COUNTRY REPORT

ETHIOPIA

EVALUATION OF UNFPA SUPPORT TO MATERNAL HEALTH

Mid-Term Evaluation of the Maternal Health Thematic Fund

EVALUATION BRANCH
Division for Oversight Services

New York, October 2012

UNFPA

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COUNTRY REPORT: ETHIOPIA

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http://www.unfa.org/public/home/about/Evaluation/EBIER/TE

Layout and design: uPwelling.net

EVALUATION OF UNFPA SUPPORT TO MATERNAL HEALTH

Including the contribution of
the Maternal Health Thematic Fund

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List of Acronyms

AMDD	Averting Maternal Death and Disability
ARRA	Administration of Refugees and Returnees Affaires
AWP	Annual work plan
AYRHS	Adolescent and Youth Reproductive Health Strategy
BCC	Behavior change communication
CAC	Comprehensive abortion care
CARMMA	Campaign for Accelerated Reduction of Maternal Mortality in Africa
CC	Community conversation
CCA	Common country assessment
CCCA	Comprehensive Community Conversation for Action
CCRDA	Consortium of Christian Relief & Development Associations
CMA	Country Midwife Association
COAR	Country office annual report
CORHA	Consortium of Reproductive Health Associations
CP	Country programme
CPAP	Country programme action plan
CPD	Country programme document
CPR	Contraceptive prevalence rate
CS/C-Section	Caesarean section
CSS	Clinical support service
DAC	Development Assistance Committee
DaO	Delivering as One
DHS	Demographic health survey
DP	Development partner
EMA	Ethiopian Midwifery Association
EmOC	Emergency obstetric care
EmONC	Emergency obstetric and newborn care
EOC	Ethiopian Orthodox Church
ESOG	Ethiopian Society of Obstetricians and Gynecologists
FGAE	Family Guidance Association Ethiopia
FGM	Female genital mutilation
FGM/C	Female genital mutilation/cutting
FMoH	Federal Ministry of Health
GBV	Gender-based violence

GNI	Gross national income
GOE	Government of Ethiopia
GP	Global programme
GPRHCS	Global Programme to Enhance Reproductive Health Commodity Security
GTP	Growth and Transformation Plan
H4	UNFPA, UNICEF, World Bank, WHO
HAPCO	HIV/AIDS Prevention and Control Office
HEW	Health extension worker
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
HMIS	Health management information system
HPN	Health, population and nutrition
HRH	Human resources for health
HSDP	Health Sector Development Programme
HSS	Hospital Support Service
ICAP	International Center for Health Care and Treatment Programmes
ICASA	International Conference on AIDS and STIs in Africa
ICM	International Confederation of Midwives
ICPD	International Conference on Population and Development
IDM	International Day of the Midwife
IEC	Information, education and communication
IEOS	Integrated emergency obstetric and surgery
IFHP	Integrated family health programme
IHP+	International Health Partnership
JCCC	Joint Core Coordinating Committee
JCF	Joint Consultative Forum
JFA	Joint Financing Arrangement
JRM	Joint Review Meeting
M&E	Monitoring and evaluation
MDG	Millennium Development Goal
MHTE	Maternal Health Thematic Evaluation
MHTF	Maternal Health Thematic Fund
MISP	Minimum Initial Service Package
MM	Maternal mortality
MMR	Maternal mortality rate
MoE	Ministry of Education
MoF	Ministry of Finance

MoH	Ministry of Health
MoWCY	Ministry of Women, Children and Youth
NGO	Non-governmental organization
NPC	Non-physician clinician
NPO	National Programme Officer
PAC	Project Appraisal Committee
PASDEP	Plan for Accelerated and Sustained Development to End Poverty
PFSA	Pharmaceutical Fund Supply Agency
PHCU	Primary Health Care Unit
PMTCT	Preventing mother-to-child transmission
PPH	Postpartum hemorrhage
PRS	Poverty Reduction Strategy
RCMA	Regional Coordination Mechanism Advisor
RHB	Regional Health Bureau
RHCS	Reproductive health commodity security
SIDA	Swedish International Development Cooperation Agency
SNNPR	Southern Nations, Nationalities and Peoples Region
STI	Sexually transmitted infections
SWAp	Sector wide approach
TD	Technical Division
ToT	Training of trainers
TVET	Technical and Vocational Education and Training
TWG	Technical working group
UN	United Nations
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
UNV	United Nations Volunteers
USD/ US$	US dollar
WAHA	Women and Health Alliance
WFP	World Food Programme
WHO	World Health Organization

1. Purpose and scope of the evaluation

Maternal health remains a major challenge to health systems worldwide. The world is on track to reach some targets of the Millennium Development Goals (MDGs) by 2015, but falling short on others; maternal health is the least likely to meet the 2015 target. A recent analysis found an annual rate of reduction of 1.3 per cent during the period of 1990–2008, well short of the 5.5 per cent needed to attain the MDG target by 2015. At the current rate of decline, it will take more than 188 years to meet the goal of 100 per 100,000 live births.

Given the current lack of sufficient progress in tackling maternal mortality, it is critical that effective interventions are implemented and monitored. Careful evaluation of these interventions is crucial for determining what works and for ensuring that scarce resources are allocated effectively. This is particularly true for developing countries, where maternal mortality is highest and access to maternal health services is poor. For this reason, United Nations Population Fund (UNFPA) has launched the evaluation of its support to maternal health in the last eleven years and the mid-term evaluation of the Maternal Health Thematic Fund. Following the terms of reference, the evaluation covers the period from 2000 until 2010, and also includes information related to a number of interventions implemented in 2011.

The aim of conducting both evaluations in parallel; i.e. the Maternal Health Thematic Evaluation (MHTE) and the Mid-Term Evaluation of the Maternal Health Thematic Fund (MHTF); is to take advantage of potential synergies in the evaluation portfolio of UNFPA and obtaining deeper and better substantiated insights on the thematic area of maternal and reproductive health as a whole, as well as on the MHTF individually.

1.1 Scope of the Maternal Health Thematic Evaluation

The MHTE assesses to what extent UNFPA support to maternal health has been relevant, effective, efficient and sustainable in contributing to the improvement of maternal health. The evaluation covers all programmatic interventions that have been directly relevant to maternal mortality and morbidity within UNFPA mandate, including all activities financed from core and non-core resources; and those financed through UNFPA Reproductive Health Thematic Funds.[1] MHTE focuses on key elements of reproductive health including family planning, skilled birth attendance and Emergency Obstetric and Newborn Care (EmONC), i.e. the "three pillars" of reducing maternal mortality. The thematic scope of the MHTE is defined by a list of twelve evaluation questions (a table with all evaluation questions and related judgment criteria is presented in Annex 6.3).

1.2 Scope of the Maternal Health Thematic Fund mid-term evaluation

The objectives of the mid-term evaluation of the Maternal Health Thematic Fund (MHTF) are to assess to what extent MHTF support has been relevant, effective, efficient and sustainable in contributing to the improvement of maternal health. The mid-term evaluation focuses on technical areas (midwifery, family planning and emergency obstetric and newborn care)

1. I.e., the Maternal Health Thematic Fund, the Global Program to Enhance Reproductive Health Commodity Security and the joint UNFPA-UNICEF Female Genital Mutilation Program.

and on the potential of the MHTF to act as a catalyst in these areas. The evaluation also covers the internal coordination and management processes of the MHTF (support to planning, programming and monitoring, coordination and management mechanisms, and the facilitation of the integration and use of synergies). Additionally, aspects of leveraging and visibility are assessed. The temporal scope of the mid-term evaluation covers the period since the launch of the MHTF in 2008.

The strategic framework of the MHTF (i.e., the MHTF business plan) provides a clear reference framework for the mid-term evaluation. The specific thematic scope of the mid-term evaluation of the MHTF is defined by a list of eight evaluation questions (a table with all evaluation questions and related judgment criteria is presented in Annex 6.3).

1.3 Geographical scope of the overall evaluation

The scope of this evaluation is limited to those 55 countries whose maternal mortality ratio in the year 2000 was higher than 300 deaths per 100,000 live births. The main rationale for this delimitation of the scope is to allow the evaluation to a) include those countries that have or have not made improvements in addressing maternal heath since the year 2000; and b) to focus the analysis on those countries that, relative to others, have experienced the greatest challenges in improving maternal health in accordance with MDG 5.

1.4 Purpose and structure of this country report

This country report has been prepared following the completion of the country case study in Ethiopia and summarizes its findings and conclusions. The findings presented in this country report, together with nine other country reports, inform the final evaluation reports for the MHTE and the mid-term evaluation of the MHTF.[2]

The country report is structured as follows:

- Chapter 2 explains the case study methodology. It discusses:
    - The process and criteria for selecting case study countries overall, and the specific reasons for choosing Ethiopia as a case study
    - The preparation and implementation of the case study
    - The limitations and constraints experienced by the evaluation team
- Chapter 3 provides a short description of the reproductive health sector in Ethiopia, and describes the overall approach of UNFPA to supporting maternal health in the country.
- Chapter 4 presents the findings of the country case study.
- Chapter 5 presents the conclusions of the country case study drawing on the findings for each of the evaluation questions. While Chapter 5.1 draws conclusions for UNFPA overall maternal health support in the country, Chapter 5.2 focuses on the added value of the Maternal Health Thematic Fund.

2. Final evaluation reports for MHTE and MHTF are available on the following web page: http://www.unfpa.org/public/home/about/Evaluation/EBIER/TE/pid/10094.

2. Methodology of the case study

The methodology for the case study has been developed based on the overall methodology for the MHTE and the mid-term evaluation of the MHTF (see final reports for MHTE and MHTF). The purpose of the country case study is to use the field visit to collect data and information to verify the hypotheses developed during the desk phase of the evaluation and to further inform the answers to the evaluation questions.

2.1 The selection of country case studies

2.1.1 The process and criteria for selecting country case studies

The evaluators carried out a comprehensive staged sampling process to select the countries to be included in the field phase of both evaluations. The first sampling stage resulted in the selection of all 55 UNFPA program countries with a maternal mortality ratio (MMR) higher than 300 deaths per 100,000 live births in the year 2000.[3] In the second sampling stage, 22 countries out of the initial 55 were selected for inclusion in the extended desk phase. In order to ensure that different types of country contexts were included in this second-stage sample, the countries were grouped and selected according to the following criteria (see Table below)

Criteria used to create a typology of desk phase countries

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

3. The sampling criterion has been selected to establish a close ling to the MDG5 indicators. The data have been taken from the H4 report "Trends in Maternal Mortality: 1990-2008" in agreement with UNFPA.

In the third sampling stage, ten countries out of the group of 22 were selected for in-depth case studies (field phase); eight of these countries were recipients of the MHTF. Case studies were selected so that each type was represented by two[4] cases: One country that had made large improvements; and a similar country (according to the above selection criteria) that only had made small improvements in reducing maternal mortality. Overall, this systematic approach to selecting countries for the field phase allowed for different types of country contexts to be equally covered by the evaluations.

2.1.2 Justification for selecting Ethiopia

Within the sample of ten countries selected for the field phase, Ethiopia was one of six countries that had made relatively large progress in reducing maternal mortality: Having started with a maternal mortality ratio (MMR) of 750 deaths per 100,000 live births in the year 2000, the country was able to lower this ratio by about 37 per cent to 470 deaths per 100,000 live births in 2008.[5]

Relative to other case study countries, such as Ghana, Cambodia, Burkina Faso or Zambia; Ethiopia had a relatively low per-capita Gross National Income (GNI) of US$ 992.[6] The assumption was that this relatively low GNI would have reduced the availability of national resources to address bottlenecks in maternal health service provision without external assistance, which also would have put higher demands on UNFPA and other development partners to support the efforts of the government in reducing maternal mortality.

Based on a 2009 governance[7] index, Ethiopia also had scored high in the category of 'quality of public administration'. This was interpreted to mean that the country should have had a greater capacity than other selected countries to take on many of its own challenges with greater independence from development partners.

Lastly, the prevalence of HIV and AIDS in Ethiopia was relatively low, in particular in comparison to countries such as Zambia or Kenya that also had been selected for the field phase. The low prevalence of HIV and AIDS was assumed to make the challenge of reducing maternal mortality less complex and therefore less challenging for the government as well as for UNFPA in comparison to these high-HIV prevalence countries.

2.2 Scope of the country case study

This country case study is one of several evaluation components used to collect evidence for answering the global evaluation questions and judgment criteria[8] of the two evaluations.[9] These evaluations draw on a number of different information sources. Consequently, this country case study provides only some of the information required to answer the global evaluation

4. Burkina Faso, Cambodia, DRC, Ethiopia, Ghana, Kenya, Lao PDR, Madagascar, Sudan, and Zambia.
5. Based on data from (WHO, UNICEF, UNFPA, World Bank, 2010).
6. This puts Ethiopia into a group of countries with per-capita GNIs lower than US$1,000, along with DRC, and Madagascar, as countries that have made relative good progress in lowering their maternal mortality ratio.
7. See "Country and Policy Institutional Assessment", 2009 Assessment Questionnaire, Operations Policy and Country Services, World Bank, Washington DC; Source: The World Bank CPIA; http://data.worldbank.org/indicator/IQ.CPA.PUBS.XQ.
8. During the inception phase of this assignment, the focus of each of these global evaluation questions had been sharpened by defining a set of judgment criteria that specified which aspects of UNFPA associated support to maternal health should be at the center of attention for each evaluation question. These judgment criteria define in greater detail the specific conditions of success of UNFPA support in each of the thematic areas covered by the evaluation questions. For a more detailed explanation of judgment criteria, please see the final reports of the MHTE and MHTF evaluations.
9. I.e., the Maternal Health Thematic Evaluation and the MHTF mid-term evaluation; see Chapters 1.1 and 1.2 above.

questions comprehensively.[10] The scope of the country case study is defined by the "issues to assess" that are listed at the beginning of the findings-section for each evaluation question, together with the judgment criteria they correspond to. These "issues to assess" were defined after analyzing the global maternal health strategy of UNFPA and its underlying theory of change. Based on this analysis, the evaluation team determined which parts of this theory of change were the most important for the overall success of the UNFPA maternal health strategy. The global list of "issues to assess" was then adapted to the context of the case study country.[11] The country case study focused on collecting information on these specific issues. Its findings therefore do not amount to complete answers to the global evaluation questions.[12] Recommendations are not elaborated at this stage, as the overall conclusions to the evaluation questions will only be developed on the level of the final reports to the MHTE/ MHTF evaluations.

Since the 20 global evaluation questions of the two evaluations[13] are designed to assess the relevance, efficiency, effectiveness, and sustainability[14] of the support to maternal health provided by UNFPA, the issues to assess that were derived from the evaluation questions are also related to these four DAC standard evaluation criteria.

2.3 Preparation of the country case study

The evaluation team prepared this country visit in cooperation with the UNFPA country office. The evaluation team mapped the relevant stakeholders, selected interviewees, identified data sources and selected data collection approaches to ensure that information on each particular issue would be collected:

1. From different sources, such as from different stakeholders, to reflect potentially differing perspectives, or from different documents (data triangulation).
2. Using complementary data collection methods, i.e., a mix of quantitative and qualitative methods, such as the use of secondary data on maternal health from demographic health surveys; and the use of feedback from key informant interview and focus groups (methodological triangulation).[15]

An overview of the triangulation for each evaluation question is presented in Annex 6.2.

2.4 Data collection methods and analysis during the country case study Ethiopia

The evaluation team used the following approaches for collecting data during the country visit to Ethiopia:

- The team conducted a series of interviews in Addis Ababa, i.e., with staff from UNFPA and with representatives of UNFPA main partners in the country, including governmental partners, non-governmental, development and other implementing partners. In these interviews, the team focused on the collection of qualitative data that would help to provide contextual information on UNFPA interventions, its contributions and roles in partnerships, etc.

10. 12 evaluation questions for the Maternal Health Thematic Evaluation and eight evaluation questions for the MHTF mid-term evaluation.
11. Issues addressed may vary from one country case study to the other. Only issues which have been addressed in this specific country case study are shown in the tables in front of each evaluation question and in the annex. This might lead in some occasions to difficulties in linking issues and judgment criteria but this is unavoidable as the methodology has been designed for the overall global evaluations.
12. See also the final reports of the MHTE and MHTF evaluations for more details on the methodological approach.
13. The Maternal Health Thematic Evaluation and the MHTF Mid-Term Evaluation.
14. I.e., four of five standard Development Assistance Committee (DAC) evaluation criteria.
15. E.g., semi-structured interviews, focus groups, document reviews.

- During the country visit, the team collected and reviewed additional documents that either had not been available during the desk phase; or that needed to be revised to verify particular information that had been received during one of the interviews.[16] Evaluators focused in particular on the following types of documents:

    - Annual work plans (AWPs), in particular those AWPs that had not been available to the evaluation team during the desk phase.
    - Relevant national strategic documents including policies and strategic frameworks for sexual and reproductive health policies, maternal health policies, family planning, EmONC and other relevant topics.
    - Needs assessments and other inputs into the policy-making process that UNFPA had supported or implemented, covering all relevant maternal health topics.
    - Documents that described and defined UNFPA relationship with its partners in the country, such as Memoranda of Understanding (MoUs) with development partners or government.
    - Evaluations or assessments of UNFPA maternal health support in the country that had not been available to the evaluation team during the desk phase of this evaluation.

- During the first week of the visit, the team travelled to Jimma to visit a selection of UNFPA project sites. During the site visits, the team interviewed representatives from local authorities, staff of health centers that had received UNFPA support, and implementing partners.
- The team also conducted a focus group discussion with second year Master Degree Students on emergency obstetrics and surgery, a UNFPA supported degree course.
- Throughout the preparation and conduct of the case study, the evaluators ensured that they differentiated between maternal health support financed by UNFPA core funds, and support financed by the MHTF.

At the end of the visit to Ethiopia, the evaluation team did a preliminary analysis of their findings for each of the evaluation questions. These findings were presented to the UNFPA country office prior to the departure of the team. In addition, the team formulated conclusions on a number of topics that cut across the thematic areas covered by the evaluation questions. These conclusions constitute an assessment of selected aspects of UNFPA support to maternal health in Ethiopia and on the added value of the MHTF. However, due to the selective nature of the case study, these conclusions do not necessarily form a comprehensive and complete assessment of UNFPA support of sexual and reproductive health in the country, as would have been the case in a country program evaluation of Ethiopia. These conclusions are presented in Chapter 5.

16. A comprehensive list of interviewees is presented in the annexes.

2.5 Limitations and restrictions

During the country visit, the evaluators encountered the following challenges or constraints:

Table 1: Challenges or constraints encountered throughout the field phase and reactions

Challenges/constraints encountered	Reactions
The Annual Review Meeting of the Federal Ministry of Health (FMoH) took place early in the first week of the visit and involved most stakeholders (interviewees). Thus, site visits took place rather early during the visit and only three days were available for interviews at national level. Some partners were not available.	Document review to support findings.
Most interviewees reported to be in their respective position for less than three years, hence in-depth knowledge about previous years' implementation could not be obtained.	Document review to support findings.
The MHTF supported programmes are in the initial phase; results in terms of impact or direct contribution to a reduction of maternal mortality (MM) is not yet measurable.	The initiatives undertaken by the UNFPA country office are in line with nationally and internationally provided evidence and the assumption can be made that these interventions will contribute to the desired outcome.

