COUNTRY REPORT

ZAMBIA

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

Evaluation of UNFPA Support to Maternal Health
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COUNTRY REPORT: ZAMBIA

Zambia Country Office

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Including the contribution of
the Maternal Health Thematic Fund

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List of Acronyms

AR	Annual report
ARP	African regional programme
AWP	Annual work plan
BCC	Behavior change communication
BEmONC	Basic emergency obstetric and newborn care
CARMMA	Campaign for Accelerated Reduction of Maternal Mortality in Africa
CCA	Common country assessment
CEmONC	Comprehensive emergency obstetric care
CFA	Country Fistula Advisor
CHAI	Clinton Health Access Initiative
CHAZ	Churches Health Association of Zambia
CIDA	Canadian International Development Agency
CMA	Country Midwife Advisor
CO	Country office
COAR	Country office annual report
CP	Country programme
CPAP	Country programme action plan
CPD	Country programme document
CPI	Consumer price index
CSS	Country Support Strategy
DANIDA	Danish International Development Agency
DFID	UK Department for International Development
DHO	District Health Officer
DHS	Demographic and Health Survey
DP	Development partner
DPS	Department of Population Studies
EmONC	Emergency obstetric and newborn care
EU	European Union
FGM/C	Female genital mutilation/cutting
FNDP	Fifth National Development Plan
GBV	Gender based violence
GDP	Gross domestic product
GIDD	Gender in Development Division
GNC	General Nursing Council

GNI	Gross National Income
GPRHCS	Global Programme to Enhance Reproductive Health Commodity Security
GRZ	Government of the Republic of Zambia
H4	UNFPA, UNICEF, World Bank, WHO
H4+	UNFPA, UNICEF, World Bank, WHO, UNAIDS
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HMIS	Health Management Information System
HRH	Human resources for health
HSSP	Health Sector Support Programme
ICM	International Confederation of Midwives
ICPD	International Conference on Population and Development
IDWG	Institutional Development Working Group
IEC	Information, education and communication
IUD	Intrauterine devices
M&E	Monitoring and evaluation
MAZ	Midwives Association of Zambia
MDG	Millennium Development Goal
MDR	Maternal Death Review
MHTE	Maternal Health Thematic Evaluation
MHTF	Maternal Health Thematic Fund
MMR	Maternal mortality ratio
MNCH	Maternal, newborn and child health
MNH	Maternal and neonatal health
MoF	Ministry of Finance
MoFNP	Ministry of Finance and National Planning
MOH/MoH	Ministry of Health
MSYCD	Ministry of Sports, Youth and Child Development
MT	Metric ton
NAC	National Aids Council
NDP	National Development Plan
NGO	Non-governmental organization
PHO	Primary Health Organization
PMO	Provincial Medical Officer
PMTCT	Prevention of mother-to-child transmission
PPAZ	Planned Parenthood Association of Zambia
PPP	Peer education/Service provision/Parents programme

PRSP	Poverty Reduction Strategy Paper
RHCS	Reproductive Health Commodity Security
RHCSC	Reproductive Health Commodity Security Committee
RHTF	Reproductive Health Thematic Fund
SAG	Sector Advisory Group
SIDA	Swedish International Development Agency
SMAG	Safe Motherhood Action Group
SNDP	Sixth National Development Plan
SPU	Strategic Policy Unit
SSP	Strategic Partnership Programme
STI	Sexually transmitted tnfection
SWAp	Sector wide approach
TBA	Traditional Birth Attendants
TNA	Training needs assessment
TNDP	Transitional National Development Plan
TV	Television
TWG	Technical Working Group
UBW	Unified Budget and Workplan
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
UNZA	University of Zambia
US	United States
USAID	United States Agency for International Development
UTH	University Teaching Hospital
WHO	World Health Organization
YFS	Youth-Friendly Services
ZAMIG	Zambian Midwifery Interest Group
ZANIS	Zambia News and Information Services
ZHWRS	Zambian Health Workers Retention Scheme
ZMK	Zambian Kwacha
ZUNO	Zambian Union of Nurses 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 percent during the period of 1990–2008, well short of the 5.5 percent 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 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 for 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 specific 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. I.e., the Maternal Health Thematic Fund, the Global Programme to enhance Reproductive Health Commodity Security and the joint UNFPA-UNICEF FGM Programme.

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) 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 the 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 Zambia 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 Zambia as a case study
    - The preparation and conduct of the case study

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.

- The limitations and constraints experienced by the evaluation team

- Chapter 3 provides a short description of the reproductive health sector in Zambia, 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.
- Chapter 6 presents the annexes of this country report including a list of all documents consulted and a list of people interviewed for this case study. The annexes also contain the methodological instruments utilized for this case study and a list of UNFPA interventions and activities in Zambia.

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

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

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

2.1.2 Justification for selecting Zambia

Zambia is one of four countries that made no or very little progress in reducing maternal mortality: the maternal mortality ratio (MMR) of 600 deaths per 100,000 live births decreased by only 130 deaths between 2000 and 2008.[5] Although this represents a reduction of 22 percent in 8 years, Zambia performance lagged behind that of most other countries whose MMR remained above the threshold of 300 deaths per 100,000 live births.

Another context factor that was considered in selecting Zambia as a case study was its relatively high per-capita Gross National Income (GNI) of US$ 1,359.[6] The assumption was that the higher resource availability would influence the ability of the government and society to address certain bottlenecks in maternal health service provision with its own resources. In turn, this circumstance would affect the demands made on UNFPA to support government efforsts in reducing maternal mortality. Zambia also scored high in the category of 'quality of public administration'. This was interpreted to mean that Zambia would have a higher capacity than other field phase countries to address many of its own challenges with greater independence from its development partners. The existence of a long-term health Sector-Wide Approach (SWAp), for example, was seen as expression of this relatively greater capacity.

Lastly, Zambia has also been affected by a very high HIV prevalence. This was assumed to make the task of reducing maternal mortality more challenging for the government as well as for UNFPA, and to require an adaptation of the maternal health approach of UNFPA, in comparison with other countries without the high incidences of HIV.

2.2 Scope of the country case study

This country case study is one of several evaluation components used to collect evidence to answer the global evaluation questions and judgment criteria[7] of the two evaluations.[8] These evaluations draw on a number of different information sources. Consequently, this country case study provides only some of the information that is required to answer the global evaluation questions comprehensively.[9] The scope of the country case study is defined by the "issues to assess", which are listed at the beginning of the findings-section for each evaluation question, together with the judgment criteria they

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 Zambia into a group of countries with per capita GNIs higher than US$1,000, along with Cambodia, Ghana, and Lao PDR as countries that have made relative progress in lowering their maternal mortality ratio; and Burkina Faso, Kenya and Sudan that, similar to Zambia itself, have not achieved a significant reduction of maternal mortality.
7. 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.
8. I.e., the Maternal Health Thematic Evaluation and the MHTF mid-term evaluation; see Chapters 1.1 and 1.2 above.
9. Twelve evaluation questions for the Maternal Health Thematic Evaluation and eight evaluation questions for the MHTF mid-term evaluation.

correspond to.[10] 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 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 focuses on collecting information on these specific issues and the findings presented in this country report do not provide 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 at the level of the final reports for 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 Zambia

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

- The evaluators conducted a series of individual interviews in Lusaka, i.e., with staff from UNFPA and with the representatives of UNFPA main partners in the country, including governmental, 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. A complete list of issues to asses for this country is also contained in Annex 6.3., the data collection results matrix for this country report.
11. Therefore, 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. 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. Evaluators focused in particular on the following types of documents:

  - Annual work plans (AWP), in particular those AWP 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.

