remote areas through distance learning and use of computer technology; currently it appears likely that this technology will be put into place through a UNFPA/ICM/INTEL partnership[98].
Findings from case study in **Lao PDR**	*The main maternal strategies i.e. the MNCH package and the SBA plan were developed prior to the introduction of MHTF. Nevertheless MHTF has contributed to their operationalization and advocacy for adequate deployment of newly trained Community Midwives. Mechanisms to ensure quality of services are so far insufficient particularly since the SBA plan is quite ambitious.* The SBA plan is part of the MNCH package as well as of National Strategic Plan for Human Resources for Health, and is in line with the next Five-year Health and Development Plan (2011-2015). It projects the training (in service and pre service) of 1500 SBA by 2012 in order to respond to the country needs in terms of midwives. Even if the SBA plan is ambitious it is supported by all donors what is a guarantee for its completion. Follow up support to the MOH may be needed to ensure the absorption of the new trainees in the health system. The SBA plan addresses issues of deployment, management, supervision and retention of human resources for Skilled Birth Attendance. These issues are discussed during the Human Resource TWG under the lead of UNFPA of UNFPA though the MHTF funded SBA Coordinator. Support is also provided to strengthen HR management through developing a national HR database. Discussions were held with DOP to follow up on the deployment of the community midwives following their training. A small survey is currently being done on the posting of newly trained community midwives with MHTF support[99]. As seen above quality assurance mechanisms were set up for midwifery education but there is still a gap in ensuring quality of services once midwives are deployed; one of the reasons being the lack of coordination between the MoH department that has the responsibility for education and the one which is responsible for service quality.
Findings from case study in **Madagascar**	*The MHTF has within its first two years of existence, supported (together with other partners) the national curriculum for midwives, equipped (or is in the process) countrywide health facilities with consumables and equipment to be able to provide BEmONC and CEmONC, and trained trainers, supervisors and health care providers. The MoH realizes the budgetary constraints of ensuring continuation and expansion of the current service provision; hence more focus should be in the coming period on more sustainable solutions. Here the MHTF could play an increasing role (in i.e. leveraging other players).* The MoH has no strategy on motivation or retention, and deployment is according to a national plan.[100] The MoH realizes that retention in remote areas is a pertinent problem and accepted the MHTF offer to place salaried midwives[101] in remote facilities. They are highly appreciated by the population[102], but no plan is yet available towards retention or motivation policies. It was argued that the deployment cannot be facilitated through higher salaries, as the infrastructure (schools, roads, safety and transportation) is the deciding factor for health care providers[103]. The diminishing health budget may limit the choice of potential strategies; nevertheless the MHTF may consider addressing the directly affected communities and potential private partners, once the piloted midwives have demonstrated to be a

[98] Interview with ICM Sub-regional Project Office
[99] UNFPA staff interview
[100] Also see MHTE findings judgment criterion 4.1
[101] The MHTF provides the salaries for one year for 28 midwives, as the MoH cannot guarantee the takeover of more. Whilst the support to salary 28 midwives for one year may not seem as significant for the whole country, it does serve as a catalytic action, as the MoH has now created budgeted positions for remote areas. Also the process of filling positions (including harmonized contracts) and the feedback from potential candidates on motivation and difficulties encountered may serve as lesson learnt for further interventions.
[102] Interview with MoH
[103] Ibid and other GP

	success. As paying salaries to public health staff is an unusual approach, this requires a good supervision and mentoring of those midwives and a strong monitoring and evaluation of the impact on health indicators. Urgent needs were identified in the EmONC survey and initiatives towards enhancement of capacities started in 2010, mainly through MHTF support. The budget constraints of the MoH are increasing as is the dependency on external funds. Whilst sustainability is a recognized problem, the MoH planning and budgeting process does not develop scenarios, but rather hopes for further and even extended funding, once the political situation has improved. One governmental partner mentioned that the trategy will remain the same, when funds run out, but how we deliver it, will be different'.
Findings from case study in **Sudan**	*At the time of the evaluation, the MHTF had not yet made a significant contribution to the development of strategies and policies to ensure the quality of midwifery service provision in Sudan. Initiatives by the newly posted ICMA, which were intended to make a contribution in this regard where still in the planning stages at the time of the evaluation.* Up to the time of the evaluation, specific MHTF funded organizational support had been relatively limited. As the posting of the MHTF-funded ICMA had happened only 4-6 months ahead of the evaluation, it was too early to observe any concrete results of her work to address deployment, motivation and retention of health care workers / midwives. The ICMA had begun to establish a cooperative relationship with the National Midwives Association of Sudan, specifically to organize a group of midwifes to discuss the issue of gender and maternal health; and to potentially use this group as an advocacy group for quality maternal health services[104]. However, this initiative was still in the planning stage at the time of the evaluation. As mentioned above, UNFPA had already been supporting the Sudanese Government in midwifery overall, and in redefining national priorities in particular well before the launch of MHTF Sudan. This prior support also included a study on the status of midwifery in the country which became the basis for the development of the "National Strategy for Scaling-Up Midwifery in the Republic of Sudan"[105]. The MHTF did not play a role in carrying out this study. MHTF-specific initiatives promoted in particular by the ICMA were still in their infancy at the time of the evaluation. They include a concept paper for short-, medium and long-term actions to strengthen midwifery education; and also the proposal to use UN Volunteers as midwifery tutors to ensure a certain quality of training and service delivery[106].
Findings from case study in **Zambia**	*UNFPA has used the MHTF to supervise and support the quality of midwifery services delivered by a new cadre of direct entry midwifes. However, the MHTF has so far not addressed the larger question of how to ensure the needs based deployment of midwifes and their retention, which remains a key challenge for the provision of midwifery services in Zambia.* Although MHTF-funds have not been used to directly work on issues of deployment and retention of midwives and nurses in Zambia[107], the CMA and CFA have established working relationships with the appropriate institutions[108] to become active in these areas in the future. The National Nursing and Midwifery Strategic Plan that was developed partly with MHTF support can also potentially become a useful tool for rallying support around these issues in the future, with or without UNFPA support. However, at the time of the evaluation, UNFPA, i.e. the MHTF-supported CMA had not yet gotten involved in deployment and retention, at least in part due to time constraints. To support monitoring and supervision of new trainees, i.e. in particular graduates of the direct entry midwifery programme, UNFPA / MHTF have supported the development of a Mentorship Programme for Direct Entry Midwifery, involving ten-day training for mentors,

[104] UNFPA interviews
[105] Document review
[106] Interviews with UNFPA
[107] Which continues to be a problem
[108] I.e., the General Nursing Council (GNC) and the Nursing Unit of the MoH

	who will provide mentoring to graduates of the Direct Entry Midwifery Programme for their first 6 to 10 months of service. The programme started in March 2010, and has the potential to improve the supervision of the new midwives, and increase the likelihood that new skills are appropriately applied by the graduates[109]. In addition, MHTF is financially supporting joint monitoring visits of the General Nursing Council, the Ministry of Health and other involved partners to follow-up on the implementation of the new curricula; and the application of the new skills in health facilities[110].
Findings from the **regional** level	Sudan, Ethiopia, Madagascar, Burundi, Cote d'Ivoire and Burkina Faso did a midwifery needs assessment that looked at different aspects of midwifery including, which were existing needs of regulatory systems. Support ranged from developing midwifery regulatory standards and disseminating them (and ensuring that council acts or legislation is reviewed), reviewing ethical codes of conduct, advocacy to help the development of regulatory bodies to training to improve on knowledge based and skills base of midwives in services. CMC helps also the regulatory body to take leadership in ensuring that educational standards are implemented. In most countries regulatory standards are weak and therefore standards are not adhered to.

[109] No monitoring data for this programme were available

[110] Interviews with UNFPA; review of Midwifery Annual Work Plan 2011 (Account Description: DSA, x5 people per trip x I trip per quarter, Transport, Fuel, Stationery for monitoring documents)

7.2.3 Judgment criterion 2.3: Midwifery associations able to advocate and support scaling up of midwifery services through MHTF support

Type of analysis	Findings
Findings from case study in **Burkina Faso**	*Les 3 groupements de sages-femmes présentes au Burkina Faso ont été soutenus par le MHTF en particulier pour mener des actions de sensibilisation sur leur profession. Ceci a permis d'accroître la visibilité de la profession et de la revaloriser. Cependant ces organisations ne sont pas encore totalement autonomes et fonctionnelles.* UNFPA par le biais du MHTF a appuyé l'Association Burkinabé des Sages-femmes (ABSF), l'ordre des sages-femmes ainsi que le syndicat pour élargir leur couverture dans le pays. Cet appui a permis d'assurer leur visibilité à travers l'organisation de journées de mobilisation des membres de la profession et des journées de sensibilisation des populations sur des thèmes de santé maternelle lors de la Commémoration de la Journée Internationale des sages-femmes (JISF). Après avoir été formée en technique de plaidoyer, l'ABSF a conduit un processus de plaidoyer de haut niveau auprès de la première dame qui a abouti à une augmentation du recrutement des sages-femmes dans le système de santé[111]. Toutefois le nombre de sages-femmes formées ne correspond pas aux nouveaux besoins. Le code de déontologie de la profession sage-femme/maïeuticiens est en train d'être disséminé dans tout le pays (grâce au MHTF) ce qui permet de mettre l'accent sur la revalorisation de la profession à un moment ou des cas de sages-femmes incriminées pour fautes professionnelles ont été cité dans les médias[112]. Les organisations de sages-femmes ne semblent pas jouer de rôle important dans la réforme visant à affecter des sages-femmes en zone rurale alors que leur profession est directement concernée. Un appui sur la durée sera nécessaire pour les rendre plus fonctionnelles[113].
Findings from case study in **Cambodia**	*The Cambodian Midwives Council (CMC) is fully operational with a mixture of German and MHTF support, but the Cambodian Midwives Association will need further MHTF support in order to evolve as an independent NGO with the ability to advocate on behalf of the profession, become a much needed 'watchdog' and help the public health sector scale up quality services.* Institutional capacity development of the Cambodian Midwives Council (CMC) and the Cambodian Midwives Association (CMA) was carried out by a local organization funded by the German Trust Fund (from late 2009 to mid-2010) to address basic capacity building and institutional needs such as the Strategic Plan (2010-2015) and Internal Regulations.[114] CMC is awaiting the announcement of decree by which it will be permanently institutionalized by the Government. MHTF has posted a full-time Programme Assistant to support both CMC and CMA, particularly in the formulation of a Code of Ethics and Standards as well as to help organize advocacy events. However, this support was not equally distributed among the two organizations, nor was it sufficiently technical. A VSO Midwife has joined, and further improvements are expected[115]. Core competencies for midwives have been defined by CMC as guidance for all midwives and training institutions to improve teaching quality and the skills of graduate midwives. MHTF supported the 2009 and 2010 International Midwives Day, organized jointly by the CMA and the CMC. The event included

[111] Entretiens avec les partenaires d'exécution
[112] Idem
[113] Idem
[114] UNFPA Cambodia MHTF Progress Report 2009, 2010
[115] UNFPA Cambodia

	participation of around 400 midwives (in total for two years), health professional organizations and provincial and district representatives, and was presided over by the Minister of Health. A result of this advocacy MoH offered to host the secretariat of both these organizations and to include CMA and CMC activities in its Annual Operating Plan. Both these organizations rely upon volunteers who recognize the importance of remaining independent and expressed concerns about the sustainability of their long-term involvement.[116]. A database of registered midwives (in Excel) is being maintained, but needs further software support. Accreditation and licensing are being discussed with the Department for Human Resources, to define responsibilities. The CMA members are involved in coaching newly trained midwives once they are deployed. However, it appeared that the CMA needs much organizational and management support from UNFPA, such as received by the Council, but with more far-reaching effects, so that it can evolve into an independent and sustainable NGO[117].
Findings from case study in **Ethiopia**	*The MHTF has supported with a broad range of activities the strengthening of the midwifery associations; the EMA now is a recognized member of the national taskforce to develop professional standards, however this work is just commencing.* The MHTF is supporting the Ethiopian Midwives Association through provision of financial, technical and material support. Also, through the ICM, the MHTF supports the EMA over three years to strengthen their capacity and advocacy for professional regulation with yearly trainings, for example in 2010 on leadership and management. Moreover, the MHTF supports the Ethiopian Nurse Midwives Association (ENMA). The international CMA (funded by the MHTF) is mentoring the two national colleagues[118], one of which is placed in the FMoH, to support the midwifery programme. Through MHTF support, the Ethiopian Midwifes Association has achieved to be a participant in the national taskforce which develops professional standards for all health cadres and to establish two additional regional branches (the SNNPR and Somali offices). Apart from a variety of activities to strengthen the midwifery associations, awareness and understanding of the role of midwives in reducing maternal and neonatal morbidity has been nationally raised through support by the MHTF to the International Day of Midwives, and advocacy meetings for the media, and for decision makers from the relevant ministries. These events led to the FMoH budgeting some funds to improve teaching and learning, and the increase of intake of midwifery students at midwifery schools[119] and the recognition of the need of training more midwives[120]. Challenges to be addressed remain; most importantly the lack of a regulatory body for midwifery reduces the potential for sustainability of all aspects of the capacity development.
Findings from case study in **Ghana**	*The Country Midwife Advisors are often members of professional associations. The ICM workshop allowed them to share experience and cross – fertilize ideas on project management and challenges of formidable midwife associations who have experienced fragmentation. Implementation rate (utilization of funds by mid-year) for midwifery was high in 2009 but low in 2010 as certain planned activities with Midwifery Council and the two associations got delayed. [121].* Ghana has a Nursing and Midwives Council (NMC) and the two Midwifery Associations received visits from counterparts in Ethiopia to

[116] Government Partner
[117] NGO Partner
[118] The national colleague is on an SSA and already the second in this position (within a year). The international CMA suggests a proper position for the NPO to decrease the high turnover rate.
[119] Whilst the increase is positive, the training schools now are overloaded and the quality of training suffers (information from ECO)
[120] Annual report for the thematic funds, 2009
121 MHTF Mid-year Review 2010

	learn about best practices, networking and advocacy in 2009. The MHTF with the support of the CMA is also currently helping to mediate tensions between the longstanding Ghana Registered Midwives Association (GRMA), whose membership is comprised of mostly private sector midwives, and the newer and smaller Government National Midwives Group (GNMG), comprised of mostly younger public sector midwives, so that the country midwives will have one uniformly representative association and a unified voice[122]. ICM in partnership with the Council (NMC) has engaged with the two associations in a self-assessment process to strengthen its self-regulation in accordance with global guidelines. MHTF supported GRMA election in 2010 where a public sector midwife was elected as an Executive Office (Organizing Secretary). The goal for both MHTF/UNFPA Ghana and ICM Sub-regional Office is to create an association whose joint voice will be credible with MoH/GHS[123]. Implementation of midwifery programming was low in 2010, only 15.8 percent in July of 2010 and did not increase by end of year as UNFPA Ghana leveraged other funds[124]. For the first time in 2011 there was a joint celebration of International Midwives Day by the two associations. After two full years of MHTF operation in Ghana, midwives benefit from systems for continued education. Most recently, MHTF has supported GHS to train 16 retired midwives (identified from the two associations), who were previously tutors, on how to conduct bi-annual field monitoring of practicing midwives' skills[125].
Findings from case study in **Lao PDR**	In Lao PDR civil society is very limited and it is not possible to create associations.
Findings from case study in **Madagascar**	*The sustained MHTF support is important to further empower the midwifery council to fulfill its envisioned role. The first important steps are made and the MHTF will have to continue to play a catalytic role so that the midwifery council is an institutional partner in the reproductive health arena.* Since 2009 the MHTF supports the national midwifery council, the L`ordre national des sages-femmes, and has enabled (through discussion with relevant partners and stakeholders) the council to elect for the first time a midwife and not a doctor as leader[126]. To increase visibility of the council and promote its agenda (the development of the accreditation function for midwifery training institutions in Madagascar, advocacy for midwifery services, and representation in relevant national policy fora) the MHTF supported 300 midwives to participate in the Congress of the Council of the National Order of Midwives in 2010, which presented the updated laws governing the midwifery profession. The MHTF also supported participation in two international workshops[127]. The regional midwifery adviser was reported to be in close contact with the nine volunteers of the council, providing advice on the implementation of the work plan and planning in 2012 a supervisory mission. The initially recruited country office midwifery advisor had been replaced after a short working period. [128]
Findings from case	*The MHTF, through the ICMA, has helped to make some initial steps toward the official creation of a midwifery association. However, at*

122 Interview with NGO
123 Interview with UNFPA staff
124 Interview with UNFPA staff
125 Interview with Government
126 The office (supported through the MHTF with furniture and equipment) was officially opened during the mission.
127 3 MW participated in the Accra ICM workshop and 1 in the Durban MW conference in 2011; all were financed by the MHTF.
128 The recently recruited midwifery advisor was reported ill during the time of the mission.

study in **Sudan**	*the time of the evaluation, the association had not been officially registered yet and was not yet operational.* The MHTF has been supporting the organizational consolidation of the Sudanese Midwifery Association at national level through some technical and logistical support. It is also promoting the creation of local chapters of the association at the level of the States[129]. However, at the time of the evaluation, the association was still in its infancy and was not yet officially registered at national level, although it already had elected some of its officers. The ICMA has been supporting the creation of a professional council for the registration and regulation of midwifery practice and also intends to enlist the support of state representatives for the creation of state-level association chapters and the enlistment of members[130].
Findings from case study in **Zambia** (3rd Submission)	*The MHTF has kick-started the creation of a separate midwifery association in Zambia, but it is too early to determine what role this association will be able to play, i.e. what added value it will be able to provide with regard to the up-scaling of midwifery services in the country.* In promoting the creation of a separate midwifery association (MAZ) in Zambia, UNFPA followed the official credo of the ICM-UNFPA Midwifery Programme, i.e. to pursue "Education, Regulation *and Association*". The initiative was welcomed[131] by Zambia professional midwives, but was met with more reservations by the already established Union of Zambian nurses (ZUNO) that to date had also represented all Zambian midwives[132]. ZUNO had preferred to represent midwives in an internal group of the existing union, as it feared the division of the nurses / midwives professional community if a separate midwives organization was created. At the time of the evaluation, a meeting was held to resolve this conflict. Up to that point, the differences between the two camps had also affected the CMA effort to organize a national Day of the Midwife in 2009: ZUNO did not support the effort to organize this day, slated to be celebrated on May 5th, as they were already preparing a separate Nurses Day for May 12th, 2009. At that time, suggestions to combine the celebration of nurses and midwives into one day were turned down for fear that the "midwifery cause" would be overshadowed by the celebration of nurses[133]. However, in 2011, ZUNO and the new Midwifery Association of Zambia organized and celebrated the two events jointly in one day on May 5th, 2011, indicating that the two organizations had made progress on coming to an understanding on their complementarity. It is important to point out that midwifery had been relatively high on the agenda of development partners and the Government before the formal launch of UNFPA midwifery programme in Zambia. Most of the above-mentioned initiatives had already been ongoing when the programme was launched. This is not to say that the MHTF has not made valuable contributions to the development of the country midwives; however, the programme has not *triggered* the majority of these initiatives[134], with the exception of the efforts to create a separate midwifery association in Zambia.

[129] Review of AWPs, annual reports and interviews at UNFPA

[130] Interview with UNFPA

[131] UNFPA interview

[132] Until the introduction of the Direct Entry Midwifery Programme, the only path for being trained as a midwife was to first complete a full nurses training; and to work as a nurse for a number of years.

[133] Feedback from UNFPA; Information in the 2009 Annual Report of the Midwifery Programme

[134] E.g., although the midwife who was eventually recruited as CMA by UNFPA (MHTF) participated in the 2008 / 2009 "Training Needs Assessment" for nurses and midwives, it seems that her participation occurred before she started working for UNFPA / MHTF: The respective Training Needs Assessment (TNA) started in late 2008; while the CMA only began working for UNFPA in early 2009. However, as she had been an established member of the midwifery professional community of Zambia well before her recruitment by UNFPA she likely participated in the Training Needs Assessment in one of her other capacities (e.g. board member of Zambia General Nursing Council (GNC), the organization that formally led the TNA).

Findings from **regional** interviews	There are no regional midwifery associations in Asia Pacific. Most of the countries in this region do not even have national midwifery associations. In West Africa linkages have been developed with the Federation of the Midwifery Associations of West and Central Africa (based in Dakar) and with national associations through the partnership ICM/UNFPA. The collaboration with regional midwives association: meeting of midwifes in Ghana in 2010, where they looked at issues of midwifery education. Improving midwives attitudes which is a serious issues in several countries was discussed as well. ICM/UNFPA initiative has liaised and consulted with midwifery associations and has used standard Midwifery Association Capacity Assessment Tools (MACAT). The ICM midwife Advisors try to engage association leadership to reflect on these capacity areas that association is supposed to possess and do a self-assessment and judge where they stand. They also had opportunities to train associations in leadership skills.