3. Short description of the reproductive health sector

3.1 Country Background

Ethiopia is the 10th largest country in Africa with the second largest population on the continent, estimated at 90.1 million in 2011[17] . Nearly 84 per cent of its citizens live in rural areas. The population is predominantly young, with 44.9 per cent under the age of 15 years. 49.5 per cent of the total population is female, with 24 per cent in the reproductive age bracket (15-49 years). Average lifetime fertility has declined from 5.5 births per woman (2000) to 4.8 births.[18] However, on average, rural women still give three more births than urban women. Even with declining fertility, the annual population growth rate is 2.6 per cent.

Table 2: Key economic data Ethiopia

Total population Ethiopia (2009)[19]	82,825,000
GDP (2009, current US$)	28.53 US$ billion
GDP/per capita (2009, current US$)	344.6 US$

Source: UN Statistical Service UN Data. Ethiopia

Ethiopia has a three-tier health care delivery system. The 1st tier Woreda/district health system is comprised of a primary hospital with coverage of 60,000–100,000 people, a health center serving a 15,000-25,000 population, and five satellite health posts, each serving 3,000-5,000 people. The second tier consists of a general hospital with population coverage of 1-1.5 million people; and the third a specialized referral hospital that covers a population of 3.5-5 million. A primary hospital, health centre and five satellite health posts form a Primary Health Care Unit (PHCU). Private-for-profit and non-governmental organizations (NGO) also play significant roles in expanding the health service coverage and utilization.

The health status of Ethiopians remains low compared to worldwide standards. Major health problems of the country are communicable diseases, nutritional disorders, largely preventable maternal and child health problems and increasingly chronic health problems such as cardiovascular diseases, diabetic mellitus and cancers.

17. Population size according to Ethiopian Statistical Bureau.
18. All data for 2000 is taken from the Ethiopian Demographic Health Survey 2005.
19. More recent UN data on the country's population is not yet available.

3.2 Ethiopia Health Sector

The GoE health response is developed in two planning cycles. The first is the five year strategic planning process called the Health Sector Development Programme (HSDP). The HSDP serves as a guiding blueprint on which all other plans are developed, such as the Regional Health Plans. The second is the annual planning cycle that translates the five-year HSDP into the annual plan of work with detailed targets, strategies and interventions at the different levels of the health care system.

A major objective of the health sector is to have the One-Plan, One-Budget and One-Report approach at all levels of the health system. Ethiopia is a signatory of the Global International Health Partnership (IHP+) Compact. The health sector is governed through key coordinating and steering committees, including the Federal Ministry of Health (FMoH), Regional Health Bureaus (RHB) Joint Steering Committee, FMoH- Health, Population and Nutrition (HPN) Joint Consultative Forum and the Joint Core Coordinating Committee. The Joint Consultative Forum (JCF) is the highest governing body and serves as a joint forum for dialogue on sector policy and reform issues between GoE, development partners (DPs) and other stakeholders. The Joint Core Coordinating Committee (JCCC) is the technical arm of the JCF.

Since the development of the Health Policy in 1993 and the HSDP 1 in 1998, the FMoH has formulated and implemented a number of policies and strategies that form an effective framework for improving health in the country. This includes strategies such as Making Pregnancy Safer (2000), the Reproductive Health Strategy (2006), the Adolescent and Youth Reproductive Health Strategy (2006) and the Revised Abortion Law (2005). Others include strategies on free key maternal and child health services and the training and deployment of two new health workforces (All Female Health Extension Workers and the Development Army Volunteers) for the institutionalization of community health care services.

HSDP IV for the period 2010/2011-2014/2015 identified maternal and newborn health as one of the priorities of the health sector, set impact and outcome indicators that are aligned to MDG health goals, and indicated mechanisms and resources to achieve the targets. National targets to be reached by 2015 in maternal and newborn health are a maternal mortality ratio of 267/100,000 live births, skilled attendance at birth at a rate of 60 per cent and a contraceptive prevalence rate of 80 per cent.[20]

The health budget share of the total government budget has been increasing significantly from US$ 522 million in 2004/05 to US$ 1.2 billion in 2007/8. In 2008/09, for example, the health budget allocation was 10.1% of the received regional public block grant from the federal government.[21] However, the health system continues to be challenged to mobilize sufficient funding for the continuous improvements necessary to reach its stated mission and vision. This drives an ongoing search for additional health resources, from community and social insurance schemes, enhanced user fee revenues and the increased mobilization of external resources from global and health development partners.

The provision of life-saving obstetric care to the most deprived women in Ethiopia is seriously impeded by the shortage of midwives and doctors, particularly in rural areas, combined with high out-of-pocket payments at health facilities. 68 per cent of the health facilities charged a fee for normal delivery or required women to buy supplies even though the national policy supports free life saving and delivery services. To address this, the Government of Ethiopia (GoE) developed a Human Resource for Health Strategy 2009/10 that has a target of training 8,635 midwives, 820 obstetricians and 233 anesthetists by the year 2015. Investment in health facilities has reduced the proportion of the population living less than 10 kilometers from a health post. The total number of health extension workers trained and deployed is 98 per cent of the total national requirement of 30,786.

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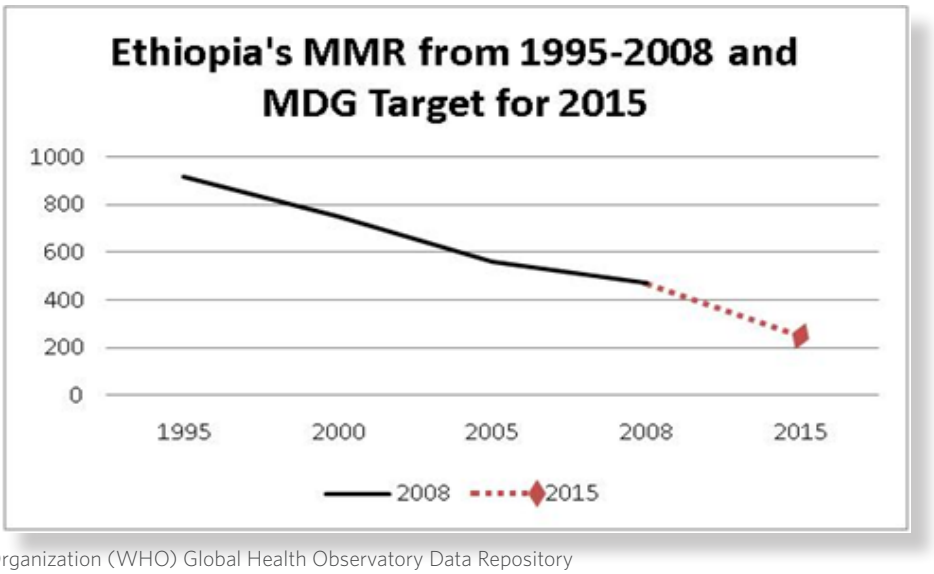
20. The mentioned targets are national targets which were aligned to, but not identical with the official MDG five goals as quoted in figure 1. National Maternal Health Targets for 2014/5 can be found under www.et.undp.org/dmdocuments/publications/other/Goal_5.pdf .
21. Health Sector Development Program IV 2010/11-2014/15.

More than 100 health centers, especially in the large regions of Amhara, Oromia and the Southern Nations, Nationalities and Peoples Region (SNNPR), are located more than 100 kilometers from the referral facilities that provide emergency obstetric surgical procedures. Most of these facilities are not equipped to provide the full range of emergency obstetric and newborn care (EmONC) functions.

3.3 Health Indicators

Although maternal mortality ratio (MMR) estimates in Ethiopia vary considerably, most agree that the country maternal mortality is among the highest in the world. The Ethiopian DHS of 2000 and 2005 put the figures for the six year period prior to the surveys at 871 and 673 deaths per 100,000 live births, respectively. A recent publication in the Lancet on global maternal mortality trends provides more optimistic figures for Ethiopia both in terms of decline in maternal mortality (MMR= 590/100 000)8 and the improvement of Ethiopia's rank among sub-Saharan African countries (28 out of 46 countries in the list, in 2008). However, the figure provided by the UN is lower, with 470 deaths per 100,000 live births8. For neonatal mortality, the rates are 48.7 deaths per 1,000 live births and 39 deaths per 1,000 live births respectively, as reported in the DHS 2000 and 2005. High mortality and morbidity rates in Ethiopia stem from a range of socio-economic, political and demographic factors.

Figure 1: Maternal Mortality Ratio Ethiopia, 1995-2008 and 2015 MDG Target



Source: World Health Organization (WHO) Global Health Observatory Data Repository

Overall, an Ethiopian woman has a one in 17 chance of dying from pregnancy related causes during her lifetime; an estimated 24,000 women die each year from hemorrhaging, infection, prolonged and/or obstructed labor, abortion complications and hypertensive disorders in pregnancy. The coverage rate for antenatal care reached 71.4 per cent in 2009/10; while health extension workers (HEWs) reached 17 per cent with clean and safe delivery service in 2009/10.

Table 3: Maternal Health Indicators. Ethiopian Demographic Health Survey 2005.

Maternal mortality ratio in 2005	673
MDG target for maternal mortality rate [22]	250
% HIV prevalence rates (aged 15-49) in 2005	1.4[23]-
% current use of contraception (all methods) in 2011	28.6
% antenatal care coverage from a skilled provider (at least one visit)	33.9
% of births attended by a skilled provider in 2011	10
% unmet need for family planning (total) in 2011	25.3

Source: Ethiopian Demographic and Health Survey (DHS) 2005 and Preliminary Report 2011

22. UN Data.
23. DHS 2005.

3.4 UNFPA response to maternal health in the country

Geographic coverage of UNFPA support:	National level
Population covered by UNFPA support[24]	90,873,739
Total spending regular sources 2004-2010[25] (ATLAS)	23,327,213.28 US$
Total spending regular sources per capita (total population)	0.27 US$
Total spending other sources 2004-2010[26] (ATLAS)	24,792,316.21 US$
Total spending other sources per capita (total population)	0,256699169 US$
Planned spending other funds CPAP 2004-2010	Total: 96,250,000 US$ out of which 22,750,000 US$ regular sources 73,500,000 US$ other sources Reproductive Health Component: 53,050,000 US$ Population and Development Component: 34,200,000 US$ Gender Component: 8,000,000 US$
Total spending MHTF[27]	2010 Budget: 1,978,863 US$ Expenditure: 1,728, 722 US$

Source: Calculation by evaluation team based on UNFPA sources

UNFPA began assisting Ethiopia in 1973 and has supported five programme cycles since, with each cycle lasting five years (although the next cycle will last four years to align with the FMoH planning cycle that ends in 2015). The early years of UNFPA presence in the country, support focused on research and capacity development for research and data collection, while promoting population issues at the policy level. UNFPA Ethiopia continues to work with the GoE, always within the framework of the government development priorities and the United Nations Development Assistance Framework (UNDAF). UNFPA also works closely with civil society, media, and faith-based organizations.

24. Population in 2011 according to DHS.
25. ATLAS data.
26. Ibid.
27. MHTF Expenditure Report 2010.

UNFPA is an active member of the UN family and promotes joint efforts to implement the International Conference on Population and Development (ICPD) Programme of Action. The MDGs are at the heart of joint programme formulation and implementation, within the context of national policies and programmes. UNFPA has actively participated in joint activities of the United Nations Country Team (UNCT) and has played a lead role in the inclusion of population, reproductive health, and gender issues in the MDGs needs assessments and into the Plan for Accelerated and Sustained Development to End Poverty (PASDEP). As a result of this advocacy, population is treated as a cross-cutting issue in the UNDAF. UNFPA chairs the UN Gender Technical Working Group whose primary function is to ensure gender mainstreaming into the UNDAF. Within the UN Joint HIV/AIDS Programme in Ethiopia, UNFPA is designated by the UNCT as a convener for HIV prevention.

UNFPA has contributed to the formulation and adoption of national population, gender, youth and reproductive health policies and legislation, and the repositioning of family planning in the development agenda. It serves as a procurement mechanism for approximately 60 per cent of the contraceptive Implanon and for ten per cent of the country's other contraceptive commodities. UNFPA provides infrastructure and equipment support to three facilities for fistula repair. Before the MHTF, UNFPA predominantly supported in-service training; recently and in line with the GoE priorities, it started supporting pre-service training to a new cadre of Non Physician Clinician (NPC) Emergency Surgical Officers, and nurse-anesthetists as well as to midwives. MHTF support through the International Confederation of Midwives (ICM)/ UNFPA partnership has been provided to the Ethiopian Midwifery Association for capacity development, advocacy for national regulation of midwives, and strengthening of the main office of the association and opening of new regional branches. The MHTF has also funded the salaries of both an international and national country midwifery adviser. UNFPA is one of the donors to the MDG fund and has annually contributed an amount of US$ 1 million through the MHTF.

4. Findings of the country case study

The following section presents the findings of the country case study.

4.1 Findings related to the MHTE

4.1.1 Evaluation question 1: Relevance/Coherence

Evaluation question 1

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

Judgment criteria [28]	Issues to address (field phase)
1.2. (Increased) availability of accurate and sufficiently disaggregated data for targeting most disadvantaged/ vulnerable groups	To what extent do UNFPA/ implementing partner monitoring tools include indicators to capture the specific situation of the most vulnerable?
1.3. Needs orientation of planning and design of UNFPA supported interventions	To what extent do UNFPA country offices utilize information from needs assessments other than the Common Country Assessment (CCAs)?
	To what extent have country offices used alternative means for needs-oriented planning and the identification of the most vulnerable groups?

Judgment criterion 1.2

- (Increased) availability of accurate and sufficiently disaggregated data for targeting most disadvantaged/ vulnerable groups

UNFPA is supporting the availability of accurate and suitably disaggregated data for planning, implementation and evaluation of programmes in population and development and sexual and reproductive health. The DHS and census identify specific vulnerable groups and include data on HIV/AIDS, sexually transmitted infections (STI) and maternal mortality. The number of users of this data could not be ascertained. However, the large number of donors supporting these surveys indicates their importance for the development community in Ethiopia.

28. For indicators associated with the judgment criteria, please see the desk report of this evaluation assignment

UNFPA has provided financial and technical support for the DHS 2005 and 2011, and the census in 2007.[29] The census collected data on a number of demographic determinants of maternal health vulnerability such as population size, age structure, gender, ethnic group, religion, fertility, mortality, migration, literacy and education, marital status, economic activity, and housing. The recent UNFPA-supported DHS also included separate questionnaires for men and women to identify gender-specific needs and vulnerabilities.[30]

Various other needs assessments have been initiated and supported by UNFPA. Most of these assessments have been done jointly with the Ministry of Health (FMoH), implementing partners or H4 partners (UNFPA, United Nations Children's Fund (UNICEF), World Bank, WHO). These assessments have become the basis for GoE health sector development plans, the UNDAF and the UNFPA annual work plans.[31] The UNFPA-initiated Emergency Obstetric and Neonatal Care (EmONC) needs assessment in 2008 became the basis for the MoH plan to scale-up EmONC services.

Needs assessments performed by other partners (i.e. WHO) have also been utilized for programme planning (e.g. midwifery schools' and anesthetic schools' assessment). At the time of the country visit, the FMoH was leading a facility assessment, jointly supported by UNFPA and other partners, to evaluate preparedness for the new cadre of integrated emergency and obstetric surgeons (IEOS).

Judgment criterion 1.3

- Needs orientation of planning and design of UNFPA supported interventions

Priorities for maternal health interventions and their geographical locations are set by governmental partners in collaboration with the country office. Needs-oriented planning by the government is based on nationwide general or targeted surveys as well as community-level assessments, supported by UNFPA and other partners.

UNFPA plans its interventions in accordance with the priorities of the government and using analyses produced by the GoE, UN agencies and other development partners. The Government of Ethiopia Growth and Transformation Plan 2011-2015 is aligned with the Millennium Development Goals timeframe and builds on the MDG Assessment Report of the Government of Ethiopia. In July 2010, the Ministry of Finance and Economic Development commissioned a series of situation analyses with a special focus on the needs of boys and girls. The Growth and Transformation Plan 2011-2015[32] was prepared with input from civil society, the private sector, development partners (including UNFPA) and communities. Participating in this process ensured that the UNFPA and partners contributed to establishing national priorities.

The Reproductive Health Component of the 6th UNFPA country programme (2007 – 2011) is therefore aligned with national health sector priorities and addresses vulnerable groups, such as adolescent girls, youth, mothers, newborn, etc. Previous UNFPA country programmes defined 'women and children' as vulnerable group. This was abandoned in the

29. and leveraged further funds for the census.
30. The Woman's Questionnaire was used to collect information from all women aged 15-49. These women were asked questions on the following topics: • Background characteristics (age, education, media exposure, etc.) • Birth history and childhood mortality • Knowledge and use of family planning methods • Fertility preferences • Antenatal, delivery, and postnatal care • Breastfeeding and infant feeding practices • Vaccinations and childhood illnesses • Marriage and sexual activity • The work of women and the background characteristics of the husband • Awareness and behaviour regarding AIDS and other sexually transmitted infections (STIs) • Adult mortality, including maternal mortality. Knowledge of tuberculosis.
31. Selected samples are: Report on the National Situational Analysis of Pre-Service Midwifery Training in Ethiopia, 2008 , National Baseline Assessment for Emergency Obstetric & Newborn Care Ethiopia 2008, Maternal Health Care Seeking Behaviour in Ethiopia: Findings from DHS 2005 National Survey on availability of Modern Contraceptives and Essential Life Saving Maternal/Reproductive health Medicines in Service Delivery Points in Ethiopia 2010, Ethiopia Young Adult Survey A Study In Seven Regions, 2010 Baseline EMONC survey in 2008.
32. This is the national poverty reduction plan, following the PASDEP 2005-2010.

6th country programme, as this would have labeled 75 per cent of the Ethiopian population as vulnerable.[33] The National Reproductive Health Strategy includes female domestic workers, migrants (national and international) and out of school youth as vulnerable.[34] Different programmes include additional groups: i.e. women and girls in Afar and Somali regions are considered as vulnerable to female genital mutilation (FGM).

4.1.2 Evaluation question 2: Harmonization and coordination of maternal health support and partnerships

Evaluation question 2

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

Judgment criteria	Issues to address
2.1. Harmonization in maternal health partnerships between UNFPA and United Nations (UN) organizations and World Bank (including H4+)[35] at global; regional and country level	To what extent do functioning mechanisms for coordination and harmonization of planning and implementation (e.g., common work plan) in UN joint programmes exist?
	What is the significance of H4+ country teams for country level maternal health harmonization and coordination?
2.2. Harmonization of maternal health support through partnerships at country and South-South/regional level	Does the donor community consider the national maternal health Road Maps to be viable components of a national health policy that allows them to use it as a focal point for aligning their support with government structures and mechanisms?
	Has UNFPA financed activities geared at facilitating the adoption and implementation of maternal health Road Maps, i.e. activities that identify and address existing bottlenecks in maternal health Road Map operationalization and implementation at country level?
2.3. UNFPA participation in partnerships for producing evidence for policy debates and definition and prioritization of coordinated operational maternal health research agenda	What kind of evidence related deliverables that were meant for adaptation at country level have been produced by partnerships for evidence creation?