- The team traveled to North-Western Province (Solwesi, Kasempa Districts) to visit a selection of intervention sites. The team interviewed UNFPA staff from the respective sub-office, representatives from local authorities, staff from health centers that had received UNFPA support, and implementing partners.
- The team also conducted three focus group discussions, i.e., with male and female members of the Safe Motherhood Action Group (SMAG) in Kasempa District,[16] and with a group of peer educators that had been trained with UNFPA funds.
- 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. In Zambia, making this distinction was relatively easy because the country office had only received MHTF funds to support midwifery and fistula work, and these funds had been administered in Annual Work Plans separate from those for the core funds. Details on the approach for comparing maternal health support financed by core funds and support from the MHTF can be found in the final reports for the MHTE and the MHTF evaluations.

At the end of the visit to Zambia, the evaluation team did a preliminary analysis of the 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 Zambia 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 programme evaluation of Zambia. These conclusions are presented in Chapter 5.

16. One group for female SMAG members; and a second group for male SMAG members.

2.5 Limitations and restrictions

Overall, the information obtained during the country visit allowed the evaluation team to compile a coherent picture of UNFPA maternal health assistance in the more recent years, i.e. approximately for the period 2007/08 to 2011. The specific challenges are detailed in the table below.

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

Challenges/constraints encountered	Reactions
It was not possible to secure an appointment with some key stakeholders: the Director of Human Resources, the Director of Planning and Policy at the Ministry of Health (MoH) and the Zambia News and Information Services (ZANIS). All of these organizations had been important counterparts of UNFPA in the past.	In order to obtain information on the UNFPA involvement in HRH, the evaluators solicited feedback from development partners on government perceptions on UNFPA role in supporting human resources for health, curriculum review and other relevant initiatives, to compensate as much as possible for missing information from MoH on the topic. As the team could not interview ZANIS in Lusaka, the evaluators conducted interviews with UNFPA staff and local authorities/ North Western Province on the role of ZANIS.
Available documentation on UNFPA interventions (AWPs, monitoring reports, or other documents) in Zambia was so limited and documents from the different years of the evaluation period so dispersed that the evaluation team was not able to easily complete a list of interventions between 2000 and 2010. Despite repeated efforts by the team and the current staff at the Zambia country office, the team was not able to locate documents for interventions for the first half of evaluation period (2000 – 2005).	The team compilated an approximate profile and portfolio of UNFPA interventions in maternal health based on interviews with UNFPA staff and complementary information from past country programme documents. The scope of the country case study had to be limited to the period between 2005 (approximate) and 2011 (the interventions portfolio examined by the evaluators was – when relevant – extended as to include a number of activities implemented in 2011).
Due to changes in staff (for UNFPA partners - e.g. Sweden, DfID, Clinton Health Initiative), the evaluation team was only able to obtain information of UNFPA support for the most recent years.	When interviews were not possible, the team consulted past reports, evaluations and other documents from partners. Where this was not possible, the temporal scope had to be limited.

3. Short description of the reproductive health sector

3.1 Country Background

Zambia, formerly known as the territory of Northern Rhodesia, attained its independence from the United Kingdom in 1964. It is a landlocked country in southern Africa that is ethnically diverse, with more than 70 ethnic groups. Zambia is the biggest copper producer of Africa, which makes its economy very vulnerable to price fluctuations of the global copper market. Since 2004, increasing global demand for copper and related foreign investments have contributed to significant annual economic growth of about 6 percent in the last five years.[17] Moreover, Zambia had a record maize harvest in 2010, which helped the country to largely avoid effects from the global economic crisis. However, despite this recent economic growth, poverty rates in Zambia have remained largely unchanged, with around 60% of the population living below the poverty line (2006 data).[18]

Table 2: Key economic data for Zambia

Total population Zambia (2010) [19]	13,257,000
GDP (2009 million current US$)	12,748
GDP/per capita (2009 million current US$)	985.5

Source: UN Statistical Service UNData.

Zambia became a multi party democracy in the early 1990s after 27 years of one party rule. In 2008 Zambia adopted a national Poverty Reduction Strategy Paper (PRSP) and a Transitional National Development Plan (TNDP) which was to further strengthen economic and social development.

3.2 Zambia Health Sector

Health services in Zambia are provided by the government as well a number of non-governmental and private sector organizations, such as the Churches Health Association of Zambia (CHAZ), mining companies, parastatal organizations, private clinics and hospitals and traditional healers. The public and essential health care services of the government are delivered through five standard types of health facilities, namely Health Post; Health Centre; and the 1st, 2nd and 3rd Level Referral Hospitals.[20]

17. UN statistical service UNData on Zambia.
18. The World Bank, Data by Country 2012; UNICEF; UNDP.
19. UN Statistics Division 2009a.
20. National Health Strategic Plan Zambia 2006-2010.

A number of factors have constrained the delivery of high-quality health services in Zambia, in particular, the concentration of health infrastructure in urban areas, inadequate funding for drugs and medical supplies, a weak supply systems and poor working conditions that have resulted in the exodus of much needed human resources from the sector. The HIV/AIDS epidemic and its subsequent impact on maternal and infant mortality and morbidity also continue to affect Zambia.

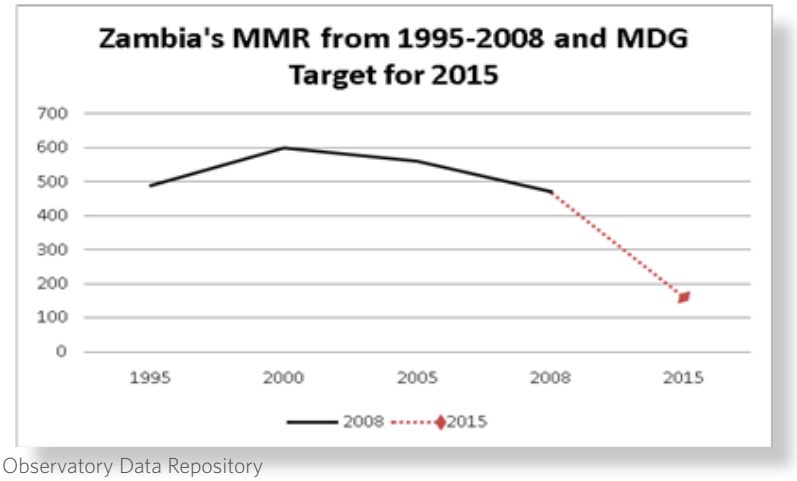
The decentralization of health service planning and provision to the 72 districts of Zambia and the emphasis on preventative rather than only curative care is meant to help the Zambian government to improve the equitable access to quality health services. As a first step towards reforming the health care system, the government launched an essential health care package and encouraged community participation in health sector planning. The main focus is to support and strengthen provision of primary care services. The government also pledged to strengthen the referral system and to better control emerging priority diseases such as non communicable diseases.[21]

Cooperating partners continue to support the effort of the government through a sector-wide approach (SWAp) in health, after a temporary freeze of support in reaction to the mismanagement of resources from development partners in the health sector.