7.2.4 Additional issues on evaluation question 2

Type of analysis	Findings
Findings from case study in **Burkina Faso**	*Le rôle de la sage-femme conseillère a été clef dans des aspects techniques tels que le renforcement de la formation de base des sages-femmes, dans la production d'outils et le support aux associations. Son rôle est plus limité en ce qui concerne l'influence des politiques nationales mais ceci est compensé par le rôle significatif de la chargée de programme au niveau du dialogue national.* Le programme sage-femme a débuté le dernier trimestre 2008 avec le recrutement de la sage-femme conseillère pays, avec des financements suédois en 2008 et 2009 relayés par le MHTF. La performance de la sage-femme conseillère est appréciée par le gouvernement, et au sein des écoles nationales de santé publique qui forment les sages-femmes qui affirment recevoir plus d'attention et d'appui de la part de l'UNFPA, ce qui incite d'autres partenaires à s'engager dans un soutien additionnel. A titre d'exemple, la Banque Mondiale est entrain de préparer un projet qui va entrer autres soutenir le recrutement additionnel de sages-femmes et le renforcement du processus de leur formation de base à travers la standardisation des compétences et la création de laboratoires additionnels de travaux pratiques[135]. Son implication a été essentielle dans le développement du guide de supervision et dans le soutien aux associations de SF, à l'ordre et au syndicat des SF. Par contre l'influence de l'UNFPA au niveau des stratégies nationales est plutôt entre les mains de l'équipe SR.
Findings from case study in **Lao PDR**	MHTF allows providing appropriate technical assistance for midwifery through funding the SBA Coordinator position. However there are concerns regarding the continuity of the technical assistance to the Ministry of Health once the funding ends. The International SBA Coordinator started supporting the SBA assessment and the drafting of the SBA plan as a consultant and joined UNFPA in order to support its implementation. She was also supporting the whole reproductive health component as the Reproductive Health Technical Advisor was vacant at the time for the evaluation. The position was initially funded by core funds, then by Luxemburg funds and then by MHTF. This position is not a permanent position in the country office staffing and that there is still an important need to support MoH as regards to strengthening midwifery. Moreover the capacity of the National Reproductive Health team needs to be

[135] Entretiens avec les partenaires techniques et financiers, les partenaires gouvernementaux et l'équipe UNFPA

	strengthened as to provide the required technical assistance to MoH. At the time of the evaluation options were being explored by the country office to fill these gaps during the 5th Country Programme[136].
Findings from case study in **Sudan**	The added staff position of the ICMA in Sudan is appreciated by the country office. However, it has been challenging for her as a midwife to promote midwifery as a discipline in a country like Sudan, where the awareness of the importance of midwives has been lost and women are marginalized socially, politically and in the workplace[137]. Overall, many of the activities that represent the core of MHTF mandate have been affected by the same challenges that also have affected UNFPA other Maternal Health support activities, in particular need for capacity building at both federal and state levels. The MoH reproductive health department has been challenged by the low motivation and high turnover of staff; the lack of political will and commitment has delayed endorsement of the registration of the Sudanese Midwifery Association as well as the establishment of a midwifery council, despite the ongoing policy advocacy efforts; the lack of interested candidates (associated with cultural barriers) hampered the availability of suitable candidates for the Midwifery Technician basic training. In addition, delays in MHTF disbursement and the recruitment of the ICMA have delayed effective implementation of activities under the AWP funded by MHTF[138].
Findings from **regional** interviews	Altogether there are 22 Midwives CMA posted in 19 Countries Offices. There are some international midwives and national ones. RO Asia Pacific does not have much contact with the ICM regional midwife advisor based in New Delhi, India. The ICM advisor organizes a workshop for the region on Midwifery in Dacca, au Bangladesh. In Africa the 3 ICM regional advisors based in Accra, Ghana, are considered to be part of the regional reproductive health team. They meet the country CMA regularly and provide support for strengthening midwife associations and undertaking midwifery assessments in countries. SRO collaborates with the CMA in countries but not with ICM. Positing CMA is a good idea if they get the right person in country office, with the right skills. They can also refer to the sub-regional office for additional support. The partnership with ICM began in 2008, looking at strengthening midwifery systems through providing technical services to country based Country Midwife Advisors employed by UNFPA and stationed in either UNFPA office or at MOH. ICM programme currently include support for 12 African countries. Anglophone countries include Ethiopia. Ghana, Zambia, Uganda, both Sudans. Hoping for near future expansion to Sierra Leone, Liberia, and Malawi. Francophone countries include Burkina Faso, Benin, Cote d'Ivoire, Burundi, Djibouti, Madagascar and looking at DRC, Mali and Chad. Along with an ICM international midwife advisor there are three regional advisers. The 2009 programme was formally launched in March in Ghana. The challenge with positioning a CMAs within the UNFPA structure - they are junior officers, sometimes their voices are not heard.
Findings from **global** interviews	The ICM/UNFPA programme implementation had to take into account the global concern to accelerate the progress towards the achievement of the MDGs and the reduction of the maternal mortality rates as well as the ICM mandate i. e. education, regulation and association. The collaboration between ICM and UNFPA has started in 2008 and has actually started with the drafting of AWP based on the 3 years Letter of Understanding and the recruitment of the recruitment one International Midwifery Advisor (IMA) and 2 Regional Midwifery Advisors. They are based in Accra and provide technical support to the CMAs, including network implementation, knowledge sharing, and evidence-based training for the CMAs. The RMA report to the IMA who in turn reports to the ICM Secretary General. It took a while for ICM and UNFPA to work together as it was the first time for both organizations to have such partnership. Initially the contact with

[136] UNFPA staff interview
[137] UNFPA interviews
[138] Interviews with IPs, UNFPA, document review

	UNFPA was through Vincent Fauveau and later Geeta Lal for guidance, trouble shooting. Following the merging of MHTF and the Midwife programme there were more contacts with Yves. One of the first roles of the team was to establish working relationship with the CMAs (already hired by UNFPA country office) as well as proper communication channel. There are accountability and reporting issues as the CMA reports to their UNFPA National Programme Officer and the RMA report to ICM structure. The country reporting had to go from country office to Headquarters and then back to the IMA what led to delays. On the other hand it is important to have the same voice while talking to partners (government, donors…) The main issues in countries are the acute shortage of midwives, their recruitment and retention and education. Sometimes the midwife definition is not appropriate and the knowledge of competencies is not right. ICM has revised competencies and global standards for midwifery in education and regulation. They are being disseminated but they need to be brought to the workplace. However the work of strengthening educators` capacity has just started in some countries. This requires for the advisors to go to country. Workshops were organized at regional level to make CMA aware of standards, existing tools and competencies. ICM has broaden its partnerships i.e. JIEPHGO, FIGO, PMNCH, White Ribbon Alliance, SC as well as with research associations (e. g. African research associations) in inviting them to workshops. In 2010 the ICM/UNFPA/MHTF collaboration started in Asia Pacific with posting one RMA in New Delhi.

7.3 Evaluation question 3: To what extent has the MHTF contributed towards scaling-up and increased access and use of family planning?

Findings from desk study
Background Among the factors underlying high maternal mortality and morbidity are very low access to and uptake of family planning and emergency obstetric care. Among MHTF supported countries high levels of unmet need for family planning is an issue of concern. The MHTF seeks to focus on the most effective interventions to reduce maternal mortality and morbidity including family planning. Together with the Global Programme on Reproductive Health Commodity Security and core funds, it thus intended to contribute to strengthening family planning scaling up (Business plan - Output 5), also by supporting a conducive policy environment, service delivery and demand creation. Family planning needs assessments were meant to help identifying the main bottlenecks to address in order to improve greater access to and use of family planning services, as input for evidence-based programming[139]. For instance the MHTF helped Benin to finalize sexual and reproductive health policies to reposition family planning. In its efforts to address demand creation for Family Planning MHTF provides support for strengthening communication and community mobilization for creating demand for Family planning through supporting the design of communication and mobilization strategies, mass media communication and advocacy campaigns[140]. **Gaps** Family planning is usually part of the guidelines or training modules developed for maternal health and MHTF supports family planning training for health care providers. However, the available documentation did not clearly document how priorities and needs are included in the planning process and whether they are accompanied by efforts to create enabling environments that will allow health care providers to apply their newly acquired skills (e.g. necessary equipment and supply to provide services, supportive supervision, and support from health managers). • Promoting the utilization of family planning is insufficient unless their service delivery is so that they are within reach for remote populations. In some countries MHTF has supported the community based distribution for family planning services or has promoted alternative family planning distribution channels. This support is limited to particular geographical areas and the MHTF contribution needs to be assessed within the context of all the interventions that take place in countries (judgment criterion.3.1). • Although positive outcomes are illustrated, the extent to which the communication and community mobilization strategies are based upon an understanding of the various barriers is not always apparent in the available documentation particularly as far as vulnerable groups are concerned and there is a lack of information on whether the appropriateness of approaches is systematically assessed. On the other hand targeting men for communication interventions is rarely mentioned whereas their key role is increasingly recognized (JC3.2). MHTF support complements the UNFPA and sometimes the development partners sexual and reproductive health plans. All the above interventions have the potential to contribute to scale up quality family planning services although measuring the MHTF contribution in particular is difficult within a combination of interventions. While there is no doubt on the complementarities between GPRHCS and MHTF the division of responsibilities is not obvious and may be confusing for the different partners, their perceptions may be assessed in countries.

[139] According to the MHTF annual report 2010, needs assessments were undertaken in Benin, Burkina Faso, Mali and Senegal.

[140] Burkina Faso reports that communications around family planning included showing films, followed by community discussions and the sensitization of local leaders.(Burkina Faso Joint Annual Report 2009) Subsequently, contraceptive prevalence rose from 26.6 percent in 2009 to 30.1 percent in 2010 (Annual Health Statistics) MHTF Annual Report 2010

7.3.1 Judgment criterion 3.1: Creation of enabling environment to facilitate scale-up of quality family planning services in priority countries through MHTF support

Type of analysis	Findings
Findings from case study in **Burkina Faso**	Le MHTF n'a appuyé aucune action spécifique en relation avec la planification familiale car cette composante du programme SR est appuyée par le programme global de sécurisation des produits de la SR (GPRHCS). Cette orientation est tout à fait logique dans la mesure où le Burkina est un pays tream 1' qui bénéficie d'un soutien important de l'UNFPA en matière de planification familiale. Néanmoins des éléments de planification familiale ont été inclus dans l'évaluation SONU ce qui a permis d'obtenir des informations additionnelles. Des formations en planification familiale sont intégrées dans les curricula des formations de base des sages-femmes et à ce titre ont fait l'objet des révisions appuyées techniquement et financièrement par le MHTF. Les différentes composantes planification familiale sont harmonisées dans tous les outils produits par les ENSP pour les formations de base et la DSME pour les formations continues[141].
Findings from case study in **Cambodia**	*Because the MHTF has so far only been present in Cambodia in the form of partial support to the UNFPA Midwifery Programme, the conduct of the National EmONC Assessment and the implementation of the EmONC Improvement Plan, the range and number of activities to improve access to family planning services financed with MHTF funds have been limited.* Until 2009, Family Planning activities were supported by UNFPA core funds and by other partners such as USAID, DFID, Options/IPAS, contraceptive security by KfW and UNFPA and social marketing by PSI, all of whom have helped create an enabling environment. However, the revision of existing family planning policies and guidelines to ensure availability of family planning services in referral hospitals and facilities providing abortion services had been planned under MHTF support but was replaced by DFID through Options/IPAS. In 2009, GPRHCS procured contraceptive commodities to support the introduction of the rod implant as a new contraceptive method and 4,500 sets of sub-dermal implants were ordered. Support to contraceptive CBD Programme is discussed under judgment criteria 3.2.
Findings from case study in **Ethiopia**	The joint 2009 and 2010 Annual Reports for the MHTF and the Global Programme to Enhance Reproductive Health Commodity Security clearly differentiated between sources of funding: either MHTF or GPRHCS[142]. The MHTF only indirectly (through the pooled MDG fund) supported any family planning related activities, mostly procurement and training on Implanon[143].
Findings from case study in **Ghana**	*In Ghana MHTF support is used predominantly for fistula, midwifery/SBA and since late 2010 also for national EmONC needs assessment, anything related to making pregnancy safer. UNFPA Ghana has the Reproductive Health Commodities Security Fund and so far there has been no need to use MHTF resources for contraceptives. Nevertheless these two Trust Funds work closely together in support of Road Map for family planning*. One critical bottleneck initially identified by the MHTF Inception Mission to Ghana and in more detail by the MHTF Needs Assessment and Gap Analysis was the shortage of supply of contraceptives in a Stream Two country like Ghana and poor quality of integrated family planning services[144]. The 2011 National EmONC Assessment included a section on family planning services due to MHTF

[141] Entretiens avec les partenaires d'exécution
[142] 2009: Expenditure report for activities against thematic trust funds, Ethiopia 2010 Joint Annual report for MHTF_RHCS
[143] MDG pool fund annual report 2009/2010
[144] MHTF Annual Report, 2009

	intervention.[145] Country Midwife Officers are expected to provide equal support to all components of MHTF support to reproductive health programming. The general impression was that Ghana CMA support was more focused by design on midwifery education, regulation, association building and EmONC needs assessment than family planning[146]. Global Fund is providing male and female condoms. Ministry has in 2011 developed a new Reproductive Health Commodities Security Strategy that goes beyond contraceptives. It was noted that the Ministry has been influenced by the MHTF to broaden reproductive health commodities to include contraceptives, maternal health kits, products and medicines. It was noted that often contraceptives are not delivered along with other health supplies and equipment, so commodity arrangements are not really working well in terms of family planning.[147]
Findings from case study in **Lao PDR**	The GPRHCS funds all family planning activities in Lao PDR which is a stream 1country so no specific activities are funded under MHTF. Family planning counseling is part of ANC/PNC training and MHTF funded technical assistance is involved in Family Planning related discussions as part of the whole reproductive health component.
Findings from case study in **Madagascar**	*The MHTF and the GPRHCS both are rather new funds for Madagascar and started within a year of each other (2008, 2009). This seems to facilitate joint planning and implementation on country office level, even if the reporting still requires differentiation, especially on financial issues. The MHTF supports family planning mainly through awareness and sensitization campaigns, jointly with other fund and partners.* In Madagascar the MHTF is mainly focused on EmONC and supports family planning related activities mostly through technical assistance and joint awareness campaigns during various cultural events, days or weeks for health. The health promotion through community health workers is a national strategy. Because of geographical remoteness, poverty, analphabetism in many rural zones, community agents are considered the best way to inform the populations about family planning and other health related information. Messages on reproductive health issues are broadcast by national and regional television stations and the population of the six UNFPA supported regions have benefited from the activities on Behavior Change. The MHTF supports training of community workers to enable them to mobilize the targeted groups (pregnant women, adolescents, women in reproductive age, etc.) to utilize health services and family planning. Through outreach activities the implementing partners monitor technical and administrative skills of the community health workers and – in case of family planning- keep track of demand and utilization, which feeds back into the CHANNEL system. Whilst the GPRHCS[148] funds commodities (including for the equipping of the supported EmONC facilities) and training on logistics, capacity building on family planning[149] – and recently more so on long acting ones - is provided, at times jointly, by both trust funds.[150] Even the humanitarian fund joined in to develop one-week training for its implementing partners on all reproductive health issues, including family planning, EmONC, GBV, etc. Similarly, capacity building interventions are monitored jointly with the implementing

[145] Interview with Government
146 Interview with UNFPA staff
147 Interview with Government
148 The GPRHCS was launched in Madagascar in 2008 as a stream 1 country.
149 See evaluation question 6 MHTE
150 The 2009 and 2010 available versions of the annual reports (see Annex) list products and principle activities per fund, followed by a joint text. Financial reporting is again per fund. The joint 2010 AWP for MHTF and GPRHCS clearly differentiates between sources of funding: either the MHTF or the GPRHCS and at times 'UNFPA' or 'regular sources' are mentioned as source of funding for MHTF reported activities. For example' the Evaluation de la Politique de gratuité des Services de Santé Maternelle et de Planification Familiale 2010' was funded by the 'fonds reguliers' and not by the MHTF, though the implementation was done by the MHTF. Also, the training on Implanon is funded by the GPRHCS and reported as activity by the MHTF.

	partners and the regional health administrations.
Findings from case study in **Sudan**	*Not applicable - MHTF funds had not been used to finance family planning support in Sudan.*
Findings from case study in **Zambia** (3rd Submission)	*Due to the fact that the MHTF has so far only been present in Zambia in the form of the UNFPA-ICM Midwifery Programme, the range and number of activities to improve access to family planning services financed with MHTF funds has been limited. MHTF funds have been used in particular to complement the trainings of midwifery tutors with lessons on family planning.* MHTF resources have been used to finance two in-service trainings of midwives in North-Western Province and to support training of midwifery tutors in family planning and other disciplines[151]. The idea of an MHTF-supported "Midwifery Tutor Programme"[152] was the result of an intensive cooperation of the MHTF-funded Country Midwife Advisor (CMA) and Country Fistula Advisor (CFA), a group of development partners and Zambia General Nursing Council, among others[153]. The group had been working on revising midwifery and nursing training curricula, and on introducing a "direct entry" midwifery training programme. The Midwifery Tutor Programme was conceived to allow appropriate follow-up tutoring of the graduates during their first 6 to 10 months "on the job", to ensure that they were able to correctly apply their newly acquired skills, including their family planning skills. The closer and more intensive involvement of the CMA and CFA in this effort has allowed UNFPA to make a more visible contribution to shaping this initiative and will enable UNFPA to follow-up more closely on its progress during the first few years of operation[154].
Findings from **regional level interview**	There is a feeling that UNFPA country offices still work in ilo' and the different reproductive health programmes are not integrated enough whereas at health facility level health workers and midwives have to integrate all the components, (EmONC, family planning, obstetric fistula, PMTCT). UNFPA is now supporting family planning through the GPRHCS which is too much focused on commodity security and the services are not strengthened enough. The fact of having two separate funds prevents the integration of the 3 pillars for maternal health (family planning, EmONC, skilled birth attendance) and staff remains attached to their own programme. At country level funds should not be separate and only global reporting could show differences.

[151] I.e., EmONC, PMTCT, Gender, FGM/C; in 2011, UNFPA had budgeted US$35,000 from MHTF sources for this purpose.

[152] That also contained a training component on family planning

[153] Midwifery activities have been done jointly with JHPIEGO and the Clinton Health Access Initiative (CHAI) under the umbrella of GNC und MoH Nursing Unit. UNFPA provided Technical Assistance (technical assistance) for Five Year Midwifery Curriculum Review, training materials and course syllables. Family planning issues are integrated into the pre-service curriculum and have undergone various reviews.

[154] As mentioned elsewhere, the representative of a development partner who had been closely involved in the review of the midwifery curriculum and the other activities with the GNC appreciated the hands-on, practical experience that UNFPA could bring to this intervention.

7.3.2 Judgment criterion 3.2: Demand increased for family planning services in MHTF priority countries, particularly among the vulnerable groups through MHTF support.

Type of analysis	Findings
Findings from case study in **Burkina Faso**	Le MHTF n'a appuyé aucune action spécifique en relation avec la planification familiale car cette composante du programme SR est appuyée par le programme global de sécurisation des produits de la SR (GPRHCS). Cette orientation est tout à fait logique dans la mesure où le Burkina est un pays tream 1' qui bénéficie d'un soutien important de l'UNFPA en matière de planification familiale. Néanmoins des éléments de planification familiale ont été inclus dans l'évaluation SONU ce qui a permis d'obtenir des informations additionnelles. Des formations en planification familiale sont intégrées dans les curricula des formations de base des sages-femmes et à ce titre ont fait l'objet des révisions appuyées techniquement et financièrement par le MHTF. Les différentes composantes planification familiale sont harmonisées dans tous les outils produits par les ENSP pour les formations de base et la DSME pour les formations continues[155].
Findings from case study in **Cambodia**	*MHTF supported the peer review of the evaluation of the Contraceptive Community Based Distribution Programme, with a view to inform and expand future programming in rural/remote areas and keep up the maternal health support to the poor and disadvantaged. The recommendations of the review have been integrated by relevant NGOs but have not been followed through or scaled up by UNFPA Cambodia.* In 2010, MHTF supported an international consultant to facilitate a workshop for the peer review of the evaluation findings of the Contraceptive CBD Programme. The evaluation was jointly financed by UNFPA and USAID. The findings and recommendations of the peer review were disseminated in October 2010, with the participation of national and international partners and national and sub-national health personnel. The review of the CBD programme was thought to be of critical importance to inform future directions of the programme to expand the service and increase family planning utilization and acceptance by women in rural/remote areas. To date, there has been no formal response from the Government to the CBD evaluation recommendations and integration into the Fast Track Road Map[156]. NGOs who work in CBD programming have integrated much of the recommendations, with great success.[157]
Findings from case study in **Ghana**	*Except for the one national launch of CARMMA in 2009, which was supported by the MHTF, regional launches were supported by core funds. MHTF has in 2011 provided support to the first Annual Family Planning Week that is to be continued by MoH.* CARMMA was launched with MHTF in 2009 and from that UNFPA Ghana developed a new concept of building district awareness and response to maternal health which the First Lady is spearheading. The first Annual National Family Planning Week in 2011 was also supported by MHTF and the Ministry has committed to hold the celebration to coincide with World Contraception Day on 26th September and for it be launched in all regions. Society for Women and AIDS in Africa (Ghana) gets support from the two Trust Funds to facilitate community based distribution agents at large markets and bars in the Central and Northern Region. Agents receive supplies from GPRHCS, while MHTF provides material correct usage education for both male and female condoms. There are ongoing discussions for replication in other regions[158].
Findings from case	See also judgment criterion 3.1

[155] Entretiens avec les partenaires d'exécution
[156] UNFPA Cambodia
[157] NGO Partner and External Development Partner
[158] Interview with CSO

study in **Lao PDR**	
Findings from case study in **Madagascar**	See also judgment criterion 3.1

7.4 Evaluation question 4: To what extent has the MHTF contributed towards scaling up and utilization of EmONC services in priority countries?

Findings from desk study
Background At country level the MHTF supported EmONC needs and gaps assessments include reviews of services and needs in human resources for health and provide the foundation for effective programming. Examples of responses based upon the bottlenecks identified during the needs or gaps assessment can be found in Madagascar where a new emergency obstetric and newborn care training programme was adopted and in Ethiopia that moved towards task shifting with the support of development partners. As needs assessment were the initial step, MHTF supported countries have not all reached the point of programming. A strong focus of national capacity building is to advocate for, introduce and institutionalize maternal death audits, which help pinpoint context specific factors in mortality and to addressee them with a more specific focus. In different countries updating EmONC curricula and supporting training of trainers and of health care providers were initiated to support scaling up EmONC services[159]. The MHTF intends to support guidelines definitions and develop supervision capacity and mechanisms as to ensure quality. Utilization and access depends largely on appropriate geographical distribution and culturally adapted services. In order to adapt services information regarding the barriers to utilization of services needs to be explored. **Gaps** • Although illustrated by few examples the ownership of programme country governments regarding the results of the needs assessments (including maternal death audits) and the responses to address the identified issues are not described clearly in the documents. As long term responses are needed, it needs to be explored whether mechanisms are in place for programme countries to sustain identified responses (judgment criterion 4.1). • Support to EmONC training can either be addressed to trainers or to health care workers, but how strategically was EmONC training support designed in specific contexts remains to be assessed particularly to respond to the needs in remote areas (judgment criterion 4.1). • Although support to strengthen quality in some programme countries could be identified in the existing documents it is unclear whether mechanisms to institutionalize quality assurance are in place and whether programme countries develop the necessary ownership of the proposed tools. • Needs assessments focus upon services and do not always explore the barriers to EmONC service utilization and it is unclear whether countries (MoH) have sufficient evidence and are committed and take action for equitable distribution and to increase demand through MHTF support (JC4.2).