33. Information from government and development partners.
34. National Reproductive Health Strategy 2006-2015.
35. UNFPA, UNICEF, World Bank, World Health Organization (WHO), UNAIDS.

Judgment criterion 2.1

- Harmonization in maternal health partnerships between UNFPA and UN organizations and World Bank (including H4+) at global, regional and country level

The country office has participated in various mechanisms to harmonize health partnerships at national and sub-national level and has used MHTF funds to contribute to a pooled funding mechanism. Prior to 2010, the division of labor between UN agencies had not been clearly defined. However, with the launch of the 'delivering as one' process in 2010, relevant coordination mechanisms have been put in place which may improve harmonisation.

UNFPA has participated in various important coordinating committees, such as the Health, Population and Nutrition (HPN) Donor Group, the International Health Partnership (IHP), the Reproductive Health taskforce, the Safe Motherhood Technical Working Group (TWG), the Family Planning TWG and other sub groups. In addition, the country office has been a regular participant in the Joint Core Coordinating Committee Meeting. The agreed division of labor allocates responsibilities for policy and health system strengthening to WHO, who also chairs the H4+ group. The World Bank is responsible for areas concerning financing, inclusion in national development frameworks and strategic planning. UNFPA and UNICEF primarily act at the level of service delivery. Under the H4 initiative, WHO, the World Bank, UNICEF and UNFPA have developed a more specific agreement on the division of labor, with overlap on preventing mother to child transmission (PMTCT) and neonatal care which had been identified a major gap.[36]

In spite of joint planning, the UNDAF has no harmonized monitoring and evaluation (M&E) plan, and there is no pooled funding for UN joint programmes in place. Coordination of programmes between different partners is facilitated through a variety of technical working groups.

UNFPA has contributed to the Health Sector Development Programme and has incorporated the International Conference on Population and Development (ICPD) indicators into the results framework.[37] UNFPA also ensured that key maternal health interventions such as EmONC, a master programme for health officers, and reproductive health commodities are considered as eligible expenditure items under the Millennium Development Goal (MDG) Fund. UNFPA used MHTF funds to join the MDG Fund, and was the first UN organization to join. WHO and the World Bank have subsequently also joined.

Judgment criterion 2.2

- Harmonization of maternal health support through partnerships at country and South-South/regional

The country office has supported the formulation and implementation of national strategies such as the maternal health road map and other health sector development plans. However, the endorsement of some strategies were delayed for long periods. Translating policy into operational plans has not been sufficiently addressed by government or development partners.

UNFPA has supported the development of the maternal and newborn health road map and previous strategy documents, such as the health sector development plans. The development of the current national maternal and newborn health road map was broadly supported by development agencies[38] who also have committed to supporting its implementation. Bottlenecks in the absorption capacity of the FMoH have delayed the translation of the road map and the other strategies into operational plans.

36. The FMoH mentioned overlaps and gaps concerning the geographical area covered by the H4 partners.
37. Such as teenage pregnancy, skilled birth attendance, contraceptive prevalence rate (CPR), maternal mortality ratio, antenatal care (1st and 4th visit).
38. During the Annual Review Meeting of the FMoH in 2011 representatives from the FMOH, WHO, UNFPA, UNICEF, FGAE, DKT, HAPCO, IFHP (Pathfinder), CORHA, ICAP, Engender Health were involved in discussions and able to comment.

In 2009, UNFPA partnered with government, other UN agencies, donors, civil society and academic institutions to hold a workshop on task-shifting. The country office also cooperated with FMoH, UNICEF and Averting Maternal Death and Disability (AMDD) to organize an international conference on Human Resources for Maternal Survival: Task Shifting to Non-Physicians Clinician. The conference brought together 42 countries with experience of deploying non-physician clinicians (NPCs) to expand access to emergency obstetric and newborn care (EmONC) as well as other countries that are either beginning this process or have significant interest in utilizing NPCs for EmONC.

Judgment criterion 2.3

- UNFPA participation in partnerships for producing evidence for policy debates and definition and prioritization of coordinated operational maternal health research agenda

UNFPA has maintained technical support partnerships with the Karolinska University in Sweden as well as cooperating with Addis Ababa University and the Johns Hopkins University through JHPIEGO, an affiliated international non-profit health organization. With these and other agencies (UNICEF, WHO) the country office has conducted research and surveys to improve the evidence base for programming. One major outcome of this work is the task-shifting initiative taking place and the advocacy work for the Growth and Transformation Plan

4.1.3 Evaluation question 3: Community involvement/demand orientation and Civil Society Organizations partnerships

Evaluation question 3

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

Judgment criteria	Issues to address
3.1. Governments commitment to involve communities translated in sexual reproductive health and maternal health strategies through UNFPA support	Examples of policy advocacy and other UNFPA support to create legal frameworks, regulations and guidelines to facilitate full participation of communities and civil society organizations in policy and programme development
3.2. Civil Society Organization`s involvement in sensitization on maternal health issues and facilitating community based initiatives to address these issues supported by UNFPA	Examples of UNFPA human resource mobilization and institutional capacity development for civil society organizations to overcome weaknesses in transparency, service accountability and responsiveness to national civil constituencies at local level (including local public institutions outside ministries and departments).
	Examples of UNFPA coordination among implementing partnerships to bring together governments and civil society organizations at local level to generate social capital through community participation.
	Examples of UNFPA-government-civil society organization- Joint Action and Monitoring Frameworks as mentioned by CPAPs.

Judgment criterion 3.1

- Governments commitment to involve communities translated in sexual reproductive health and maternal health strategies through UNFPA support

UNFPA has contributed to community and civil society engagement by supporting community dialogue and capacity development for health extension workers (HEW) under Ethiopia's national outreach strategy. The country office has also worked to strengthen the Ethiopian Midwifery Association. While UNFPA is integrated in these initiatives, it has not adequately evaluated these interventions to measure their effectiveness and impact or to gauge the contribution of UNFPA to possible improvements.

'Community conversations' were introduced by the United Nations Development Programme (UNDP) in 2002 for HIV. The FMoH adapted the tool for health extension workers (HEW), and UNFPA and UNICEF helped to develop relevant training material. Meanwhile, Community conversations have been institutionalized on every administrative level as a means to engage with civil society. The conversations addressed topics such as reproductive health, HIV, and FGM as well as sanitation, vaccination, and other health promotion activities. The country office has supported the development of a maternal health intervention centered on this approach, the 'Comprehensive Community Conversation for Action (CCCA). The CCCA has combined components from UNFPA sub-programmes on HIV/AIDS, gender, and reproductive health and has been integrated into the HEW training manual. This has increased the likelihood that the approach will be scaled up to the national level.

At the time of country visit, UNFPA was also providing technical assistance to FMoH to develop a guide for community facilitators, and was participating in the development of guidelines for maternal health, obstetric fistula and youth components. The country office was involved in the formulation of the Youth and Women Section of the new Growth and Transformation Plan (GTP). The 'Empowerment of Youth and Women' was one of seven pillars prioritized by the government in the GTP which aimed to ensure the active participation and empowerment of young people.

Judgment criterion 3.2

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

UNFPA has involved a range of civil society organizations that have medical or religious backgrounds as implementing partners in the sensitization of communities on reproductive health issues. This has included, amongst others, the formulation of a Development Bible that provides information on obstetric fistula, FGM and other maternal-health relevant topics alongside religious scripture. Civil society is formally represented in the Health Population and Nutrition (HPN) high-level coordination group, but participation of NGO members in HPN meetings is irregular. Evaluations of uptake by beneficiaries are not sufficiently integrated into the programme design.

In 2006, UNFPA started work on a 'Development Bible", together with the Ethiopian Orthodox Church (EOC). The Development Bible presented health-related messages on topics such as obstetric fistula, harmful traditions, FGM and HIV/AIDS. At the time of country visit, the Development Bible was being piloted in three regions. UNFPA also worked with NGOs to promote access to maternal and reproductive health services in remote rural areas. The country office supported the non-governmental maternal and child health center to mobilize communities on sexual and reproductive health and to advocate for the provision of comprehensive EmONC services and obstetric fistula repair.

At least formally, civil society is also represented at the Health Population and Nutrition (HPN) high-level coordination group, in the form of two NGO umbrella organizations. The HPN creates a strong link between the UNFPA country office, development partners and the GoE. At the time of the country visit, the HPN was being co-chaired by UNFPA. HPN is tracking the implementation of the government's annual plan and has also been following progress of the comprehensive plan for development partners. However, the two NGO umbrella organizations have only rarely participated in the HPN meetings and their strategic plans did not mention specific activities related to the representation of the NGO community.

The Ethiopian Midwifery Association (EMA) is the civil society organization that has benefitted most from consistent UNFPA support. However, tangible progress has only been made since the advent of the MHTF and the placement of two midwifery advisors in the country office (see MHTF).[39]

While all these initiatives are important components of the community-based approach by UNFPA, they have not been monitored consistently enough to gauge their effect on their intended beneficiaries.[40]

4.1.4 Evaluation question 4: Capacity Development - human resources for health

Evaluation question 4

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

Judgment criteria	Issues to address
4.1. Development/strengthening of national human resources for health (HRH) policies, plans and frameworks (with UNFPA support)	What mechanisms had UNFPA applied to ensure that policy makers include reproductive health in national human resource plans; and to what effect?
	To what extent was UNFPA involved in country needs assessments to inform policy makers for HRH planning (in particular also outside of MHTF countries or prior to MHTF launch)?
	To what extent was UNFPA involved in supporting the development of regulatory frameworks for reproductive health cadres in the HRH plans?
4.2. Strengthened competencies of health workers in HIV/AIDS, family planning, obstetric fistula, skilled birth attendance and EmONC to respond to sexual reproductive health/maternal health needs	To what extent was UNFPA involved in supporting capacity development in management skills of policy makers and health administrative staff?
	Which mechanisms did UNFPA utilize to ensure applicability and usability of training; and to what effect?

Judgment criterion 4.1

- Development/strengthening of national human resources for health (HRH) policies, plans and frameworks (with UNFPA support)

UNFPA has supported the development of human resource strategies and documents through technical and financial activities. The country office also has supported needs assessments that have informed reproductive health and human resources for health (HRH) strategies in Ethiopia. UNFPA has been instrumental in the implementation of task-shifting for non-clinical physicians and the development of relevant curricula.

39. Only since 2011 the EMA is able to participate increasingly in the support to the FMoH in supervising training of midwives.
40. For example the monitoring plan of the 'Development Bible' foresees control of church leader utilizing those daily messages, and not the knowledge, attitude, practice survey of recipients.

UNFPA has performed or supported several health worker needs assessments since 1997. At the policy level, UNFPA supported the human resources for health (HRH) strategy development through the joint in-country UN (WHO, UNFPA and UNICEF) concept paper on the reduction of maternal and newborn mortality in Ethiopia. This concept paper detailed the need for a focused effort to increase access to skilled birth attendants, emergency obstetric and newborn care, and family planning.

The national HRH Strategy 2009-2020 recognizes the need for scale-up of midwives and the new cadre of the integrated emergency obstetric surgeons (IEOS). A conference on task-shifting and the development of the curricula for IEOS have been substantially supported by UNFPA. In addition to initiating and conducting policy dialogue, needs assessments and workshops/conferences, UNFPA also seconded staff to the Federal Ministry of Health (FMoH) to provide technical assistance.

In 2005/06, UNFPA changed focus towards pre-service training and equipping training facilities. For example UNFPA supported the five year consultative process involving FMoH, academia, and other relevant partners, including medical associations, to develop a recognized degree for health medical officers. At the time of the country visit, the first group were graduating from the programme(see also MHTF).

Judgment criterion 4.2

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

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UNFPA has supported the training of health workers in response to ongoing FMoH requests in areas such as family planning, safe motherhood, and obstetric fistula repair. The country office has also supported curricula development and equipment provision for placement in health facilities where health workers with upgraded skills were being positioned. UNFPA and its implementing partners have monitored these capacity-development initiatives using output indicators including "number of staff trained" and "equipment distributed". However, the country office has not tracked the actual application of skills. At the time of the country visit, the country office was in the process of addressing this deficit.

UNFPA has financed the in-service training of doctors, midwives, nurses and health extension workers in areas such as family planning, EmONC, obstetric fistula, and STI management, in response to FMoH requests. In order to enable trained staff to deploy their newly acquired skills, the country office also provided equipment to the FMoH to be distributed to health facilities. However, coordination of individual inputs has been the responsibility of FMoH. This included the distribution of equipment and the deployment of UNFPA-financed trainees to positions that allow them to apply their newly acquired skills.

At the time of the evaluation, a technical working group (including UNFPA) was in the process of developing a monitoring tool for the capacity development component of UNFPA maternal health support. This tool is intended to enable UNFPA to collect information on the application of the newly acquired skills of UNFPA-supported trainees.

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

Evaluation question 5

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

Judgment criteria	Issues to address
5.1. Inclusion of sexual reproductive health in emergency preparedness, response and recovery plans	How does UNFPA monitor the effectiveness of maternal health mainstreaming activities?
	To what extent is UNFPA involved in monitoring the effective application of joint response activities and utilization of its tools?
5.2. Accessibility of quality EmONC, family planning and reproductive health/HIV services in emergency and conflict situations	To what extent do UNFPA mechanisms/procedures facilitate timely/flexible response to maternal health needs in humanitarian situations?
	What is the comparative advantage of UNFPA maternal health-support in post-emergency/humanitarian situations?
	How does UNFPA monitor the utilization and uptake of the tools in continuous training, planning and service delivery?

Judgment criterion 5.1

- Inclusion of sexual reproductive health in emergency preparedness, response and recovery plans

UNFPA increased its presence in the humanitarian field in 2007 with the aim of mainstreaming reproductive health, gender and gender-based violence (GBV) in all emergency preparedness and response activities. UNFPA is a member of all relevant coordination and working groups but has not yet achieved a satisfactory level of awareness among key stakeholders on the importance of maternal and sexual and reproductive health among the humanitarian stakeholders.

From 2007, UNFPA increased its engagement in the international response to humanitarian emergencies in Ethiopia. The country office has integrated staff working on humanitarian issues[41] into the reproductive health team and has worked on mainstreaming reproductive health, gender-based violence, management of rape survivors and the reduction of HIV transmission in all of its programmes and documents. The UNFPA humanitarian team also participated in joint humanitarian assessments, and provided on-site technical support to humanitarian partners. UNFPA has also supported the development of the Ethiopian Disaster Risk Management Strategy.

41. One national programme officer (NPO), two United Nations Volunteers (UNV).

Humanitarian issues were integrated in the country office advocacy strategy in 2007. Gender mainstreaming in humanitarian response was included in the UN Gender technical working group (TWG) action plan, and an inter-agency subgroup was established to address this specific issue. A concept note was developed and a questionnaire was sent to other agencies as part of a mapping exercise. However, a lack of commitment and expertise on humanitarian issues among gender focal points challenged this initiative. Human resource bottlenecks in the country office have also exacerbated these challenges.[42] In addition, the international NGOs that UNFPA chose as implementing partners were not able to create the required sense of ownership for the initiative amongst local authorities.[43]

Finally, the country office was also represented and active in the numerous humanitarian coordination structures.[44] However, despite its activities, the country office still noted insufficient concern and awareness among humanitarian stakeholders of the ICPD mandate in emergency situations.[45]

Judgment criterion 5.2

- Accessibility of quality EmONC, family planning and reproductive health/HIV services in emergency and conflict situations

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UNFPA provided commodities and related training to improve access to services for most vulnerable groups in regions affected by humanitarian emergencies. This also included support for the availability of the Minimum Initial Service Package (MISP). The country office has also helped the Ethiopian Government to build a stock of emergency reproductive health kits to increase its capacity to respond to emergency situations. UNFPA has trained medical staff on issues including community conversations, clean and safe deliveries, management of rape victims, and commodity distribution.

UNFPA comparative advantage in the humanitarian context is its ability to provide commodities and corresponding training at short notice (e.g. training on the delivery of the MISP package). UNFPA-supported activities include baseline surveys, training, dissemination of clean delivery kits to pregnant mothers, and the provision of equipment and commodities to health facilities. Commodities are stored and distributed through the national Administration of Refugee and Returnee Affairs (ARRA), a government organization.

Several assessments and baseline surveys on reproductive health, HIV and gender-based violence (GBV) have been conducted in humanitarian settings either directly by UNFPA or with its support. In 2007, UNFPA helped to establish a stock of emergency reproductive health kits to improve national capacity to distribute kits during emergency situations.

UNFPA also supported the training of health extension workers in a number of areas, such as community conversations and clean and safe delivery. Medical staff was trained on the use of clinical management of rape cases, post-exposure prophylaxis, distribution of family planning commodities, reproductive health kits, drugs, and safe delivery kits. In addition, UNFPA also supported awareness–raising activities on family planning, sexually transmitted infections, and HIV/AIDS in regions with humanitarian emergencies. Government counterparts have recognized UNFPA contribution to the timely dissemination of reproductive health equipment and essentials drugs, and for training of health personnel in key regions affected.[46]

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42. The lack of human resources to undertake or coordinate regular data collection/research on reproductive health, HIV and GBV in humanitarian context made advocacy and programme design difficult (COAR 2010).
43. Evaluation of the UNFPA Integrated Reproductive Health Response Project in Food-Insecure Areas, SNNPR, 2009.
44. The Health and Protection cluster, Strategic Disaster Management Team, UN Technical Officers group, Emergency Health and Nutrition task force, HIV/AIDS Emergency task force, Early Warning working group, UN/NGO coordination meeting, Humanitarian Response Fund Review board, UN Communication Officers group, etc.
45. Interview with UNFPA.
46. Ibid.

4.1.6 Evaluation question 6: Sexual and reproductive health services – family planning

Evaluation question 6

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

Judgment criteria	Issues to assess
6.1. Increased capacity within health systems for provision of quality family planning services in UNFPA programme countries	Are (UNFPA-supported) national reproductive health strategies geared towards integration of family planning services in all service delivery points?
	Are systems in place to monitor the integration and availability of family planning services in all service delivery points?
	Are capacity development interventions accompanied by interventions ensuring an environment where trained health care providers can practice their newly acquired skills (equipment, material, and infrastructure)?
	What are the mechanisms developed to ensure that training curricula and standards are adopted across the entire country?
6.2. Increased demand for and utilization of family planning services in UNFPA programme countries, particularly among vulnerable groups[46]	To what extent were communication initiatives aimed at increasing demand for family planning (undertaken with UNFPA support) based upon evidence?
	What are the monitoring and evaluation in place to measure the impact of these communication initiatives?
	How has UNFPA supported community-based distribution of family planning been translated into sustainable national strategies?
6.3. Improved access to contraceptives (commodity security)	What are the mechanisms in place to monitor and follow up MOH/responsible line ministry supply chain
	What are the mechanisms in place to sustain actual achievements and governments' commitment to RHCS?

47. Approximation of "increased demand", which is difficult to capture.

Judgment criterion 6.1

- Increased capacity within health system for provision of quality family planning services in UNFPA programme countries

UNFPA has supported policy development, procurement and dissemination of contraceptives and capacity development activities in Ethiopia. Ethiopia has been a recipient of the Global Programme on Reproductive Health Commodity Security (GPRHCS) since 2007 and is considered a "Stream One" country. Coordinated monitoring is not yet in place, in spite of UNFPA providing support and related tools.