3.3 Health Indicators

Currently, Zambia has a population of about 13 million with an estimated annual growth rate of 3 percent. Around 46.7 percent of Zambians are between 0-14 years old and 50.8 percent are between 15 and 64 years old, with an average life expectancy of 52 years. 51 percent of Zambians are female, 49 percent are male.[22]

Figure 1: Maternal Mortality Ratio Zambia, 1995-2008 and 2015 MDG 5 target



Source: WHO Global Health Observatory Data Repository

21. PHR, Decentralization of Health Systems: Preliminary Review of Four Country Case Studies, 2009
22. WHO/UNICEF/UNFPA/World Bank. Trends in maternal mortality: 1990 to 2008. Estimates developed by WHO, UNICEF, UNFPA and The World Bank.

Zambia is among the 30th worst performers worldwide in terms of maternal mortality. The maternal mortality ratio (MMR) of the country in 2008 was 470 deaths per 100.000 life births,[23] which was the lowest maternal mortality ratio in Zambia since 1995 from a peak in 2001/02 of a MMR of 729 (see Table 1).[24] Based on the slow progress so far, it is unlikely that Zambia will be able to meet the MDG target for a maternal mortality rate (MMR) of 162 in 2015.

According to the World Development Indicators,[25] the adolescent fertility rate has declined from 152 births per 1,000 women in 2000 to 139 births per 1,000 women aged 15-19 in 2009. The contraceptive prevalence increased from 22 percent to 41 percent between 2000 and 2009 for women aged 15-49. With regard to unmet need for family planning the percentage amongst married women aged between 15 and 49 grew from 13 percent in 2000 to 27 percent in 2009. Moreover, within the same time period the percentage of births attended by skilled staff and percentage of women receiving prenatal care remained relatively unchanged around 47 percent and 94 percent respectively. The United Nations Development Programme (UNDP) views improvements on these two indicators as key factors for Zambia to achieve the MDGs. Even though improvements towards the achievement of MDG 5 have been rather small, the performance of Zambia in reaching MDG four (Reducing Child Mortality) and MDG six (combating HIV/AIDS, Malaria and other diseases) has been significant according to the 2011 MDG Report for Zambia.

The table below presents data for key maternal health indicators from the most recent Demographic Health Survey for Zambia (2007):

Table 3: Maternal Health Indicators. Zambia Demographic Health Survey 2007

Maternal mortality ratio[26] in 2007	591
MDG target for maternal mortality rate	162
% HIV prevalence rates (aged 15-49) in 2007	14.3
Contraceptive prevalence rate (CPR) in % (2007)	25
% receiving antenatal care (ANC) from a skilled provider in 2007	93.7
% of births which were assisted by skilled birth attendants (SBA)[27] in 2007[28]	46.5

Source: Zambia Demographic and Health Survey (DHS) 2007.

23. WHO/UNICEF/UNFPA/World Bank. Trends in maternal mortality: 1990 to 2008. Estimates developed by WHO, UNICEF, UNFPA and The World Bank.
24. Zambia Demographic and Health Survey 2007.
25. For reasons of comparability, the text uses the World Banks World Development Indicator Data which gives information on country developments throughout the evaluation period and is in line with the data published by H4+ sources. Additionally, the latest available information on health indicators by the Demographic and Health Survey in 2007 is presented in Table 2 although it is not always equivalent to UN data. This is done in order to allow comparison between the ten country case studies for the global evaluation. A new national consensus is planned for 2012.
26. WHO/UNICEF/UNFPA/World Bank. Trends in maternal mortality: 1990 to 2008. Estimates developed by WHO, UNICEF, UNFPA and The World Bank.
27. Doctors, clinical officers, and nurse/midwives.
28. All data on MMR, HIV prevalence, CPR, ANC and SBA attendance from Zambia DHS 2007.

3.4 UNFPA response to maternal health in the country

Geographic coverage of UNFPA Support	Limited support at national level
	Intensive support in two (as of 2011 three) provinces: • Luapula provinces (population in 2010: 958.976) • North-Western Provinces (population in 2010: 706.462)[29]
Population covered by UNFPA support in 2010 (only focus regions)	1,665,438
% of total population in Zambia covered by UNFPA support in focus regions	12.6%
Total spending regular sources 2004-2010[30]	16,674,644.04 US$
Total spending regular sources per capita (based on focus regions)	10 US$
Total spending other sources 2004-2010[31]	3,348,104.49 US$
Total spending other sources per capita (based on focus regions)	2 US$
Allocation according to CPD 2002-2006 (5th Country Programme)	Total: 10,250,000 US$
Allocation according to CPD 2007-2010 (6th Country Programme)	Total: 15,300,000 US$ of which 10,000,000 US$ regular sources 5,300,000 US$ other sources Reproductive health component: 9,100,000 US$ population and development component: 4,100,000 US$ Gender component: 1,600,000 US$
Total spending MHTF (started in 2008)	2010 Budget: 398,475 US$ Expenditure: 241,306 US$

Source: Calculation by evaluation team based on UNFPA sources

UNFPA support for sexual and reproductive health in Zambia under its Fifth and Sixth Country Programmes remained fairly consistent throughout both programming cycles. Under both programmes, UNFPA supported both national and decentralized level maternal health activities.

29. Central Statistical Office, Republic of Zambia, 2011.
30. ATLAS data.
31. ATLAS data.

At the national level, the programme provided support for the development of the reproductive health policy,[32] supported the Census, the Demographic and Health Survey (DHS) and worked on issues such as reproductive health commodity security and family planning. During this period, UNFPA also participated in the health sector SWAp, which included annual contributions to the district pooled funds and UNFPA participation in joint annual reviews of the sector and long-term technical assistance for the Reproductive Health Unit of the Ministry of Health. At the provincial level, UNFPA supported adolescent and youth sexual and reproductive health activities, contributing to behavior change communication (BCC) in communities, assisted with the training of care providers, training of pre-service nurses, i.e. for emergency obstetric and newborn care (EmONC). UNFPA also supported capacity development for the management of gender based violence (GBV), strengthening of the referral system by providing ambulances, an integrated reproductive health for in-service training, and the mobilization of communities for reproductive health services including HIV/AIDS prevention and facilitating the formation of Safe Motherhood Action Groups (SMAGs). In addition, UNFPA worked on sensitizing traditional initiators[33] and parent elders to create a supportive environment for youth and training of health care providers.