[159] e.g. in Benin (AWP) and Burkina Faso (BF Joint Annual Report 2009)

7.4.1 Judgment criterion 4.1: Creation of enabling environment that facilitates scale-up of EmONC services through MHTF support

Type of analysis	Findings
Findings from case study in **Burkina Faso**	*Depuis son lancement le MHTF a contribué à la planification et à l'amélioration de l'extension des services SONU, d'une part en initiant et en appuyant la réalisation de l'évaluation des besoins en SONU et en appuyant la mise à jour des modules de formation en SONU et le renforcement des capacités de certains prestataires comme contribution à la prestation de services SONU de qualité.* Comme indiqué ci-dessus, l'UNFPA, en collaboration avec les autres partenaires du H4+, a apporté un soutien financier et technique (par le biais du MHTF) à la réalisation d'une étude nationale exhaustive des besoins en SONU qui a débuté en 2009 après une longue préparation et concertation avec les partenaires et a été finalisée en 2010. L'Institut de Recherche en Sciences de la Santé (IRSS) a mis en œuvre cette étude avec le support technique de l'AMDD. Les résultats de ladite étude servent actuellement de référence pour la planification de l'amélioration des services en SONU et leur couverture à tous les niveaux. La première étape a été une dissémination des résultats au niveau de chaque région avec le soutien du MHTF. L'évaluation SONU est très appréciée et le gouvernement s'est approprié son exécution ainsi que les résultats obtenus et le processus de planification basée sur les résultats est enclenché aux niveaux: national, régional et district.[160]. Le MHTF a soutenu la DSME pour standardiser le processus de formation en SONU en adaptant un module national de formation en SONU pour les attachés de santé en gynécologie et obstétrique le module de formation sur les audits des décès maternels et un guide intégrée de supervision en SONU, planification familiale, PTME. L'appui à la formation de base des sages-femmes et à la formation continue SONU, en complément de l'évaluation SONU, permet l'extension de la couverture de services SONU de qualité. Ces interventions ont fourni des bases sur lesquelles le Ministère de la Santé peut s'appuyer pour mettre en œuvre l'extension des services SONU à condition qu'il reçoive un accompagnement approprié[161].
Findings from case study in **Cambodia**	*Like the National EmONC Assessment, the EmONC Improvement Plan will remain an MHTF initiative for UNFPA Cambodia regardless of different funding sources. MHTF has contributed to the implementation of the EmONC Improvement Plan by supporting the MoH EmONC Coordination Team and by supporting the Master Training component of the Improvement Plan (discussed in judgment criteria 2.1).* The EmONC Improvement Plan is implemented simultaneously at national and provincial level as an ongoing process. The National Mother and Newborn Child Health Centre is responsible for the execution of the Improvement Plan and the National Reproductive Health Programme (NRHP) is responsible for overall management and coordination. EmONC focal points have been established and are part of the referral system[162]. The EmONC assessment worked closely with the Human Resource Department of the MoH and MHTF implementation was timely as discussions "*could be held on upgrading young and enthusiastic primary midwives into secondary midwives*[163]". In 2010, an EmONC Unit was established with a national coordinator, four technical staff and two support staff appointed to the Unit. This team is responsible for monitoring and supervision in accordance with the Ministry of Health (MoH) guidelines. The Unit is closely

[160] Entretiens avec les partenaires d'exécution, les partenaires gouvernementaux et les partenaires techniques et financiers.
[161] Entretien avec les partenaires gouvernementaux et l'équipe UNFPA
[162] External Development Partner
[163] Government Partner

	supported by a full-time UNFPA National Programme Officer for Maternal Health (known as the EmONC Officer, but also responsible for midwifery) and employed with MHTF funds. For 2010 only, two more staff were hired by MHTF, based on task allocation (National programme officer (NPO) midwifery and EmONC Midwifery Skills Enhancement Coordinator), to support trainings included in the Improvement Plan. In 2011, MHTF continued to fund the EmONC Officer (solely devoted to the Improvement Plan) and the EmONC Midwifery Skills Enhancement Coordinator, who supports the integration process of the two flagship programmes. "*This has allowed MHTF resources to be used more for activities than salary".*[164] The planned recruitment of a National Technical Assistant to support the NRHP in building the capacity of EmONC data collection and monitoring was not successful, despite two rounds of recruitment. "*The MoH /NRHP decided to stop recruitment and instead identified a civil servant responsible for this work from amongst the new staff recently recruited to work with the Midwifery Programme"*[165]*.* In 2009 and 2010, MHTF supported the first National Maternal Health Symposiums on EmONC services quality to disseminate guidelines and technical updates with 400 health professionals. It was a useful forum for experts and health professionals to share experiences and learn about the EmONC assessment, Improvement Plan, the Master Training for midwives and doctors, new EmONC guidelines and technical updates.
Findings from case study in **Ethiopia**	*The MHTF has taken up the SIDA funded midwifery programme and supports the capacity development of NCPs and nurse anesthetists, two new cadres evolved from the task-shifting initiative. Activities broadly support the initial set up, but have not sufficiently focused on the time after deployment, legal regulation; quality assurance and retention strategies have not been addressed fully.* Based on the experience from a tracer project in Tigray, UNFPA has been engaged since 2007 in supporting the development of a three years training for non-physician-clinicians (Health officers) master degree in Integrated Emergency Obstetric and Surgery (IEOS)[166]. It is an innovative programme developed by the Ministry of Health and Education (MoH/ MoE) supported by UNFPA as part of a national Human Resource Strategy to alleviate shortage of skilled human resource particularly in rural areas by employing a 'Task Shifting' approach for Emergency Obstetric Care. It is co-funded by MHTF and the Global Programme on Reproductive Health Commodities (GPRHCS). In addition, due to the active advocacy and involvement of ECO on the development of the International Health Partnership+ process in Ethiopia, the master programme for health officers was considered as one of the eligible fundable intervention under the MDG Performance pool fund opening up an opportunity for national scale up and resource mobilization for training institution capacity building. Activities funded include training of trainers, preceptors, Non-Physician Clinicians, study tours, conferences, and vehicles for students transport, equipment for clinics and training centers, review of curricula, development of curricula. The MHTF (through SIDA funds) also supports capacity development of nurse anesthetists to enable comprehensive EmONC facilities to function. The MHTF targets identified gaps in resources, staffing and training, whilst retention policies and equitable distribution of health facilities and newly trained staff does not seem to be sufficiently addressed. Quality control mechanisms for emergency surgical officers and nurse anesthetists appear to be under development, but no clear visible plan yet exists for how mentoring, case consultation, quality assurance for skills, supplies, operating theatre functionality, decision making will be provided. Hence, major gaps for the safe employment of the NPCs seem to be important to be addressed (eventually by the MHTF) in the nearest future:

[164] UNFPA Cambodia
[165] Government Partner
[166] The first batch of trainees has been admitted in January 2008. The trainees are expected to serve at a primary hospital serving 100,000 people mostly addressing the needs of rural poor women and their families.

	• the lack of legal provisions, defining the new cadres and their job descriptions, and • the process of supervision and follow-up after the deployment to ensure clinical competence
Findings from case study in **Ghana**	*MHTF has advocated for, helped to design and financially supported the National EmONC Needs Assessment, supported MoH/GHS inputs and based on findings is expected to include education, facility upgrades, equipment, and training of health providers in the Improvement Plan.* There has been support for basic EmONC services in both CP4 (2001-2005) and CP5 (2006-2010). The initial imperative for doing comprehensive EmONC Needs Assessment was provided by the MHTF inception mission in 2009 which had also included a review of emergency obstetrics and the state of neo-natal care. The mapping exercise carried out by H4 in 25 countries including Ghana was an important advocacy to get MoH on board. The National EmONC Needs Assessment was meant to start in early 2010 but did not and was completed in late 2011 due to delays caused by the census collection and the busy schedule of Ghana Statistical Service. UNFPA Ghana, UNICEF and WHO pooled funds and AMDD provided the technical support resourced by MHTF[167]. At the time of this evaluation, fact sheets on the initial finding was being circulated while the report was still being finalized for submission during the National Health Summit in November 2011 so that it could be included in the Aide Memoire. The Needs Assessment findings will complement the development of the EmONC Improvement Plan in 2012. Equipment being provided by the MHTF for EmONC services includes aspirators, ambulance bags, weighing scales, mannequins for fistula repair training, blood pressure equipment, MVA equipment for post abortion complications, labor beds/couches, labor equipment, and blood bank fridges. Funds are also used for minor facility refurbishments[168]. MHTF supports two-week in-service Life Saving Skills trainings for both public and private sector midwives in several regions including rural and remote areas. The certification provides authorization to administer the core set of interventions which included 7 basic EmONC functions. Through the MHTF supported midwifery curriculum, students since 2009 are introduced to "Intervening in Emergency Situations" and receive additional training on how to take necessary action during pregnancy, labor, and delivery and after birth[169].
Findings from case study in **Lao PDR**	*MHTF has contributed to an enabling environment that is conducive to EmONC up-scaling in different ways, ranging from supporting SBA training to undertaking the EmONC assessment and supporting the development of an improvement plan that will provide clear directions and define priorities for the different partners. Supportive supervision and follow up of newly trained personnel once back in health facilities has not been addressed so far.* As part of its support to the SBA plan (see Evaluation question 2) MHTF contributes to strengthen the capacity of the training institutions (through building teachers' capacity and equipment supply). It also supports the training of community midwives, the SBA training (3 modules) as well as clinical training of hospital EmONC teams (physicians, medical assistants and nurses). MHTF has provided technical support to strengthen the Department of Organization and Personnel (DOP) to supervise the SBA training institutions with a view to follow up on the quality of training. Unfortunately there is no provision for supervision and follow up of the newly graduates once they return in their health facility as it is the responsibility of the national MCH Centre. The objectives of the EmONC assessment funded by MHTF were to determine the availability, utilization and quality of EmONC services, to identify gaps in service delivery, to identify interventions for the reduction of maternal and newborn mortality. It is the basis for preparing a strategic EmONC improvement plan for phased upgrading of EmONC facilities in line with the MNCH Package.

[167] Interview with External Development Partners
[168] Interview with Regional Training Centre
[169] Interview with Regional Health Directorate staff

Findings from case study in **Madagascar**	*The political priorities in the health sector provide an enabling environment for the scale up of EmONC services through the MHTF. The MHTF supported EmONC survey provided a strong incentive for the MoH to focus on midwifery education, but without the financial and technical support of the MHTF, the MoH could not have expanded and harmonized the midwifery training. The sustainability beyond the MHTF in terms of adequate supply of commodities for the newly trained staff is not yet obvious and depends to a great extent on the political context and the ability of the MHTF to solicit sustainable resources. Maternal death audits are being institutionalized by the MHTF thus introducing a quality control mechanism on clinical and community level.* The MHTF supported a new round of EMONC training[170], because a MoH-led evaluation of EmONC training (in 2009) revealed that it had been too long, inefficient, requiring a long absence from the workplace, and a placement in a hospital for practice[171]. The MHTF supported the MoH to develop a new training curriculum to upgrade skills of midwives, based on the use of mannequins for practice, rather than placement in a hospital. The MHTF also supported the development of the graduate midwife training programme which includes EmONC. All newly graduated midwives[172] will have had a module of EmONC, also with practical sessions on mannequins. The MHTF purchased training equipment and supplies of consumables for all BEmONC and CEmONC facilities targeted in the national operational plan.[173] Quality control mechanisms, supported by the MHTF, are two-fold: • the development of a monitoring tool for supportive supervision • training of technical supervisors (ongoing, and observed during the mission) The district health administrations are tasked to monitor facilities bi-annually, but this does not include technical skills supervision, which will be included as soon as the training on the new tool has been finalized. Furthermore, ten protocols for the management of obstetric complications have been developed and distributed to two thousand health facilities and six paramedical training institutes[174]. A major new approach for quality assurance in Madagascar is supported by the MHTF: The Ministry of Health began a process to institutionalize the maternal death audit. A National Audit Committee for maternal deaths has been established and developed tools for the audit in health facilities. In 2010, the audit of maternal death was introduced in nine referral hospitals (4 university hospitals, 2 regional hospitals and two district hospitals). As less than 50 percent of deliveries take place with skilled birth attendance, and less than 10 percent in a health facility offering at least BEmONC[175], the importance of community inclusion is well recognized by the MHTF which supported the establishment of four sentinel sites for monitoring maternal deaths in the community through verbal autopsy. Ten trainers were trained in audit of maternal death and 60 community stakeholders (community workers, community leaders) were trained in verbal autopsy.[176]
Findings from case study in **Sudan**	*MHTF funds have been used to complement core funding of EmONC support projects, including repair of obstetric fistula. No additional initiatives were launched that were linked exclusively to the MHTF.*

[170] The first round had been implemented in 2005
[171] Interview with GP
[172] Annually 140 midwives graduate from the public institution, 3000 midwives exist country wide
[173] The MHTF supported with about 10 percent the 'Regular funds' in the acquisition, but developed the distribution plan.
[174] In several clinical sites the mission was able to validate this.
[175] Annual Report 2010
[176] The rationale behind this lies in the traditional societal norms in Madagascar, whereby decision makers for all family or community members are the head of the household or the community leader.

	As in other technical areas, MHTF funds have been used to complement financing with UNFPA core funds to support EmONC projects that pre-date the launch of MHTF in Sudan. This includes the prevention and management of obstetric fistula, and supports development of Obstetric Fistula repair capacity through training of physicians and construction of operating theatres and wards[177]. Also with regard to supporting the MoH to maintain its commitment to EmONC, MHTF funds were used as complementary funding to finance relevant country office activities, such as the costing of the maternal health Road Map, with its component on EmONC services. No specific projects on identifying barriers to EmONC had been financed with MHTF funds[178]. The country office has used MHTF to support obstetric fistula campaigns in Khartoum, Kassala state and Nyala, Darfur. Campaigns include community mobilization to find women in need of repair, training of physicians and refurbishing or building of centers[179]. No fistula prevention activities were funded with MHTF resources[180].
Findings from case study in **Zambia** (3rd Submission)	*As the MHTF to date had been present in Zambia only in the form of the UNFPA-ICM Midwifery Programme, the issue of EmONC has only been addressed in the context of the general review of Zambia nursing and midwifery training curricula that had received technical support from the MHTF-funded CMA and CFA. In addition, MHTF has also funded a number of fistula-related activities.* MHTF funds were used to finance the integration of EmONC into the nursing and midwifery curriculum. For more details, please see Evaluation Question 2 on MHTF support for human resources for health. Through the MHTF, UNFPA also supported the fistula repair programme of the Zambian Government that started around 2005; and had been supported by UNFPA already prior to the launch of the MHTF in Zambia[181]. MHTF-funds have been used to produce a documentary on fistula repair[182], to finance "outreach fistula repair camps"[183], and to conduct supportive visits to satellite sites to assess fistula integration in Gynecology clinics in Luapula and Northern Provinces. The funds have also been used for the sensitization of Health Care Providers on fistula and its prevention.
Findings from **interviews on regional** level	The Africa Regional Office seeks to support the Institutionalization of maternal death reviews as an organizational priority in the region; and set up a working group to provide technical advisory support to countries (members from country offices with experience in maternal death reviews)[184]

[177] Review of AWPs, other documents, interviews with UNFPA

[178] Apart from a planned project to undertake operational research on the "Obstetric Fistula caseload in the three national obstetric fistula centers and five tertiary hospitals" (planned for 2011, but not yet implemented at the time of the evaluation)

[179] Interviews with IPs in focal states, UNFPA; document review

[180] Challenges that UNFPA was faced with in the training of health staff on EmONC was the turnover of staff and outmigration of physicians who previously had been trained by UNFPA.

[181] UNFPA, through the Campaign to End Fistula, picked up the support of the Zambian fistula programme in 2005, after Zambian stakeholders had initiated a number of fistula repair campaigns without external support.

[182] During the visit of the evaluation team to Zambia, the team (by chance) witnessed the broadcast of a UNFPA-financed documentary on fistula repair twice; on Zambian national television; documentary followed the cases of fistula patients, interviewed patients at fistula repair camps and interviewed doctors. The UNFPA Country Representative concluded the programme with a closing statement on UNFPA Fistula support.

[183] E.g., in 2010, UNFPA had budgeted US$30,000 of MHTF money to finance three outreach fistula repair camps, by financing "medical equipment and supplies for a hosting hospital, snacks, fuel to and from ferrying clients, overtime allowance for staff teams and food for clients" (UNFPA Zambia, 2010).

[184] Africa Region-wide Knowledge-Sharing and Capacity-Building for Sexual and Reproductive Health, including HIV Prevention Johannesburg, South Africa. 9-14 November, 2009.

7.4.2 Judgment criterion 4.2: Utilization and access of EmONC services improved through MHTF support

Type of analysis	Findings
Findings from case study in **Burkina Faso**	*Le soutien à la mise en œuvre de l'approche IFC dans certains districts avec l'appui du MHTF présente un potentiel certain pour une mobilisation accrue des communautés pour la santé maternelle. Cependant sa mise en place requiert un suivi régulier et un engagement sur la durée.* Le MHTF soutient des actions complémentaires pour identifier et lever les obstacles à l'accès aux SONU à travers la mise en œuvre de l'approche IFC (Travailler avec les Individus, Familles et Communautés) qui permet une planification participative des actions communautaires en faveur de la santé maternelle telle que la mise en place ou renforcement de cellules villageoises des urgences qui assistent les familles à la préparation à l'accouchement et aux complications tout en organisant des systèmes de transport communautaires au cas où une évacuation est nécessaire. Ce type de mécanismes est d'un grand intérêt dans des zones rurales ou l'isolation des communautés rend l'accès aux services de santé difficile. Au moment de l'évaluation l'approche IFC avait été pilotée dans certains districts et montrait un potentiel important pour mobiliser les communautés pour la santé maternelle de façon intégrée dans les plans du district à la condition qu'elle soit accompagnée d'un suivi régulier, tout au moins au début de sa mise en œuvre. Elle agit de façon synergique avec les interventions de sensibilisation sur l'accouchement assisté mis en œuvre à travers plusieurs supports de communication- (radio, télévision, théâtre forum, causeries de groupe et individuelles, affiches) du plan stratégique de communication en SR développé et mis en œuvre avec le support de l'UNFPA.
Findings from case study in **Cambodia**	*UNFPA/AusAid and MHTF provided support to the EmONC Improvement Plan, ensuring that both supply and demand side inputs are equally reflected. Utilization and access has been provided to some extent by MHTF early support to Equity Fund for Maternal Health, MoH-approved guidelines for the establishment and operating of Maternity Waiting Homes and the support for the operation and functioning of maternity homes (see judgment criteria 1.3). Currently, these initiatives are very limited and will require scaling up to increase effectiveness.* The EmONC Improvement Plan provides MHTF an opportunity to create an enabling environment to help UNFPA fast track and sustain the reduction of maternal and newborn mortality and morbidity in Cambodia, towards the achievement of the MDGs 4 (reduce child mortality) and five (improve maternal health). The purpose of the 5-year Improvement Plan (2010-2015) is to improve coverage and utilization of quality EmONC and services and skilled care, particularly among the poor and vulnerable. This purpose aligns well with MHTF objective of facilitating equitable access to key reproductive and maternal health services for the poor[185]. The expected results are improved minimum standards, access, skills, utilization, referrals, and PHD/DHD plans and links to communities. Strengthening links to community is related to improved linkages through Health Centre Management Committee and Commune Councils, upgrading referral support and providing transport schemes as well as strengthening the TBA Midwifery alliance. MHTF link to community remains weak, as the focus is overwhelmingly on EmONC trainings for midwives, doctors and CMC/CMA[186]. The EmONC Improvement Plan has been adopted by the Fast Track Road Map, but there are indications that implementation is slowing down and many point to the lack of incentives for the higher-level health professionals to participate in trainings, lack of support to community groups and CBD[187].

[185] Cambodia EmONC Improvement Plan, MoH 2010-15
[186] Outcomes of the group discussion (Annex 6.5) suggest that access and utilization of health outlets by poor and uneducated community women (who still form a large part of the population) is limited; also based on information from NGO Partner
[187] UNFPA Cambodia and NGO Partner

Findings from case study in **Ethiopia**	*Utilization and access to health services is thought to happen automatically with well-resourced facilities, but the MHTF may decide to conduct operational research on barriers other than quality services; this OR may be linked to the deployment of new cadres.* In 2008 the FMOH and partners (UNFPA, UNICEF and WHO, AMDD) embarked on a large emergency obstetric and newborn care (EmONC) facility-based survey that canvassed all hospitals and health centers in the government and non-governmental sectors. The purpose of this large initiative was to inform Health Sector Development Programme (HSDP) -IV and provide evidence for guiding policy and planning to strengthen the health system using emergency obstetric and newborn care as a point of entry. In 2009 the MHTF supported a results dissemination conference and agreement by all partners was reached to upgrade nationwide EmONC facility. The MHTF, the FMoH and Development Partners implied that with well-resourced health centers patients will follow[188]. However, as main further barriers identified are distance, unfriendliness of staff and costs, the MHTF may consider supporting operational research on barriers to access and utilization, which can be linked to the deployment of the first batch of the new cadres.
Findings from case study in **Ghana**	*The EmONC needs assessment was initially planned for 2010 but carried out in 2011 and it assessed a total of 1,158 facilities doing deliveries.* Funds allocated for EmONC needs assessment were under-utilized in 2010, (until July it was zero but there were requests pending) and the bulk carried over to 2011. Criteria for facilities to be included in the assessment were a minimum of 5 deliveries per month, but in 3 northern regions at least 1 birth per month. The assessment looked at skills and training needs, staff strength, equipment, infrastructure and family planning services. Assessed facilities included teaching hospitals, regional hospitals, district hospitals, health centers, family planning centers and CHPS. Due to delay of the National EmONC Report, fact sheets and checklist for initial improvement have been circulated to facilities. One of the biggest achievements of MHTF was to influence Ghana Health Service to broaden reproductive health commodities, including oxytocin and magnesium sulphate in every CHPS, MVA equipment and other essential EmONC supplies in those facilities where lack of supplies was noted as critical in the assessment[189]. No services quality control mechanisms appear to have been established for EmONC as the needs assessments had yet to be finalized a the time of this evaluation.
Findings from case study in **Lao PDR**	*Although MHTF is not directly involved in improving utilization of EmONC services besides the part it plays in improving service quality, it concurs to addressing barriers though advocacy work done as regards to midwives incentives and free delivery for poor women. However besides the cost of accessing services it does not take the other barriers into consideration.* The barriers to EmONC services have been explored and are known to a certain extent. UNFPA support, more specifically, has allowed to explore the barriers to EmONC access through the 'Working with Individuals, Families and Communities' (IFC) approach and put in district MNCH plans (Luxemburg funding) as well as through the PEER Study in some provinces. The EmONC assessment explored the services aspects but did not look into barriers. In the assessment report it is acknowledged that there was not enough information to elucidate why women had or had not used EmONC services'[190]. Conducting the EmONC assessment could have provided an opportunity to investigate further the factors hindering the access to EmONC services as perceived by the communities. MHTF funds are not used to support communication or social mobilization activities. One of the barriers already identified to the access of EmONC services is the cost incurred to travel to the health facilities and all the other additional costs. The government wishes to

188 Information from development and government partners
189 Interview with Regional Health Directorate
190 Emergency Obstetric and Newborn Care Needs Assessment in 12 Selected Provinces, Final Report - University of Health Sciences, Faculty of Post-Graduate Studies and National Institute of Public Health - 2011 - Lao People Democratic Republic

	establish free skilled attendance at birth for poor women and UNFPA/MHTF was involved during the national level discussions. It also took part in the discussions regarding incentives for midwives in remote areas what contributes to improve access to services. The SBA modules based on the ICM competencies promote culturally sensitive work with communities. This definitely has the potential to improve health care providers' attitude and thus the motivation of the women to attend services. This aspect however is often over looked and it may require increased attention[191].
Findings from case study in **Madagascar**	*The MHTF expects increase in utilization of its supported EmONC services as some barriers are being addressed through its interventions. In those facilities where free services were provided the utilization had increased immediately, but it is too early to assess an impact on health indicators.* Barriers to EmONC services have been identified by most interviewees as poverty (no money for transport[192]), geographical remoteness, opposing traditions and cultural values. Linked to this is lack of education and analphabetism. UNFPA supported a Master Degree Research[193] which confirms this: The study examines the barriers to the use of health centers for delivery in rural communities, and the preference for Traditional birth attendants (TBAs) for delivery. [194] Some of the barriers are addressed by the MHTF, which supports social mobilization, sensibilization campaigns in communities and health facilities, and also targeted illiterate populations to inform about the danger signs in pregnancy that require medical attention and health facility care.. Free delivery kits for normal and C- Section delivery have immediately led to an increase of facility based deliveries, thus confirming the importance of the cost factor. BEmONC and CEmONC services will be provided in all 22 regions with the support of UNFPA/MHTF and other partners, especially in identified underserved areas. Demand is expected to rise with availability of quality services. As health seeking behavior in Madagascar does not primarily lead to visit a health facility[195], the MHTF supported sensitization campaigns seem highly important.
Findings from case study in **Sudan**	See 4.1
Findings from case study in **Zambia** (3rd Submission)	See 4.1

[191] MOH SBA Collaborating and Responsible Committees with technical assistance from UNFPA, WHO and JICA - SBA development plan, Lao PDR 2008 – 2012

[192] And even less so funds for the return of a corpse, if the patient died in hospital

[193] "Mécanismes d'attachement socioculturel a l'accouchement traditionnel dans la région de Vakinankavatra" in 2009/2010

[194] A total of 61 percent women delivered with the assistance of TBAs while 39 percent delivered in a health center. TBAs advise their clients to visit the health center at least once during their pregnancy. The cost of delivery by the traditional birth attendant is 2-4 times higher than the cost in a public health center. The TBAs reported that the major reasons for not going to the health centers for delivery are: fear of injection, fear of episiotomy, fear of curettage or a C-section that will prevent the women from working for many days and would be extremely costly. In addition, some women do not like to be delivered by male health workers. Another reason is to deal with the negative attitude of the health workers who are mistreating them, and poverty, marginality, traditional life routine. Also, the health workers are often absent and sometimes the Centre is closed.