Family planning is a priority area within the national Reproductive Health Strategy, reproductive health commodity security has also been mainstreamed into national health policy and programmes, and the implementation of the national strategies for reproductive health and adolescent and youth reproductive health are fully costed. However, the GoE has provided approximately 60 per cent of the required funds for family planning, and is largely dependent on external aid for continuity. Nevertheless, regional governments in Ethiopia have gradually increased their allocation of resources to family planning. Health extension workers (HEWs) are providing support for family planning to their communities and report on occasional stock-outs.[48] The technical working group (TWG) on family planning tasks UNFPA and its partners[49] to monitor service provision.

UNFPA has developed trainings in family planning jointly with FMoH and other partners, usually based on prior needs assessments and in accordance with national priorities. Family planning curricula have been prepared and approved by the respective universities and colleges, under the guidance of FMoH. Stakeholders from the technical working group on family planning have been consulted on curriculum development in a series of workshops. Courses need to be officially accredited by the Ministry before being implemented.

Training has been provided in a cascade format (training of Trainers (ToTs)) and 10,000 decision-making guides were also distributed to health extension workers.[50] UNFPA trained post-graduate students from the Addis Ababa School of Public Health and warehouse managers on supply chain management systems, in collaboration with School of Public Health of Addis Ababa University.

From 2007 to 2011, the GPRHCS disbursed approximately US$ 5.1 million for capacity development activities and US$ 27.2 million for commodities for family planning in Ethiopia.[51] The GPRHCS has helped to strengthen the commodity supply chain by providing training, technical assistance and computer equipment, and also provided assistance to make long-term contraceptive methods more widely available, in particular Implanon and intra uterine contraceptive devices, by providing commodities, assisting in strategy development and offering training.[52]

In conjunction with the training events, UNFPA has performed supportive supervision visits using a Health Facility Pharmacy Service Assessment Tool that addressed all areas of drug supply management. The tool had been designed by the national Pharmaceutical Fund Supply Agency (PFSA). In addition, all development partners monitor their own programmes in accordance with their own M&E standards but also frequently with the participation of a FMoH staff member in review missions. At the time of the country visit, the FMoH had neither developed standardized M&E tools nor standard quality assurance mechanisms. Tulane University has been supporting a programme to assist the FMoH in its supervision tasks but the Ministry had not yet allocated staff to work on this programme.[53]

48. Information from government partners.
49. Such as Packard, Pathfinder, Family Guidance Association Ethiopia (FGAE), Engender health, etc.
50. In 2009, UNFPA supported the Policy, Planning, and Monitoring and Evaluation Directorate of the FMOH in training 400 health workers on the use of HMIS registers and forms; the registration and reporting forms were printed and distributed to all pilot regions.
51. Ethiopia belongs to the 11 stream one countries that receive medium term support of up to US$ 5 million per annum, to be spent on commodity supply, developing political commitment to RHCS and capacity development of national systems that impact on RHCS.
52. Ethiopia Case Study MTR GPRHCS, 2011.
53. Information from development partners and country office.

Judgment criterion 6.2

- Increased demand for and utilization of family planning services in UNFPA programme countries, particularly among vulnerable groups

UNFPA has initiated several interventions to increase demand for family planning. The country office has supported the production of a Development Bible that complements daily and weekly prayers with messages on maternal health, has helped to organize a number of advocacy workshops, and has provided financial and technical support to a national mass-media campaign. However, monitoring and evaluation of these interventions has been insufficient.

In addition to supporting reproductive health commodity security in Ethiopia, UNFPA developed a communication strategy to increase demand for family planning services in the general population. Activities supported by UNFPA included:

- Production of the Development Bible, which added messages on reproductive health-related topics (family planning, HIV, early marriage, etc) to daily and weekly prayers of the Ethiopian Coptic Church;
- Advocacy workshops to raise the awareness of religious, community and political leaders on the reproductive health rights of women and the importance of access to sexual and reproductive health and family planning services;
- A national mass media radio programme to discuss reproductive health commodity security (RHCS), family planning, maternal health and adolescent and youth reproductive health and HIV prevention.

At the time of the country visit, no standardized M&E tools or quality assurance mechanisms were in place and the FMoH had not allocated resources for the monitoring and evaluation of these activities.

Judgment criterion 6.3

- Improved access to contraceptives (commodity security)

UNFPA has helped to improve commodity security in Ethiopia by assisting in the procurement of contraceptives and helping to develop the country's organizational capacity to manage health commodities. The Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS) has played an important role since its launch in Ethiopia in 2007.

Since 2000, UNFPA has financially and technically supported the Federal Ministry of Health in the procurement and distribution of various family planning commodities. The aim of this assistance was to ensure the availability of a mix of contraceptive methods in health facilities, including long-term and permanent contraceptive methods (intra-uterine contraceptive devices, implants, tubal ligation, vasectomy and emergency contraceptives). The Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS) was launched in Ethiopia in 2007. Implementation began with a mapping exercise of partners working in reproductive health and family planning in order to reduce overlaps and to accelerate the expansion of family planning services to under-served remote areas. A newly established parastatal organization (the Pharmaceutical Fund Supply Agency (PFSA) was allocated responsibility for the management of all reproductive health commodities. UNFPA has provided PFSA with equipment (logistics, computers, software, etc) and capacity development support). Stock-outs have not been reported by the government partners, with only occasional unavailability of certain methods due to problems with distribution.[54]

54. Information from government partners.

4.1.7 Evaluation question 7: Sexual and reproductive health services – EmONC

Evaluation question 7

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

Judgment criteria	Issues to assess
7.1.Increased access to EmONC services	Which mechanisms has UNFPA applied to ensure most efficient use of resources of support to EmONC providing facilities?
	How has UNFPA supported functioning referral systems from home to tertiary care?
	Has UNFPA support improved the equitable distribution of EmONC facilities (affected the planning process for placement of EmONC facilities)
7.2.Increased utilization of EmONC services	What mechanisms is UNFPA utilizing to mobilize the communities to support women in accessing EmONC; and to what effect?
	To what extent does UNFPA support research to evaluate barriers to EmONC?

Judgment criterion 7.1

- Increased access to EmONC services

UNFPA has supported increased access to quality EmONC series through training, provision of equipment to targeted hospitals and the purchase of ambulances. At the time of the country visit, the introduction of Integrated Emergency Obstetric Surgeons (IEOS) for comprehensive EmONC services and the upgrading of midwifery skills to deliver basic EmONC services were ongoing.[55]

UNFPA support for emergency obstetric and newborn care (EmONC) has shifted since the 5th country programme from mainly in-service training to predominantly pre-service training. This was because the ongoing decline in numbers of trained staff through attrition was considered too high in relation to the cost of the trainings. A joint in-country UN (WHO, UNFPA and UNICEF) concept paper on the reduction of maternal and newborn mortality in Ethiopia[56] demonstrated the need for a concerted effort to increase access to skilled birth attendants, emergency obstetric care and family planning. UNFPA therefore began to support the pre-service master degree course for a new health cadre - the Integrated Emergency Obstetric Surgeons (IEOS). In accordance with the findings of the national EmONC assessment, the country office also started to support trainings for nurse anesthetists and for midwives.[57]

55. As most of the implementation of these initiatives is funded by the MHTF, more information will be provided in the chapter 4.
56. Mid-Term Review (MTR) of the GoE/UNFPA 6th country programme (CP) components, 2009.
57. National Baseline Assessment for EMoNC , Ethiopia, Final report 2010.

The FMoH is fully committed to EmONC and finances the three year emergency surgical officer training programme to scale up national human resources for health for surgical and obstetric emergencies. The FMoH also accelerated the midwives training and was in the process of preparing plans to provide health facilities with relevant equipment. At the time of the country visit, UNFPA was supporting facility-based trainings in ten facilities and supported staff from five facilities to attend the master degree course.

UNFPA has been a member of the relevant technical working group and has been formally consulted on issues including deployment of staff, site assessments and site preparations. However, UNFPA usually supported the government's deployment-related decisions that were formulated on the basis of its geographical allocation formula.

Judgment criterion 7.2

- Increased utilization of EmONC services

Negative attitudes towards the formal health sector and the use of non-traditional medicine for maternal health-related practices have contributed to the persistence of dramatically low rates of facility-based delivery and utilization of EmONC services in rural areas. In spite of this, UNFPA has not systematically supported ongoing efforts to assess socio-economic and cultural EmONC access barriers. Instead, the approach of UNFPA and most other donors has focused on the provision of new EmONC facilities and the training of a new cadre of integrated emergency obstetric surgeons (IEOS).

Facility-based delivery and the utilization rate for EmONC services remained dramatically low between 2000 and 2010, particularly in rural areas, where the rate of facility-based deliveries remained below 5 per cent for the entire period.[58]

Negative attitudes towards the formal health sector have been a contributing factor. According to a 2008 survey,[59] the formal health sector in Ethiopia is seen as insensitive to traditional attitudes related to childbirth. In particular, beneficiaries in rural areas have considered modern medical procedures to be alienating and inappropriate. In contrast, traditional birth attendants and relatives are thought to provide moral and practical support consistent with community beliefs and traditions. Women distinguish between the practical advice, interventions and material support offered by traditional birth attendants, and the theoretical advice given by formal health providers. Moreover, female access to health services is frequently determined by their husbands who also inhibit the utilization of non-traditional health services.[60]

At the time of the country visit, a national study on barriers to EmONC services was underway, at the request of FMoH and financed by USAID. However, UNFPA was not supporting this study and, like most development partners, instead used the provision of new EmONC facilities and the placement of the new cadre of integrated emergency obstetric surgeons (IEOS)[61] to increase EmONC utilization[62]. Community mobilization activities supported by UNFPA have not been directly focused towards increasing EmONC utilization.

58. Rates of facility based deliveries in rural areas were 1.8 per cent (2000), 2.6 per cent (2005), 4.1 per cent (2011).
59. UNFPA (2008), Safe Motherhood Community Based Survey, Final Report.
60. UNFPA (2008), Safe Motherhood Community Based Survey, Final Report.
61. See evaluation questions 4 on human resources for health (HRH).
62. Information from UNFPA interviews.

4.1.8 Evaluation question 8: Results/evidence orientation of UNFPA maternal health support

Evaluation question 8

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

Judgment criteria[63]	Issues to assess
8.2. Consideration and integration of relevant maternal health/sexual reproductive health evidence and results data during development of country strategies	What process have country offices gone through to use lessons from past support for future programming?
	What factors have prevented country offices from using lessons from past programming?
8.3. Results- and evidence based management of individual projects throughout project life	What were main factors that contributed to weak monitoring of most country offices?
	To what extent did UNFPA take into account capacity gaps in M&E among its implementing partners and its own staff when developing its M&E calendars?

Judgment criterion 8.2

- Consideration and integration of relevant maternal health/sexual reproductive health evidence and results data during development of country strategies

UNFPA has used joint and collaborative mechanisms, such as the joint review meetings (JRM) and associated joint review missions, for planning and monitoring of its country programmes. Evidence presented at JRM led UNFPA to reduce the number of regions it covers in Ethiopia, and to offer more comprehensive support in a smaller number of target areas.

The country office prepared UNFPA country programmes on the basis of data from surveys and assessments, including census and DHS data, in consultation with the government and other partners. UNFPA has been participating in the UNDAF mechanism and is also integrated into governmental mechanisms for strategic planning at national level.

The country office has been participating in the annual joint review meetings (JRM) for development and governmental partners. The JRM have also been used as a forum for joint sector-wide monitoring, and have allowed participating stakeholders to adopt joint recommendations for further action. For example, the UNFPA 6th country programme 2007-2011 mentioned that "lessons [from the JRM] suggest the need to focus programme interventions thematically so that resources are made available where needs are greatest". This has led UNFPA to reduce the number of regions it covers, and instead to finance a more comprehensive combination of activities in each of the remaining regions. UNFPA also conducted a collective baseline survey as a basis for monitoring of the 6th country programme (2007 – 2011).

63. The previous judgment criterion 8.3 was deleted; the assessment of the operationalization of UNFPA support in annual work plans was put together with the development of UNFPA country strategies (CPD/CPAP).

Judgment criterion 8.3

- Results- and evidence based management of individual projects throughout project life

The country office collects results-based data throughout projects, which are analyzed in annual review meetings. Lessons learnt and recommendations are fed into the subsequent annual work plans. Monitoring systems for implementing partners are in place. The supervisory mechanism for the task-shifting project has yet to be developed.

The country programme results framework includes indicators at all levels of the health system. All implementing partners monitor their own programmes according to pre-defined indicators and work plans, and have received training on results-based management. The country office has two M&E officers and is in the process of aligning its results framework and improving coordination with, and reporting by, implementing partners.[64]

Supervision by governmental partners was identified as a major problem in Ethiopia due to lack of staff, funds and technical expertise. Quality assurance standards have not yet been developed, which are key to the supervision of the new cadres.

4.1.9 Evaluation question 9: Integrating maternal health into national policies and development frameworks

Evaluation question 9

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

Judgment criteria	Issues to assess
9.2. Maternal health and sexual reproductive health integration into policy frameworks and development instruments based on (UNFPA supported) transparent and participatory consultative process	What are the principal mechanisms by which UNFPA advocacy and awareness raising campaigns contribute to the development/ revision/ integration of maternal health issues into national policies?
	How coherent are efforts under the different relevant initiatives for maternal health policy making and policy dialogue: CARMMA, Maputo/maternal health Road Maps and UNFPA participation in SWAp forums
9.3. Monitoring and evaluation of implementation of sexual reproductive health/maternal health components of national policy framework and development instruments	To what extent have M&E tools that were developed with UNFPA support been adopted to monitor national maternal health/sexual reproductive health policies and programmes?

64. Backstopping Mission to Addis Ababa, from 17th to 29th, June 2010, Mission Report .

Judgment criterion 9.2

- Maternal health and sexual reproductive health integrated into policy frameworks and development instruments based on (UNFPA supported) transparent and participatory consultative process

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The country office has provided financial, technical and logistics support for the formulation of policies and strategies; the issues of maternal and sexual reproductive health are prominently represented in the relevant documents. UNFPA also supported regional initiatives such as CARMMA together with other partners.

UNFPA influenced and supported policy-making through its participation in technical working groups, and through surveys and research. The country office lobbied successfully to include gender, HIV, maternal health and reproductive health commodity security indicators in the 2011 Demographic Health Survey. UNFPA also advocated for recognition of the vulnerability of adolescent girls and young women to poor sexual and reproductive health, HIV, and harmful traditional practices and gender-based violence, including child marriage and female genital mutilation/cutting. The country office supported the launch of the National Adolescent and Youth Reproductive Health Strategy (AYRHS, 2007-2015) that aimed to address problems of early marriage and pregnancy, female circumcision, abduction, rape and poor access to care. UNFPA also contributed to the standardization processes through the development of protocols for the management of major obstetric complications (jointly with FMoH, WHO, UNICEF and national partners). Finally, the country office supported the development of the national guidelines for "Repositioning Family Planning in Ethiopia" that were in use for family planning programming at the time of the country visit.

The UNFPA-supported launch of the Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA) in Ethiopia in 2010 helped to increase the commitment of the Ethiopian Government to reach MDG five.

Judgment criterion 9.3

- Monitoring and evaluation of implementation of sexual reproductive health/ maternal health components of national policy framework and development instruments

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While UNFPA has supported the development of a variety of policy documents, standards and guidelines, no specific tool has been utilized to monitor the uptake and implementation of these policies.

4.1.10 Evaluation question 10: Coherence of sexual reproductive health/maternal health support with gender and population and development support

Evaluation question 10

To what extent have UNFPA maternal health programming and implementation adequately used synergies between UNFPA sexual and reproductive health portfolio and its support in other programme areas?[65]

Judgment criteria	Issues to assess
10.1. Linkages established between programmes (Reproductive health with gender and population and development) in intervention design	To what extent has UNFPA identified specific gender constraints as affecting and impeding reproductive health programme objectives at country level in its planning?
	How have these gender constraints been addressed in UNFPA programming?

Judgment criterion 10.1

- Linkages established between programmes (reproductive health with gender and population and development) established in intervention design

The country office has promoted the integration of sexual and reproductive health programming with two other UNFPA sub-programmes by promoting the collection of gender-disaggregated data. The country office has also established a project appraisal committee (PAC) consisting of heads of the three sub-programmes to review the integration of sub-programmes into new project proposals and to select joint implementation sites for new interventions.

UNFPA has acknowledged that the significant gender gap in Ethiopia significantly influences its work in Ethiopia.[66] The Ethiopia Gender Survey 2010[67] identified distinct health and education constraints for girls and women. Women and girls suffer from harmful practices such as early marriage and sexual and gender-based violence. Female genital cutting is practiced in 73 per cent of the country. School enrolment is 80.4 per cent for males and 67.6 per cent for females. The adult literacy rate is 33 per cent for men and 11 per cent for women.

Consequently, UNFPA has provided advocacy and technical support for the collection of gender disaggregated data at all levels to help improve the national health management information system. The country office also supported the revision of the community conversation guidelines to include sexual and reproductive health and gender issues, which were incorporated into the health extension worker (HEW) manual. Staff from the population and development sub-programme worked with country office reproductive health colleagues to develop maternal health, HIV/AIDS, and family planning indicators to be included in the DHS 2005.

65. Gender (including female genital mutilation/ cutting (FGM/C), gender-based violence (GBV)), HIV-PMTCT (Prevention of mother-to-child HIV transmission); Population and development, Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS)) GPRHCS should be addressed under evaluation question 6 on Family Planning.
66. Country programme document (CPD) 2007-2011.
67. Published by the National Population Council, with support from UNFPA.

Maternal health interventions have been designed based on collated evidence from all the sub-programmes (reproductive health, population and development, and gender). Within the country office, a project appraisal committee (PAC) was put in place to integrate the different sub-programmes. The PAC is an advisory committee that consists of the heads of all the units in the country office and reviews all project proposals before they can be approved by the Representative. This committee provided the opportunity to review the extent of integration between the different components in draft projects.

At the project level, the reproductive health team selects joint implementation sites in consultation with the population and development and gender sub-programmes. Humanitarian and gender issues have been mainstreamed in reproductive health training and advocacy material. The country office gender officer participates in reproductive health programming in order to 'mainstream' gender into the proposals. A reduction of implementation sites was meant to facilitate joint operational research to demonstrate the impact of best practices.

Country office annual reports (COAR) provide information on each sub-programme in separate sections. However, these sections include discussions of cross-cutting issues, such as the 'incorporation of reproductive health, HIV/AIDS and gender equality in the health sector policy/plan and budgeting' in the population and development sub-programme; 'gender equity and gender-based violence GBV' in the reproductive health sub-programme; and 'reproductive rights of women and adolescent girls incorporated in national human rights protection systems' in the gender sub-programme.

4.1.11 Evaluation question 11: Coherence between country, regional, global programmes

Evaluation question 11

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

Judgment criteria	Issues to assess
11.2. Alignment of UNFPA organizational capacities at country level and the (intended) division of labor and delineation of responsibilities	How time consuming was the recruitment of reproductive health expert into country offices? Could all required positions be filled?