Zambia was one of the first countries to be selected for additional support under MHTF, however, to date; it has only received support for the midwifery programme. The MHTF-funded country midwife advisor started working in the country office in early 2009. In addition, the country office has benefitted from a fistula advisor (CFA), also funded by the MHTF Campaign to End Fistula. Zambia has received support from the Campaign to End Fistula since 2005.

32. However, at the time of this evaluation, the reproductive health policy still not had been finalized.
33. Community members who are responsible for accompanying and facilitating the transformation from children to adults.

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[34]	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 (IP) 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 have UNFPA country offices utilized information from needs assessments other than the Common Country Assessments (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 has been targeting its maternal health support geographically, i.e. by offering service delivery support in three focal regions, without prioritizing any specific demographic group in these provinces and without collecting and making available data on the maternal health situation of specific demographic groups in these provinces.

The concept of "most vulnerable" is not consciously applied or operationalized in UNFPA planning and implementation in Zambia.[35] Instead, UNFPA has targeted its maternal health support primarily geographically, i.e. by supporting the

34. For indicators associated with the judgment criteria, please see the final reports of the MHTE and MHTF evaluations.
35. Feedback from interviews with UNFPA staff.

delivery of maternal health services in initially two provinces; and since 2011, in three of the nine provinces (Luapula, North-Western and Western Provinces). Beyond that, UNFPA has addressed maternal mortality broadly and without using survey or monitoring data to deliberately target specific demographic groups, neither nationally, nor within the three provinces. However, it must be noted that the three provinces supported by UNFPA are among the lower-performing provinces in Zambia, at least when judged on the basis of the percentage of births attended by skilled personnel.[36]

Judgment criterion 1.3

- Needs orientation of planning and design of UNFPA supported interventions

UNFPA has provided financial and logistical support to the Zambian Government to generate data that could be used to improve the needs oriented planning of maternal health services. However, the country office has generally not followed up on the actual use of the data, but has left the definition of priorities solely in the hands of the government.

UNFPA has supported a number of needs assessments on different topics related to maternal health. In 2005, UNFPA supported a needs assessment on fistula[37] that helped to launch the current UNFPA-supported Fistula programme. In midwifery and nursing, UNFPA contributed to a Comprehensive Training Needs Assessment on Education and Practice of Nursing and Midwifery[38] that was carried out in 2009.[39] UNFPA support of EmONC[40] is based on an EmONC needs assessment from 2005 that had been funded and supported by UNICEF and that became the basis for the Ministry of Health (MoH) plan to scale-up access to EmONC services in the provinces of Zambia.[41] Finally, UNFPA has also supported some rapid Socio-Cultural Research as a way for informing its sexual and reproductive health and HIV/AIDS programming in one of its Provinces.[42]

In recent years, UNFPA priorities for programming were primarily set by its government partners, without a clearly identifiable attempt from the country office to maintain an evidence-based dialogue on the needs orientation of this support; or to ensure the strategic coherence among the UNFPA-funded activities. As a result, UNFPA maternal health support has become somewhat diffuse with UNFPA responding to a large number of various small-scale, separate funding requests from the government.[43] Although the interventions fall under the priority areas of the Country Programme Document (CPD) and the Country Programme Action Plan (CPAP), this practice has prevented the country office from developing a clear and carefully designed operational strategy to bind the individual activities together. The approach also has prevented UNFPA from using its relatively small maternal health/sexual and reproductive health budget strategically to exploit synergies with other development partners.

36. The UNFPA-supported Demographic and Health Survey (DHS) still does not provide geographically disaggregated data on maternal mortality (UNDP Zambia, 2011), so that the MDG progress report 2011 can only discuss the inequality in Zambia regarding maternal health in the following terms: "However, there is reason to believe that maternal mortality rate is worse in rural areas, where access to health services is much poorer" (UNDP Zambia, 2011).
37. Supported by the Global Campaign to End Fistula.
38. The needs assessment was led by Zambian General Nursing Council; in partnership with the Health Sector Support Programme (HSSP), the Clinton Foundation and UNFPA.
39. This particular needs assessment was finalized before MHTF (in particular the Midwifery programme) started operating in Zambia.
40. Mostly in the three provinces (North-Western, Luapula, Western) that receive direct support from UNFPA.
41. Both basic and comprehensive EmONC.
42. I.e., in North-Western Province (Zambia GRZ/UNFPA 2005).
43. This trend expressed itself in the structure of the Annual Work Plans (AWPs) that consists of a large number of small-scale activities (e.g., "Daily Subsistence Allowance (DSA) and fuel" for national level supervision of reproductive health and maternal, newborn and child health (MHCH) weeks participation; "Participant accommodation, Meals, Participant out of pocket allowances, DSA for facilitators and support staff, Transport refunds", etc. for youth councillor trainings) and in interviews with UNFPA and Governmental partners.

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+[44]) at global; regional and country level	To what extent do functioning mechanisms for coordination and harmonization of planning and implementation in UN joint programmes exist? What is the extent of use of pooled funding in UN joint programmes?
	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	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?
	Is UNFPA financing activities that are 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?

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

UNFPA contribution to an increased harmonization of maternal health support has been relatively small, in part because the country office has rarely used its membership in key coordination committees to influence the maternal health agenda. The H4+ concept has not yet led to a more harmonized maternal health support among the partners.

Apart from the UNDAF, UNFPA has used relatively few additional mechanisms to harmonize its maternal health support with other UN organizations at country level.[45] SWAp structures are the main and most inclusive multi-lateral forum in Zambia for coordination and harmonization between Zambian Government, development partners, and civil society. They include, amongst other things, a "Sector Advisory Group"[46] a "Cooperating Partners Group" and a large number of thematic Technical Working Groups and sub-groups. UNFPA is formally a member of all of these groups. However, its attendance

44. UNFPA, UNICEF, World Bank, World Health Organization (WHO), UNAIDS.
45. UNFPA in Zambia had only used the joint programming approach in one case, i.e., a joint programme on HIV/Aids.
46. Government of Zambia, development partners, civil society.

has been relatively irregular and in most groups, UNFPA did not stand out as a vocal, pro-active contributor.[47] At least in part, this has been due to severe staffing bottlenecks at the country office.[48] In the case of the Family Planning Technical Working Group that has been led by UNFPA, its attendance and input was more regular and appreciated by the members.[49]

Introducing the H4+ concept in Zambia has provided some motivation to intensify an already ongoing cooperation between UN agencies in maternal health. The H4+ group was formally constituted in 2009 and consists largely of UN agencies that had already been cooperating under the UNDAF sub-group for health. Since the introduction of the H4+ concept in 2009, members of the group have submitted two proposals for joint programmes related to maternal health.[50] Both proposals have been funded;[51] however, implementation had not yet started at the time of the evaluation. Cohesion of the UNDAF sub-group is being driven to a large extent by long-standing working relationships between national staff members that pre-date the introduction of the H4+ concept[52]. The group continues to meet as the UNDAF subgroup,[53] and does not convene meetings under the H4+ label.[54]

Judgment criterion 2.2

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

Due to low awareness of its existence among development partners, Zambia Maternal and Newborn Health (MNH) Road Map[55] has not yet helped to increase harmonization of maternal health support among development partners in Zambia.