[195] The top reason is the fact that illness is not considered to be serious. (Household Survey 2005, INSTAT)

7.5 Evaluation question 5: To what extent has the MHTF contributed to improve planning, programming and monitoring to ensure that maternal and reproductive health are priority areas in programme countries?

Findings from desk study
Background Three outputs of the MHTF business plan (Output 1, 3, 6) are oriented towards improving planning, programming and monitoring as to ensure that sexual and reproductive health and maternal health are priority areas in programme countries. As a first and necessary step, national level advocacy strategies are developed in order to raise sexual and reproductive health and maternal health agenda and to encourage governments to take increasing action to address maternal health issues. As a result some countries are in the process of including sexual and reproductive health/maternal health in Poverty Reduction Strategies and other national policies. The evidence brought about through needs assessments supported by the MHTF can be the basis for advocacy and for elaborating reproductive health/maternal health policies, strategies and plans if the findings are widely disseminated and if the elaboration process is facilitated with the full involvement of the various stakeholders. Posting technical advisors is meant to push the sexual and reproductive health/maternal health agenda and to take part in facilitating the elaboration sexual and reproductive health/maternal health strategies and plans and coordinating their implementation. Fulfilling such a role requires sound technical guidance and recognition among the various partners. Increased governments' commitment for sexual and reproductive health and maternal health is usually translated by dedicated budget lines for sexual and reproductive health/maternal health and increased budget shares for sexual and reproductive health/maternal health. It is expected that advocacy activities and elaboration of policies, strategies and plans will foster national commitments for sexual and reproductive health/maternal health. Whether this expected effect has occurred will have to be assessed in programme countries. The MHTF supports MoH to cost their sexual and reproductive health/maternal health plans, in particular the midwifery component what facilitates and supports the elaboration of resource mobilization strategies in some countries. Supported countries have reached different planning and budgeting stages that will have to be assessed in the field. Monitoring and evaluation support for following the progress in order to strengthen sexual and reproductive health/maternal health programming is provided such as advocacy to integrate international sexual and reproductive health/maternal health indicators in HMIS developing and monitoring and evaluation plans with a particular focus on maternal death audits as mentioned above. **Gaps** • As a result of advocacy efforts, the extent to which MHTF support has been instrumental in ensuring that sexual and reproductive health/maternal health issues are integrated in national policies remains to be clarified in countries that will be visited during the field phase. • Setting up sexual and reproductive health inter-ministerial committees to address maternal mortality issues have the potential to contribute towards improving maternal health through involving various sectors. However, if they are functional and that different sectors can coordinate actions remains a challenge. • For stakeholders it is required to adhere to national orientations and coordinate the implementation of developed plans, dissemination of the developed policies, strategies and regulations and strong and functional coordination mechanisms under government leadership. Whether these conditions are in place will be explored during the field phase (judgment criterion 5.1). • The available information does not allow assessing whether necessary conditions such as capacity building for costing and budgeting national plans are in place (judgment criterion 5.2). • The various efforts described above can be sustained if appropriate tools are in place and if national teams` M&E capacity is built along the process. The

extent to which national counterparts have the capacity to measure progress and base programming on results will have to be assessed further (judgment criterion 5.3).

7.5.1 Judgment criterion 5.1: Improved positioning of maternal and reproductive health in national strategies and policies through MHTF support

Type of analysis	Findings
Findings from case study in **Burkina Faso**	*L'UNFPA a toujours été un acteur clé dans le dialogue concernant les politiques et stratégies nationales dans le domaine de la santé de la reproduction. L'appui du MHTF à certains axes prioritaires a pu accroître leur visibilité et donc leur positionnement.* Tous les documents nationaux d'orientation politique tels la feuille de route pour l'accélération de la réduction de la mortalité maternelle, le plan national de développement sanitaire (PNDS)[196] et la stratégie de croissance accélérée et de développement durable (SCADD) intègrent la planification familiale, l'intégration du VIH dans les services de SR, l'assistance qualifiée a l'accouchement et les soins obstétricaux d'urgence comme interventions de très grande priorité (avant le MHTF). Le plan d'accélération pour la réduction de la mortalité maternelle et néonatale et infanto-juvénile a été revu avec l'appui du MHTF en 2010. Récemment l'UNFPA a contribué à l'évaluation du PNDS 2001-2010, et à la revue du secteur de la santé dont un des thèmes spécifiques était l'état des lieux en matière de santé maternelle et infantile et à l'élaboration d'un document de plaidoyer et présentation de ce document en, conseil des ministres pour la gratuité des services de santé maternelle et la planification familiale. Bien que l'équipe SR du bureau pays ait toujours participé au dialogue avec le gouvernement en matière de SR, l'introduction du MHTF a pu accentuer son influence en précisant ses priorités[197].
Findings from case study in **Cambodia**	*MHTF has a synergistic effect when combined with UNFPA Cambodia strategic position in donor coordination mechanisms, such as Health Sector Support Programme II, active participation in Health Strategic Plan and the Fast Track Initiative on Reducing Maternal and Newborn Mortality.* MHTF has supported a high-level international advocacy conference (Women Deliver) and the SGs Joint Plan of Action. These two initiatives have allowed UNFPA to show its commitment to maternal health and youth with its advocacy points and increasing public awareness of maternal health. In late 2010, UNFPA recruited the First Lady to be the national advocate and champion for maternal health. [198]. There are three coordination bodies, which provide a framework for MHTF project portfolio and "*new ideas for maternal health activities are most welcome*"[199]: • The MoH second Health Strategic Plan (HSP 2008-2015) identified reproductive health, maternal, newborn and child health (RMNCH) as top priority, and the second Health Sector Support Programme (HSSP 2006-10), which is jointly funded by seven development partners, including UNFPA, has also aligned its priorities with HSP II, placing RMNCH as the top priority for support. • UNFPA is a member of Technical Working Group (TWG) for Health; lead on TWG sub – group for Maternal Health and

[196] Ministère de la santé : Plan national de développement sanitaire; Tranche 2006-2010; Mars 2007
[197] Entretien avec les partenaires gouvernementaux et l'équipe UNFPA
[198] External Development Partner
[199] UNFPA Cambodia

	member of TWG Human Resource for Health (HRH). • A Fast Track Initiative for RMNCH was proposed by MoH and accepted by the Government in order to improve access to quality reproductive health/maternal health services and to reinforce quality improvement at referral hospitals and health centers. The UNFPA country office is a member of the MNCH Task Force.
Findings from case study in **Ethiopia**	*The MHTF has successfully supported/is supporting initiatives that fed into health policies and strategies; it has the capacity to increase this potential through providing evidence (operational research) on the impact of its interventions* Technical assistance has been provided by the MHTF in the elaboration of the HSDP IV, including by ensuring that the results of the EmONC assessment were available for each district. Also, the human resources projections for midwives were revised based on work MHTF technical assistance. The MHTF enhanced ongoing initiatives concerning the HRH strategy and especially provided support to the master degree programme for NPCs and the midwifery education, including support to the midwifery associations. Important advocacy mechanisms that have influenced the human resources planning in Ethiopia (and in other participating countries[200]), was the MHTF supported Task Shifting Conference in 2009, which has underscored the need for capacity development using novel approaches and the above mentioned work on Midwifery. (see MHTF Evaluation question 4)
Findings from case study in **Ghana**	*MHTF utilizes the Sector Working Groups to align its three critical areas of programming namely in midwifery training, comprehensive fistula treatment and care and EmONC assessment findings. The national budget does not yet have specific budget lines for family planning, SBA and EmONC, but UNFPA Ghana with the help of MHTF is advocating for dedicated budget lines.* As noted above, MoH has also been influenced by MHTF to broaden reproductive health commodities and will develop action plans based on EmONC needs assessment findings. The bulk of the non-core funding to UNFPA Ghana comes from CS Luxemburg and from the UNFPA Trust Funds. However MHTF is a dedicated and earmarked funding that over the past two years has provided Ghana a little over half a million US$ (not including GPRHCS support).[201] UNFPA has been able to persuade MoH/GHS to assign MHTF monies for specific activities, but if budget lines were in the national budget it would more likely guarantee sustainability and this is slowly happening as decentralization takes hold and regional support for services grows[202]. Ghana First Lady however is a strong advocate since 2011 for putting these line items in the district health budget. With the exception of SWAA (NGO), the bulk of the TTF (both maternal health and GPRHCS) is provided to GHS in Accra and GHS in five UNFPA programme regions. A very small amount goes to Ministry of Chieftaincy and Culture. Coordination takes place within the sector working groups. – refer to MHTE section for detail. Ghana has taken serious steps to lower the cost of health services and made EmONC services free of charge. During the costing of Ghana MDG Accelerated Framework to Reduce Maternal and Neonatal Mortality (MAF), UNFPA utilized the MHTF to bring a consultant to guide the country on how to do the costing. This costing model is currently used by GHS[203].
Findings from case study in **Lao PDR**	*MHTF has mainly contributed to raising the profile of midwives in Lao PDR with government officials and the National Assembly through its advocacy events and their media coverage. It initiated advocacy at provincial level as well. The technical expertise and financial support it provides has contributed to boost midwifery and EmONC services and helped in putting maternal health high in the MOH agenda.*

[200] Information from ECO
[201] Core and Non-Core Funding CP 4 and 5, UNFPA Ghana
[202] Intrerview with UNFPA staff
[203] Interview with External Development Partner

	MHTF supports advocacy events such as the Celebration of the International Day of the Midwife, graduation ceremonies of the community midwives helped in raising the awareness of the officials at all levels (including community representatives) on the role and function of the midwives and the benefits to be gained for seeking out skilled care in pregnancy and for childbirth. The SBA Coordinator in participating in the various Technical Working Groups and task forces related to the implementation of the MNCH package has provided a strong technical support, particularly in the human resource task force 2 that UNFPA leads. MHTF support to undertake the EmONC assessment has helped in ensuring that EmONC services are a priority at all levels i.e. national, provincial and districts.
Findings from case study in **Madagascar**	*The MHTF may not have added a specific role or function to UNFPA, that had not been provided before, but the resources of the MHTF (staff and funds for implementation) have been able to support the MoH in accelerating planning, programming and implementation of its reproductive health priorities.* The only really 'new' input from the MHTF was the sensitization on obstetric fistula[204], with the subsequent operation of about 100 women and the development of a reintegration programme together with ILO. Family planning and 'Maternité sans risque' are a national priority since 2005. EMONC has been trained long before the arrival of the MHTF, but not in a sustained manner. It can be argued that the MHTF fell on fertile ground in Madagascar and with the increased financial and technical input evidence was created and utilized to develop a more targeted approach to maternal health. The obstetric fistula operation is for example now integrated into the hospital services in at least one hospital in most regions and EmONC training modules – practical and theoretical- are part of the national curriculum of midwives. UNFPA is participating and /or leading in coordination mechanisms, whereby the MHTF officer is part of the technical working groups related to reproductive health and was especially involved in the H4+ group operational plan development[205]. The operational plan is considered by all partners (including the MoH) as the blueprint for the Malagasy commitment to MDG 4 and 5.
Findings from case study in **Sudan**	*At country level, the MHTF had only made a small contribution to an improved positioning of maternal and reproductive health in national strategies and policies. The only related activity was the preparation and implementation of the international day of the midwife.* The Maputo Plan of Action, one of the most prominent regional campaigns that has received support from MHTF globally and regionally, also has translated into the development of an maternal health Road Map in Sudan, albeit without MHTF funding at country level. After having sat idly for a few years, the draft Road Map was finished under the leadership of a UNFPA-funded technical assistant and is now available as a cost strategy[206]. Still, many open questions remain regarding the feasibility of raising the required funds[207]. Apart from that, the only advocacy event that was financed with MHTF funds was the International Day of the Midwife. Some other campaigns are being planned for the future[208].

[204] Obstetric fistula was initiated through a MHTF supported campaign followed by a survey, provision of supplies and education of surgeons

[205] H4+ partners include all donors (JICA, Ambassade de la France, USAID, CSOs etc.), it meets monthly and has prepared a 3 y costed operational plan, (till 2015), the document is also being used as an advocacy tool for resource mobilization. And more importantly as the basis for the development of the next MoH strategic national plan, even with expansion to other areas of the health sector.

[206] For more details, see Evaluation Questions 2 and 9 of the Maternal Health Thematic Evaluation

[207] See Evaluation Question 2 of the Maternal Health Thematic Evaluation for more details

[208] Review of documents and interviews with IPs, UNFPA

	The MoH intends to establish a coordination committee for midwifery; however at the time of the evaluation, this committee did not yet exist. UNFPA intends to support its formation, in part with MHTF resources[209].
Findings from case study in **Zambia** (3rd Submission)	*As the MHTF in Zambia has so far only supported midwifery, its contribution to the improved positioning of maternal and reproductive health in national policies and strategies so far was also limited to this thematic area. Most significant in this regard has been UNFPA MHTF funded cooperation with the Zambian General Nursing Council, which has led to the development of a National Nursing and Midwifery Strategic Plan.* With the General Nursing Council (GNC), the MHTF has aligned itself and is supporting the Zambian agency in charge of regulating training and education for nurses and midwives in the country. The GNC has led various reviews of training curricula (prior to MHTF and since its involvement has begun), has overseen a recent "Training Needs Assessment" for nurses and midwives, and also has led the development of a "National Nursing and Midwifery Strategic Plan". MHTF-financed UNFPA staff also has established close working relationships with the Nursing Unit of the Ministry of Health that has also been involved in the above initiatives.

7.5.2 Judgment criterion 5.2: National plans consider sustainable funding mechanisms for sexual and reproductive health/maternal health through MHTF support

Type of analysis	Findings
Findings from case study in **Burkina Faso**	*Bien que le MHTF ne soutienne pas directement le financement de santé maternelle sa contribution à la planification de l'amélioration des services SONU fournit une base d'information précise pour établir les coûts de ces services*. Des activités de soutien au costing de la feuille de route étaient planifiées en 2010 mais le ministère de la santé s'est approprié l'outil « *Marginal Budgeting for Bottlenecks* « (MBB) promu par les organismes du système des Nations Unies (l'UNICEF en particulier) pour une budgétisation basée sur l'évidence[210]. Les compétences des décideurs en charge de la planification au niveau central et décentralisé ont été renfoncées pour l'utilisation effective dudit outil qui a servi de référence pour la budgétisation du PNDS[211]. Cette activité n'a pas donc été réalisée avec le soutien du MHTF[212]. Le budget national contient des lignes budgétaires pour la SR (contraceptifs, subvention SONU…). Le montant alloué et décaissé pour ces lignes est régulièrement croissant. L'inscription de ces éléments dans la SCADD est un gage de durabilité de l'engagement du gouvernement. L'introduction du MHTF avec sa contribution à l'évaluation SONU dont les résultats servent d'arguments additionnels et aident à la micro-planification des services SONU basée sur l'évidence peut servir de base pour établir des coûts plus précis.
Findings from case study in **Cambodia**	*UNFPA Cambodia has well-developed funding mechanisms through HSSP II. So far, no MHTF support has been necessary to allow for systematic, sound costing and budgeting of reproductive health/maternal health, as this is handled by the agency itself.* UNFPA channels all its core resources for reproductive health through HSSP II. MHTF is non-core funding (non-pool) and is applied directly to activities. UNFPA has a programme-based approach, and its reproductive health/maternal health activities are considered

[209] Interview with UNFPA
[210] Entretiens avec les partenaires techniques et financiers
[211] Entretiens avec les partenaires gouvernementaux
[212] Entretien avec les partenaires gouvernementaux et les partenaires techniques et financiers.

	sustainable for the near future. National health budgets in Cambodia have dedicated budget lines for maternal health activities and midwifery programming and the EmONC Improvement Plan, as reflected in the budget of the National Reproductive Health Programme and Fast Track Initiative Road Map[213]. Due to its small size in comparison to the total budget, MHTF resources do not seek to replace any of the core funding or other resources of the country office. However, MHTF has been significant and helpful to cover gaps in some crucial activities, such as technical assistance, the implementation of EmONC and family planning commodity supplies (most of it GPRCHS).
Findings from case study in **Ethiopia**	*Currently the GoE is not able to sustainably finance its reproductive health programme; it relies on development partners and donors. The MHTF is one of them.* Systematic institutional development of managerial or administrative government staff is not a priority of the MHTF. Training institutions have been supported in the capacity to deliver training. A dedicated budget line in the FMoH exists for contraceptives' procurement, otherwise there are no distinct budget lines, rather the FMOH has a portfolio for Maternal/Newborn and adolescent health, or it can use emergency funds. Prospects for sustainability are low without further and continuous external support[214].
Findings from case study in **Ghana**	*See 5.1*
Findings from case study in **Lao PDR**	*It is anticipated that the EmONC improvement plan which currently being developed will provide a good basis for costing and budgeting the EmONC services improvement.* UNFPA has supported the costing and budgeting of the SBA plan and WHO the budgeting of the MNCH package. So far MHTF has not directly supported costing and budgeting of sexual and reproductive health / maternal health intervention packages but the EmONC improvement plan will provide the government with a good basis for costing its operationalization. So far no budget lines have been allocated for reproductive health and maternal health. Discussions are ongoing about the regulations and the costing of the free delivery policy but the modalities of government contribution are still unclear.
Findings from case study in **Madagascar**	*The political context hampers the development of plans for sustained funding, nevertheless the MHTF has been involved in preparing the costed operational plan for the MDG 4 and 5 goals for Madagascar, which has been accepted by all partners and is utilized as resource mobilization document.* The MoH relies on international funding for many of its activities; the health budget is considered insufficient, and its technical and managerial absorption capacity on national and regional level low. The MoH develops its annual work plan and proposes to the international community to participate and fund activities according to their respective mandates. The MHTF is not involved in financial or managerial skills building of MoH staff (the frequent re shuffling in the MoH is hindering sustained institutional development on managerial level)[215], but rather is supporting the training of the community health workers, health care staff and it supports their participation in national and international workshops. The training is predominantly technical and institutional capacities are developed through joint M&E missions, tools and protocols development and continuous technical assistance. National budgets include specific budget lines, for example family planning has a budget line, albeit the amount is marginal. The MHTF has addressed

[213] Government Partner
[214] Information from governmental partner
[215] For example the focal point for reproductive health has changed 5 times since 2009

	financial sustainability together with the other partners in developing the H4+ costed operational plan which will also be used as advocacy tool for resource mobilization.[216]
Findings from case study in **Sudan**	*MHTF funds have been used to help finance the costing of the maternal health Road Map at federal and state level.* As mentioned above, the MHTF has at least in part supported the costing of the MNR Road Map for Sudan. UNFPA has also supported a costing exercise in its five focal states. Costing support included sending MoH staff for costing training, recruitment of a consultant to support the costing in-country and to work with a team of national colleagues from five target states. These staff members from the MoH in the five focal states were also sent to a costing training outside of Sudan.
Findings from case study in **Zambia** (3rd Submission)	*MHTF support of the General Nursing Council has also helped to provide technical assistance for the development of a national strategic plan for nursing and midwifery, which has the potential for increasing harmonized cooperation of development partners of this sub-sector.* The MHTF has not provided any direct support to improve costing and budgeting of sexual and reproductive health / maternal health intervention packages. The most relevant MHTF supported initiative is the development of the National Nursing and Midwifery Strategic Plan (Technical Assistance, finances) that serves as the basis for training, deployment, etc. of nurses and midwives for 5 years (2009-2013) (see above). In addition, the two MHTF-funded officers (CMA and CFA) have been involved in national EmONC Technical Working Group (TWG), Safe Motherhood TWG and family planning TWGs, thus bolstering the organizational capacity of the UNFPA country office beyond the area of midwifery and fistula.