Judgment criterion 11.2

- Alignment of UNFPA organizational capacities at country level and the (intended) division of labor and delineation of responsibilities

Staff in the country office has been challenged to address all aspects of implementation of the UNFPA country programme. It is anticipated that this will continue and may be exacerbated as a result of the upcoming devolution of responsibilities in Ethiopia, whereby regional health bureaus will require more technical inputs from UNFPA.[68]

68. Quote from development partner.

UNFPA could not participate in all relevant coordination forums or technical working groups due to limited staff capacity.[69] As a result, the national guidelines on family planning were written without the participation of UNFPA in the respective working group.[70] In the three years prior to this evaluation, the number of staff positions had been reduced from 65 to 55. tThe post of the international reproductive health advisor was vacant, as were a number of other positions. The MHTF funded two midwifery advisors who were responsible for the midwifery, nurse anesthetist and obstetric fistula programmes. National staff are usually employed on short-term contracts with a maximum duration of 11 months. Formal recruitment takes five to six months.

The regional office supported the work of the country office when requested and advised on the choice of consultants (e.g., the regional office provided a consultant to assist in the curriculum development for the training of nurse anesthetists).

4.1.12 Evaluation question 12: Visibility

Evaluation question 12

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

Judgment criteria	Issues to assess
12.2. UNFPA leadership of maternal health advocacy campaigns at national level	What mechanisms or approaches has UNFPA used to advance its mission vis-á-vis the government and public (cite concrete examples in how UNFPA displays its convening power, where, how and who utilize its technical expertise, etc.)?
12.3. Increased financial commitments of partner governments to sexual reproductive health and maternal health	What are the tools, information and evidence provided by UNFPA Country Office that has been utilized (in the last three years) in reproductive health/ maternal health resource mobilization (non-cash) and fundraising (cash) by partner governments?
	In what way did these tools improve the ability of governments to raise additional funds for maternal health; or the willingness of governments themselves to devote more funds to maternal health? Governments themselves to devote more funds to maternal health?

Judgment criterion 12.2

- UNFPA leadership of maternal health advocacy campaigns at national level

UNFPA partners a broad range of maternal health-related advocacy campaigns and is the recognized leader on issues of family planning commodity security, obstetric fistula repair and, since the advent of the MHTF, midwifery and task-shifting. Neonatal and postpartum health is an area that is not covered by development partners in Ethiopia and several government partners suggested that UNFPA address this issue.

69. 'Increase staff to provide stronger representation in regional health bureaus and to be able to attend all technical working groups, where UNFPA should be the lead' (interview with government partner); '[UNFPA was] assigned a broad mandate with difficult issues but not enough staff to cover all issues to the extent required' (interview with development partner).
70. Information from development partner.

UNFPA has demonstrated leadership in family planning commodity security and advocacy, obstetric fistula, midwifery training, master degree training and midwifery association support. It has been recognized as a collaborative partner, supporting the GoE with a flexible approach and channeling the funds mainly through the Ethiopian Treasury. Main advocacy instruments have included general advocacy (speeches, etc. on issues of maternal health), support for high-level advocacy campaigns and strategic documents, and safe motherhood month. UNFPA is currently the co-chair of the Health Population and Nutrition Group, which is the most important coordination group for health and is tasked task to harmonize and agree on priorities, led by the MoH. The H4 is led by WHO and there is no other functioning technical working group to coordinate or harmonize reproductive health.

In the last three years UNFPA provided financial, technical and logistics support for several South-South interventions, including the launch of the Campaign on Accelerated Reduction of Maternal Mortality (CARMMA), the SMH month, the Midwifery Day and a regional conference on task-shifting.

It has been noted that neonatal health is not addressed by any development partner and UNFPA is well positioned to address this issue. Government partners suggested that, as family planning is addressed by donors with huge funds, UNFPA should shift to neonatal and postpartum health. However, current UNFPA capacity may not support additional activities and the additional workload due to the planned administrative devolution may be challenging.

Judgment criterion 12.3

- Increased financial commitments of partner governments to sexual reproductive health and maternal health

Resource mobilization is a task for the country office, but is an additional activity for technical officers and is pursued by a dedicated staff member. UNFPA engagement in maternal health has attracted extra-budgetary funds.

Country office annual reports (COARs) include a section on local resource mobilization which includes the presence or absence of a resource mobilization plan and associated funds (UNFPA reported a plan in 2006, no plan in 2008, and provided no information in 2009). However, COAR do not specify which programme funds are intended for, unless they are earmarked for a UN joint programme (as, for example, in 2006 the 'pooled funding for the UN HIV/AIDS programme'). In 2006, the country office mobilized over US$ 1.4 million (trust fund) and in 2008 was the holder of the census pooled fund (over US$16 million) and successfully coordinated the preparation of the gender section of the Spanish MDG Achievement Fund.[71] In 2009, no additional funds were mobilized.[72] SIDA funds (US$ 3 million) were raised at the country level, based on advocacy and Swedish interest in the UNFPA midwifery programme.

The country office has some experience with pooled funding, and UNFPA currently supports the MDG fund with US$ 1 million annually from MHTF and has leveraged an additional US$ 6 million for family planning and maternal health (see findings related to MHTF for further details). Following WHO has also subsequently joined the fund and the World Bank is also considering participating.

The 2015 MDG deadline is one of the main incentives for the GoE to engage in maternal health, and UNFPA has successfully used its technical and financial support to increase GoE investments in maternal health. Public spending on midwife salaries, new cadres for the task-shifting programme, and maternal health-relevant equipment for health facilities have consequently increased.

71. COAR 2008.
72. COAR 2009: 'Mid-way through the programme cycle, UNFPA Ethiopia was able to surpass its mid-point resource mobilization target by mobilizing over US$40.7. As a result, much more focus was given in 2009 in effectively and efficiently using the already mobilized resources by setting up new internal mechanisms and strengthening programme management and monitoring mechanisms rather than mobilizing additional funds'.

4.2 Findings related to the Mid-Term Evaluation of MHTF

4.2.1 Evaluation question 1: Relevance

Evaluation question 1

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

Judgment criteria	Issues to assess
1.1. MHTF countries selection processes support the role of MHTF as strategic instrument to improve maternal health among the most vulnerable populations	How/to what extent has the global agreement on the division of responsibilities among the H4/IHP+ partners been translated into concrete cooperation agreements among the agencies at country level?
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)	To what extent are MHTF supported needs assessments (see output two of the MHTF business plan) sufficiently "owned" by national governments to guide the subsequent planning and implementation of national maternal health support?
	To what extent have findings from the needs assessments been considered in the planning of government owned maternal health interventions?
1.3. National policies and sub national level sexual reproductive health/ maternal health planning and programming priorities the most vulnerable groups and underserved areas	To what extent is the subsequent MHTF support targeted to address the identified gaps and needs of the most vulnerable?

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

MHTF provides strategic support to the FMoH towards the achievement of MDG 5, and is focused on the weakest links in the current maternal and child health programmes: pregnancy, child birth and the immediate postpartum period. MHTF resources have been used to support essential components of the health system: qualified human resources at all levels' drugs, supplies and equipment, and functioning referral systems.

UNFPA is signatory to the H4 'Flagship Joint Programme on Improving Maternal and Newborn Health and Survival for 2010-2011,[73] which aims to support the country in achieving MDG5 and to contribute to MDG4 & 6. The Joint Plan is supporting FMoH efforts to scale-up the implementation of evidence-based high impact maternal health interventions through a continuum of care approach. UNFPA has been contributing to this endeavor using MHTF, SIDA and RHCS funds. The guiding cooperation agreement is the joint action plan, which was signed by all H4 partners in Ethiopia in

73. 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 contributed US$ 19,152,000. The remaining US$ 19,105,000 is requested from the UNCT through a proposal.

September 2010. A costed joint work plan has been approved, and monthly meetings are chaired by WHO. The cooperation is guided inter alia by the "traditional" division of labor and "added value" of each organization, with only a few activities in the Joint Plan attributed to more than one organization. Family planning and skilled attendance at birth have been assigned to UNFPA.

To help address the significant shortage of midwives in Ethiopia, the country office contributed US$ 4.6 million from MHTF to complement efforts initiated by the Midwifery Programme to address maternal health concerns. One supported activity has been midwifery training.

Based on the experience with a previous tracer project in Tigray, MHTF has been investing in human resource strengthening by supporting a three year master degree course for non-physician-clinicians (health officers) in Integrated Emergency Obstetric and Surgery (IEOS) to enable the expansion of comprehensive EmONC facilities.

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)

MHTF has supported several national assessments that survey the needs of the most vulnerable populations and address national (by the GoE) and international priorities (by the development partners). Both sets of priorities are in alignment.

MHTF has supported national assessments to generate evidence on the unmet needs of most vulnerable groups such as pregnant women, poor women, and adolescent girls in remote or hard to reach areas. Supported assessments include:

- National Baseline Assessment for Emergency Obstetric and 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 these assessments, MHTF has utilized reports from other development partners to guide its planning and implementation of programmes, such as:

- Capacity gaps and cost implications in selected universities and affiliated hospitals for the 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

FMoH has frequently joined assessment missions, proposed areas of research and utilized the results for national programmes or strategy development.

Judgment criterion 1.3

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

While national policies address the most vulnerable populations in hard-to-reach areas, and the MHTF-supported newly trained cadres are supposed to fill gaps in those areas, the GoE had not yet taken the initiative to develop a national EmONC facility upgrade plan.

MHTF resources are used in alignment with the UNFPA country programme and national priorities of the Ethiopian Government. Vulnerable groups have been identified as pregnant women in hard–to-reach and under-served areas. The national EmONC baseline survey[74] contains indicators that measure the equitable distribution of, and access to, facilities. UNFPA has used MHTF funds to support the upgrade of skills for EmONC services. However, there is no obvious link between the facilities identified in areas with the greatest need and the target areas for refurbishment, equipment provision and placement of new cadres of trainees.

Neither the EmONC survey nor the FMoH HRH strategies provide a list of priority areas or a definition of what constitutes 'most in need' for the purpose of health sector planning. Neither does the 2012 – 2015 UNDAF include a baseline, nor a target for upgrading EmONC services. At the time of the country visit, the Road Map for Accelerating the Reduction of Maternal and Newborn Morbidity and Mortality in Ethiopia, 2011- 2015 still required an implementation plan.

74. 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 four and five.

4.2.2 Evaluation question 2: Capacity development - human resources for health

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	Issues to assess
2.1. Partner countries midwifery education upgraded based upon ICM (International Confederation of Midwives essential competencies through MHTF support	How does the MHTF support mechanisms for long term national midwifery education funding, country wide integration of new curricula and monitoring of effective uptake of new knowledge/ training?
	What follow up mechanisms are instituted by the MHTF to assess the relevance of the training content, the trainers' capacities and the appropriate utilization of the training equipment?
2.2. Strategies and policies developed to ensure the quality of midwifery services provision in programme countries through MHTF support	To what extent does the MHTF support the relevant national institutions to address deployment, motivation and retention policies for health care workers (particularly midwives)?
2.3. Midwifery associations able to advocate and support scaling up of midwifery services through MHTF support	What approaches is the MHTF considering to enabling midwives' associations, to take on the role envisioned in the programme (capacity to advocate for and implement the scaling up of midwifery services)?
	How does MHTF support partner counties to define the most urgent needs/ priorities of midwifery scaling-up within the financial and political constraints?

Judgment criterion 2.1

- Partner countries midwifery education upgraded based upon ICM essential competencies through MHTF support

Staff members and funds provided by MHTF have supported midwifery education based on ICM competencies, the standardization of curricula for all levels and the development of a monitoring and supervision tool for the FMoH. At the time of the country visit, it was too early to evaluate the results of the capacity development component. However, the development of a tool for supervision is a very important step.

To alleviate the shortage of midwives in Ethiopia,[75] the country office used MHTF resources to complement capacity development efforts initiated by the midwifery programme within the ICM strategic framework. Based on a capacity gap assessment of midwifery and anesthesia training schools,[76] MHTF funds[77] have been used to expand the existing midwifery training (using SIDA funding through 2012) and to support the three levels of midwifery trainings in the country. As a result, eleven universities were providing midwifery bachelor degree programmes and 20 institutions were providing midwifery training at diploma level. In March 2011, FMoH started accelerated midwifery training, a one year programme for diploma level nurses. The first group of students was due to be deployed in health centers in mid-2012. Support includes teaching and learning materials, practice mannequins, vehicles and upgrading tutor skills.

A set of curricula were developed by a task force organized by FMoH, which included JHPIEGO, UNFPA (financed with MHTF resources) and WHO. The curricula were developed to be in line with the seven ICM essential competencies and also Ethiopian professional standards. In 2010, the task force attempted to standardize various existing curricula. However, all curricula will be reviewed and redesigned again in light of the released new midwifery education standards by the ICM and a new requirement from the GoE for the organization of curricula in modules.

To ensure the appropriateness of training and application of new skills, FMoH established an additional task force for the supervision of professional training. The body is comprised of staff from FMoH, WHO, UNFPA (through MHTF) and JHPIEGO. The plan is to monitor newly graduated students at their sites, to ensure access to needed equipment, and to monitor the adequacy of the skills of new trainees. JHPIEOG has assisted midwifery schools to conduct quality assurance assessments, using JHPIEGO tools, and to develop action plans as a basis for further upgrades of professional skills, to be supported by UNFPA.[78]

Judgment criterion 2.2

- Strategies and policies developed to ensure the quality of midwifery services provision in programme countries through MHTF support

The country office has used MHTF funds to engage with its partners to ensure quality midwifery services through the development of a supervisory framework, the standardization of curricula and the provision of equipment to health facilities. The subject of staff retention has not yet been raised at the strategic level by the country office.

UNFPA has used MHTF resources to strengthen its participation in relevant technical working groups and to address the issue of quality of midwifery services and the development of a corresponding supervisory framework. Objective one of the draft Road Map for Accelerating the Reduction of Maternal and Newborn Morbidity and Mortality in Ethiopia (2011) is to increase skilled attendance during pregnancy, childbirth and postnatal period at all levels of the healthcare delivery system. It includes targets to train and deploy 8,635 midwives and to staff all health centers with at least two midwives by 2015. However, the Road Map is neither costed nor has an implementation plan.

The WHO, FMoH, Ethiopian Society of Obstetricians and Gynecologists (ESOG), and UNFPA all play a role in trying to ensure that facilities are ready for the deployment of the health cadres that have been trained using MHTF resources. At the time of the country visit, monitoring and assessment visits were underway to identify how these facilities needed to be strengthened prior to the arrival of newly deployed health workers.[79]

75. 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).
76. Capacity assessment in seven midwifery training institutions and the Ethiopian Midwifery Association, 2009
77. 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 country office level.
78. Information from development partner.
79. Ibid.

UNFPA has considered deployment, retention and motivation to be the responsibility of FMoH. The country office has not raised these issues with its governmental counterpart, as the new cadres and trainees will only be in post in 2012. The midwives currently in training are required to remain in post for a period of two to five years. For nurse anesthetists and IEOS, FMoH was expecting that good salaries; higher status and improved equipment would facilitate their retention.

The mentoring programme for the Gode Health Sciences College by the University of Gondar provides a good example for midwife training. All tutors and instructors from Gode indicated that they had gained knowledge and changed some of their negative practices after the mentorship programme.[80]

Judgment criterion 2.3

- Midwifery associations able to advocate and support scaling up of midwifery services through MHTF support

MHTF funds have been used to support a broad range of activities to strengthen the Ethiopian Midwives Association (EMA). At the time of the evaluation, EMA had become a recognized member of the national taskforce to develop professional standards. However, work on these standards was just beginning.

MHTF has supported the Ethiopian Midwives Association (EMA) through the provision of financial, technical and material support. In addition, MHTF helped to organize annual trainings for EMA staff over a period of three years to strengthen their capacity to advocate for the improved regulation of midwives for example, in 2010 EMA staff attended a training on leadership and management. MHTF funds have also been used to support the Ethiopian Nurse Midwives Association (ENMA). MHTF support helped EMA to become a member of the national taskforce for the development of professional standards for all health cadres, and to establish two additional regional branches (the SNNPR and Somali offices).

The international country midwife advisor (ICMA) (funded by the MHTF) has been mentoring two national colleagues.[81] One of the two national midwifery advisors has been placed in FMoH to support the midwifery programme.

MHTF funds have also been used to organize the International Day of the Midwife; and to set up advocacy meetings for the media and for decision-makers from the relevant Ministries. These events led FMoH to provide additional funds to improve teaching and learning, and to increase the intake of midwifery students at training schools.[82] However, a number of challenges remain. The most important gap is the lack of a regulatory body for midwifery, as this reduces the potential for sustainability of all aspects of the capacity development efforts.

80. A full evaluation of the programme would be needed to determine the long term results of the intervention.
81. 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.
82. Whilst the increase is positive, the training schools now are overloaded and the quality of training suffers (information from country office).

4.2.3 Evaluation question 3: Sexual and reproductive health services – family planning

Evaluation question 3

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

Judgment criteria	Issues to assess
3.1. Creation of enabling environment to facilitate scale-up of quality family planning services in priority countries through MHTF support	What were the specific family planning activities funded through MHTF (categorize between fully or partly MHTF funded)?

Judgment criterion 3.1

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

MHTF only has provided indirect support for family planning through the pooled MDG fund. These funds were mostly used for the procurement and training of staff for the use of the Implanon.[83]

4.2.4 Evaluation question 4: Sexual and reproductive health services – EmONC

Evaluation question 4

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

Judgment criteria	Issues to assess
4.1. Creation of enabling environment that facilitates scale-up of EmONC services through MHTF support	What mechanisms does the MHTF support to upgrade/ provide continuous EmONC education in remote areas?
	What mechanisms does the MHTF support to provide continuous EmONC education in remote areas?
4.2. Utilization and access of EmONC services improved through MHTF support	What are the mechanisms MHTF utilizes to address the identified barriers and to increase demand of quality EmONC services?
	How does the MHTF ensure that its quality control mechanisms (including institutionalizing supportive supervision) are adopted by the programme countries?

83. MDG pool fund annual report 2009/2010.

Judgment criterion 4.1

- Creation of enabling environment that facilitates scale-up of EmONC services through MHTF support

Through the SIDA-funded midwifery programme, MHTF supports the capacity development of non-physician clinicians (NPCs) and nurse anesthetists, two new cadres evolved from the task-shifting initiative. Activities broadly supported initial activities, but have not sufficiently focused on post-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 year training for non-physician clinicians (health officers) master degree in Integrated Emergency Obstetric and Surgery (IEOS).[84] It is an innovative programme developed by the Ministry of Health and Education (MoH/ MoE), supported by UNFPA, and part of a national Human Resource Strategy to alleviate shortages 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 to Enhance Reproductive Health Commodity Security (GPRHCS). In addition, due to the active advocacy and involvement of the country office in the development of the International Health Partnership+ process in Ethiopia, the master programme for health officers was considered an eligible fundable intervention under the MDG Performance pool fund, which created an opportunity for national scale-up and resource mobilization for training institution capacity development. Funded activities included training of trainers, preceptors, non-physician clinicians, as well as study tours, conferences, vehicles for students transport, equipment for clinics and training centers, and review and development of curricula.

MHTF (through SIDA funds) also supports capacity development of nurse anesthetists to enable comprehensive EmONC facilities to function.