The Maternal and Newborn Health Road Map was integrated into the last National Health Strategic Plan (2006 – 2010) and was used as a resource document for the launching of the CARMMA[56] initiative in Zambia. The government also used the Road Map to showcase its commitment to maternal and newborn health, most prominently during the consultations with the United States (US) government that led to the "Clinton challenge", an increased commitment of US resources for reducing maternal mortality in Zambia.[57] However, none of the development partners outside of the UN agencies were familiar with the current status of the Road Map or considered the document to be a guide for joint donor action. This has prevented the Road Map from making any contribution to an increased harmonization of donor support.[58]

47. Interviews with UNFPA staff, development partners.
48. Before the two MHTF advisors for fistula and midwifery were posted at the country office, the sexual and reproductive health portfolio was managed by one national advisor. Considering that the SWAp structure boasts 10+ sexual reproductive health-relevant Technical Working Groups, it would not have been possible for this advisor to be regularly present in all the meetings.
49. Information from interviews with different partners.
50. One programme on adolescent sexual and reproductive health; the second programme on maternal and child health.
51. The programme on adolescent sexual and reproductive health has received funding from the European Commission; the programme on maternal and child health has received funding from the Canadian International Development Agency (CIDA).
52. No specific input of UNFPA into the work of this group; or initiatives undertaken by this group were identified.
53. No specific initiative of the UNDAF sub-group existed.
54. For details on the introduction of the H4+ concept in Zambia, please see evaluation question 1 in the MHTF section of this country report.
55. I.e., as the country-specific translation of key principles of the Maputo Protocol, a major regional initiative on the reproductive rights of women.
56. Campaign for Accelerated Reduction of Maternal Mortality in Africa.
57. Information from interviews.
58. Interviews with five development partners.

4.1.3 Evaluation question 3: Community involvement/demand orientation and civil society organizations (CSO) partnerships

Evaluation question 3

To what extent has UNFPA support contributed to a stronger involvement of communities that has helped increase current levels of demand and utilization of services, in particular through its partnerships with civil society?

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 UNFPA support to create clear legal frameworks, regulations and guidelines to facilitate government partnerships with communities and CSOs
	Examples of UNFPA support to overcome weaknesses of government (national, sub-national level) in transparency, service accountability and responsiveness to national civil constituencies at local level (including local public institutions outside ministries and departments).
3.2. Civil society organization (CSO) involvement in sensitization on maternal health issues and facilitating community based initiatives to address issues supported by UNFPA	Examples of UNFPA support to civil society and communities to overcome the lack of financial support to civil society
	Examples of UNFPA coordination among implementing partnerships to bring together Governments and civil society organizations especially at local level to intensify community participation.
	Examples of UNFPA-Government-CSO 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 helped to establish the community-based Safe Motherhood Action Groups (SMAGs) in Zambian maternal health policy as a way to organize communities around the issue of maternal health and to create a link between communities and health centers. Since their introduction in 2003/04, SMAGs have helped to increase the awareness and knowledge of maternal health issues amongst beneficiaries. However, SMAGs were not able to address many of the other remaining barriers, such as transport, that continue to prevent women from accessing maternal health services in remote rural areas.

UNFPA has worked with civil society in Zambia at different levels and on different issues. UNFPA support to Safe Motherhood Action Groups (SMAG) is the most prominent example of UNFPA engagement with civil society at community level.[59] The scaling-up of the SMAG model from one province (i.e., North-Western Province) to all nine provinces and to over 50 of the 72 districts evolved out of UNFPA initial support of a grass-roots initiative to create a support group for mothers to better

59. I.e., in this case communities are targeted directly, through the formation of community based organizations, the SMAGs.

address the prevailing maternal health needs in the community. UNFPA adopted the concept of Safe Motherhood Action Groups (SMAGs) as an advocacy cause at the national level and, during the 5th Country Programme, lobbied intensively for the replication of the model in other districts and provinces; and for the integration of the concept in national frameworks, policies and guidelines.[60] At the time of the evaluation, the SMAG concept had firmly taken hold in Zambian government policy, implementation plans; and also in maternal health initiatives of other development partners.[61]

SMAG and other community education initiatives (with parent elders, peer educators, traditional initiators) have helped to increase the awareness and knowledge about maternal health issues in communities, e.g., with regard to bleeding as warning signs for complications during pregnancy, or to the importance of relieving pregnant women from some of the more arduous household tasks, such as fetching water or collecting firewood.[62] However, in spite of positive examples of improved behavior and attitudes towards pregnant women and mothers, the continued popularity of traditional practices in medicine and inequitable attitudes towards women continue to constrict women choices and opportunities for accessing maternal health services.[63] Moreover, the trends in some key indicators in North-Western and Luapula Provinces[64] suggest that either the improvements in the awareness of (some) beneficiaries are not sufficient to reverse an overall negative trend in these areas; or that despite the improved awareness in the population of these two provinces, other barriers[65] so far have prevented women from improving their access to maternal health services, including the delivery in health facilities with skilled personnel.

Judgment criterion 3.2

- Civil society organization (CSO) involvement in sensitization on maternal health issues and facilitating community based initiatives to address issues supported by UNFPA

UNFPA previously involved Non-Governmental Organizations (NGO) in Zambia as implementing partners of some of its programmes, but has recently transferred this role back to the government. This has somewhat weakened the position of the former CSO implementing partners to provide meaningful input and to lobby the government in the area of maternal health.

In addition to its support of SMAGs, UNFPA has supported the creation of a professional association of midwives in Zambia,[66] and also has provided funds to NGOs that have functioned as implementing partners of UNFPA-funded interventions. From the 4th Country Programme onwards, for example, UNFPA has cooperated with a consortium of NGO in the "PPP programme", a programme supporting peer education, service provision and supports the role of parents in maternal health/sexual reproductive health education, with administrative arrangements that changed over time. While during the 5th Country Programme (2002 – 2006), a NGO[67] had been directly responsible for managing the programme,

60. Based on information from UNFPA staff and other stakeholders.
61. To illustrate: the 2011 work plan of the MoH foresees support to SMAGs from government budget resources (e.g., the "scale-up of SMAGs to 10 districts"; supported with approx. 89 million Kwacha (approx. US$ 18,000); other SMAG related activities are to be financed with donor funds); UK Department for International Development (DfID), and USAID are utilizing the SMAGs in their maternal health-related interventions in Zambia.
62. Information from focus groups.
63. In focus groups, male and female members of the SMAGs conceded that the positive examples of attitude and behavioural change in men and women notwithstanding, the influence of traditional practices, such as the use of herbs for stopping bleeding instead of using health services in a health centre; or the attitude of men that fetching water and collecting wood was "women' work" remained strong.
64. In two of the three Provinces where UNFPA is directly working in training and service delivery (Luapula, North-Western), the rate of births attended by skilled personnel has actually decreased between 1992 and 2007, i.e. from approximately 36 percent (1997) to 34 percent (2007) in Luapula; and from approximately 50 percent (1992) to 41 percent (2007) in North-Western Province (UNDP Zambia, 2011). These figures are based on the Zambia Demographic and Health Survey (DHS) from 2007.
65. Such as the far distances to health centres from many remote communities, for example.
66. The "Midwifery Association of Zambia (MAZ)", discussed in more detail in the section on MHTF of this report.
67. The "Planned Parenthood Association of Zambia" (PPAZ).