7.5.3 Judgment criterion 5.3: National and subnational health plans include clear monitoring and evaluation frameworks for family planning, skilled care in pregnancy and child birth, EmONC, obstetric fistula and reproductive health/ HIV linkages

Type of analysis	Findings
Findings from case study in **Burkina Faso**	*Le MHTF a contribué à l'intégration des indicateurs de SONU dans le SNIS ainsi qu'à établir une base de données de base recueillies au cours de l'évaluation des besoins en SONU qui peuvent être utilisées pour mesurer les progrès des services SONU.* Le MHTF a permis de plaider l'intégration des indicateurs de SONU dans le SNIS ainsi que principaux indicateurs de suivi de la santé maternelle qui seront utilisés pour le suivi régulier des progrès. Par contre, des indicateurs de suivi du nouveau-né tel que la mortalité néonatale ne sont pas inclus dans le SNIS ainsi que des indicateurs permettant d'apprécier la qualité des services[217]. Le MHTF s'arrête à la définition des indicateurs mais n'intervient pas dans l'amélioration du suivi dans son ensemble. Par contre grâce au MHTF l'enquête SONU a permis d'obtenir des données de base des niveaux de services SONU qui pourront être utilisées pour mesurer les progrès[218].
Findings from case study in **Cambodia**	*Key internationally agreed reproductive health/maternal health indicators are integrated into the HMIS in Cambodia. MHTF in Cambodia follows the MHTF Business Plan indicators and the Annual Progress Report publishes country indicators as reflected in CDHS 2010 and MoH (HMIS) for 2009 and 2010, as evidence of UNFPA contribution. There is growing interest within MoH on the qualitative indicators of*

[216] Interview with H4+ partners
[217] Entretien avec les partenaires gouvernementaux et les partenaires techniques et financiers.
[218] Entretiens avec l'équipe UNFPA

	the MHTF Business Plan. At the level of operational districts, UNFPA relies on annual tracking by the Health Information System (HIS) for all the major indicators, as reflected in the Basic and Comprehensive Package of Activities[219]. The reproductive health/maternal health national indicators like MMR, CMR, IMR, TFR and CPR are followed via the DHS (Cambodia has had three surveys). The indicators from the MHTF Business Plan have been shared with the National Maternal Newborn Child Health Centre (NMNCHC) when UNFPA was preparing the 2009 Progress Report and during Fast Track Road Map discussions. There are qualitative indicators that MoH has shown an interest to include in its own reporting.*"*[220] Monitoring and supervision of the implementation of EmONC activities and facilities is carried out by EmONC Co-ordination Team of the NMCHC, with the support of the MHTF funded National Programme Officer for Maternal Health (EmONC Officer). The Improvement Plan and its log-frame form the basis for monitoring and evaluation of EmONC activities.
Findings from case study in **Ethiopia**	The MHTF resources are seen as supplemental to what the ECO does with its resources, it follows the annual work plan within the overall annual planning of UNFPA, the UNDAF and the umbrella for the health sector: the Health Sector Development Programme, now HSDP4, under which all strategies including the reproductive health strategies operate. The national reproductive health/maternal health indicators are aligned with the MDG indicators. There are no frameworks that can be attributed to the MHTF.
Findings from case study in **Ghana**	*In 2009 and 2010 MHTF in Ghana identified several areas for improving monitoring and evaluation as a critical step to improve care using a variety of quality assurance mechanism in comprehensive emergency obstetric and neo-natal facilities, fistula support and human resources (midwives) the provision.* The finding of the MHTF midwifery needs assessment and gap analysis has helped develop a data base of all practicing and non-practicing midwives, according to location and their age distribution. It has been utilized and upgraded to help Ghana Health Service (GHS) to plan and monitor recruitment, placement and deployment. MHTF has supported GHS to review the falling standards of service provision by midwives and nurses. A strategic plan and monitoring tool has been developed with the support of the Nursing and Midwifery Council to address standards and the dissemination of the comprehensive code of ethics. After two full years of operation MHTF has contributed to Ghanaian midwives benefitting from systems for compulsory supportive supervision[221]. With West African Health Organization (WAHO) and MHTF support, GHS has selected 16 retired midwives who were previously tutors, gave them a week training on how to monitor, follow up and report. These midwives go into field and monitor trained midwives who are posted to maternity homes and GHS facilities in all 10 regions. They are used for family planning monitoring. The 16 midwives will in 2011 monitor around 600 new midwives according to the bi-annual monitoring plan. The midwives can each choose a region where they will be comfortable to monitor (language), older women, there will be back up for each one and will receive support from other regional GHS staff[222]. Findings of the poor state of reporting by the MHTF needs assessment and gap analysis was catalytic in Ghana GHS upgrading the mandatory notification and surveillance of maternal deaths. The MHTF has also supported a multi-sectoral M&E plan to monitor the new, expanded Reproductive Health Commodities Security strategy starting in 2011 (developed with input from NPC and NGOs/CSOs).
Findings from case	*MHTF funds have been used for developing tools for Maternal and Perinatal Death Review and for piloting them in 5 provinces. It is*

[219] MHTF Progress Report 2009, 2010
[220] UNFPA Cambodia
[221] Interview with ICM Project Office Accra
[222] Interview with External Development Partner

study in **Lao PDR**	*expected that the EmONC assessment will be used as a baseline for monitoring EmONC services provision. Both types of support have the potential to improve monitoring for maternal health provided systems are in place and government monitoring and analysis capacity is strengthened.* The MNCH package indicators had been defined prior to MHTF, joint efforts focus upon revising these indicators (see MHTE part). Monitoring is mainly based on the HMIS which is weak due to weak capacity and lack of motivation at the health facility level. Several development partners work to strengthen the information system. The EmONC needs assessment will be providing baseline data upon which future intervention to improve EmONC services could be monitored. With a view to help addressing the lack of reliable data about maternal deaths UNFPA (through MHTF) and WHO have supported training and the development of tools for Maternal and Perinatal Death Review in 5 pilot provinces. After reviewing the tools they will be introduced in other provinces.
Findings from case study in **Madagascar**	*National and sub-national health plans that have been developed with the support of the MHTF (i.e. the national and regional micro-plans to implement EmONC) include relevant and internationally agreed indicators*[223]*, as well as the monitoring and evaluation frameworks for each implementing partner*[224]*. The development of M&E plans and mechanisms are part of the annual work plan meetings whereby the MOH and partners elaborate the action plan based on priorities, identified needs and results of previous interventions.*

[223] MoH: Plan Operationnel de Mise en Œuvre des Recommendations des Besoins en SONU 2010-2012
[224] Interview with IP

7.6 Evaluation question 6: To what extent have the MHTF management mechanisms and internal coordination processes at all levels (global, regional and countries) contributed to the overall performance of the MHTF in fulfilling its mission?

Findings from desk study
Background The joint reproductive health thematic funds Interdivisional Working Group (RHTF – IDWG) established at global level provides a good exchange and collaboration between the reproductive health thematic funds. It appears that the IDWG decision making processes has been affected by gaps in documentation but also insufficient analysis of the existing documents[225]. Joint planning (joint AWP) and joint reporting at country level as well as regional level joint planning meetings for all the reproductive health thematic funds can be expected to certainly enhance the coherence of all the interventions even if funded by different sources. It appears that some countries prepared coherent annual plans based on MOH MNCH policies and strategies (each output contributes to MNCH strategy expected results) and some countries joined separate plans into one with little overall coherence. The MHTF has rapidly expanded and faces therefore challenges such as: administrative systems (delay in disbursements), human resources (insufficient country office staff with relevant capacity e.g. to respond programmatically to societal and political diverse environments within one country). The MHTF at global and regional level has set up different mechanisms to provide technical support to country offices as shown above. These inputs contribute to raise the technical profile of country offices for improved technical assistance to their national counterparts. They also contribute to improve the MHTF management in countries. A high demand for technical support was also expressed by county offices. MHTF management emphasizes the importance of regular financial monitoring for ensuring accountability and has set up mechanisms to strengthen this important aspect. However the mechanisms developed for a regular follow up are not clear in the reviewed documents. **Gaps** • Complementarities in resource allocation between the different funds can only be facilitated though transparent mechanisms and the existing documentation did not allow to exploring this mechanisms. Further study will allow to clarifying the allocation processes and mechanisms. • The extent to which COs joint planning ensures overall coherence and synergies between the different funds needs to be assessed in light of the country level planning process (judgment criterion 6.1). • Despite MHTF efforts to supporting country offices there is still a high demand for technical support and the extent to which MHTF respond to country office specific needs remains to be assessed (JC6.2). • Considering that financial accountability is a growing concern with increasing donors' pressure, this is an area that needs to be explored in the field phase (JC6.3).

[225] Oversight Assessment of the UNFPA Thematic Trust Funds(TTF) – DOS - March 2010

7.6.1 Judgment criterion 6.1: Coordination of the MHTF contribution within the overall UNFPA support to maternal health

Type of analysis	Findings
Findings from case study in **Madagascar**	*The MHTF on global level has provided relevant support to the country office and facilitated learning experience through regular reviews and feed backs. The reporting format of the MHTF loosely follows the MHTF results framework.* The MHTF is closely monitored by HQ, which provides tools, formats and close supervision of the planning and implementation processes with feedback and counter-feedback procedures. The MHTF annual work plan is reviewed[226] and then approved by HQ and the country office. The AWP of the MHTF is developed within the framework of the country office and the national priorities. Obstetric fistula and midwifery activities are included[227]. The GPRHCS [228] produces an annual work plan and there exists also the country annual work plan.[229] The three different AWP do not demonstrate a clear and obvious cohesion of the programmes, for example their products/outputs differ[230]. Annual reports are similarly structured, there exists an overall country office annual report (sent to the RO), and a MHTF and a GPRHCS report. This joint annual report has been in 2009 more or less just a collation of two reports and did not reflect the close collaboration that is actually happening on country level. In the annual report 2010 more cohesive reporting seems to have been achieved. The regional office has not been engaged in the management or technical issues. Technical assistance from the HQ was reported as important, timely and good.[231] Financial, monitoring and evaluation processes of the MHTF follow the country office standards[232]. The annual work plan does not follow the MHTF results framework, whilst the outputs and activities are in line with it.
Findings from **interviews regional** level	ROs support more at policy and advocacy level in the region. The SROs are supposed to provide technical support and follow up as well as oversight to raise country office awareness on what needs to be done on new guidelines or orientations. In regional offices there is no MHTF funded staff and the staff responsible for reproductive health and maternal health (Technical Adviser reproductive health/maternal health) is responsible for the MHTF follow up. Two positions were recruited in 2011 with MHTF funds I.e. a consultant for obstetric fistula in Johannesburg regional office and one maternal health advisor in the sub-regional offices in Dakar. Funds were allocated for two reproductive health/maternal health advisors (1 for SRO/Johannesburg and one at SRO/Dakar) to be recruited in the last quarter of 2010 but the recruitment all the new positions are put on hold. ICM advisors are part of the sexual and reproductive health team in the African region. Sometimes consultants are hired from regional rosters but the quality varies. In 2009 a leadership and management training was organized for reproductive health and maternal health advisors. Initially RO was not

226 PTA Review 2010, Cas de Madagascar
227 PTA 2010 FTSM UNFPA FINAL
228 PTA 2010 GPRHCS
229 PTA 2010 Joint MHTF GPRHCS Regular Programme
230 For example: MHTF: Produit 1: Planning Familial. Accès à la contraception facilité, en particulier pour les méthodes de longue durée, dans toutes les institutions de prestation de services de santé maternelle du pays (visites pré et post natales)/ GPRHCS : Produit 1: Approches intégrées de la SPSR améliorées à tous les niveaux dans le pays (mettre l'accent sur les liens avec les programmes et politiques sur la SR, y compris le VIH / sida) and CO Plan Produit 1: La population, particulièrement les groupes vulnérables, ont accès et utilisent les services de qualité en santé de la reproduction et planification familiale.
231 Interview of UNFPA staff
232 Interview of UNFPA staff

	involved much. In 2010 sub-regional advisors from ARO attended an Orientation meeting on what the MHTF was all about – including on all its components (midwifery, etc.). They are requested to monitor what is happening in the countries and to review the annual work plans, and to coordinate it with HQ. But this coordination has not been as effective as it should be. There has been a lot of direct communication between HQ and the country offices and missions have been undertaken by headquarters rather than the SRO. Most is decided by HQ and SRO only get instructions – countries are overburdened and should not have different systems. In HQ there are different staff members for the different components but at SRO or country office only one person to respond. If there is a mission we are not involved and do not get timely information. GPRHCS work through Regional offices but not MHTF[233].
Findings from **Global** level	The reproductive health Inter-divisional group under the Director of Technical Division does not meet enough. The MHTF reports to the sexual and reproductive health Branch Chief[234].

7.6.2 Judgment criterion 6.2: Instruments and mechanisms developed by the MHTF to strengthen country offices capacities to manage the fund at global and regional level

Type of analysis	*Findings*
Findings from case study in **Burkina Faso**	*Le soutien apporté à l'équipe du Burkina Faso grâce au MHTF est considéré comme utile que ce soit au niveau régional comme au niveau global. L'échange entre pays est aussi considéré comme enrichissant.* L'utilité de différents types de support pourvu par le MHTF est reconnue par les équipes pays. Par exemple l'appui de l'AMDD (bien que difficile à mobiliser) pour la méthodologie et mise en œuvre de l'évaluation SONU a été utile ainsi que les outils proposés[235]. La revue des modules SONU s'est fait en partenariat avec l'AMDD et JPHIEGO. Le programme sage-femme reçoit un soutien régulier en commençant par la première réunion ICM à Accra (Ghana) qui a permis d'orienter les conseillères sage-femme. Les conseillères ont des rencontres organisées 2 fois par an au niveau régional avec le soutien du MHTF. Elles reçoivent régulièrement le support de la sage-femme conseillère régionale ICM. Une évaluation multi pays des écoles de bases a été encadrée par un consultant à la suite d'un atelier tenu à Dakar pour développer la méthodologie et les outils. L'échange entre les conseillères sage femmes des pays francophones lors des ateliers régionaux de même que par courrier électronique est un support précieux. Le soutien du siège est aussi apprécié pour sa rapidité de réponse et sa flexibilité. La planification et le rapportage conjoint des fonds de SR sont appréciés bien que la gestion des différents fonds reste verticale (cf. la question d'évaluation N°7).
Findings from case study in **Cambodia**	*Analysis of UNFPA Cambodia Annual Work Programme shows that MHTF project portfolio is closely linked to Country Programme III reproductive health Outputs and planned activities reflect what was requested by MoH, based on their 2009 and 2010 Annual Operational Plans (AOP). MHTF has introduced and defined 4 areas of its operations; thus contributing to better integration and deeper synergy by supporting the review and upgrading of the National reproductive and sexual health Strategy.* The final proposal for MHTF was prepared by the country office with close support from Asia Pacific Regional Office and UNFPA HQ. The country office now reports directly to Headquarters, which accelerates responses on both sides[236]. MHTF activities are part of

[233] Interview with Regional and sub-regional offices and review of RO/SRO AWPs
[234] UNFPA interview at global level and documents reviews
[235] Entretiens avec l'équipe UNFPA

	national and regional meetings to review Annual Work Programmes and receive feedback from HQ. All of this has ensured MHTF requirements are well integrated and strengthens the capacities of the country office.
Findings from case study in **Ethiopia**	*The MHTF on global level has provided relevant support to the country office and facilitated learning experience through regular reviews and feed backs. The reporting format of the MHTF loosely follows the MHTF results framework.* The MHTF is closely monitored by HQ, which provides tools, formats and close supervision of the planning and implementation processes with feedback and counter-feedback procedures. Planning and monitoring processes followed the country office standards and similarly to the H4 and the MDG fund, a joint annual work plan with a monitoring framework is developed[237]. Reporting is within the COAR and additionally a joint report for the thematic funds (midwifery activities are included) is annually produced. The format is rather narrative and not similar to the COAR format, and not consistent in 2009 and 2010[238]. Tools, advice and editing of reports are provided from the TD. Tools for the midwifery programme are provided on regional level[239]. The actual activities implemented in Ethiopia by the CMA corresponded directly to the guidance given to MHTF country staff during this inception forum as "activities that should be completed by June 2009. In regards of South-South technical assistance cooperation, the MHTF supported Task Shifting Conference in 2009, provided a forum for other African countries to exchange experiences and lessons learnt.
Findings from case study in **Ghana**	*While MHTF Ghana is a separate funding stream, planning, programming, budgeting and reporting is conducted in close conjunction with country office and MHTF HQ support. The separation of Francophone and Anglophone countries for the purpose providing group technical assistance was considered a good idea but this should not prohibit the flow of information between the two groups.* MHTF has provided UNFPA Ghana with a Country Midwife Advisor (CMA) who has been trained on effective work planning, monitoring and reporting and took part in the mid-term review of the country Midwifery Programme. The CMA who is based in the UNFPA office works closely with MoH/GHS, however the latter would like to have the position based in their office but no room has been provided as yet[240]. The CMA is part of the reproductive health team in the country office and reports to the reproductive health specialist[241]. MHTF Ghana is closely co-ordinated by the MHTF Coordinator at HQ who steers the programme strategically with the help of two senior Maternal Health Advisors and an M&E Officer. The ICM project office is based in Accra and has a Regional Midwifery Advisor placed

[236] UNFPA Cambodia

237 'reproductive health is a comprehensive strategy. At CO level we try to harmonize and integrate our key interventions. For example the Trust funds and global programme we plan together, and try also to implement activities together. Same districts, same sites. ' Information from the ECO

238 2009: Output1. Service delivery and systems development strengthening efforts; Output 2. Advocacy to strengthen policy, political support and leadership for Greater commitment of national and regional political, religious and cultural leaders for RHCS and Family Planning as a priority issues

2010: Output 1: National responses to the human resource crisis in maternal health, with a focus on planning and increasing the number of midwives and other mid-level provider; Output 2: Leveraging of additional resources for MDG 5 from governments and donors

239 Four members of the Ethiopia Midwives Association and the International Country Midwifery Advisor participated in the global inception forum in Ghana in March 2009 where MHTF staff from the global and regional level laid out the vision of the MHTF; and helped to review the annual work plans for the UNFPA/ICM Midwifery programme. This included the "preparation of the International Midwives Day, the "Capacity needs assessment in seven midwife training institutions and the EMA", etc. Apart from this initial forum and two subsequent visits by the Regional Coordination Mechanism Advisor (RCMA), additional support in terms of tools and advice has been provided by headquarters and the regional office. Tools from the ICM are available on the internet and deemed very useful.

240 Interview with Government and UNFPA

241 UNFPA Ghana, Organogram 2010

	within it. MHTF HQ has provided MHTF Ghana support in proposal development, inception report, needs assessment and gap analysis for midwifery, introduction of ICM tools and competencies and technical support for EmONC National Assessment[242]. UNFPA Ghana has benefited from a variety of regional workshops supported by MHTF in conjunction with ICM namely the Inception Forum for CMA and Capacity Building, the Mid-year Progress Review and Technical Capacity Building, the WHO regional meeting and the Core Steering and Programme Management Group Meeting. West African Health Organization (WAHO) and MHTF Ghana are working closely with heads of National Health Information Systems about routine tracking of maternal health indicators, utilization of retired midwives and general monitoring of maternal health services including family planning. Other South–South collaborations under MHTF include a regional meeting in Senegal for information exchange between MHTF and RHCSF[243] MHTF Ghana hosted a variety of country teams to learn about different topics: for example MoH Eritrea came to Ghana to observe the fistula repair hospital, its management and linkage with the setting up of rehabilitation and re-integration of clients; the Ethiopian Midwifery Association came to learn about regulations, standards and codes. MHTF Ghana has faced language barrier with Francophone countries which can create challenges, especially for the exchange of technical information during meetings and separate meetings are easier to handle. However translations of reports could be exchanged so that the two groups can still learn from each other[244].
Findings from case study in **Lao PDR**	*The funding of the International SBA Coordinator position helped in strengthening the country office not only to manage the fund but also the other reproductive health components. The support provided by the headquarters is considered useful however the lack of harmonization of the tools between the different funds is seen as burden.* MHTF has allowed strengthening the country office capacities through funding the SBA Coordinator position. In Lao PDR technical advisors are absolutely needed on the long term to guide the country office staff who sometimes lacks the sufficient capacity to provide technical assistance to counterparts and to coordinate the programme implementation (e.g. task force 2). Particularly since regional level technical support is felt to be limited. The country office team found the joint planning process useful and valued the feedback on joint plans received from the headquarters and the peers. Even though the tools provided for the headquarters were appreciated by the country office staff, it was noted that they are not always harmonized between all the reproductive health funds what added on the burden of country office staff[245]. The MHTF Business Plan is perceived as being too prescriptive and more constraining than giving directions[246]. The MHTF AWP implementation has been delayed because the work plan was only approved in April and the Ministry of Health did start planning activities prior to funds approval.
Findings from case study in **Madagascar**	See judgment criterion 6.1
Findings from case study in **Sudan**	*Apart from providing funds for an additional staff position, i.e. the ICMA, the MHTF has not helped to strengthen the capacity of UNFPA country office in Sudan. Moreover, the reporting requirements and conditions attached to MHTF resources have placed an additional administrative burden on country office staff that exceeds the administrative burden that would have been associated with the same*

242 MHTF Annual Report 2009
243 Interview with UNFPA
244 Interview with UNFPA
245 Idem
246 UNFPA staff interview

	amount of core funds. Up to the date of the evaluation, the country office had made little use of planning tools provided by MHTF at global level, at least in part, because MHTF funds so far had been merely used to co-finance projects that had been planned as normal part of the annual planning process of the country office, independently of MHTF[247]. Since the launch of the MHTF, the country office has supported a number of events to foster South-South cooperation. For example, the MHTF-funded visit of the ICMA to South Sudan has the potential to contribute to drafting a successful proposal for using UN Volunteers as midwifery tutors in Sudan. The ICMA was able to observe the operations of UNV midwives in South Sudan and to learn lessons for her own funding proposal[248]. Most of these events have occurred relatively recently, which made it difficult to determine the specific outcomes they had contributed to. Although the additional money that the MHTF, as added to the country office resources, has been helpful, the various requirements and conditions attached to the funds had reduced the net-benefit the country office has received from the MHTF. Also, in the particular context of Sudan, UNFPA has had funding needs that could not be filled with the MHTF, such as money for renovations of buildings, or additional resources for addressing the cultural barriers that prevent women from seeking medical care during pregnancy. In at least one instance, money from the MHTF had to be returned to headquarters because the country office had not been able to use it within the time and reporting constraints defined by New York[249].
Findings from case study in **Zambia** (3rd Submission)	*Technical support facilitated by MHTF helped the country office to set up the UNFPA-ICM midwifery programme in Zambia and to determine its strategic direction. The ICM partnership provided the Country Midwife Advisor and her colleagues with a well appreciated regional professional network.* The launch of the MHTF in Zambia was accompanied by an adequate increase in technical guidance for MHTF planning and implementation in the country office, primarily from the global level and to a lesser extent from the regional level. UNFPA partnership with the International Confederation of Midwives (ICM) is seen to have provided valuable input to the MHTF-financed CMA and the midwifery cause in Zambia overall, not least because Governmental partners have accompanied the CMA to regional or global midwifery meetings, which has helped to provide additional guidance to Government counterparts as well[250]. However, the launching of the MHTF neither has significantly improved the technical guidance on M&E of maternal health support, nor has it enhanced the actual monitoring and evaluation of MHTF-financed interventions[251]. The UNFPA country office has also benefitted from the additional guidance in the initial set-up of the UNFPA-ICM Midwifery Programme. The MHTF-funded CMA participated in global inception forum in Ghana in March 2009, where UNFPA staff from the global and regional level laid out the vision for the MHTF; and helped to review the annual work plans for the MHTF. The actual activities implemented in Zambia by the CMA and CFA ultimately corresponded very closely to the guidance given to MHTF country staff during this inception[252]. Activities that were taken on board from the regional suggestions were the “preparation of the International Midwives Day”, the “Launch of the Investing in Midwives Programme” and the “desk review to determine what levels of support exist” and “what the gaps are that

247 Interview with UNFPA
248 Interview with UNFPA
249 Interviews with UNFPA
250 Interview with UNFPA
251 Interviews with UNFPA and review of intervention documents
252 Guidance was given in the form of “activities that should be completed by June 2009” that UNFPA country offices were asked to adopt.

	must be assessed". The UNFPA Zambia country office also hosted the second Capacity Building Workshop for all national and international Country Midwife Advisors in Lusaka, in cooperation with ICM[253]. The AWP review workshops have also been perceived as a positive and generally helpful experience[254].
Findings from **interviews RO+HQ** level	Regional offices have overall sexual and reproductive health work plan to make sure that every activity is integrated and that not vertically, but horizontally. In the past there were different tools for RHCS, for MHTF, for fistula, etc. In 2009, during a big meeting of country offices and regional offices countries said there are too many different tools. Efforts were really to streamline the reporting more and more. Now there are attempts to integrate the different reports and to link it to the country programme outputs. In the Asia Pacific region the regional team was involved from the MHTF proposal development stage and looked at all the joint programming AWPs from the countries. All the MHTF annual reports sent to the HQ are copied to the regional office. Sometimes they are asked to comment. During the last 2-3 years thematic funds have organized joint meetings – facilitated by HQ - with the RO advisors. In SRO Johannesburg an annual work plan was developed with MHTF funds: • to prepare a documentation of maternal death reviews in 4 countries (done in 2 countries with a regional university) • to monitor the Obstetric Fistula programme (with a UNFPA Europe staff), • to support Malawi to institutionalize maternal death review. • To do an assessment of midwifery training in some countries (with AMREF, in Nairobi). They have financed some training through MHTF, some workshops (on EmONC needs assessments and workshop for obstetricians societies on EmONC. Tools such as EmONC tools, originally developed by AMDD, are useful. We have managed to standardize those. In Francophone Africa it is difficult to use tools in English (e.g. Obstetric fistula guidelines). Africa RO provided advocacy tools to countries such as policy and advocacy briefs[255]. RO/SRO have developed links with institutions in the region that can provide support to other countries, with AMDD holding hands. E.g. International Centre for Diarrhea Disease Research, Bangladesh (ICDDR, B) for APRO. An assessment of institution capacities has been done in West Africa[256].
Findings from **global** level	Tools have been developed and provided to country offices in order to harmonies planning and reporting between the different thematic funds; Guidance notes were elaborated in 2011 in order to support planning in building g upon the MHTF first years of experience and latest international debates[257]. Collaboration with regional offices has not worked well especially in Africa where the bulk of MHTF work is (particularly West Africa). Country offices don't copy the Programme Division or Regions because they face delay if they do. They do not give feedback on AWP.