MHTF resources were used to address identified gaps in resources, staffing and training, while retention policies and equitable distribution of health facilities and newly trained staff had not been addressed sufficiently. 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, and decision-making will be provided. Hence, major gaps for the safe employment of the NPCs need to be addressed by MHTF in the near future, i.e., 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.

Judgment criterion 4.2

- Utilization and access of EmONC services improved through MHTF support

Utilization and access to health services is assumed to happen automatically with well-resourced facilities. However, at the time of the evaluation, UNFPA was considering the use of MHTF funds to conduct operational research on additional barriers to services.

In 2008, 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 government and non-governmental sectors. The purpose of this large initiative was to inform Health Sector Development Programme (HSDP IV) and provide evidence to guide policy and planning to strengthen the health system using emergency obstetric and newborn care as a point of entry. In 2009, MHTF supported a conference to disseminate results and agreement was reached by all partners to upgrade nationwide EmONC facilities. The assumption of FMoH and development partners was that resourcing health

84. The first batch of trainees has been admitted in January 2009. 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.

centers would ensure attendance by patients.[85] However, additional barriers include distance, unfriendliness of staff, and costs. UNFPA was considering supporting operational research on these additional barriers to access and utilization, to complement the deployment of the first group of new cadres.

4.2.5 Evaluation question 5: Support to health planning, programming and monitoring

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?

Judgment criteria	Issues to assess
5.1. Improved positioning of maternal and reproductive health in national strategies and policies through MHTF support	How have the advocacy campaigns/activities supported by the MHTF been translated into national policies and strategies (that include family planning, skilled care in pregnancy and childbirth, emergency obstetric and neonatal care, obstetric fistula and sexual reproductive health and reproductive health/HIV linkage)?
5.2. National plans consider sustainable funding mechanisms for sexual reproductive health/ maternal health through MHTF support	To what extent institutional capacities have been developed through MHTF support to allow systematic and sound costing and budgeting of sexual reproductive health/maternal health interventions/packages? What are the capacity development activities supported by MHTF?
	Do national health budgets include dedicated budget lines for family planning, skilled care during pregnancy and child birth, emergency obstetric and neonatal care and obstetric fistula in MHTF supported countries? What are the prospects for sustainability?
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	Are key internationally agreed sexual reproductive health/maternal health indicators integrated in Health Management Information System (HMIS) in MHTF countries and properly measured and used for programming?

Judgment criterion 5.1

- Improved positioning of maternal and reproductive health in national strategies and policies through MHTF support

UNFPA has used MHTF funds to support the development of maternal health policies and strategies; it has the capacity to provide evidence (operational research) on the impact of its interventions

85. Information from development and government partners.

MHTF has provided technical assistance on the elaboration of the HSDP IV and has helped to make the results of the EmONC assessment available at district level. In addition, human resources projections for midwives were revised based on contributions from MHTF-supported technical assistance. MHTF resources were also used to fund work on a national HRH strategy and to support the master degree programme for NPCs, the training of midwives, and the strengthening of the midwifery associations. Important advocacy mechanisms that have influenced human resource planning in Ethiopia (and in other participating countries)[86] was the MHTF-supported Task Shifting Conference in 2009, which underscored the need for capacity development using novel approaches and midwifery activities (see MHTF evaluation question 4).

Judgment criterion 5.2

- National plans consider sustainable funding mechanisms for sexual reproductive health/ maternal health through MHTF support

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The GoE has not been able to sustainably finance its reproductive health programme, but has had to rely on support from development partners, including UNFPA and MHTF. The systematic institutional development of managerial or administrative government staff has not been a priority for the MHTF, with the exception of support to training institutions.

Apart from a dedicated budget line in FMoH for contraceptive procurement, no budget lines exist that are earmarked for sexual and reproductive health or maternal health. Without continued external support, the prospects for sustained funding are low.[87]

Judgment criterion 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

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The country office has considered MHTF resources as supplementary to UNFPA core resources. The allocation of MHTF funds has followed the annual work plan within the overall annual planning of UNFPA, the UNDAF and the umbrella fund for the health sector: the Health Sector Development Programme, now HSDP4, under which all strategies including the reproductive health strategies operate. The national reproductive and maternal health indicators are aligned with the MDG indicators.

86. Information from country office.
87. Information from governmental partner

4.2.6 Evaluation question 6: Management of MHTF

Evaluation question 6

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

Judgment criteria	Issues to assess
6.2. Instruments and mechanisms developed by the MHTF to strengthen country office capacities to manage the fund at global and regional level	To what extent the needs of country offices in terms of technical guidance and tools are responded to?
	What are the outcomes of South-South collaboration for technical assistance?
6.3. Monitoring and evaluation of the MHTF supported proposals including financial monitoring	What are the mechanisms in place for regular financial monitoring of MHTF support in countries, at regional and global level?

Judgment criterion 6.2

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

Global MHTF support has been relevant to the country office and facilitated learning experiences through regular reviews and feedback. The reporting format on MHTF loosely follows the MHTF results framework.

MHTF is closely monitored by UNFPA headquarters, which provides tools, templates and close supervision of the planning and implementation processes via feedback and counter-feedback procedures. Planning and monitoring processes followed country office standards and, similar to the H4 and the MDG fund, a joint annual work plan with a monitoring framework is developed.[88] MHTF reporting is incorporated within the COAR and an additional joint report for the thematic funds (midwifery activities are included) is produced annually. However, the format is predominantly narrative and not similar to the COAR format, and was not consistent in 2009 and 2010.[89]

Tools, advice and editing of reports are provided by the UNFPA Technical Division. Tools for the midwifery programme are provided at the regional level.[90]

88. 'Reproductive health is a comprehensive strategy. At country office level we try to harmonize and integrate our key interventions. For example the Trust funds and global program we plan together, and try also to implement activities together. Same districts, same sites. Information from the country office.
89. 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 five from governments and donors.
90. 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

In regards of to South-South technical assistance and cooperation, the MHTF-supported Task Shifting Conference in 2009 provided a forum for other African countries to exchange experiences and lessons learnt.

Judgment criterion 6.3

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

Standard office procedures are in place for the financial monitoring of the MHTF.

MHTF is managed by accountants in the country office, and budget reporting includes all funding sources together. The country office has ensured that minimum standards for UNFPA financial monitoring are also in the Joint Financing Arrangement (JFA), and has pooled funds to align with the new aid environment guidance to help ensure that financial monitoring processes are harmonized and consistent. Of the H4 partners in Ethiopia, UNFPA was first to follow this new guidance note. UNFPA annual (financial) reports detail MHTF expenditures and also indicate where the two reproductive health funds have been used in complementary ways to maximize effectiveness.

4.2.7 Evaluation question 7: Coordination/ coherence

Evaluation question 7

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

Judgment criteria	Issues to assess
7.1. Integration of the components of the Campaign to End Fistula into Maternal Health programmes after the integration in MHTF	Do MHTF supported countries include obstetric fistula in their advocacy campaign for sexual reproductive health/ maternal health?
7.2. Joint and coordinated planning at country level with GPRHCS	What are the mechanisms in place between GPRHCS and MHTF to harmonize pharmaceuticals, medical supplies and medical equipment lists in programme countries?
7.5. MHTF plans integrate HIV activities in synergy with core funds, Unified Budget and Workplan (UBW) and other resources	To what extent national and sub national service health delivery plans have an integrated sexual reproductive health/HIV component (with MHTF support)?
	Do the revised midwifery curricula include PMTCT in country with high HIV prevalence supported by MHTF?

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.

Judgment criterion 7.1

- Integration of the components of the Campaign to End Fistula into Maternal Health programmes after the integration in MHTF

MHTF supports the obstetric fistula programme by co-funding the programme coordinator. However, coordination or joint planning is not foreseen in the annual work plans.

Obstetric fistula work is mainly funded by SIDA resources that are channeled through the MHTF. The country midwifery advisor has been responsible for the obstetric fistula programme. Funds have been used to provide equipment and supplies for in-service training and obstetric fistula wards/clinics,[91] and to fund the training of health extension workers on fistula symptoms and referral pathways. FMoH followed an integrated strategy whereby patients with fistula were admitted into every hospital that was able to carry out the repair procedure.

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 headquarters is made.[92] Apart from the fact, that the CMA is funded by the MHTF and is responsible for the programme, no further coordination could be observed.

Judgment criterion 7.2

- Joint and coordinated planning at country level with GPRHCS Judgment criterion

Although the MHTF and the GPRHCS jointly developed their annual work plans, they had not planned any joint activities at the time of the evaluation.

MHTF and the Global Programme to Enhance Reproductive Health Commodities have joint annual work plan (AWP) and joint reports, but a distinct division of labor with no overlaps. MHTF supports capacity development for non-physician clinicians (NPC) and midwives; the GPRHCS has supported workshops on logistics and warehouse management. However, the GPRHCS had procured equipment and supplies for the refurbished EmONC health facilities. While AWP development is a joint exercise, this practice had not yet led to any joint activities between MHTF and the GPRHCS.

The establishment of joint planning and reporting in a combined report was still ongoing at the time of the country visit. The 2010 annual report for thematic funds still listed MHTF activities and RHCS activities in separate chapters, without exploring any possible linkages. Nevertheless, both funds were implemented in the same districts and provided support for the same facilities.[93]

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

MHTF resources were not used to support HIV/AIDS activities. PMTCT is addressed in the HIV module and the ante-natal care, labor and delivery, post-natal care module of the midwifery curricula, but it is not clear that this is direct result of MHTF funding/intervention.

91. 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.
92. Annual Report Thematic Funds 2010: Support Fistula research: US$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 headquarters since it involves multi-country research.
93. Information from country office.

4.2.8 Evaluation question 8: Leveraging and visibility

Evaluation question 8

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

Judgment criteria	Issues to assess
8.1. (MHTF-facilitated) presence of UNFPA in global and regional maternal health initiatives	To what extent are the various MHTF supported advocacy and communication efforts translated into higher visibility and additional resources for maternal health?
	To what extent benefit programme countries from regional maternal health related initiatives (conferences, workshops) supported by MHTF?
8.2. Effect of MHTF on (increased) external financial commitments to UNFPA/MHTF for maternal health support (at global, regional, country level)	To what extent contributed the MHTF support to an increase in the share of external financial commitments earmarked to support maternal health at country level?
	What kind of mechanisms are in place to support programme countries to increase their efforts to leveraging additional resources with external donors?
8.3. Effect of MHTF on (increased) financial commitments of partner governments to sexual reproductive health and maternal health	To what extent programme countries governments intended/ committed to allocate additional resources for maternal health with MHTF support?

Judgment criterion 8.1

- (MHTF-facilitated) presence of UNFPA in global and regional maternal health initiatives

MHTF has helped UNFPA to promote maternal health at national and supra-national (regional) level, through communication campaigns and conferences. UNFPA is recognized as a leader on maternal health by development partners and other national stakeholders.

UNFPA has used MHTF resources in Ethiopia to help develop promotional materials to attract more students to midwifery as a profession.[94] More students have also applied for midwifery courses since the International Day of Midwifery event. The country office also used MHTF resources to support a conference on task-shifting in Addis Ababa in 2009 that was attended by health ministers, senior government officials, health programme managers, clinicians and heads of health training institutes from 36 African countries. MHTF resources were also used to develop a radio programmes on the importance of facility-based deliveries that were a regular feature in the national "Radio Bana".[95]

94. Interview with Ethiopian Midwifery Association (EMA).
95. Information from implementing partner.

UNFPA is recognized as a strong advocate for midwives in Ethiopia.[96] The advocacy and communication efforts financed by the MHTF have been instrumental in this regard.

Judgment criterion 8.2

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

Funds from MHTF enabled the country office to support activities that have directly contributed to the health SWAp process. This includes the national EmONC baseline, UNFPA support to the midwifery programme, health system strengthening in human resources for health, the strengthening of the financial system of FMoH, and resource pooling. The country office used MHTF funds to contribute US$ 1 million to the MDG pooled fund and secured an additional five-year grant of US$ 3.2 million from SIDA to support midwifery.

Judgment criterion 8.3

- Effect of MHTF on (increased) financial commitments of partner governments to sexual reproductive health and maternal health

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MHTF has helped to leverage additional financial commitments for maternal health from governmental and development partners.

UNFPA was the first UN organization to contribute to the MDG fund (using MHTF resources) and thus secured a strategic place among the development partners and FMoH as part of the corresponding governance mechanism. The Joint Coordination Committee of the MDG fund is the best-functioning coordinating mechanism in health in Ethiopia. It meets every two weeks, and its members discuss and agree every plan and programme. MHTF contribution of US$ 1 million to the MDG pooled fund helped to leverage an additional US$ 6 million for family planning and EmONC commodities from partners.[97] However, the MDG fund is not co-funded by the GoE, and is thus not a true basket fund. Nevertheless, FMoH agreed to cover the salaries of the new health cadre, which represents a de facto increase of government expenditures for maternal health.

96. Interviews with development partners.
97. 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).

5. Conclusions [98]

Based on the findings on the issues to assess for each of the evaluation questions, the evaluation team has drawn some cross-cutting conclusions which are presented below. These are country-specific conclusions and are not to be confused with the conclusions of the MHTE/MHTF final reports. The conclusions presented in this section are based on the selective analysis of UNFPA maternal health support in Ethiopia only, and as such do not provide a judgment on the quality of UNFPA country program in Ghana overall, which would only be provided by a comprehensive country program evaluation. The conclusions cover the overall maternal health interventions of UNFPA in Ethiopia and the specific added value of MHTF in the country.

5.1 Conclusions on UNFPA overall maternal health portfolio - Ethiopia

1. The absence of a clear and coherent strategy for supporting maternal health in Ethiopia has limited the overall contribution of UNFPA to maternal health in the country. [99]

    - UNFPA in Ethiopia has established itself as a close development partner of the government. It has made a number of valuable contributions to improving maternal health, such as capacity development in family planning, EmONC, midwifery and obstetric fistula repair. However, the assistance was fragmented, geographically dispersed and centered on individual activities that were not sufficiently linked by a common strategic framework. Until recently, UNFPA had not addressed challenges of deployment and retention of staff, although these challenges had directly limited the effects of UNFPA support for the training of health cadres.
    - It is positive that, in response to lessons from monitoring and evaluation, UNFPA decided to target its support on 47 districts, as the organizational resources had been stretched too thinly.

2. The UNFPA country office has had an insufficient number of staff to be able to implement UNFPA country programmes in Ethiopia.[100]

    - The difficulties of UNFPA to assign sufficient staff time to attend and substantively contribute to key maternal health coordination forums, i.e. the technical working groups and the other higher level forums, shows how understaffing has limited UNFPA performance in this area.
    - Staff members need to cover a broad range of topics, at times even outside of their own technical background. The National Programme Officer (NPO) for sexual and reproductive health has been responsible for attending technical working groups, preparing technical input, conducting preparatory and follow-up negotiations with government and development partners; preparing, administering and supervising the implementation of UNFPA sexual reproductive health programming; supervising programme monitoring, and carrying out any administrative tasks related to programme implementation. In addition, the NPO also was expected to stay at the forefront of maternal health relevant topics to fill out the intended technical leadership role of UNFPA in the area of maternal health.

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98. Recommendations are not elaborated at this stage, as the overall conclusions to the evaluation questions will only be developed on the level of the final reports to the MHTE/ MHTF evaluations.
99. Based on MHTE evaluation questions 1 (Relevance), 2 (Harmonization), 4 (HRH), 7 (EmONC), 8 (Evidence), 9 (Frameworks).
100. Based on MHTE evaluation questions 2 (Harmonization), 4 (HRH), 11 (Internal Coherence), and MHTF evaluation questions 1. (Relevance), 2 (HRH).

3. UNFPA has helped to improve the evidence-base on maternal health challenges in Ethiopia through monitoring, evaluation and research.[101]

   - UNFPA has supported the generation and use of demographic and research data and information from monitoring and evaluation to improve the focus on maternal health by the government and development partners and to improve the performance of its own programmes.
   - However, overall UNFPA has made too little use of the available data for its own programming and for adjusting its interventions to new information from the "field". End-beneficiary surveys and assessments, such as knowledge attitude practice studies have not been part of the M&E provisions of UNFPA-funded projects.

4. UNFPA has used its potential for strategic and sustained policy advocacy at the highest level to influence the maternal health policy agenda in Ethiopia,[102] but neglected the translation of policy into operational planning.

   - The Ethiopian health sector has strong leadership and management which is committed to achieving the health MDGs and recognizes the critical roles of development partners. This has facilitated the targeted and intense advocacy of UNFPA to promote specific maternal health approaches and initiatives, such as family planning, task shifting or the midwifery programme.
   - UNFPA has supported the development of relevant maternal health strategies, and has helped to direct public attention to the issue of maternal health. However, sound operational plans to implement the maternal health policies and strategies have been lacking. The low capacity of the Ethiopian Government at operational level, high staff turn-over and the recent reform in the Federal Ministry of Health have posed challenges for UNFPA in this regard.

5.2 Conclusions on the added value of MHTF in Ethiopia

5. The MHTF has helped UNFPA to leverage funds and commitment for maternal health from development and government partners.[103]

   - The MHTF has allowed UNFPA to contribute US$1 million to the MDG fund, which allowed the country office to participate in the joint coordination committee of this fund and to advocate for additional financial commitments to maternal health and MDG five.
   - MHTF-financed advocacy allowed UNFPA to retain a SIDA grant for the midwifery and obstetric fistula component, and secured the commitment of the FMoH to pay the salaries for the newly trained health cadres.

6. The MHTF has given strategic direction to UNFPA support in the area of midwifery and non-physician clinician (NPC) as part of the UNFPA maternal health support portfolio.[104]

   - The MHTF-financed staff was able to approach its work with relatively clear and compelling strategic guidance on the kinds of support that the MHTF was mandated to fund. The "earmarking of funds" for a smaller range of MHTF-sanctioned purposes has also helped to protect these funds from too many individual funding demands for other areas.

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101. Based on MHTE evaluation questions 1 (Relevance), 2 (Harmonization), 6 (Family planning), 7 (EmONC), 8 (Evidence & results), 9 (Frameworks), 10 (Internal coherence), 12 (Visibility).
102. Based on MHTE evaluation questions 2 (Harmonization), 4 (HRH), 8 (Evidence & results), 9 (Frameworks), 12 (Visibility).
103. Based on MHTF evaluation question 2, 4, 8.
104. Based on MHTF evaluation questions 1 (Relevance), 2 (HRH), 4 (EmONC), 5 (Planning), 8 (Leveraging & visibility).

- The guiding principle of "education, regulation, association" provided a concise template against which the country office could identify worthwhile areas of support. In Ethiopia, this happened to be mainly the support to midwifery education and associations and the master degree programme for the NPC (task shifting). However, the latter is still lacking the legal foundation and integration into the medical professional system.
- The partnership with ICM provided UNFPA and the country midwifery advisors with a valuable and respected resource that the country office could draw on for the training of its own staff; and also to support its technical contributions and advocacy efforts.