UNFPA transferred the management to the government of Zambia[68] with the beginning of the 6th Country Programme (2007 – 2010), and left only the implementation in the hands of NGOs. Although this increased the government ownership of the programme, the role of civil society partners was weakened, making them less able to provide meaningful input, and to advocate for sufficient coordination between civil society and the Government, in particular at the national level.[69] Also, with less funds available from UNFPA for civil society, some of the NGO that are active in maternal health found it increasingly difficult to advocate with the government on the issue of maternal health.[70]

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?
	To what extent was UNFPA involved in country needs assessments to inform policy makers for HRH planning (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?

Judgment criterion 4.1

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

UNFPA has made no clear contribution to the strengthening of Zambian national human resources for health policies, plans and frameworks. The country office neither actively participated in the development of the HRH Strategic Plan of the country, nor ensured that a bonding mechanism[71] propagated by UNFPA was integrated into this plan.

68. Specifically the Ministry of Sports, Youth and Child Development (MSYCD).
69. Based on interviews.
70. One example given in an interview was that without funds given directly to NGOs instead of through government it was more difficult for civil society to advocate against the purportedly ongoing attempt to lower the national MDG target for maternal mortality, to increase the chance of Zambia of meeting the formal target.
71. A bonding mechanism would bind graduated midwives to a particular post for a number of years before being allowed to choose their posting freely.

Zambia has had a "Human Resources for Health Strategic Plan" for the period from 2006 - 2010 (Ministry of Health, 2005). Maternal health and the human resource challenge in relation to maternal health are mentioned in the Plan; however the document makes no mention of any specific maternal health sub-areas and related training requirements, such as EmONC, family planning or fistula repair. For UNFPA, the main mechanism that would have allowed it to influence the development of the HRH Strategic Plan was the respective "technical working group" that was part of the Zambian Health SWAp coordination structure. UNFPA was member of this working group at the time when the HRH Strategic Plan was developed. However, UNFPA did not play a particularly active role in the development the content of the Strategic Plan.[72] As a consequence, UNFPA is known for promoting the "two-year bonding" of the midwives, but the bonding mechanisms was not mentioned in the HRH strategic plan as a specific strategy[73] that should be replicated by the government, or by other development partners.[74]

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

Despite the fact that needs-based deployment of trained health workers has remained a challenge in Zambia, UNFPA so far has not sufficiently addressed these kinds of systemic challenges to ensure that trained staff with UNFPA support can optimally apply their newly acquired skills.

UNFPA main focus has been on financing the training of midwives and nurses in response to requests from the government. UNFPA has not addressed the issues of deployment, including the existing challenge of matching skilled personnel with appropriately equipped and financed positions that allow staff to utilize their skills.[75] Factors that have kept UNFPA from taking up these issues have been a lack of human and financial resources in the UNFPA country office,[76] as well as UNFPA tendency to limit itself to providing small scale financing in direct response to specific requests by the government that are within the "traditional" areas of intervention for UNFPA in Zambia (such as scholarships for nursing students, equipment, logistics for workshops).[77] As a result, UNFPA has left the responsibility for coordination of the individual inputs largely in the hands of the government. For example, while UNFPA has financed the training of nurses and midwives, e.g. by providing scholarships and support for materials, it has not followed up to ensure that UNFPA-financed trainees are deployed in ways that ensure that their newly acquired skills can be appropriately applied.[78]

72. No specific input of UNFPA to HRH strategic plan mentioned in interviews (neither UNFPA nor development partners); UNFPA not mentioned in the "Proposed Ministry of Health 2006 Budget Estimates for Human Resources Activities" (Annex 9 of HRH Strategic Plan). Note: WHO is mentioned even though it only pledged a small amount, i.e., 76,000,000 Zambian Kwatscha (US$16,170) for "Coordinating human resource planning across health sector based on the best available data".
73. Bonding was mentioned as a way in which UNFPA (prior to 2005, the year the HRH plan was published) had contributed to addressing the human resource crisis in Zambian health sector.
74. One development partner commented on the bonding mechanism by saying that it was a mechanism that was hardly ever enforced.
75. All stakeholders acknowledged that these challenge need to be addressed; Challenges included recent problems with absorbing all trained nurses in North-Western Province, retention, and enforcement of the bonding.
76. UNFPA interview.
77. Confirmed by UNFPA, government Partners and development partners.
78. For example, UNFPA also has not been conducting systematic monitoring of the training initiatives; and their effect on the availability of trained personnel in specific underserved locations.

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

The evaluation team did not collect information for evaluation question 5 (maternal health and humanitarian support) for the Maternal Health Thematic Evaluation (MHTE). Humanitarian support has been a relatively small component of UNFPA support in Zambia throughout the evaluation period, and it became clear that Zambia as a case study would not be able to contribute substantially to the overall answer to evaluation questions 5.

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

Evaluation question 6

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

Judgment criteria	Issues to assess
6.1. Increased capacity within health system for provision of quality family planning services in UNFPA partner countries	Are national reproductive health strategies geared towards integration of family planning services in all service delivery points?
	Are systems in place to monitor integration and the availability of family planning services in all service delivery points?
	Are the capacity development interventions designed strategically i.e. taking into account national strategies and orientations, supervisory mechanisms, potential for replication?
	Are the capacity development interventions accompanied by interventions ensuring an environment where trained health care providers can practice their newly acquired skills once they are back in their health facilities (equipment, material, and infrastructure)?
	What are the mechanisms developed to ensure that training curricula and standards are adopted across the partner countries?
	Are the mechanisms promoted/introduced by UNFPA oriented towards ensuring quality service provision? Are these mechanisms adopted at national level with a view to sustain them and to scale them up?

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

6.2. Increased demand for and utilization of family planning services in UNFPA partner countries, particularly among vulnerable groups[79]	To what extent communication initiatives aimed at increasing demand for family planning (undertaken with UNFPA support) are based upon evidence?
	Which monitoring and evaluation mechanism are in place to measure the impact of these communication initiatives?
	How is UNFPA supporting community based distribution of family planning translated into sustainable national strategies?
	Are UNFPA supported initiatives contributing to the increase of family planning utilization among vulnerable groups?