253 For mid-year progress reviews, knowledge sharing, developing standardized strategies for reviewing national midwifery curricula, and strengthening the advocacy skills of the CMAs.

254One lesson that UNFPA staff had taken away from this workshop was to focus UNFPA support on interventions that allowed the office to retain some "control" over what happened with funds provided. For example, the country office had originally planned to pay Zambian parliamentarians a small grant for organizing maternal health sensitization workshops with their own staff. Upon receiving the above feedback during the Johannesburg workshop, the country office abandoned this intervention.

255 Interview with Regional and sub-regional offices and review of RO/SRO AWPs

256 Analyse Institutionnelle des Institutions Régionales de Formation et de Recherche en Santé de la Reproduction : CEFOREP, IRSP, IRSS - Pour le Bureau Sous Régional de l'UNFPA à Dakar - Draft - 2011

257 The Maternal Health Thematic Fund – 2011 Guidance Note - Accelerating Progress towards Millennium Development Goal 5 - Focus, Partnerships, Results

	COs need technical assistance but RO are not aware and are not asked for. HQ and country office relationship is good. There are difficulties for staff to work with 2 different funds, integration would solve many issues. There is not optimal synergy between the Sexual and Reproductive Health Branch, the Programme Division and the GPRHCS. There are bottle necks e.g.; approval takes too long and funds are not available to start activities in countries (planning meetings are in the fall, funds are sent in January but approval is only done in March). For a country to be funded the RD has to consider thematic fund guidelines, PPM, sexual and reproductive health framework, Country Programme Action Plan etc. All approval follows normal procedures.
Findings from **online survey**	The results of the Asia & Pacific region and the Africa region show that the improvements of assistance from regional level differ considerably. The African region countries seem to be much more satisfied with the assistance of the regional office since the launch of MHTF. In all categories 15 percent to 50 percent of the countries consider that there is a lot of improvement. Particularly the provision of guidance documents, phone or email support from the RO and exchange with other country office (facilitated by RO) improved a lot. The Asia & Pacific region only sees 10-20 percent of improvement on all aspects particularly in standardized workshops and guidance documents. They see no improvement at all with regard to in-country technical assistance by external consultant and on demand workshop since the launch of MHTF. Regarding the improvement in the support countries received regarding technical topics, the great majority of the countries Africa region sees improvement or a lot of improvement whereas only 30 – 40 percent of the countries in the Asia & Pacific region stated that there was improvement. Their feedback also indicates that assistance from regional level in Obstetric fistula, EmONC, family planning and reproductive health commodities and Midwifery improved a lot since the launch of MHTF particularly for obstetric fistula and PP&RHCS in African countries. Only 30 percent countries in the Asia & Pacific region saw improvement in the support for midwifery and family planning & RHCS. Regarding HRH, STIs/RTIs, integration with gender and population and development, approximately 50 percent of the countries did not receive any assistance and if they receive they don't see as much improvement as in the other categories. Almost 40 percent of respondents say that they did not receive any assistance received from the regional level of UNFPA in the field of programme planning and management. Among the other 60 percent more than half of the respondents stated that there has been an improvement since the launch of MHTF in the field of programme planning and management[258]. The regional breakdown shows that Africa and the Asia & Pacific Regions found improvement in the assistance they received in Development of Country Programmes (CPDs / CPAPs) (although not directly related to MHTF), annual programme planning in maternal health after the launch of MHTF.. In Africa Region support related to budgeting and financial management improved but not the in the Asia & Pacific Region. Support to monitoring has less improved than in the other areas. Generally, feedback from the country offices on satisfaction with the overall support received from the RO has been positive since the launch of MHTF. More than half of the countries are either satisfied or highly satisfied with the support of the regional office. Particularly the countries from the African continent and the Arab States indicated satisfaction. Countries depending from Dakar SRO consider that following the launch of MHTF the skill mix was improved mainly for UNFPA being the lead agency for evidence-based technical contributions to promote maternal health and to fulfill all of the responsibilities related to the overall maternal health component. However the type of skills available has not improved in areas such as effective policy advocacy for maternal health with Government & development partners and appropriate monitoring and evaluation of maternal health

[258] See On line survey report in Chapter 6, Volume 2

	interventions. The latest was also reported in Johannesburg sub region and in Cairo region. Skills to provide technical contribution (e.g. leading of technical working groups, provision of technical guidance on maternal health) in maternal health are not considered to have improved much except in Dakar sub region.

7.6.3 Judgment criterion 6.3: Monitoring and evaluation of the MHTF supported proposals including financial monitoring

Type of analysis	Findings
Findings from case study in **Burkina Faso**	*Les rapports conjoints introduits par le MHTF et le GPRHCS améliorent la documentation de des interventions qui ont été mis en œuvre grâce à ces fonds. Par contre les indicateurs proposés dans le cadre de suivi ne sont pas assez spécifiques et ne reflètent pas assez directement les résultats des interventions soutenues par ces fonds.* Les formats introduits pour les rapports conjoints des fonds thématique pour la sante de la reproduction ont permis de documenter les interventions ainsi qu'une certaine analyse du contexte dans lequel elles sont mises en œuvre. Bien que le mécanisme de suivi introduise par le MHTF contribue à développer une culture de gestion basée sur les résultats et de suivi des progrès réalisés l'équipe de l'UNFPA considère que les indicateurs de suivi sont de niveau trop élevé et ne reflètent pas l'activité réelle soutenue par les fonds thématique et par l'UNFPA. Ils souhaiteraient utiliser des indicateurs de processus / intermédiaires qui sont plus spécifiques. L'équipe de SR était sur-sollicitée au moment de l'évaluation et il était prévu que 2 postes additionnels soient financés fin 2011 par le MHTF et le programme global: un poste suivi-évaluation et un poste fistules obstétricales afin de renforcer ces 2 composantes[259]. Un suivi régulier de la gestion financière du programme sage-femme n'a pas pu se faire parce que l'outil de gestion ATLAS n'était pas totalement maitrisé par le personnel chargé du programme
Findings from case study in **Cambodia**	*MHTF resources in 2009-10 have been underutilized due to UNFPA Cambodia success in leveraging external funds for MHTF activities, such as National EmONC Assessment, Improvement Plan and family planning policy assessment. GPRHCS funds were fully utilized when requested. MHTF is expected to have a more expanded role in 2011, as donor funds ended in late 2010. Internal M&E system is integrated within UNFPA Cambodia for all sources of funding.* In late 2010, MHTF supported the monitoring and supervision of the implementation of EmONC activities and facilities carried out by the EmONC Co-ordination Team of the National Mother Newborn Child Health Centre. Monitoring support from UNFPA side is provided jointly by NPO for sexual and reproductive health and the EmONC Officer (supported by MHTF), under the purview of the reproductive health manager. The long-term reproductive health manager resigned in April 2011, and a new reproductive health manager was designated six months later. This situation was not seen as affecting MHTF activities[260]. The Monitoring template of the MHTF is helpful to track EmONC and midwifery developments. MHTF uses FACE system to monitor financial expenditure. The Finance Associate was extensively trained, especially in 2009, on MHTF and Harmonization Approach of Cash Transfers training (HACT). He then provided training to UNFPA Laos and South Africa[261]. Trust funds are considered flexible but less predictable, and programme implementation is therefore less smooth than that of

[259] Idem
[260] UNFPA Cambodia
[261] UNFPA Cambodia

	programmes supported by other funds. Implementing Partners must absorb and understand how to integrate new activities from external donors into mainstream activities, which tend to be more structured[262]. When a new donor comes in, it is usually MHTF funds that face re-allocation, as it is perceived as internal funding and hence more flexible. Planned activities do not suffer; they are simply assigned a new donor. High Operating Fund Account (OFA), such as MHTF, is a challenge particularly in the context of the Programme Based Approach and HSSP II, but the financial training that has been provided has helped integration. There were some queries on the selection criteria of MHTF *"which may actually be detrimental to countries doing good work[263]"*. For example, does the rapid decline of Maternal Mortality ratio from 437 in 2008 to 206 per 100,000 live births in 2010 mean that Cambodia is no longer eligible for MHTF funding in the future? The MoH Annual Operational Plan development, implementation and monitoring are still weak and not flexible to embrace new ideas. This proves challenging to UNFPA, when new funding is available on short notice.
Findings from case study in **Ethiopia**	The MHTF is financially managed by accountants in UNFPA office; budget reporting is done for all funding sources together. The ECO has ensured that minimum standards of UNFPA financial monitoring paragraphs are also in the Joint Financing Agreement, and has pooled money to align with the new aid environment guidance note, in view of making sure that financial monitoring processes are harmonious and consistent. Among the H4 partners in Ethiopia, UNFPA was first to follow this new guidance note. UNFPA annual (finance) reports detail MHTF expenditures and also show where the two reproductive health funds have been used in complementary ways to maximize effectiveness.
Findings from case study in **Ghana**	*MHTF Ghana has a lot to show in two years. The Mid-term Midwifery Review 2010 showed that even though full attribution may not be possible, MHTF contribution has been carefully tracked by its annual progress report. Core support by UNFPA Ghana, MHTF and GPRHCS are all monitored together.* In its effort to strengthen the country office effort, MHTF Ghana in two years has contributed to the following in the area of family planning/RHCS, midwifery, EmONC and Obstetric Fistula:[264] • Development of the National Comprehensive Communication and Advocacy Strategy. • Reproductive health Co-ordination Team in place led by MoH with UNFPA, WHO and UNICEF and other partners. • Up-to-date needs assessment for maternal health as part of National health Plan. • Existence of a costed National Development Plan for essential sexual and reproductive health package • Sixteen percent of the midwifery training institutions have fully integrated the WHO/ICM revised curricula • Midwives are authorized to administer core set of life saving skills • Midwives benefit from supportive supervision and continued professional education • Nursing and Midwifery Council is active on regulations, standards and codes and the two fragmented associations are in a dialogue • Doctors are trained in fistula repair and health personnel in management of fistula cases in nine centers • Internationally agreed HMIS indicators integrated in national HMIS • Mandatory notification of maternal deaths, routine practice of maternal death audits and a confidential enquiry system in place. Just as with UNFPA core funds, for the MHTF an annual work plan is developed with Implementing Partners, in this case mostly with

[262] UNFPA Cambodia MHTF Progress Report 2010
[263] UNFPA Cambodia
[264] MHTF Annual Report 2010

	Ghana Health Service, then each IP submits a FACE and engages in the usual UNFPA monitoring and reporting process (see Evaluation question 8 and Evaluation question 9 in MHTE section). UNFPA is providing strong leadership for M&E at MoH/GHS level and current CP6 planning and programming is designed to build on strengthened capacity and align with national indicators especially those coming out of MHTF supported EmONC needs assessment[265].
Findings from case study in **Lao PDR**	*Joint planning and reporting provide clear documentation on the type of activities that the RHTF have undertaken. However the Result Based Framework is not adapted to the situation of Lao PDR and could be used as monitoring tool.* Annual Working Plans and reports have integrated all the reproductive health funds. The joint report provides clear information on what has been achieved as well as an analysis of the context in which these achievements were attained. Since the funds are managed separately being earmarked financial reporting dates for MHTF and GPRHCS are different what led to difficulties for the team. The MHTF monitoring tools are difficult to use in Lao PDR as they require data that are not readily available due to weak information systems.
Findings from case study in **Madagascar**	See 6.1
Findings from **global** level	So far financial monitoring was done only. In HQ the MHTF works with programme division on monitoring and evaluation. We set up monitoring for maternal health and family planning with GPRHCS. It is easier because it is country focused. UNFPA still lacks accountability systems and since MHTF operates within the same systems weaknesses are the same.

7.6.4 Additional issue evaluation question 6

Sudan	One added value of the MHTF has been, however, that it has opened up a channel of communication to UNFPA headquarters. Since the regionalization of UNFPA, and the disbanding of the Country Support Teams, it had become difficult to access technical support from UNFPA staff members. The current regional offices often only refer the country office to a consultant. The MHTF structure allows the country office to access UNFPA staff in the technical division in New York[266].

[265] Interview with UNFPA
[266] Interview with UNFPA staff

7.7 Evaluation question 7: To what extent has the MHTF enhanced and taken advantage of synergies with other UNFPA thematic funds e.g. the Global Programme on Reproductive Health Commodity Security, the Campaign to End Fistula and the UNFPA-ICM Midwives Programme and HIV-PMTCT in order to support maternal health improvements?

Findings from desk study
Background Progress has been made towards harmonization of reproductive health efforts. The integration of the reproductive health thematic fund processes is recognized as appropriate and relevant because it reduces burden and duplication; it enhances coordination and harmonization of efforts and should lead to more efficient and effective use of resources[267]. At country level joint planning and joint reporting and also joint needs assessment and monitoring and evaluation in some instances helps stakeholders to view sexual and reproductive health/maternal health and HIV as one block provided the integration is systematically facilitated. However, since each component used to be run as a separate programme the transition may take time before integration becomes reality. **Gaps** • Greater synergies and harmonization can only happen if planned for systematically and if COs planning capacities are sufficient. These conditions will be explored during the field phase. • One of the conditions to maintain the momentum gained through vertical approach (e.g. Fistula Campaign) is to plan strategically the integration process with a view to maintain this momentum and the mobilization of the different partners. Whether the integration process allows maintaining such momentum will have to be explored.

[267] Idem

7.7.1 Judgment criterion 7.1: Integration of the components of the Campaign to End Fistula into maternal health programmes after the integration in MHTF

Type of analysis	Findings
Findings from case study in **Burkina Faso**	*L'intégration entre les différents fonds SR est variable.* Par exemple, la composante de prévention des fistules obstétricales, dans le cadre du projet de lutte contre les fistules obstétricales au Sahel (financé par le Grand-Duché du Luxembourg), est mise en œuvre par *Family Care International* qui appuie des Organisations à Base Communautaire qui mènent des actions de sensibilisation pour l'accouchement assisté et le recours à des soins qualifiés[268]. Le MHTF a financé une campagne de traitement des fistules obstétricales dans la zone d'intervention ainsi qu'un atelier d'élaboration d'un guide en vue d'harmoniser et standardiser les stratégies et méthodes de prise en charge chirurgicale des fistules obstétricales. L'intégration avec les autres composantes SR reste insuffisante pour être synergique.
Findings from case study in **Cambodia**	*Obstetric fistula is a potential area for funding by MHTF, but so far has only been partially addressed.* In 2011, UNFPA Cambodia started a small Campaign on Fistula in remote provinces through radio and has provided leaflets to health care providers through the Provincial Health Department[269]. Obstetric Fistula in Cambodia is not a well-known phenomenon. No assessment on Obstetric Fistula has been performed in Cambodia.[270] Previously, UNFPA country office had reports of 13 total cases, through an NGO called Children Surgical Centre (CSC). In 2011, there were four cases. The Representative has recently received a request to seek funds towards an assessment. Since October 2011, there has been some support from core to CSC, for reconstructive surgery free of charge.
Findings from case study in **Ethiopia**	*The MHTF supports the obstetric fistula programme by co-funding the programme coordinator; coordination or joint planning is not foreseen in the annual work plans.* Obstetric fistula work is mainly funded with SIDA funds, which are seen as belonging to the MHTF, (whilst the funds are earmarked for obstetric fistula, MW, and anesthetic nurses' education). The Country Midwifery Advisor has been in charge of the obstetric fistula programme. UNFPA (through the SIDA funds) supported the provision of equipment and supplies for in-service training and obstetric fistula wards/clinics[271], as well as health extension workers training on fistula symptoms and referral pathways. The Federal Ministry of Health (FMoH) followed the integrative strategy whereby patients with fistula were admitted into every hospital that was able to accomplish such surgery. In the annual report 2009 of the MHTF, no mention is made of the fistula programme and in the 2010 report only a reference to HQ is made[272]. Apart from the fact, that the CMA is funded by the MHTF and is responsible for the programme, no further coordination seems to be happening.
Findings from case study in **Ghana**	*The Fistula Programme started in 2003 with regular funds from UNFPA and is now 100 percent funded by MHTF. The country office sees that core funding to the Campaign to End Fistula has ended and being replaced partially by MHTF and then eventually all of it by GHS.*

268 Entretiens avec les partenaires d'exécution et l'équipe UNFPA
269 UNFPA Cambodia
270 UNFPA Cambodia
271 For the new fistula center in Gondar, provided by WAHA, UNFPA provided beds and mattresses. Also, women are supported by UNFPA to travel to surgical repair facilities.
272 Annual Report Thematic Funds 2010: Support Fistula research: $70,000 was allocated for supporting fistula research. However, implementation arrangement with Fistula Foundation in Addis has not been working and this activity is negotiated to be implemented by HQ since it involves multi-country research.

	Since 2009, the Campaign to End Fistula is supported wholly by MHTF. This included a comprehensive advocacy package spearheaded with the participation of Miss Ghana in the Northern Region, Upper East and Upper West as well as programme integration which included expert surgical trainings in 2010[273]. The three main results of the Campaign in 2009-10 are: a) the inclusion of obstetric fistula treatment in the National Health Insurance Scheme (NHIS) and Livelihood Empowerment against Poverty (LEAP) programme to reduce financial barriers and increase possibilities for income generation; b) the establishment of an upgraded fistula center of excellence which was officially commissioned by MoH and Ministry of Women and Children Affairs. Key excellence components are: on the supply side - quality assurance, supportive supervision, global partnership for capacity building (International Society of Fistula Surgeons), set up of the Fistula Working Group (FIGO) who in turn developed the standardized competency manual for training and protocol and on the demand side - the utilization of fistula survivors peer group and the NGO SWAA to accelerate community participation in registration with NHIS, rehabilitation and re-integration[274]; and c) south-south collaboration with Ghana hosting Eritrea in fistula repair training. MHTF has ensured that UNFPA addresses fistula within the maternal health programme in the Accelerated Road Map (MAF) but the document does not have good indicators. Currently no baseline data exists for fistula. GHS is contemplating to upgrade FIGO into a National Fistula Task Force to develop a national strategy to support treatment and rehabilitation. Due to some audit challenges with GHS, UNFPA has been delayed in its ability to implement this and other activities related to fistula that were intended for 2010-11 such as expanding the number of doctors trained in repair work and budgets remained underutilized[275].
Findings from case study in **Lao PDR**	*MHTF support has allowed creating awareness among health professionals and decision makers about Obstetric Fistula in Lao PDR where the issue had been unrecognized so far.* Obstetric fistula is not known in Lao PDR, people are not aware of it even among health care professionals and there is no word for it in Lao language. MHTF started supporting activities to sensitize some health managers and providers by supporting their participation in a fistula repair conference and study tour in Nepal and also to sensitize decision makers by documenting stories of patients suffering from obstetric fistula through a partnership with Care International[276].
Findings from case study in **Madagascar**	*The MHTF has implemented obstetric fistula related activities since 2010, over 100 women with obstetric fistula (from an estimated number of 7000 countrywide) have meanwhile benefited from surgery and a micro-credit project between ILO and UNFPA for women who have been operated is planned for 2012[277]. Since the MHTF supported the obstetric fistula campaign, sexual and reproductive health/maternal health policies include obstetric fistula. The H4+ plan and the new national strategic plan for 2012-2015 have integrated obstetric fistula, which can be directly linked to the technical contribution of the MHTF.*
Findings from case study in **Sudan**	*MHTF funds have been used to co-finance various fistula-related activities since the launch of MHTF in Sudan.* MHTF funds have been used to complement core-funding for fistula repair and fistula campaigns. Apart from supporting the costing of the maternal health Road Map, the MHTF has not been involved in promoting maternal health policies. However, the MHTF has provided complementary funding for a number of other fistula-related activities, in relation to the development of fistula treatment protocols[278], the

[273] Interview with UNFPA staff
[274] Interview with Government and NGO
[275] Non-core resources for CP5, UNFPA Ghana
[276] International Non-Governmental Organization
[277] Toliary field visit
[278] E.g., in cooperation with the Abbo Fistula Management Centre

	training of surgeons in fistula repair in Sudan and abroad, some renovations[279] and the establishment of additional satellite fistula centers. MHTF and core-funds have helped to build a cooperative long-term relationship with the Abbo Fistula Center.
Findings from case study in **Zambia** (3rd Submission)	*The MHTF has been relatively well integrated into UNFPA overall portfolio in Zambia, which became evident by shared responsibilities of MHTF-funded and regular technical staff for interventions funded by core funds as well as by the MHTF. Integration also extended to the field of fistula.* The CMA and CFA have worked together closely, including in particular on the General Nursing Council-led curriculum review for training of nurses and midwives. Although the review was formally under the auspices of the CMA, the fistula advisor shared responsibilities with the CMA, and also worked to ensure that fistula prevention and identification was adequately covered in the revised curriculum. The involvement of UNFPA at community level in three provinces[280]; and its support of SMAGs in those provinces, has been used as an opportunity by the fistula advisor to integrate the sensitization of communities on fistula into the SMAG trainings and outreach activities[281]. Also, two documentaries that had been produced with UNFPA / fistula funds were used in UNFPA-funded trainings of nurses and midwives in UNFPA three provinces, to ensure that these were sensitized on fistula. Finally, the fistula outreach camps were used as a training opportunity for midwives and nurses to assist in fistula repairs[282]. UNFPA partnership with ICM has provided the Country Midwife Advisor with a number of opportunities to participate in regional capacity building activities and workshops, i.e. the initial "inception meeting" of the programme in Ghana, and a subsequent mid-year review workshop with all African CMAs that was held in Lusaka. An ICM regional advisor has visited Lusaka during the first year of the programmes operation and has provided feedback to the CMA on the set-up of the programme. As mentioned above (Evaluation Questions 6), ICM input during these meetings was directly translated into activities in Zambia, i.e. with regard to the launch of the International Midwives Day"[283]and the creation of a "Midwives Association of Zambia" (MAZ). Also, the guiding principle of the ICM-UNFPA programme, "Education, Regulation, and Association" has been acknowledged as a guiding principle for the set-up and operation of the programme in Zambia[284]. No integration of HIV activities into MHTF funded interventions has been observed.
Findings from **regional** interviews	While the fistula fund helping repairs, there is also an equal emphasis on prevention... prevention is through good access to EmONC services. If you are only spending money on repairing fistula, I will raise this issue with the respective country. And to tell them to shift the balanced to prevention.