7. Up to now, MHTF-funded operations have remained too isolated from UNFPA overall maternal health portfolio to bring about an overall more strategic approach to maternal health support in Ethiopia and to thereby safeguard its own short-term achievements in midwifery and NPCs.[105]

- The positive contributions of the MHTF to the operations of UNFPA country office in Ethiopia and the overall good working relationships between MHTF-financed and UNFPA core staff notwithstanding, the MHTF-funded operations have so far remained relatively separate from the rest of UNFPA maternal health support.
- The stronger emphasis on midwifery and NPCs, for example, has not brought about a stronger involvement of the country office overall into human resource issues like deployment and retention of trained NPCs, midwifes and nurses. This is in spite of the fact that the persisting challenges in these areas are threatening to reduce the efficacy of MHTF-supported improvements in training of health cadres for actually increasing the access to services, in particular in remote rural areas.
- Similarly, the country office had not yet invested in finding appropriate models for improving access to and demand of maternal health services in remote districts.

8. The MHTF had not sufficiently addressed the persisting challenges of the UNFPA monitoring system, which meant that evidence on results for MHTF-funded interventions remained scarce[106]

- It has been one of the core tenets of the MHTF to only finance proven interventions and to apply a results- and evidence-based approach. In spite of this commitment, the MHTF had not yet succeeded in improving the results-based monitoring of MHTF-financed initiatives in Ethiopia.
- Since the MHTF had not provided any separate country-level resources for monitoring and evaluation, the monitoring of MHTF-funded activities was affected by the same weaknesses as UNFPA overall.

105. Based on MHTF evaluation questions 1 (Relevance), 2 (HRH), 6 (Management).
106. Based on MHTF evaluation questions 1 (Relevance), 2 (HRH), 6 (Management).

6. Annexes

6.1 Key data of Ethiopia

ETHIOPIA		
Summary statistics		
Region	2000	Eastern Africa
Currency	2008	Birr (ETB)
Surface area (square kilometers)	2008	1104300
Population (estimated, 000)	2008	80713
Population density (per square kilometer)	2008	73.1
Largest urban agglomeration (population, 000)	2007	Addis Ababa (3101)
Economic indicators		
GDP: Gross domestic product (million current US$)	2008	25727
GDP: Gross domestic product (million current US$)	2005	12286
GDP: Growth rate at constant 1990 prices (annual %)	2008	11.3
GDP per capita (current US$)	2008	318.7
GNI: Gross national income per capita (current US$)	2008	319.3
Gross fixed capital formation (% of GDP)	2008	21.2
Exchange rates (national currency per US$)	2008	9.96
Balance of payments, current account (million US$)	2008	-1806

CPI: Consumer price index (2001=100)	2008	267
Agricultural production index (1999-2001=100)	2007	135
Food production index (1999-2001=100)	2007	135
Unemployment (% of labor force)	2008	16.7*
Employment in industrial sector (% of employed)	2005	6.6*
Employment in agricultural sector (% of employed)	2005	80.2*
Labor force participation, adult female pop. (%)	2008	79.8
Labor force participation, adult male pop. (%)	2008	90.8
Tourist arrivals at national borders (000)	2008	330
Energy production, primary (000 MT oil equivalent)	2007	290
Telephone subscribers, total (per 100 inhabitants)	2008	5.1
Internet users (per 100 inhabitants)	2008	0.5
Exports (million US$)	2008	1601.8
Imports (million US$)	2008	8680.3
Major trading partners (% of exports)	2008	Germany (10.5), Saudi Arabia (7.7), Netherlands (7.4)
Major trading partners (% of imports)	2008	China (20.2), Saudi Arabia (14.2), United Arab Emirates (8.4)
Social Indicators		
Population growth rate (avg. annual %)	2005-2010	2.6
Urban population (%)	2007	16.6
Population aged zero-14 years (%)	2009	43.5
Population aged 60+ years (women and men, % of total)	2009	5.3/4.7
Sex ratio (men per 100 women)	2009	99.0

Life expectancy at birth (women and men, years)	2005-2010	56.5/53.6
Infant mortality rate (per 1 000 live births)	2005-2010	79.1
Fertility rate, total (live births per woman)	2005-2010	5.4
Contraceptive prevalence (ages 15-49, %)	2005	14.7
International migrant stock (000 and % of total population)	mid-2010	548.0/0.6 (incl. refugees)
Refugees and others of concern to UNHCR	end-2008	85417
Education: Government expenditure (% of GDP)	2005-2008	5.5
Education: Primary-secondary gross enrolment ratio (w/m per 100)	2005-2008	62.8/73.7
Education: Female third-level students (% of total)	2005-2008	23.8
Seats held by women in national parliaments (%)	2009	21.9
Environment		
Threatened species	2009	101
Forested area (% of land area)	2007	12.7
CO2 emission estimates (000 metric tons and metric tons per capita)	2006	6002/0.1
Energy consumption per capita (kilograms oil equivalent)	2007	29.0

Source: UN World Statistics Pocketbook

Figure 2: Map of Ethiopia

6.2 Data Triangulation

Table 4: Data and methodological triangulation – Maternal Health Thematic Evaluation

Evaluation question - Maternal Health Thematic Evaluation	Country Office	Nat. Government (MoH)	Sub-national Government	Civil Society	Development Partners	Implementing Partners[107]	Beneficiaries	Data collection methods
1. Relevance	▲ O	▲ O	▲ O	▲ O	▲ O	▲ O	▲ O	Interviews, Focus Groups, Evaluations, project reports, planning documents, etc.
2. Harmonization, coordination, partnerships	▲ O	▲ O	▲ O	▲	▲ O	▲ O	▲	Interviews, Evaluations, project reports, planning documents, etc.
3. Community involvement and demand orientation	▲ O	▲ O	▲ O	▲ O	▲ O	▲ O	▲ O	Interviews, Evaluations, project reports, planning documents, etc.
4. Capacity development – Human Resources in Health (HRH)	▲ O	▲ O	▲	▲	▲ O	▲ O	▲ O	Interviews, Evaluations, project reports, planning documents, etc.
5. Maternal Health in humanitarian contexts	▲ O	▲ O			▲ O			Interviews, Evaluations, project reports, planning documents, etc.
6. Sexual and reproductive health services – family planning	▲ O	▲ O	▲ O	▲	▲	▲ O	▲ O	Interviews, Evaluations, project reports, planning documents, etc.
7. Sexual and reproductive health services – EmONC	▲ O	▲ O	▲ O	▲ O	▲ O	▲ O	▲ O	Interviews, Focus Groups, Evaluations, project reports, planning documents, etc.
8. Results/evidence orientation	▲ O	▲ O	▲ O	▲	▲ O	▲ O		Interviews, Evaluations, project reports, planning documents, etc.
9. Integrating maternal health in national policies and frameworks	▲ O	▲ O			▲ O	▲ O		Interviews, Evaluations, project reports, planning documents, etc.
10. Coherence of maternal health support with Gender and Population and Development	▲ O	▲ O	▲ O			▲ O		Interviews, Evaluations, project reports, planning documents, etc.
11. Coherence between country, regional, global programmes	▲ O	O						Interviews, Evaluations, project reports, planning documents, etc.
12. Visibility	▲ O	▲ O	▲ O	▲ O	▲ O	▲ O	▲	Interviews, Evaluations, project reports, planning documents, etc.

▲= Primary Sources (Interviews, Focus Groups), O = Secondary Sources (Evaluations, project/ intervention reports, planning documents, etc.)

107. Other than national government (in particular the Ministry of Health (MoH)) or sub-national governments.

Table 5: Data and methodological triangulation – Mid-Term Evaluation of the MHTF

Evaluation question - Maternal Health Thematic Evaluation	Country Office	Nat. Government (MoH)	Sub-national Government	Civil Society	Development Partners	Implementing Partners [108]	Beneficiaries	Data collection methods
1. Relevance	▲ O	▲ O	▲ O	▲ O	▲ O	▲ O	▲ O	Interviews, Evaluations, project reports, planning documents, etc.
2. Capacity Development – HRH	▲ O	▲ O	▲ O	▲ O	▲ O	▲ O	▲ O	Interviews, Evaluations, project reports, planning documents, etc.
3. Sexual and reproductive health services – family planning	▲ O	▲ O	▲ O	▲ O	▲ O	▲ O		Interviews, Evaluations, project reports, planning documents, etc.
4. Sexual and reproductive health services - EmONC	▲ O	▲ O	▲ O	▲ O	▲ O	▲ O	▲ O	Interviews, Focus Groups , Evaluations, project reports, planning documents, etc.
5. Health planning, programming and monitoring	▲ O	▲ O	▲ O		▲ O	▲ O	O	Interviews, Evaluations, project reports, planning documents, etc.
6. Management of MHTF	▲ O	▲ O			▲ O	▲ O		Interviews, Evaluations, project reports, planning documents, etc.
7. Coordination and Coherence	▲ O	▲ O	▲ O		▲ O	▲ O		Interviews, Evaluations, project reports, planning documents, etc.
8. Leveraging and Visibility	▲ O	▲ O	▲ O	▲ O	▲ O	▲ O	▲	Interviews, Evaluations, project reports, planning documents, etc.

▲= Primary Sources (Interviews, Focus Groups), O = Secondary Sources (Evaluations, project/ intervention reports, planning

108. Other than national government (in particular MoH) or sub-national governments.

6.3 Data collection result matrix

Overview evaluation questions MHTE	
Evaluation question 1 To what extent is UNFPA maternal health support adequately focused on addressing the reproductive and maternal health needs of the vulnerable groups among countries and within countries?	
Judgment criteria	1.2. (Increased) availability of accurate and sufficiently disaggregated data for targeting most disadvantaged/vulnerable groups
	1.3. Needs orientation of planning and design of UNFPA supported interventions
Evaluation question 2 To what extent has UNFPA successfully contributed to the harmonization of efforts to improve maternal health, in particular through its participation in strategic and multi-sectoral partnerships at global, regional and national level?	
Judgment criteria	2.1. Harmonization in maternal health partnerships between UNFPA and United Nations (UN) organizations and World Bank (including H4+[109]) at global, regional and country level
	2.2. Harmonization of maternal health support through partnerships at country and South-South/ regional
	2.3. UNFPA participation in partnerships for producing evidence for policy debates and definition and prioritization of coordinated operational maternal health research agenda

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

Evaluation question 3 To what extent has UNFPA support contributed to a stronger involvement of communities that has helped to increase current levels of demand and utilization of services, in particular through its partnerships with civil society?	
Judgment criteria	3.1. Government commitment to involve communities translated in sexual and reproductive health and maternal health strategies through UNFPA support
	3.2. Civil society organization involvement in sensitization on maternal health issues and facilitating community-based initiatives to address these issues supported by UNFPA
Evaluation question 4 To what extent has UNFPA contributed to the strengthening of human resources for health planning and human resource availability for maternal health?	
Judgment criteria	4.1. Development strengthening of national human resources for health (HRH) policies, plans and frameworks (with UNFPA support)
	4.2. Strengthened competencies of health workers in HIV/AIDS, family planning, obstetric fistula, skilled birth attendance and EmONC to respond to sexual and reproductive health/ maternal health needs
Evaluation question 5 To what extent has UNFPA anticipated and responded to reproductive health threats in the context of humanitarian emergencies?	
Judgment criteria	5.1. Inclusion of sexual and reproductive health in emergency preparedness, response and recovery plans
	5.2. Accessibility of quality EmONC, family planning and reproductive health/ HIV services in emergency and conflict situations

Evaluation question 6 To what extent has the UNFPA contributed to the scaling up and increased utilization of and demand for family planning?	
Judgment criteria	6.1.Increased capacity within health system for provision of quality family planning services in UNFPA programme countries
	6.2 Increased demand for and utilization of family planning services in UNFPA partner countries, particularly among vulnerable groups.
	6.3. Improved access to contraceptives (commodity security)
Evaluation question 7 To what extent has UNFPA contributed to the scaling up and utilization of skilled attendance during pregnancy and childbirth and EmONC services in programme countries?	
Judgment criteria	7.1. Increased access to EmONC services
	7.2. Increased utilization of EmONC services
Evaluation question 8 To what extent has UNFPA use of internal and external evidence in strategy development, programming and implementation contributed to the improvement of maternal health in its programme countries?	
Judgment criteria	8.2. Consideration and integration of relevant maternal health/sexual and reproductive health evidence and results data during development of country strategies
	8.3. Results- and evidence based management of individual interventions throughout project life

Evaluation question 9 To what extent has UNFPA helped to ensure that maternal health and sexual and reproductive health are appropriately integrated into national development instruments and sector policy frameworks in its programme countries?	
Judgment criteria	9.2. Maternal health and sexual reproductive health integration into policy frameworks and development instruments based on (UNFPA supported) transparent and participatory consultative process
	9.3. Monitoring and evaluation of implementation of sexual and reproductive/ maternal health components of national policy framework and development instruments
Evaluation question 10 To what extent have UNFPA maternal health programming and implementation adequately used synergies between UNFPA sexual and reproductive health portfolio and its support in other programme areas?[110]	
Judgment criteria	10.1. Linkages established between programmes (reproductive health with gender and population and development) in intervention design

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

Evaluation question 11 To what extent has UNFPA been able to complement maternal health programming and implementation at country level with related interventions, initiatives and resources from the regional and global level to maximize its contribution to maternal health?	
Judgment criteria	11.2. Alignment of UNFPA organizational capacities at country level and the (intended) division of labor and delineation of responsibilities
Evaluation question 12 To what extent did UNFPA maternal health support contribute to the visibility of UNFPA in global, regional and national maternal health initiatives and help the organization to increase financial commitments to maternal health at national level?	
Judgment criteria	12.2. UNFPA leadership of maternal health advocacy campaigns at national level
	12.3. Increased financial commitments of partner governments to sexual reproductive health and maternal health

Overview evaluation questions MHTF	
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/ 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
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	6.2. 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-ICM[111] Midwives Programme and HIV-PMTCT[112] 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
	7.5. MHTF plans integrate HIV activities in synergy with core funds, Unified Budget and Work plan (UBW) and other resources

111. International Confederation of Midwives.
112. Preventing Mother-to-Child Transmission.

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
	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

6.4 List of documents consulted

TITLE	YEAR	TYPE OF DOCUMENT
Advocacy Strategy Ethiopia: Working Document 2007-2011	2007	Planning Document
African Union Commission: Sexual and Reproductive Health and Rights. Continental Policy Framework	2006	Planning Document
Anti-Malaria Association: Report and Accounts for the Year ended 30 Sene, 2001	2009	Report
CEDPA/ UNFPA: From Challenge to Consensus: Adolescent Reproductive Health in Africa	1998	Report
Center for National Health Development in Ethiopia: Ethiopia Health Extension Program Evaluation Study	2007	Evaluation Report
Central Statistical Agency Ethiopia: 2007 Population and Housing Census – Strategy and Implementation Plan	2006	Planning Document
EC/ ACP/ UNFPA: Sexual and Reproductive Health Project EC/ ACP/ UNFPA Programme 2004-2008	2008	Project Report
ECA: Fifteen-Year Review of the Implementation of the ICPD PoA in Africa – ICPD PoA in Africa – ICPD at 15 (1994-2009)	2009	Review Report
ERCS/ UNFPA: Training Report on reproductive health, GBV & HIV/ AIDS Intervention in a Humanitarian Setting	2008	Training Report
Erulkar, Mekbib, Simie & Gulema: Adolescent Life in Low Income and Slum Areas of Addis Ababa, Ethiopia	2004	Report
Ethiopian Society of Population Studies: Factors Fuelling the Prevalence of HIV and Contributing for Regional Variations	2008	Report
Ethiopian Society of Population Studies: Gender Inequality and Women's Empowerment	2008	Report
Ethiopian Society of Population Studies: Levels, Trends and Determinants of Lifetime and Desired Fertility in Ethiopia	2008	Report
Ethiopian Society of Population Studies: Maternal Health Care Seeking Behaviour in Ethiopia	2008	Report
Ethiopian Society of Population Studies: Maternal Mortality	2008	Report

GOE/ Ministry of Women's Affairs: National Action Plan for Gender Equality 2006-2010	2006	Planning Document
GOE/ MoFED/ MoWA/ UNFPA, et.al.: Joint Program on Leave no Woman Behind (incl. Monitoring Report)	2009	Planning Document
GOE/ MoFED: Country Report for the Fifteen-Year Review and Assessment of the Implementation of the Dakar/Ngor Declaration and the ICPD Programme of Action	2008	Country Report
GOE/ MoFED: Ethiopia: Building on Progress: A Plan for Accelerated and Sustained Development to End Poverty (PASDEP) 2005/06-2009/2010	2006	Planning Document
GOE/ MoFED: Growth and Transformation Plan 2010/11-2014/15	2010	Planning Document
GOE/ MoFED: Manual for Integrating Population Variables/Issues into Development Planning at Macro Level	2009	Planning Document
GOE/ MoFED: Performance Evaluation of the First Five Years Development Plan (2006-2010) and Growth and Transformation Planning Next Five Years (2011-2015)	2010	Evaluation Report/ Planning Document
GOE/ MoFED: Sustainable Development and Poverty Reduction Program	2002	Planning Document
GOE/ MoH/ National HIV/ AIDS Prevention and Control Office: Aids in Ethiopia	2006	Report
GOE/ MoH: Annual Performance Report on HSDP-III	2008	Annual Report
GOE/ MoH: Community-Level Prevention of Postpartum Hemorrhage: The Role of Misoprostol	2008	Report
GOE/ MoH: Compact between the Government of the Federal Democratic Republic of Ethiopia and the Development Partners on Scaling Up for Reaching the Health MDGs through the Health Sector Development Programme in the Framework of the International Health Partnership	2008	Report
GOE/ MoH: Essential Health Services Package for Ethiopia	2005	Planning Document
GOE/ MoH: Ethiopia Health Sector Development Programme HSDP III. Mid-Term Review	2008	Review Report
GOE/ MoH: Health Sector Development Programme II 2002/03-2004/05	2002	Planning Document
GOE/ MoH: National Adolescent and Youth Reproductive Health Strategy 2007-2015	2007	Planning Document
GOE/ MoH: National Fact Sheet	2006	Fact Sheet

GOE/ MoH: National Reproductive Health Strategy 2006-2015	2006	Planning Document
GOE/ UNFPA: Capacity Assessment for the GOE/ UNFPA 6th CP	2006	Assessment Report
GOE/ UNFPA: Country Programme Action Plan (CPAP)	2007-2011	Planning Document
GOE/ UNFPA: Country Programme Documents (CPD)	2007-2011	Planning Document
Internal Medical Corps: Integrated Reproductive Health Response in Food-Insecure Areas of East Hararghe Zones	2009	Assessment Report
International Confederation of Midwives/ UNFPA: Report for ICM/ UNFPA Programme for Investing in Midwives and Others with Midwifery Skills to Accelerate Progress towards MDG five	2010	Report
International Medical Corps: Report on Assessment of Emergency Obstetric Care Referral System	2009	Assessment Report
NOP/ UNFPA: Integration of Population Issues into the MDGs Needs Assessment for Ethiopia	2004	Report
UN Theme Group on HIV/AIDS: Female Condom Fact Sheet	N/A	Fact Sheet
UN: Ethiopia United Nations Development Assistance Framework (UNDAF) 2012-2015	2011	Planning Document
UN: UNDAF 2007-2011	2006	Planning Document
UNDG: Revised Standard Joint Programme Document. Flagship UN Country Team Programme Improving Maternal and Newborn Health and Survival 2010 - 2012	2008	Planning Document
UNDP: HIV/AIDS and Gender in Ethiopia	2004	Report
UNFPA, UNICEF & WHO: Joint Work Plan	2010	Planning Document
UNFPA: Annual Joint Reporting for GP: RHCS & MHTF including Midwifery Programme	2009	Annual Report
UNFPA: Annual Work Plans with Implementing Partners	2001, 2002, 2003, 2004, 2008, 2009, 2010, 2011	Planning Documents
UNFPA: CO Humanitarian Report	2007	Report
UNFPA: Country Office Annual Report (COAR)	2004, 2005, 2006, 2007, 2008, 2009	Management Reports