Judgment criterion 6.1

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

UNFPA has supported the strengthening of health system capacity for family planning services in various ways, including the revision of family planning guidelines, the launching of a Reproductive Health Commodity Security Committee (RHCSC) and support for in-service training of nurses and midwives in family planning. However, without sustained and systematic support to bind these isolated activities together, the support has not translated into a sustained capacity improvement in the health system to deliver family planning services.

UNFPA approach towards integration of family planning in all service delivery points consisted mainly in: (a) establishing a "Reproductive Health Commodity Security Committee" (RHCSC) to put commodity security into the hands of the government;[80] (b) integrating family planning into the pre-service curriculum for facility-based health workers and training of health care providers[81] particularly for long acting family planning methods like intrauterine devices (IUD) and implants; (c) training community-based volunteer health workers[82] in family planning; and (d) supporting demand creation for family planning through the activities of the SMAGs. However, the first two interventions faced significant challenges: The RHCS committee ceased to function after only four meetings,[83] mainly because of time constraints of the intended members, and because of difficulties with finding committed leadership for the committee.[84]

Nurses and midwives who were trained in family planning at times lacked the necessary supplies for staff to apply their skills.[85] UNFPA staff has advocated with government partners for the improvements in the deployment of trained staff. However, beyond this, UNFPA has not been involved in systematic efforts and technical assistance to improve the mechanisms and processes for deployment of staff in accordance with their training.[86]

80. Original members included UNFPA, DfID, National Aids Council (NAC), now others have bought into (Ministry of Finance (MoF), MoH, USAID, UNICEF "and others").
81. Nurses, midwives.
82. Safe Motherhood Action Groups (SMAGs), Community-based-distributors, peer educators.
83. Mainly to inform about its intended mandate and purpose.
84. Although the MoH identified a chair and co-chair for the RHCSC committee, the individuals had competing priorities; and the RHCS meetings were usually not prioritized (Interviews with MoH, UNFPA).
85. Training of health staff in family planning is following an overall "training plan" that is managed by MoH. UNFPA has been funding trainings in two provinces (North-Western, Luapula) in accordance with this training plan.
86. UNFPA interviews.

UNFPA has supported the revision of the guidelines on "Family Planning in Reproductive Health of 1997" and ensured the integration of HIV and Sexually Transmitted Infections (STIs) into the Guidelines.[87] However, it is not clear to what extent these guidelines have been utilized and applied.

Although in theory, systems[88] are in place to monitor the availability of family planning services in all delivery points,[89] in practical terms regular monitoring is severely challenged by insufficient human resources.

Judgment criterion 6.2

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

ZANIS, UNFPA major implementing partner for family planning campaigns and other behavioral change communication on sexual reproductive health, focused on the national and provincial levels and worked through SMAGs at the district level. As data on the results of these campaigns were not available, it was not possible to gauge, if their financial support by UNFPA had helped to increase demand for and utilization of family planning services. Interventions were complemented by MoH funds. No data on the results, i.e., the effects of the campaigns was available. In 2008, UNFPA also supported the development of the maternal health communication strategy, which also included family planning.

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 partner 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?
	To what extent does UNFPA support research to evaluate barriers to EmONC?

87. Using funds from the UNFPA-WHO "Strategic Partnership Programme".
88. The quarterly monitoring data collected by MoH supervisors/coordinators is processed at the national level and shared with the annual MoH reports.
89. Integrated Reproductive Health Performance Assessment Tool.

Judgment criterion 7.1

- Increased access to EmONC services

UNFPA has contributed to an increased access to EmONC services in Zambia through a number of independent initiatives, including the training of service providers in Comprehensive Emergency Obstetric and Newborn Care (CEmONC), Basic Emergency Obstetric and Newborn Care (BEmONC) and Focused Antenatal Care (FANC), provision of radios and ambulances to strengthen the EmONC referral system, the introduction of maternal death reviews and the strengthening of adolescent-friendly health services.[90]

The overall effort to increase access to EmONC service in Zambia originated from an EmONC needs assessment in 2005 [91] that showed that EmONC and BEmONC services were "essentially non-existent" in Zambia.[92] The Ministry of Health responded by developing a national EmONC scale-up plan that foresaw that, every year, 18 health facilities should be equipped and staffed to deliver BEmONC services. UNFPA has been supporting the scale-up plan by financing the training of staff (midwives, nurses, clinical officers, medical doctors), by financing equipment (notably ambulances) to strengthen the referral system in the three provinces it is operating in, and by training SMAGs for community mobilization and support. [93] UNFPA role consisted primarily in responding to specific Ministry of Health requests for EmONC related funding without setting its own priorities for funding.[94] UNFPA therefore missed the opportunity to plan the strategic use of its limited support, e.g. to actively create synergies with other development partners.

In addition to fulfilling specific EmONC funding requests (see above), UNFPA has formally been a participant and member of a number of policy-level forums on EmONC. UNFPA has participated in working groups and the sector advisory group during the development of the MoH National Health Strategic Plan (2006 – 2010) and the Annual Work Plans of the Ministry. UNFPA is also member of EmONC relevant Technical Working Groups that are chaired by the Ministry of Health to solicit and coordinate technical input from development partners. Finally, UNFPA has also supported high level policy initiatives such as CARMMA and the development and amendment of the Maternal and Newborn Health Road Map,[95] both of which pledge increased attention to EmONC in Zambia. However, sustained effects from UNFPA formal involvement in these forums and initiatives, e.g. with regard to ensuring an equitable distribution of EmONC facilities, have been constrained by the fact that the UNFPA country office has found it difficult to consistently be present and active in the relevant working groups.[96] As a result, CARMMA and the Maternal and Newborn Health Road Map could not yet realize their full potential for affecting commitment and attention to EmONC because of low levels of operational follow-up to their initial launches.

Judgment criterion 7.2

- Increased utilization of EmONC services

UNFPA has supported the mobilization of communities to enable the access of women to EmONC services by supporting Safe Motherhood Action Groups (SMAGs) and through communication campaigns.

90. Training peer educators in psychological counseling, providing equipment for youth friendly corners located in health facilities.
91. Supported by UNICEF.
92. Interview with governmental partner.
93. North-Western, Luapula, Western. Other donors, including USAID, DfID, are supporting the implementation of the EmONC scale-up plan in other districts.
94. Feedback from interviews.
95. Information from interviews.
96. With the exception of the technical working group on family planning, which is chaired by the UNFPA country office; i.e., by the UNFPA sexual reproductive health adviser. For details, see evaluation questions 9 on UNFPA role in advocacy; and evaluation questions 6 on family planning.