[279] E.g., of the Abbo Fistula Management Centre
[280] Under the "Integrated reproductive health programme"
[281] Information from fistula Annual Work Plans and annual reports; as well as UNFPA interviews
[282] More information on fistula support is presented in Evaluation Question 4 for MHTF above
[283] Which eventually failed, because of conflicts with the Zambian Nurses Union Organization (ZUNO)
[284] Feedback from UNFPA staff interviews

7.7.2 Judgment criterion 7.2: Joint and coordinated planning at country level with GPRHCS

Type of analysis	Findings
Findings from case study in **Burkina Faso**	*Il existe une certaine complémentarité entre le MHTF et le programme global.* Par exemple l'évaluation SONU a été financé à la fois par le MHTF et par le GPRHCS[285]. Les formations en SONU sont appuyées par le MHTF, alors que la sécurisation des médicaments SONU ainsi que les actions de communications sont soutenues par le programme global[286].
Findings from case study in **Cambodia**	*MHTF coordination with GPRHCS occurs at the budget level and during procurement (Area 2 – strengthening EmONC services and Area 2 - contraceptive supply). There has been no joint planning with MHTF in Area 3 (strengthening family planning services).* In order to support the development of the EmONC Improvement Plan and to meet critical needs for improving maternal health services, GPRHCS (in late 2009) provided Manual Vacuum Extractors and Heart Fetal Detectors. All equipment and commodities were distributed to health facilities by the time the Plan implementation began, in line with MoH distribution procedures. Sub-dermal Implants (Implanon) were procured to support the critical needs for improving family planning services, particularly to support the introduction of a new contraceptive method[287]. Procurement was planned for contraceptive security in 2010, but there was no request from MoH.
Findings from case study in **Ethiopia**	*The MHTF and the GPRHCS were reported to develop their annual work plans jointly, but have so far not demonstrated (in their annual plans and reports) joint activities. This is not astonishing, as the activities and beneficiaries differ quite substantially.* The MHTF and the Global Programme on Reproductive Health Commodities have joint AWPs and joint reports, but quite a distinct division of labor and no overlaps. The MHTF supports capacity development on NPC and midwifery training, the GPRHCS on logistics and warehouse management. The GPRHCS procures (through the national agency) equipment and supplies for the refurbished EmONC health facilities. Whilst the annual work plan development was reported as joint exercise, no joint activities can be differentiated in the plans or annual reports. The 2010 report lists first the MHTF activities and then the RHCS activities. The progress towards a joint planning and reporting leading into an overall combined report seems to be still ongoing, and may be hampered by the vertical reporting structures of both funds (each to their own TD). Nevertheless, both funds implement in the same districts and wherever possible, provide for the same facilities[288].
Findings from case study in **Ghana**	*MHTF and GPRHCS have jointly convened the process of peer reviewing the Annual Work Plans in 2010-11 which has contributed to south – south learning and sharing of good practices. This has resulted in strengthening family planning efforts by supporting favorable policy environment and service delivery.* In synergy with UNFPA Global Programme on Reproductive Health Commodity Security (GPRHCS), technical assistance is provided to develop capacity in support of Re-positioning family planning in Ghana. The key contributions are: a) joint support to Ghana Health Service on integration of family planning logistics (supply chain) into the national logistics system; b) training for family planning service providers to manage logistics appropriately so that scheduled delivery of supplies are going directly to facilities c); in-service training for health workers to provide long term methods; d) general support for M&E in conjunction with West African Health Organization (WAHO) and e) general agreement that GPRHCS will fulfill supply of $2 million for contraceptives in 2009-11[289]. Midwives can prescribe oral

[285] Revue documentaire
[286] Rapport Conjoint pour le Fonds Thématique Sante Maternelle, Programme Global, Projet Sage Femme, Programme Fistule 2009 et 2010, PTA 2010
[287] See judgment criterion 6.3.
[288] Information from ECO
[289] Interview with UNFPA staff

	contraceptives; also do Depo and implants, IUDs and training is supported by GPRHCS. Students go out for 2 week family planning practicals and learn to do all, then work with community midwives in all these areas. This part of their learning is supported by MHTF[290]. It was mentioned during one country office interview that MHTF provides some support for JSI DELIVER, but no details were provided and this was not verified.
Findings from case study in **Lao PDR**	*GPRHCS and MHTF are seen as complementary to the overall reproductive health component. Even if the joint planning process (between MHTF and GPRHCS) triggered somehow a shift towards joint planning instead of the previous vertical planning it requires longer practice to be more strategic. Increased coordination during implementing would also increase synergy.* Under the partnership with the Medical Products Supply Centre (MPSC) contraceptives and lifesaving drugs for maternal health are part of the unified logistic system for the health sector with the exception of oxytocin and magnesium sulphat that are part of the Revolving Drug Scheme. This system was in place before the introduction of MHTF[291]. As seen above a joint AWP was developed for GPRHCS and MHTF. It is seen as to complement the reproductive health interventions funded under core funds and other donors' funds. Regardless the funding sources all the interventions are planned in order to achieve the UNDAF and CPAP outcomes. Both funds allow UNFPA to lead on two different fronts in support to the MNCH package i.e. RHCS primarily support a health system strengthening and MHTF supports HR but they are managed separately[292]. Lao PDR country office had too many Annual Work Plans (AWP) with many implementing partners to follow up, which is extremely difficult to manage. Therefore the country office wants to integrate all the AWPs on the model of the joint RHTF AWP starting in 2012 what will certainly contribute to increased harmonization.
Findings from case study in **Madagascar**	The MHTF has supported the MoH and the health administrations to prepare an EmONC implementation plan which includes a detailed list of required equipment and consumables. The GPRHCS has together with the MHTF developed a plan for purchase and dissemination of the agreed items and implements the distribution and follow-up through its implementing partners. The synergy between the two funds is recognizable in the annual work plans, there is no overlap of activities and the day-to-day collaboration is demonstrated by the joint M&E missions and sensitization campaigns. The MHTF seems to provide more the technical input whilst the GPRHCS brings the logistical know-how. [293]
Findings from **regional** interviews	At country level, there is still a lot of work to be done to increase synergies between RHCS and MHTF. The HQ needs to encourage RHCS and MHTF to work together better. But this has been improving since 2009; before it was absolutely vertical silos. But at country level midwives are the ones to implement family planning, SONU, obstetric fistula, and PTME and they need to be trained for that. GPRHCS focuses strongly on commodity security but the quality of family planning services is not strengthened enough. The 3 pillars (family planning, EmONC, skilled birth attendance) are not integrated enough. And the division GPRHCS/MHTF does not help integration. (See evaluation question 3)

[290] Interview with Regional Government Staff
[291] Government partners interview
[292] UNFPA staff interview
[293] Joint AWP 2010

7.7.3 Judgment criterion 7.3: Integration of Midwifery programme strategic directions in MHTF plans in countries

Type of analysis	Findings
Findings from case study in **Burkina Faso**	*Dans le cadre de la mise en œuvre du programme sage-femme, les compétences essentielles ICM (International Confederation of Midwives) ont été intégrées dans les curricula de formation de base des sages-femmes ainsi que dans le guide de supervision.* Les autres composantes du programme sagefemme telles que la régulation de la profession et l'appui aux associations sont également appuyées par le MHTF. Le soutien régulier de la conseillère régionale ICM est très apprécié par l'équipe SR et semble suffisant. D'autres partenariats avec l'OMS, JHPIEGO, AMDD permettent un appui supplémentaire.
Findings from case study in **Cambodia**	*MHTF does not support an ICM Country Adviser (there was a Midwifery Adviser in 2007-mid 2009). ICM tools have been adopted to develop pre-service curriculum but still at preliminary stage (see judgment criteria 2.1). Cambodian Midwifery Council is making first round effort to boost partnership with ICM, Cambodian Midwives Association has potential for partnership if some organizational and management issues can be resolved (see judgment criteria 2.3). MHTF role in 2009-10 has been to continue to build on the achievements of the German Fund.* Integration of Midwifery Programme strategic direction in MHTF project portfolio in line with MoH Annual Operating Plan has included the following: • Instead of a full time Midwife Adviser MHTF has supported a short-term consultant in 2010 to facilitate the Department of Human Resource Development, MoH for the development of a Bachelor Degree in Midwifery, EmONC Master training (ToT) and coaching in-service midwives on site. • Support country participation in international and regional technical workshops on reproductive health/maternal health and high-level advocacy conferences (Women Deliver). • Support to implementation of Midwifery Training in Regional Training Centers • Support roles and functions of Cambodian Midwives Council and Association. • Support the review and update of the National Strategy on Reproductive and Sexual Health to incorporate key findings from the Midwifery Review (2007), monitoring reports of the Midwifery Action Plan (2007-10), key findings on midwifery in the National EmONC Assessment and integration of Midwives role and responsibilities in the EmONC Improvement Plan. This activity has been postponed to 2011.
Findings from case study in **Ethiopia**	*Whilst the implementation of the midwifery programme seems closely joined with the MHTF, the planning and reporting formats do not reflect that yet.* The midwife programme and the MHTF are to a certain extent integrated. The MHTF includes in the annual thematic fund reporting the activities of the midwifery component, but an extra Midwifery report exists (Report for the ICM/UNFPA Programme for Investing in Midwives and Others with Midwifery Skills to accelerate progress towards MDG 5). Also the annual work plans exist independently; there is one for the midwifery component and one for the GPRHCS and MHTF together[294]. (See evaluation question 2 for more information on midwifery).
Findings from case study in **Ghana**	*ICM supports MHTF/UNFPA Ghana in advocacy issues regarding the role of midwives in EmONC services based on the needs assessment and gap analysis without waiting for the actual national assessment. Through the MHTF work with the Nursing and*

[294] AWP GPRHCS, MHTF 2010

	Midwives Council which is a regulatory body, the upgraded policy began in 2010-11 to allow trained midwives to practice some or all core signal functions. ICM also looks to ensure that Council acts or legislation is reviewed to so that international regulatory standards are reflected. See Evaluation question 14, 15 and 18 for elaborations on MHTF/ICM contribution to Ghana. ICM and UNFPA relationship was formalized in 2009. ICM Project Office in Accra has global and regional standards and tools, e.g. "Essential Competencies for Midwifery Practice" for midwifery education, regulation and association and partners which has been shared with MHTF HQ to use or adapt these tools for UNFPA Ghana. In launching of midwifery regulatory standards, ICM has with MHTF looked to ensure to the greatest extent possible that acts or legislation pertaining to midwifery and put forward by National Nursing and Midwifery Council is reviewed and that global and regional regulatory standards are embodied. The Associations in turn are the backbone of ICM and the latter uses standard midwifery capacity assessment tool with both Ghanaian associations. ICM is also a partner with MHTF HQ for feedback on midwifery training curriculum for various levels of training in Ghana and other countries of the region[295]. There is a feeling among ICM Regional Advisors that ICM is not well recognized across countries because UNFPA Country Representatives have not shared sufficient information with MoHs about the value that ICM adds. They also feel that the MHTF needs to give better direction and that countries need national dialogue with both maternal health advocates and mothers to discuss need for midwifery resources in countries[296]. GHS on the other hand noted that ICM has not made its presence felt within the Ministry and would like ICM to dedicate some time to GHS (one day a week to begin with)[297]. GHS mentioned that the Country Midwife Adviser position was initially seen as being posted full time in the Ministry and that it was remiss of UNFPA Ghana not to have made the shift in two years.[298]
Findings from case study in **Lao PDR**	The ICM competencies are part of the curriculum and were the basis for midwifery standards and licensing exam of the community midwife course. There is no regional ICM Adviser in this part of the world but the SBA Coordinator is fully knowledgeable of the ICM tools[299].
Findings from case study in **Madagascar**	*The regional midwifery adviser was reported to be in close contact with the midwifery council, providing advice on the implementation of the work plan and planning in 2012 a supervisory mission.*[300] *The man partner for the midwifery council is the MHTF but increasingly it is recognized by the MoH, which even plans to introduce a focal point for midwifery in the MoH.*[301]
Findings from case study in **Sudan**	*Although the ICMA has used some of ICM tools and standards, the ICM-UNFPA midwifery programme has not yet influenced the strategic direction of MHTF midwifery support; nor has it been able to ensure that ICM standards are integrated into Sudan midwifery curricula.* The ICMA has utilized ICM tools and standards that are available on the ICM website. However, as midwifery as a profession currently is not well respected in Sudan, advocacy for midwifery needs to intervene at a higher level than is possible for the ICMA to do, especially in the context of Sudan. No such support has been received from the ICM.

[295] UNFPA Ghana feedback during de-briefing
[296] Interview with ICM Project Office
[297] Interview with Government
[298] Interview with Government
[299] UNFPA staff interview
[300] See also judgment criterion 2.3
[301] Interview with Midwifery Council

Findings from case study in **Zambia** (3rd Submission)	*The MHTF has been relatively well integrated into UNFPA overall portfolio in Zambia, which became evident by shared responsibilities of MHTF-funded and regular technical staff for interventions funded by core funds as well as by the MHTF. Integration also extended to the field of fistula.* The CMA and CFA have worked together closely, including in particular on the General Nursing Council-led curriculum review for training of nurses and midwives. Although the review was formally under the auspices of the CMA, the fistula advisor shared responsibilities with the CMA, and also worked to ensure that fistula prevention and identification was adequately covered in the revised curriculum. The involvement of UNFPA at community level in three provinces[302]; and its support of SMAGs in those provinces, has been used as an opportunity by the fistula advisor to integrate the sensitization of communities on fistula into the SMAG trainings and outreach activities[303]. Also, two documentaries that had been produced with UNFPA / fistula funds were used in UNFPA-funded trainings of nurses and midwives in UNFPA three provinces, to ensure that these were sensitized on fistula. Finally, the fistula outreach camps were used as a training opportunity for midwives and nurses to assist in fistula repairs[304]. UNFPA partnership with ICM has provided the Country Midwife Advisor with a number of opportunities to participate in regional capacity building activities and workshops, i.e. the initial "inception meeting" of the programme in Ghana, and a subsequent mid-year review workshop with all African CMAs that was held in Lusaka. An ICM regional advisor has visited Lusaka during the first year of the programmes operation and has provided feedback to the CMA on the set-up of the programme. As mentioned above (Evaluation Questions 6), ICM input during these meetings was directly translated into activities in Zambia, i.e. with regard to the launch of the International Midwives Day"[305]and the creation of a "Midwives Association of Zambia" (MAZ). Also, the guiding principle of the ICM-UNFPA programme, "Education, Regulation, and Association" has been acknowledged as a guiding principle for the set-up and operation of the programme in Zambia[306]. No integration of HIV activities into MHTF funded interventions has been observed.

[302] Under the "Integrated reproductive health programme"
[303] Information from fistula Annual Work Plans and annual reports; as well as UNFPA interviews
[304] More information on fistula support is presented in Evaluation Question 4 for MHTF above
[305] Which eventually failed, because of conflicts with the Zambian Nurses Union Organization (ZUNO)
[306] Feedback from UNFPA staff interviews

7.7.4 Judgment criterion 7.4: Harmonized MHTF integration strategies and mechanisms at global and regional level

Type of analysis	Findings
Findings from case study in **Burkina Faso**	*Les différents fonds thématiques apparaissent regroupés dans les documents de planification et dans les rapports conjoints mais les différentes composantes sont définies en fonction de leur différents mandats et ne sont pas encore planifiées afin d'obtenir une synergie optimale entre composante.* La planification entre les différents fonds correspond à une distribution des ressources en fonction des axes prioritaires de chaque fond ainsi que des priorités énoncées par le gouvernement. Les cadres stratégiques nationaux tels que le PNDS, la feuille de route sont pris en compte pour la planification de toutes les interventions en SR de l'UNFPA quel que soit la source de financement. Bien que les Plans de Travail Annuels (PTAs) et les rapports soient conjoints les programmes restent parallèles. Toutefois étant donné qu'il n'y a eu que deux cycles de planification conjointe (2010 et 2011) le processus est nouveau et ne permet pas assez de recul pour confirmer une tendance vers une intégration plus stratégique. Le sentiment au niveau du bureau pays est que « L'intégration du programme global et du MHTF permettrait une rationalisation des ressources ». Le PTA 2010 pour la composante 'Renforcement de la disponibilité et de l'utilisation des services SR de qualité' regroupe toutes les sources de financement ce qui permet une vue d'ensemble de la composante[307]. Par contre les rapports ne concernent que les fonds thématiques.

7.7.5 Judgment criterion 7.5: MHTF plans integrate HIV activities in synergy with core funds, UBW and other resources

Type of analysis	Findings
Findings from case study in **Burkina Faso**	*Dans un contexte où l'intégration SR/VIH est encore à son début et ne fait pas encore partie de toutes les stratégies nationales le MHTF a introduit la PTME dans la formation de base des sages-femmes et a formé les enseignants à cet effet ce qui stimulera le dialogue plus avant.* En ce qui concerne l'intégration SR/VIH, la lutte contre le Sida au Burkina reste très verticale et l'intégration de la composante VIH/PTME au cours des CPN n'est pas encore systématique. Il y a une volonté d'intégration de la part des acteurs (UNFPA, UNAIDS, Ministère de la Santé). Elle existe dans certains documents stratégiques mais la mise en œuvre est progressive[308]. Par contre la PTME ainsi que l'intégration SR/VIH n'est mentionnée que très succinctement dans la feuille de route qui ne contient aucune direction opérationnelle[309]. Le MHTF a permis que la PTME soit incluse dans tous les curricula de formation de base des sages-femmes et les enseignants ont été formés à cet effet.
Findings from case study in **Cambodia**	*MHTF could have supported the integration of sexual and reproductive health/HIV component, but another donor stepped in. MHTF has provided indirect support.* On the insistence of the National Reproductive Health Programme (NRHP), the National Strategy (2006-10) is currently called

[307] Fonds propres, fonds thématiques et financements des bailleurs de fonds
[308] Entretien avec les partenaires techniques et financiers
[309] Revue documentaire

	Reproductive and Sexual Health Strategy. The review and update supported by MHTF will change the name back to National Strategy on Sexual and Reproductive Health (2010-2015). PMTCT is part of the integrated Minimum and Complimentary Package of Activities and as such, midwives are trained in it. However, it was noted that the HIV aspect of the package was not functioning systematically (less so than family planning)[310]. The MoH regards VCT as an important intervention and an entry point for PMCT, which was expanded from 28 centers in 2006 to 36 by 2007. MHTF would have supported expansion in 2008, but UNICEF was already implementing PMCT in 2007 and training midwives. There has been a UN Team MARP assessment led by UNICEF, with UNFPA UNESCO and WHO as partners. The assessment found reproductive health services are meaningful to the group, and there is a great need for primary prevention of pregnancy, i.e. family planning counseling and contraceptive services.[311] These are potential areas for MHTF funding under Reproductive health component output 2 (strengthening capacity).
Findings from case study in **Ethiopia**	The MHTF is not active on the HIV/AIDS issue in Ethiopia; PMTCT is addressed in the HIV module and the ANC/L&D/ PNC module of the midwifery curricula, but it is not clear that this is direct result of MHTF funding/intervention.
Findings from case study in **Ghana**	*MHTF is interacting strategically with other programmatic areas within UNFPA as the reproductive health, gender and population and development specialist attend the Joint Strategic Review Meeting of the Thematic Trust Funds started in 2010. Ghana has benefited from several tools that have helped formulate the first the Unified Budget and Work plans between MHTF and GPRHCS. The joint plan is then integrated into the country office Annual Work Plan.* UNFPA Ghana requires that annual planning takes into account core funds, MHTF, GPRHCS and other sources of funding and that all planning is done in conjunction with Ministry. In preparation for the MoH/GHS meeting Joint Strategic Review meetings (Dakar and Johannesburg) have started in 2010 and 2011. These Review meetings firstly considered MHTF and GPRHCS highlights, issues, challenges and opportunities for 2009-10, discussions on the Unified Budget and Work plan and the technical inputs of the sub-regional office and followed by country presentations. Thematic sessions were held on emerging issues, new technologies, scaling up services and M&E[312]. The deliverables of the meeting was joint action plans on M&E and technical assistance as well as development of country annual work plans which at a later stage discussed with MoH/GHS. There are tools to help prepare the joint MHTF and GPRHCS plan and these include results and indicators matrix, outline for documenting good practice, format for expenditure report, joint annual work plan template and notes for preparation. During the joint review, MHTF Ghana supported the PMTCT component of midwifery training. MHTF Ghana has taken advantage of synergy or linkage to gender mainstreaming through the Fistula programming which has a lot of social and poverty dynamics – women married too early, pregnant too early, neglect of pregnancy care and abandonment[313]. Campaign to End Fistula and ICM Midwives Programme for UNFPA Ghana are all under the MHTF[314].
Findings from case study in **Lao PDR**	*HIV prevention and PMTCT were integrated in the SBA curricula prior to MHTF introduction but the fund support to training institutions has strengthened their systematic inclusion.* HIV prevalence is low and most cases were found in at risk populations thus linking HIV/AIDS with maternal health is not seen as a priority. Nevertheless UNFPA and UNAIDS co-operated to introduce HIV prevention and PMTCT in the SBA curricula. Condom

[310] Government partner (sub-national)
[311] External Development Partner
[312] Agenda of the Joint Strategic Meeting 2010 and guidelines
[313] Interview with UNFPA
[314] Interview with UNFPA

	programming will include messages about dual protection but integration is constrained by the capacities of the public health system. Thanks to UNFPA and UNICEF, 3 questions related to HIV were integrated in the Lao Social Indicators Survey (LSIS) i.e., HIV/AIDS related knowledge and behavior, capacity of married women to negotiate condom as well as information about Men having Sex with Men (MSM)[315].
Findings from case study in **Madagascar**	*Following the national strategy, the HIV component is an integrated component of health services and community health workers' promotion activities. The MHTF and the HIV/AIDS programme jointly plan and implement sensitization campaigns for the general population and/ or for targeted groups, such as adolescents. The revised midwifery curricula include training on PMTCT and ART training[316]. HIV is mainstreamed in the UNFPA programme in Madagascar and contributes to nearly all products.*[317]
Findings from case study in **Zambia** (3rd Submission)	*The MHTF has been relatively well integrated into UNFPA overall portfolio in Zambia, which became evident by shared responsibilities of MHTF-funded and regular technical staff for interventions funded by core funds as well as by the MHTF. Integration also extended to the field of fistula.* The CMA and CFA have worked together closely, including in particular on the General Nursing Council-led curriculum review for training of nurses and midwives. Although the review was formally under the auspices of the CMA, the fistula advisor shared responsibilities with the CMA, and also worked to ensure that fistula prevention and identification was adequately covered in the revised curriculum. The involvement of UNFPA at community level in three provinces[318]; and its support of SMAGs in those provinces, has been used as an opportunity by the fistula advisor to integrate the sensitization of communities on fistula into the SMAG trainings and outreach activities[319]. Also, two documentaries that had been produced with UNFPA / fistula funds were used in UNFPA-funded trainings of nurses and midwives in UNFPA three provinces, to ensure that these were sensitized on fistula. Finally, the fistula outreach camps were used as a training opportunity for midwives and nurses to assist in fistula repairs[320]. UNFPA partnership with ICM has provided the Country Midwife Advisor with a number of opportunities to participate in regional capacity building activities and workshops, i.e. the initial "inception meeting" of the programme in Ghana, and a subsequent mid-year review workshop with all African CMAs that was held in Lusaka. An ICM regional advisor has visited Lusaka during the first year of the programmes operation and has provided feedback to the CMA on the set-up of the programme. As mentioned above (Evaluation Questions 6), ICM input during these meetings was directly translated into activities in Zambia, i.e. with regard to the launch of the International Midwives Day"[321]and the creation of a "Midwives Association of Zambia" (MAZ). Also, the guiding principle of the ICM-UNFPA programme, "Education, Regulation, and Association" has been acknowledged as a guiding principle for the set-up and operation of the programme in Zambia[322]. No integration of HIV activities into MHTF funded interventions has been observed.
Findings at **regional**	From 2009 at regional level the importance of linkage and integration of comprehensive sexual and reproductive health, (maternal

315 Development partner interview
316 The treatment is free of charge
317 Interview with HIV/AIDS officer
318 Under the "Integrated reproductive health programme"
319 Information from fistula Annual Work Plans and annual reports; as well as UNFPA interviews
320 More information on fistula support is presented in Evaluation Question 4 for MHTF above
321 Which eventually failed, because of conflicts with the Zambian Nurses Union Organization (ZUNO)
322 Feedback from UNFPA staff interviews

level	health, HIV, GBV, Adolescent Health, RHCS, etc.) at all levels has been highlighted as well as the need to develop an integrated strategy: combine the regional sexual and reproductive health and HIV strategies; Harmonize all the planned interventions(including thematic trust funds) for the 2009 and 2010 focus countries for both HIV and Maternal Health[323]
Findings at global level	The thematic fund is integrating across branches and work with HIV. " we co-fund posts in HIV but we need to do much more in Southern Africa" [324]

323 Africa Region-wide Knowledge-Sharing and Capacity-Building for Sexual and Reproductive Health, including HIV Prevention Johannesburg, South Africa. 9-14 November, 2009.
324 Interview at global level

7.8 Evaluation question 8: To what extent did the MHTF increase the visibility of the sexual and reproductive health/ maternal health support of UNFPA and help the organization to leverage additional resources for maternal health at global, regional and national level?