UNFPA: Detailed Midwifery Work plans for 18 Midwifery Training Institutions and Ethiopia Midwifery Association	2011	Planning Document
UNFPA: Ethiopia Gender Survey. A Study in seven Regions	2010	Report
UNFPA: Expenditure Report GPRHCS & MHTF	2009-2010	Planning Document
UNFPA: Final Report on the Safe Motherhood Community-Based Survey, Ethiopia	N/A	Report
UNFPA: GBV Assessment Report. Kebri Beyah Refugee Camp Somali Region and Shimelba Refugee Camp Tigray Region, Ethiopia	2007	Assessment Report
UNFPA: Integrated Reproductive Health Response Project in Food-Insecure Areas, SNNPR. Project Evaluation Report	2009	EvaluationReport
UNFPA: Joint Reporting for the Thematic Funds	2009	Report
UNFPA: MHTF Result Framework	2011	Planning Document
UNFPA: MHTF Results, Frameworks, Indicators, Baselines and Targets: Midwifery Indicators	2009	Report
UNFPA: Office Management Plan	2006	Planning Document
UNFPA: Operational Challenges in Designing and Managing Country Programmes in the Context of the New Aid Environment and UN Reform: Experience in Ethiopia	2006	Discussion Paper
UNFPA: Population and Gender Issues in Development Planning in Ethiopia. Challenges and Prospects	2006	Report
UNFPA: Project Budget Balance	2010	Report
UNFPA: Report – Global Programme on Reproductive Health Commodities & Maternal Health Thematic Fund	2010	Annual Report
UNFPA: Review Annual Reports 2009/AWP 2010	2010	Review Report
UNFPA: Second Quarter Progress Report	2009	Progress Report
UNFPA: The Policy and Legal Framework Protecting the Rights of Women and Girls in Ethiopia	N/A	Planning Document
UNFPA: Work Plan and Monitoring Tool	2010	Planning Document
Yusuf: Report on the Mid Term Review of UNFPA CPAP – reproductive health Component	2009	Review Report

6.5 List of people interviewed

Organization/Unit	Name	Position
Ethiopia		
Ethiopian Midwives Association	Ms Hiwot Wubeshest	Executive Director
Ethiopian Society of Obstetricians and Gynecologists	Dr Dawit Desalegn Ms Selamawit Kifle	` ESOG Board Member and Project Coordinator
Family Guidance Association of Ethiopia	Ms Haregewoin Kiflom	Technical Assistant Manager
Family Guidance Association of Ethiopia, South Western Area Office	Mr Dessalegn Workineh Dr Zewdie Mulissa	Area Manager Clinical Director
Federal Ministry of Health	Ms Miheret Hiluf	Rural Directorate Director
Federal Ministry of Health, Disease Prevention and Health Promotion Department	Dr Mengistu H/mariam	Disease Prevention and Health Promotion General Directorate
JHPIEGO	Ms Alemnesh T/Berhan	MCH team leader
Jimma Town Health Office and Jimma Health centre	Mr Ahmed Jemal Ms Fatuma Mohammed	Deputy Head of Town Health Centre Head of Health Centre
Jimma University Hospital	Dr Chuchu Girma	Medical Director
Jimma University Integrated Surgical and Obstetrics Training	Focus Group	Second Year MSc students
SIDA	Mr Abdi Foum	Counselor, Head Development Cooperation Section
UNFPA Country Office (CO)	Mr Benoit Kalasa	Representative
UNFPA CO	Ms Helen Amdemikael	Assistant Representative
UNFPA CO	Dr. Muna Abdullah	NPO Reproductive Health
UNFPA CO	Ms Bethlehem Solomon	National Programme Assistant
UNFPA CO	Dr. Michael Tekie	NPO reproductive health NOB
UNFPA CO	Ms Dorothy Lazaro	International Midwifery Advisor
UNFPA CO	Ms Beza Nardos	Programme Assistant
UNFPA CO	Mr Ayehualem Tameru	NPO HIV NOC

UNFPA CO	Ms Dursit Abdishekur	NORAD NPO (Programme Coordinator)
UNFPA CO	Mr Berhanu Legesse	NPO NOC GENDER
UNFPA CO	Mr Behailu Gebremedhin	NPO NOB M&E
UNFPA CO	Ms Tsigereda Tiruneh	National Midwifery Advisor
UNFPA CO	Mr Wondimagegn Fanta	Humanitarian Office
UNICEF	Dr. Luwei Pearson	Chief of Health Section
WHO	Dr Atnafu Getachew	Maternal and Newborn Health Team
World Bank	Dr Miraf Tadesse	Project Coordinator: Ethiopia and Diaspora Health and Education Professional Mobilization Project

6.6 List of UNFPA interventions in Ethiopia (2008-2011)

Annual Work Plans (AWP)

Component of CP	Implementing partner	Project/ programme titles	Volume in US$ (contracted) from UNFPA	Year
Reproductive health	EMA	Midwifery Programme (focus on Midwifery)	306,754	2010
Reproductive health	FMOH/ RHB/ DKT/ FGAE/ UNFPA/ IHFP/ Universities/ EMA	Maternal Health Trust Fund/ Enhancing GP: RHCS	10,362,304	2010
Reproductive health	Gondar University/ Mekele University/ Hawassa University/ Jimma University/ Harumaya University	MSc. Programme	6,318,727 Birr	2010
Reproductive health	Ministry of Youth and Sports	(focus on YFS)	579,848	07/2009-06/2010
Reproductive health	Ministry of Youth and Sports	(focus on YFS)	300,000	07/2008-06/2009
Reproductive health	MoFED	(Basic Social Services and Human Resources; focus on YFS)	308,270	07/2008-06/2009
Reproductive health	UNFPA/ Ethiopia Midwives Association (EMA)	UNFPA/ICM investing in midwives to accelerate progress towards MDG5 (focus on Midwifery)	542,600 (MHTF)	2010
Reproductive health	Addis Ababa City Government	(POP/FLE; focus on Capacity Building)	2,700	07/2011-06/2012

Reproductive health	Addis Ababa City Government	(POP/FLE; focus on Capacity Building)	2,700	07/2010-06/2011
Reproductive health	Addis Ababa City Government Education Bureau	(POP/FLE; focus on Capacity Building)	22,033	07/2009-06/2010
Reproductive health	Addis Ababa City Government Education Bureau	(POP/FLE; focus on Capacity Building)	18,526	07/2008-06/2009
Reproductive health	AFAR Education Bureau	(POP/FLE; focus on Capacity Building)	1,005	07/2011-06/2012
Reproductive health	AFAR Education Bureau	(POP/FLE; focus on Capacity Building)	1,005	07/2010-06/2011
Reproductive health	AFAR Education Bureau	(POP/FLE; focus on Capacity Building)	8,283	07/2009-06/2010
Reproductive health	AFAR Education Bureau	(POP/FLE; focus on Capacity Building)	7,229	07/2008-06/2009
Reproductive health	Amhara	(POP/FLE; focus on Capacity Building)	75,736	07/2009-06/2010
Reproductive health	Amhara	(POP/FLE; focus on Capacity Building)	61,926	07/2008-06/2009
Reproductive health	Benishangul Gumuz Education Bureau	(POP/FLE; focus on Capacity Building)	4,219	07/2009-06/2010
Reproductive health	Benishangul Gumuz Education Bureau	(POP/FLE; focus on Capacity Building)	4,219	07/2008-06/2009
Reproductive health	Dire Dawa REB	(POP/FLE; focus on Capacity Building)	2,695	07/2009-06/2010
Reproductive health	Dire Dawa REB	(POP/FLE; focus on Capacity Building)	2,902	07/2008-06/2009
Reproductive health	Gambella REB	(POP/FLE; focus on Capacity Building)	3,094	07/2009-06/2010

Reproductive health	Gambella REB	(POP/FLE; focus on Capacity Building)	2,931	07/2008-06/2009
Reproductive health	Harari Education Bureau	(POP/FLE; focus on Capacity Building)	1,922	07/2009-06/2010
Reproductive health	Harari Education Bureau	(POP/FLE; focus on Capacity Building)	1,999	07/2008-06/2009
Reproductive health	Ministry of Education	(POP/FLE; focus on Capacity Building)	51,462	07/2009-06/2010
Reproductive health	Ministry of Education	(POP/FLE; focus on Capacity Building)	43,228	07/2008-06/2009
Reproductive health	Oromia National Regional State Education Bureau	(POP/FLE; focus on Capacity Building)	98,737	07/2009-06/2010
Reproductive health	Oromia National Regional State Education Bureau	(POP/FLE; focus on Capacity Building)	82,747	07/2008-06/2009
Reproductive health	SNNPSREB	(POP/FLE; focus on Capacity Building)	59,324	07/2009-06/2010
Reproductive health	SNNPSREB	(POP/FLE; focus on Capacity Building)	48,579	07/2008-06/2009
Reproductive health	Somali REB	(POP/FLE; focus on Capacity Building)	20,060	07/2009-06/2010
Reproductive health	Somali REB	(POP/FLE; focus on Capacity Building)	17,234	07/2008-06/2009
Reproductive health	Tigray Education Bureau	(POP/FLE; focus on Capacity Building)	19,332	07/2009-06/2010
Reproductive health	Tigray Education Bureau	(POP/FLE; focus on Capacity Building)	16,751	07/2008-06/2009
Reproductive health	Addis Ababa City Administration	(focus on RHS/ Capacity Building)	125,473	07/2011-06/2012

Reproductive health	Addis Ababa City Administration	(focus on RHS/ Capacity Building)	125,473	07/2010-06/2011
Reproductive health	Addis Ababa	(focus on RHS/ Capacity Building)	134,204	07/2009-06/2010
Reproductive health	Addis Ababa	(focus on RHS/ Capacity Building)	112,841	07/2009-06/2010
Reproductive health	Afar RHB	(focus on RHS/ Capacity Building)	46,670	07/2011-06/2012
Reproductive health	Afar RHB	(focus on RHS/ Capacity Building)	46,670	07/2010-06/2011
Reproductive health	Afar RHB	(focus on RHS/ Capacity Building)	50,451	07/2009-06/2010
Reproductive health	Afar RHB	(focus on RHS/ Capacity Building)	47,076	07/2008-06/2009
Reproductive health	Amhara RHB	(focus on RHS/ Capacity Building)	461,301	07/2009-06/2010
Reproductive health	Amhara RHB	(focus on RHS/ Capacity Building)	377,187	07/2008-06/2009
Reproductive health	Benishangul Gumuz RHB	(focus on RHS/ Capacity Building)	27,984	07/2009-06/2010
Reproductive health	Benishangul Gumuz RHB	(focus on RHS/ Capacity Building)	25,695	07/2008-06/2009
Reproductive health	Dire Dawa RHB	(focus on RHS/ Capacity Building)	16,416	07/2009-06/2010
Reproductive health	Dire Dawa RHB	(focus on RHS/ Capacity Building)	17,672	07/2008-06/2009
Reproductive health	FMOH	(focus on RHS/ Capacity Building)	140,915	07/2009-06/2010
Reproductive health	FMOH	(focus on RHS/ Capacity Building)	118,482	07/2008-06/2009
Reproductive health	Gambella RHB	(focus on RHS/ Capacity Building)	18,848	07/2009-06/2010
Reproductive health	Gambella RHB	(focus on RHS/ Capacity Building)	17,853	07/2008-06/2009

Reproductive health	Harari RHB	(focus on RHS/ Capacity Building)	11,709	07/2009-06/2010
Reproductive health	Harari RHB	(focus on RHS/ Capacity Building)	12,167	07/2008-06/2009
Reproductive health	HEEC	(focus on RHS/ Capacity Building)	92,154	07/2008-06/2009
Reproductive health	Ministry of Education	(focus on RHS/ Capacity Building)	109,599	07/2009-06/2010
Reproductive health	Oromia National Regional State Education Bureau	(focus on RHS/ Capacity Building)	16,525	07/2011-06/2012
Reproductive health	Oromia National Regional State Education Bureau	(focus on RHS/ Capacity Building)	16,525	07/2010-06/2011
Reproductive health	Oromia RHB	(focus on RHS/ Capacity Building)	503,603	07/2008-06/2009
Reproductive health	SNNPR	(focus on RHS/ Capacity Building)	361,332	07/2009-06/2010
Reproductive health	SNNPR	(focus on RHS/ Capacity Building)	295,889	07/2008-06/2009
Reproductive health	Somali RHB	(focus on RHS/ Capacity Building)	122,187	07/2009-06/2010
Reproductive health	Somali RHB	(focus on RHS/ Capacity Building)	104,970	07/2008-06/2009
Reproductive health	Tigray RHB	(focus on RHS/ Capacity Building)	117,755	07/2009-06/2010
Reproductive health	Tigray RHB	(focus on RHS/ Capacity Building)	102,032	07/2008-06/2009
Reproductive health	Oromia RHB	(POP/FLE; focus on Capacity Building)	628,034	07/2010-06/2011
Reproductive health	Oromia RHB	(POP/FLE; focus on Capacity Building)	628,034	07/2011-06/2012

Reproductive health	SNNPR	(focus on RHS/ Capacity Building)	523,955	07/2010-06/2011
Reproductive health	SNNPR	(focus on RHS/ Capacity Building)	523,955	07/2010-06/2011
Reproductive health	Tigray National Regional State	(focus on RHS/ Capacity Building)	118,781	07/2010-06/2011
Reproductive health Activities in total:			**9,884,892**	
	18 Midwifery Training Institutions/ EMA	(Midwifery Programme)	1,219,392	2011
	Universities and Colleges/ MOH	Maternal Health Trust Fund (focus on Capacity Building)	2,000,000	2011
	UNFPA/ WHO/ UNICEF	Joint Work Plan	6,048,000 (UNFPA)	2011
	UNFPA/ WHO/ UNICEF	Joint Work Plan	11,382,000 (UNFPA)	2010
	UNFPA/ WFP/ UNDP	Leave No Women Behind Joint Programme (Joint Programme)	3,200,362 (UNFPA)	2009

Note: These are not complete expenditures for the mentioned period, but just an indicative overview about the activities within the three components reproductive health, population and development and Gender, according to the available Annual Work Plans

Source: Annual Work Plans, Ethiopia

Table 6: UNFPA Interventions in Ethiopia 2004-2010 (based on ATLAS data)

Time period	Project ID	Project Title	Budget	Expenditure
2008 - 2010	ETH6R51D	A Right Based approach to Adol	8,691,616.90	5,035,248,6
2007 - 2010	ETH6R301	Awareness about sexual reproductive health/RR/ Gemder	2,046,208.32	1,727,263,7
2007 - 2010	ETH6R207	Capacity to Manage Integrated	662,732.54	638,123,94
2008 - 2009	GRP6R21A	CD to integrate maternal heath	197,492.85	101,346,84
2006 - 2010	ETH5G102	CHILD MARRIAGE PROJECT	2,626,594.09	1,500,547,07
2007 - 2010	ETH6R201	Comprehensive Reproductive health	7,093,348.54	6,720,362,55
2010	GRP6R44A	Coordinated UN response to HIV	21,400	21,400
2009 - 2010	ETH6R21J	Emergency Capacity Enhancement	100,001	82,424,26
2010	ETH6R21M	Emergency Reproductive Health	297,046	204,572,52
2009 - 2010	ETH6R21K	Emergency Response on Maternal	200,000	176,100,28
2008 - 2010	ETH6R21C	Enhancing GP: RHCS	3,805,426.01	3,718,440,17
2008 - 2010	ETHM0809	ETH BSB MANAGEMENT	2,054,472	2,094,345,18
2008 - 2010	CGH6G42B	FGM/FGC PROGRAMME	379,278.55	115,396,58
2009 - 2010	GRP6G42A	Global awareness on GBV impact	283,366.06	223,759,64
2007 - 2008	CMB5R2H1	Globla Programme to enhance Reproductive health	701,266.42	462,679,51

2009 - 2010	ETH6R44A	HIV/AIDS Governance Pooled Fun	781,846.66	764,787,99
2009	ETH6R21F	Humanitarian Response	45,000	23,478,89
2004 - 2007, 2009 - 2010	ETH02P01	Integrated Reproductive health Serv. and Reproductive health/IEC	7,083,640.86	6,301,933,75
2009 - 2010	ETH6G21A	Leave No Women Behind (MDG - S	2,068,634.88	1,340,059,46
2004 - 2006	ETH5R203	Maternal Care and EOC	625,595	579,307,64
2009 - 2010	ETH6R21I	Maternal Health Survival	407,760	374,447,56
2009 - 2010	ETH6R21G	Maternal Health Trust Fund	4,018,579.30	2,714,588,81
2009 - 2010	ETH6R21H	Midwifery Programme	529,897.53	253,360,83
2008 - 2009	ETH6R41A	PAF	829,499	466,511,47
2008 - 2010	ETH6G41A	Prevention of VAW	4,616,661.08	2,433,796,63
2007 - 2009	ETH6R206	Programme Officer	313,039	226,425,94
2008 - 2010	ETH6R21D	Reducing Maternal Morbidity an	70,967.69	34,389,74
2008 - 2009	ETH6R21A	Reproductive Health response i	450,000	408,837,18
2007 - 2010	ETH6G103	Resource Planning for Gender	1,426,717.24	1,174,092,99
2006 - 2007	ETH5R206	Reproductive health in Emergency/Post conflict	49,755	51,223,46
2008 - 2009	ETH6R21E	Reproductive health response in drought affecte	286,913.22	227,854,16
2008 - 2009	ETH6R21B	Reproductive health response in food insecure a	200,001	198,508,36
2006 - 2007	ETH5R209	Scaling up for HIV prevention	97,173.79	47,226,79
2007 - 2010	ETH6R209	Scaling-up for HIV prevention	2,263,879.51	2,047,572,52

2010	ETH6R21L	sexual reproductive health Response Programme in Food	500,000	478092,17
2007 - 2009	ETH6R208	STI/HIV/AIDS Information/ Servi	941,601	478,458,77
2004 - 2010	ETH5R201	Strengthening Integrated Reproductive health Se	3,416,798.03	1,571,022,80
2005 - 2010	ETH5R202	Strengthening obstetrical and	1,135,409.43	685,790,7
2004 - 2010	ETH02P04	Strenthening Advocacy	744,965	624,012,17
2006	CMB5R201	THEMATIC TRUST FUNDS FOR RHCS	0	0
2008 - 2009	GRP6R13A	Tools & guidelines to incl. RHCS	156,308.97	50,029,26
2007 - 2010	ETH6G102	WOMEN'S EMPOWERMENT ADVOCACY	1,887,495.98	1,741,708,61
Total			**64,108,388.45**	**48,119,529,49**