Findings from desk study
Background One of the MHTF mandates is to act as a catalyst to leverage additional resources for maternal health. Greater visibility of maternal health issues can lead towards higher commitment to address these issues from both governments and donor community. The Media and Communication Branch prepared a media and communication strategy for raising awareness about reproductive health and increase UNFPA visibility through a large range of communication and advocacy initiatives. At country level an assessment of the MHTF proposals regarding maternal health advocacy and communication was carried out in 2009, which revealed a need to strengthen this area[325]. Particular effort is put in reporting in order to respond to different donors' requirement that contributes to increase transparency and accountability. Specific advocacy events are organized to sensitize decision makers from donor countries. Some example of leveraging resources can be found i.e. in Ethiopia, following the results of an MHTF-supported gap analysis, the Midwifery Programme helped secure US$3.2 million from the Swedish International Development Cooperation Agency for improving the coverage of skilled attendance at birth. The MHTF also received US$4 million in additional year-end funding from Sweden for strengthening midwifery globally and nationally. The UNFPA country office in Bangladesh has raised an additional US$140,000 from the United Kingdom Department for International Development to build up two midwifery training centers in 2011[326]. In its efforts to leverage additional national resources for maternal health MHTF has a key role in encouraging governments to allocate the necessary resources to address maternal health issues. Advocacy for maternal health, as a first step, contributes to sensitize governments on maternal health issues. Then clearly defined sexual and reproductive health/maternal health policies and strategies are essential for increased governments' commitment. The MHTF supports both steps. Creating partnerships with governments and development partners is also an important condition to increase commitment for sexual and reproductive health/maternal health. At country level joint programming allows to pool resources for specific maternal health interventions or programme. Either MHTF initiated interventions are co funded by governments and other development partners or the MHTF contributes to national maternal health related initiatives (funds, programmes, etc.). **Gaps** • The extent to which all the initiatives undertaken at different levels (i.e. production of key maternal health related documents, the organization and facilitation of conferences, workshops and meetings related to maternal health at international and regional level) contribute to higher visibility and additional resources for maternal health could not be tracked down from existing documents and remains to be assessed (JC8.1). • The MHTF contribution and actual effect on increased financial commitment from donors for maternal health in the different countries could not systematically be measured from documents and will be explored during the field visit (JC8.2). • Increasing national commitments for maternal health is strongly linked to enhanced partnerships and to building national financial management capacities in order to optimize the use of resources for maternal health. The MHTF contribution to enhance both conditions will be explored in case study countries (JC8.3).

[325] MHTF Annual report 2009
[326] MHTF Annual report 2010

7.8.1 Judgment criterion 8.1: (MHTF-facilitated) presence of UNFPA in global and regional maternal health initiatives

Type of analysis	Findings
Findings from case study in **Ethiopia**	*The MHTF has been at the right time at the right place to push the maternal health agenda of UNFPA in support of the Ethiopian health priorities.* On national level, the MHTF has supported the development of promotional materials designed to attract more students to midwifery as a profession (EMA). Also more students have applied for the MW courses since the International Day of Midwifery event. On regional level, the MHTF has supported the Task shifting conference in 2009. Awareness raising campaigns that were supported by UNFPA (MHTF) increased facility based deliveries in some regions, which is anecdotal, but likely, as radio programmes addressing Safe Motherhood are a regular feature in the country wide Radio Bana[327]. 'UNFPA is a strong advocacy partner for value of midwives in Ethiopia'[328] ; this recognition, which is shared by many partners, and the advocacy and communication efforts done by the MHTF have been instrumental in the additional SIDA funds to the MHTF for midwifery.
Findings from case study in **Ghana**	*In general MHTF does not have any special visibility compared to any other non-core earmarked funding. MHTF is however well known to MoH/Ghana Health Service for two reasons: a) participation by influential stakeholders in the Women Deliver Conference and Midwives in Ghana has been featured in an MHTF supported documentary and b) GHS is in receipt of the bulk of UNFPA non-core resources including MHTF. With the MHTF focus on midwifery, fistula and EmONC needs assessment the funding was seen as catalytic and synergistic.* MHTF supported high level members of MoH/GHS and policy makers to attend the Women Deliver Conference in 2010 and UNFPA HQ as part of the Advisory Committee facilitated the Ministers and Parliamentarian Forum and Midwifery Symposium where issues, achievements and challenges in midwifery programming in Ghana was featured. The MHTF supported documentary "Ghana Midwives Deliver" has also been broadcasted by BBC, National Public Radio, CNN, ABC and Al Jazeera and was used by MHTF HQ in political advocacy and donor events throughout the world. UNFPA Ghana, GHS staff and NGOs interviewed for this evaluation mentioned the documentary with great pride as an accurate depiction of the achievements of Ghana and the challenges that remain[329]. The trainings in Life Saving Skills were highly appreciated by the Health Directorate in the Central Region but have been noted as supported by direct project funding from UNFPA most probably due to decentralization.[330]. Overall GHS saw MHTF as critical funding and that the EmONC needs assessment when made public in December 2011 and utilized as a planning document would help to redirect funds more visibly. There appears to be a need for better strategic vision for use of Funds now that two full years of funding is over. In 2011 MHTF was starting to be used to fill several gaps: EmONC needs assessment, equipment for midwifery training, lifesaving skills, fistula programme in the north, CMA salary, support for midwife association conflict resolution, support for startup of bachelor degree midwifery programme, some support for JSI DELIVER for contraceptives commodities delivery. All of these were continuing activities from previous years. By the third year of funding innovation was declining[331].

[327] Information from Implementing partner
[328] Quote from Development partner
[329] Interviews with Government and NGO
[330] Interview with Regional Health Directorate
331 ICM Project Office

Findings from case study in **Sudan**	As already mentioned the MHTF-funded ICMA was in the process of preparing a proposal to bring international midwives to Sudan as UN Volunteer tutors to staff the midwifery schools. She was marketing the idea to various donors at the time of the evaluation. Also, the country office has used MHTF funds to finance the costing of the maternal health Road Map, both at state and federal levels. However, it is not clear if this will lead to the commitment of additional resources for maternal health. Overall, therefore, the MHTF had not yet triggered any commitments of additional funds for maternal health in Sudan at the time of the evaluation.
Findings from case study in **Zambia** (3rd Submission)	*The MHTF has helped UNFPA to translate its involvement in global and regional maternal health campaigns and partnerships (CARMMA, Maputo Plan, H4+) into national level awareness raising campaigns under its leadership. However, in most cases, high profile launches have not been used sufficiently to leverage additional resources to support maternal health in Zambia, neither from Government nor from development partners.* Potential MHTF contributions to an increased visibility of UNFPA in matters of maternal health in Zambia are primarily linked to the H4+ initiative, to CARMMA and the maternal health Road Map, and finally, to the increased presence of UNFPA staff in national technical fora, i.e., the General Nursing Council-led review of training curricula for midwives and nurses. Although the H4+ concept has not yet been firmly established in the working relationships of the respective partners in Zambia (see Evaluation Question 2 on the thematic evaluation above), the H4+ initiative provided a focal point for the partners at country level to submit two maternal health-relevant proposals for funding, i.e. to CIDA and to the European Union. The submitted budget for the CIDA-funded intervention alone was US$ 9,991,500. Implementation of neither of the programmes had started at the time of the evaluation. The two regional policy initiatives, CARMMA and the maternal health Road Map that were linked to the Maputo Plan of Action, created visibility for UNFPA and maternal health in the short-term, in particular through the well-publicized and MHTF-supported launch of the CARMMA initiative in Zambia. However, follow-up to either of these initiatives has been relatively weak. As stated above (Evaluation Questions 2 and 9 for the thematic evaluation), neither the maternal health Road Map, nor CARMMA have been used to systematically advocate for maternal health support in Zambia SWAp forums in the wake of the official launch. Development partners who tried to find information on the operational dimensions of CARMMA were discouraged by the fact that no information was readily available[332] and, as a result, decided not to pursue CARMMA any further[333]. MHTF-support has allowed UNFPA to become more visible in technical forums surrounding maternal health, specifically in the General Nursing Council-led review of training curricula, as mentioned above. The participation of the MHTF-funded CMA and CFA raised the profile of UNFPA in this group, as both development partners and Governmental partners acknowledged their contributions[334].
Findings from UNFPA **regional/ sub-regional office**s	Some country offices used MHTF money for launching CARMMA - , without it, not as many countries would have launched CARMMA. This has helped countries to commit additional resources, maybe not money, but certainly commitment. It is used as a mechanism to draw attention to maternal health, and more donors are getting interested, and provide funding at the country level. MHTF has boosted midwifery and EmONC, being complementary with WHO that develops guidelines and UNFPA helps operationalization. EmONC assessment will be undertaken in 3 new French speaking African countries with funding from the French Ministry of Foreign Affairs.

[332] There is, for example, no website with CARMMA-related information for Zambia. Staffing in the Ministry of Health to provide follow up, e.g. on pledges made during the launch or to solicit more financial contributions is limited.
[333] Feedback from interviews with several development partners
[334] Feedback from interviews with Development Partners and Governmental partners

Findings from **global level**	UNFPA/MHTF have participated in global maternal health initiatives such as: 1. The H4 (the World Health Organization, the United Nations Population Fund, UNICEF, and the World Bank) initiative that seeks to bring greater focus, integration, and resources to significantly reduce maternal and newborn mortality in countries with the highest incidences of maternal and newborn illness and death. UNFPA and particularly the MHTF coordinator drafted the joint statement. And was the coordinator for 6 months (rotating coordination). 2. Liaison with the Muskoka Initiative in which Canada CIDA has committed $50 million over the next five years for H4 work with national governments and civil society organizations to help strengthen maternal and reproductive health[335]. 3. Women Deliver Conference 2010 4. The UN Secretary General global initiative aimed at 'improving reproductive, maternal and newborn health' was launched in 2010; it was pushed by bi-laterals. UNFPA was initially ignored but is now part of it. **There is a consensus on** maternal health strategies (family planning, EmONC and skilled birth attendance) which is now a basis for further collaboration with the **SG Initiative on maternal health** at HQ, Country and Africa Region 5. Contributions to the reports: "Countdown to 2015: Taking stock of maternal, newborn and child survival," the MDG 2010 report and the State of World Population report; and conceptualization and development of the State of the World Midwifery report Most of these undertakings are supported by the media and communication branch (MBC) that maternal health agenda is pushed with an emphasis put on UNFPA role and relevance. Tools were developed by MCB such as: • A country office idea catalog was developed for country offices in 2010 regarding communication and advocacy for maternal health. An expanded package was developed in 2011 with a specific focus on midwifery and made available on the intranet. It is unclear how and how much these advocacy helping tools are used, but the key messages are used and suggested activities carried out in various countries. • The development in 2010 of a 15 minute advocacy video called Midwives Deliver about midwifery in Ghana, heavily featuring UNFPA work and the work of the midwifery programme. It was shown at the global Women Deliver conference, broadcast on National TV in Ghana and shown at various MHTF donor events, midwifery meetings, exhibitions etc. • A pilot project on evidence information communication was initiated in 2010. At regional level, particularly in Africa, the MHTF supported 1. the five-year review of the African Union (AU) Maputo Plan of Action 2. to ensure that maternal health is on the agenda of regional initiatives such as Harmonization for Health in Africa (HHA) aiming at 'tackling the barriers to scaling up in health' [336] At global level the Resource mobilization Branch (RMB) works with the MHTF in order to mobilize additional funds for the MHTF including the Obstetric Fistula Campaign and the midwifery programme. It elaborated a resource mobilization strategy for MHTF and Fistula for 2010-13. The RMB

[335] With the following components: i) country health plans to ensure that these are UN Millennium Development Goal-driven and performance-based; ii) Budget plans to rapidly bring required resources to support maternal and newborn health needs and to reduce financial barriers to access, especially for the poorest; iii) access to reproductive health services including family planning, skilled attendance at delivery, emergency obstetric and newborn care, and links with HIV prevention and treatment; iv) Training for skilled health workers, particularly midwives; v) Country plans to tackle the root causes of maternal mortality and morbidity, including inequality between women and men; low access to education, especially for girls; child marriage; and adolescent pregnancy; vi) Monitoring and evaluation system

[336] Interviews at UNFPA headquarters and document review

7.8.2 Judgment criterion 8.2: Effect of MHTF on (increased) external financial commitments to UNFPA / MHTF for maternal health support (at global, regional, country level)

Type of analysis	Findings
Findings from case study in **Burkina Faso**	*L'évaluation des besoins en SONU ainsi que l'appui à la formation de base des sages-femmes appuyé par le MHTF ont aidé l'UNFPA à se positionner en tant que leader dans ces domaines et ont également motivé les partenaires techniques et financiers à s'engager dans ces actions.* Les différentes actions de plaidoyer de l'UNFPA et des partenaires ont conduit à la programmation de nouveaux projets de soutien à la SR et santé maternelle avec la Banque Mondiale, l'Union Européenne, l'Agence Française de Développent (AFD), l'Agence Canadienne de Développement International (ACDI). A l'exception de ce dernier, la part que le MHTF a jouée est difficile à apprécier étant donné son lancement récent. Par contre le large plaidoyer pour le passage à l'échelle de la formation des sages-femmes a conduit la Banque Mondiale à soutenir les écoles de formation de base. L'évaluation SONU soutenue par le MHTF et appréciée par tous les partenaires a permis à l'UNFPA de gagner une certaine reconnaissance de l'action de l'UNFPA. La participation des partenaires (équipes de l'évaluation SONU, représentantes de l'association et de l'ordre des SF/ME à différents ateliers et congrès (évaluation SONU à Dakar, conférence en France, congrès ICM à Duban pour le lancement du *Midwifery Report* 2011) contribue à la visibilité de l'UNPA au niveau du pays et au niveau régional.
Findings from case study in **Cambodia**	*MHTF has brought in ideas, concepts and tools to Cambodia, together with some preliminary funding, but donors (AusAid and DfiD) and HSSP II have replaced MHTF funding, thus allowing UNFPA Cambodia to increase financial commitments to maternal health.* The effects of the above-mentioned leveraging by MHTF has meant its own funds could be released to further consolidate human resources for maternal health, with a focus on midwives and support to HRD/MoH, technical assistance for the National EmONC assessment and enhancement of EmONC Improvement Plan procurement possibilities for family planning (as and when required through GPRHCS) and Maternity Waiting Homes and guidelines for its operations.
Findings from case study in **Ethiopia**	The MHTF set to address the three pillars of maternal health Family Planning, Skilled Birth Attendance, and EmONC. Through the MHTF the ECO has been enabled to undertake activities that are directly contributing to the SWAp process such as national EmONC baseline, support to midwifery programme, health system strengthening in HRH and financial system strengthening to the FMOH, and resource pooling. The MHTF contributes annually to the ECO US$1 million and the same amount to the MDG fund and it secured a further $3.2 million grant for 5 years from Swedish SIDA for midwifery.
Findings from case study in **Ghana**	*The country office believes that MHTF has helped UNFPA Ghana and GHS to attract additional resources for MDG 5 goals a and b, to evaluate services and develop proposals to leverage other funds.* UNFPA Campaign to End Fistula in Ghana started in 2003; its goal was to sensitize people about fistula toward understanding that fistula can be treated and women do not need to be shunned. MHTF focused first on midwifery in 2009-10, and the fistula focus which started earlier got much needed impetus too. MHTF in Ghana is currently mapped as a strategy for fistula support. The first focus of MHTF was on community awareness; then the programme expanded to focus on treatment and rehabilitation. The Campaign in Ghana was considered as most commendable by all questioned, and has affected national policy on fistula. The programme has been able to identify patients and is ongoing; women who have been repaired become advocates. MHTF replaced an initial Swedish Midwifery Programme at a critical time of its development. It was always intended to include midwifery from the conception phase of the MHTF (see national output 4 in the business plan). However, Sweden at the time preferred to fund an initial project, but rapidly agreed to have this included in the MHTF as soon as it was practical; this occurred at the end of March 2009.

	Whilst the Netherlands wanted a focus on midwifery within maternal health - with which MHTF at HQ agreed - the Netherlands provided their funding directly to the MHTF right from the beginning and Ghana was one of the early beneficiaries (together with 10 other countries). GHS has received a loan from the Royal Netherlands government and is hoping for an EU grant as well to supplement funding from UNFPA to strengthen Fistula, Midwife and EmONC services. The country office believes that MHTF has helped to bring in this and other funds. The R3M (Reduction of Maternal Mortality and Morbidity) is a consortium of donors led by an Anonymous Donor (AD). The R3M focuses on a neglected area of maternal health – deaths due to unsafe abortions. There are five consortium partners besides the AD (Ipas, EngenderHealth, Marie Stopes International, Willows Foundation, and Population Council, which coordinates all); the consortium is focusing on three regions - Eastern Region, Greater Accra and Ashanti – as these are the 3 regions with highest abortion related maternal fatality rates.
Findings from case study in **Lao PDR**	*The MHTF supported EmONC assessment and improvement plan have helped in providing concrete directions and guidance. These are useful instruments to trigger increased commitment of development partners and donors.* The joint project upport for implementation of the National Skilled Birth Attendance Plan' funded by Luxembourg is an example of UNFPA leveraging capacity as it was based upon its participation to the MNCH package and the SBA plan development. It was approved before the start of MHTF. The MHTF support allowed different agencies to get mobilized in order to conduct the EmONC assessment e.g. UNICEF co-financed the assessment. The EmONC improvement plan will provide a useful tool for leveraging additional resources from development partners[337].
Findings from case study in **Madagascar**	*A document entitled "pledging document" was developed by UNFPA (including the MHTF) in conjunction with other UN agencies to mobilize additional resources from donors, but except for the Monaco/Andorra fund for the UNFPA/WPF joint programme, no additional funds could be mobilized by UNFPA.*
Findings from case study in **Sudan**	See 8.1
Findings from case study in **Zambia** (3rd Submission)	See 8.1

337 UNFPA staff interview

7.8.3 Judgment criterion 8.3: Effect of MHTF on (increased) financial commitments of partner governments to sexual and reproductive health and maternal health

Type of analysis	Findings
Findings from case study in **Burkina Faso**	*Le gouvernement était déjà favorable au renforcement des SONU avant l'introduction du MHTF mais les informations détaillées recueillies au cours de l'évaluation SONU facilitera des allocations budgétaires pus rationnelles.* Comme mentionné plus haut (partie MHTE) l'UNFPA a contribué à motiver l'engagement gouvernement du Burkina pour l'allocation de ressources additionnelles à la santé maternelle. Ce processus a été enclenché avant l'introduction du MHTF. L'évaluation SONU permet de démontrer la situation réelle et de faciliter la planification en fonction des goulots d'étranglement ce qui peut accroître la prise de conscience auprès des décideurs et un engagement accru.
Findings from case study in **Cambodia**	The MHTF approved budget for 2009 was originally US$865,000, of which US$388,871 was approved. This budget was revised upwards in October 2009 to US$464,721 (53 percent of the original total supported by AusAid). EmONC and Midwifery activities of the proposal received 16 percent of the budget, as National EmONC Assessment had to be completed and the remainder was allocated for commodity procurement (86 percent) to meet shortfall in contraceptives. Actual expenditure on revised activities for MHTF was 97 percent[338]. The approved budget for 2010 was US$500,000, of which US$128,400 came from GPRHCS for procurement of family planning commodities. However, the country did not need support from UNFPA commodity supplies in 2010, as KfW support was still ongoing. Therefore, the budget revisions were made in July and November 2010 and the final budget requested from MHTF in 2010 was US$337,419 (67.4 percent of the original total), of which US$334,161 was expended (99 percent). UNFPA was able to leverage funding by being an active part of sector plans and HSSP II (40 percent to maternal health in 2010) and being in the pool. National Committee on Population and Development, engagement by Parliamentarians and Fast Track Road Map has led to ad hoc funds being provided by Government upon request of MoH for extra activities in maternal health. There is also a 10 percent annual increase in 2011, compared to the regular health budget over the previous year, which will be continued until 2015. The extent to which MHTF has contributed to increased commitment for maternal health is clear in the strong support by Government and donors to the National EmONC Assessment and EmONC Improvement Plan in Cambodia and has in no doubt increased financial commitments to maternal health.
Findings from case study in **Ethiopia**	*The MHTF can be considered instrumental in leveraging from governmental and development partners financial commitments to maternal health issues.* UNFPA was the first UN organization to join the MDG fund (with MHTF funds) to have a strategic place in the joint governance structure between development partners and the FMOH. The Joint coordination committee is the most functional coordinating mechanism; it meets every two weeks, discusses and agrees on every plan and programme. The MHTF contribution of $1M into the MDG pooled fund served to leverage from partners an additional $6M for family planning[339] and EmONC commodities. Likewise, the efforts of the MHTF have certainly contributed and directed the commitment of the FMoH towards its investment in capacity development and refurbishing of EmONC facilities. The MGD fund is not co-funded by the Government of Ethiopia (GoE), hence not a true basket funding, nevertheless salaries of the new cadre will be covered by the FMoH which represents de facto an increased contribution towards maternal health of

[338] UNFPA Cambodia Financial Report 2009 and 2010

[339] Which were for example utilized for the health extension worker programme (funded by the MDG fund), which had a major impact on rapidly increasing contraceptive prevalence in Ethiopia, as demonstrated by the difference in coverage measured by the DHS 2005 (14 percent) and the DHS 2010 (29 percent).

	the GoE.
Findings from case study in **Ghana**	See 8.2
Findings from case study in **Lao PDR**	The EmONC assessment saw a mobilization of the government at different level during the phase of data collection, the improvement plan may lead to increased commitment of the government but it is still early to figure it out.
Findings from case study in **Madagascar**	*The political crisis in the country has considerably weakened the economic performance and the health system. The government is internationally not recognized which leads to a suspension of bi-lateral funding, normally accounting approximately 60-80 percent of the state budget. The operating budget of the MoH has been reduced from 9 percent to 6 percent of the GDP within two years and no further commitments to maternal health have been made by the MoH.*

8. Team of external consultants

The evaluation was conducted by the Evaluation Branch (DOS) in collaboration with a team of independent experts from AGEG Consultants eG.

Core team	
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