At community level, UNFPA has supported the establishment of the SMAG mechanism to mobilize communities to support women in demanding access to EmONC services. The SMAG element of the country programme, which addresses the first EmONC delay, i.e. the delay at the family/community level, has been integrated in the National Development Plan as a pilot strategy for community involvement, and the Ministry of Health has been allocating funds toward SMAG interventions. Other implementing partners have also started to integrate the SMAG concept into their maternal health/EmONC programmes.[97] In addition, UNFPA has supported community-related communication activities, i.e. by providing funding to ZANIS, a Zambian state agency providing News and Information Services. ZANIS has used community radios, plays, video shows, TV and radio programmes to convey messages about maternal health.[98] UNFPA has not directly supported any specific research on identifying barriers to accessing EmONC services in Zambia. Its current support is based on a 2005 EmONC assessment that had been financed by UNICEF.

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 partner countries?

Judgment criteria[99]	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?
	What were the reasons for the weak monitoring of most country offices?
8.3. Results- and evidence based management of individual interventions throughout their life	To what extent did UNFPA take into account capacity gaps in Monitoring and Evaluation (M&E) among its implementing partners when developing its M&E calendars?

97. For details, see evaluation questions 3 on community involvement and demand creation.
98. Information from interviews.
99. 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 8.2

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

and

Judgment criterion 8.3

- Results- and evidence based management of individual interventions throughout intervention life

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UNFPA has largely limited itself to responding to small-scale funding requests from the Zambian Government, there is little evidence to suggest that UNFPA has used lessons from its past support in order to help shape the policy priorities of the government in the health sector or with regard to maternal health,[100] that UNFPA has adequately monitored the interventions it has financed or that it has supported its implementing partners in strengthening their own M&E capacity.

During the development of the current UNFPA country programme, UNFPA efforts to develop and use lessons-learned from its previous programmes have been closely tied to efforts of the government and other development partners (including UNDAF partners) to draw lessons from previous years. UNFPA participated in sessions of the Sector Advisory Group that accompanied the preparation of the Zambian health sector plans that set health sector priorities for the 5th and 6th National Development Plans (NDPs). In accordance with the UNDAF planning process, UNFPA subsequently took the main priorities for its country programme from the common UNDAF that the UN negotiated with the government on the basis of these NDPs. Therefore, to increase the coherence between its own programming and the strategy development of the government, UNFPA aligned its programming cycle with the planning cycle of the government, starting with UNFPA 6th Country Programme (2007 – 2010).

Beyond that, there have been a number of factors that have limited UNFPA ability to draw and apply "lessons learned" from past programming to its future work. Firstly, UNFPA has carried out a relatively small number of studies and evaluations to analyze lessons and experiences from its past programming. Most of the reporting activities and monitoring have focused on reporting on activities and outputs, but much less on the analysis of outcomes of UNFPA support.[101] Secondly, findings of existing studies have not been disseminated broadly enough among government and development partners. Thirdly, the fact that most studies have been implemented under the Population and Development component of the country programme, and that there have been relatively weak linkages between population and development and the Reproductive Health component in UNFPA country office have at times prevented the reproductive health staff from fully becoming aware of relevant findings and from integrating them into reproductive health programming.

With only an M&E focal point in the country office since 2009, but no budget at country office level for monitoring, and no real monitoring plan, there was nobody to "push" monitoring of implementing partners. The population and development officer was assigned this responsibility for M&E in 2009/2010. However, even after his nomination, there has been virtually no support in training the new M&E Focal Point on M&E[102] or to provide guidance on the responsibilities of an M&E Focal Point in UNFPA. UNFPA has also not provided any specific support or guidance to implementing partners on monitoring and evaluation, nor has it provided specific tools for implementing partner to use for monitoring of UNFPA financed interventions.[103]

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100. Instead, UNFPA stressed that the government was setting the priorities, and that it was UNFPA role to support the government in implementing these priorities.
101. Based on review of monitoring reports and feedback from implementing partners.
102. Apart from his participation in one workshop on evidence-based programming which had been organized by headquarters.
103. Interviews with implementing partners.

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 partner 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 fora
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 monitoring and evaluation (M&E) tools that were developed with UNFPA support been adopted to monitor national maternal health/sexual reproductive health policies and programmes?
	To what extent are maternal health indicators included in the monitoring (and evaluation) systems of national policies?

Judgment criterion 9.2

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

Overall, UNFPA contribution to policy and regulatory initiatives has been focused on logistical and financial support of planning and policy dissemination workshops. The mostly logistical and financial support provided by UNFPA to the launching of CARMMA and the development and revision of the Zambian Maternal and Newborn Health Road Map did not translate into a coordinated and coherent push to strengthen the integration of maternal health into the Zambian health policy framework.

UNFPA support to the development of policies and frameworks for maternal health focused on providing financing for logistics (printing) or workshops for planning and dissemination. UNFPA often had to be absent from relevant policy level forums[104] and has even been perceived at times to shy away from addressing sensitive policy issues with the government.[105] On the other hand, UNFPA advocacy for the Safe Motherhood Action Groups (SMAGs) that had started during UNFPA 5th

104. Feedback from UNFPA (with reference to the low staffing levels at the country office) and from the majority of development partners.
105. An example given was the initiative of the GRZ to procure a number of mobile health units/hospitals for use in rural areas. The majority of development partners opposed this effort because they doubted the sustainability of this approach. UNFPA was perceived to "attempt to avoid bringing this issue up in the first place".

Country Programme is seen as a positive contribution that has helped to establish the SMAGs in the government strategies and policies; and in the approaches of development partners.[106]

CARMMA and the revision of the Zambian Maternal and Newborn Health Road Map are coherent at the level of objectives and have fed into each other. For example, the Road Map was used in the launching of CARMMA and informed the focus of the campaign. However, UNFPA has not successfully established coherence between these UN-driven initiatives and the maternal health support of other donors, i.e. those represented in the SWAp.[107] Although formally introduced into these fora, neither of these initiatives has been adopted by other partners. In the case of CARMMA, no concrete information on the operational follow-up to the CARMMA launch was readily available to partners or to the interested public in general, which deterred at least some development partners from following up on the initiative.[108]

The low level of follow up to the CARMMA launch is also exemplified by the fact that the Ministry of Health has no designated staff member to help maintain the momentum that had been created; and that the Ministry itself does not have an operational plan for following up on the launch. The status of the MNH Road Map is somewhat unclear: the majority of UNFPA development partners were not familiar with the document, suggesting that the document has not yet had a significant effect on shaping the maternal health agenda of the development partners of Zambia in maternal health (e.g. in relation to Zambian health SWAp). At the same time, the Ministry of Health used the MNH Road Map to underscore the commitment of the government to reducing maternal mortality during the negotiations between the United States Government and Zambia for an increased US-engagement in maternal health in Zambia.[109] The government also maintained that the amended version of the Road Map[110] had been integrated into the latest National Health Strategic Plan.[111]

Judgment criterion 9.3

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

Apart from supporting the implementation of long-term national health surveys (e.g. the Zambia Demographic and Health Survey, UNFPA has not supported the development of any maternal health specific monitoring and evaluation tools.

106. To illustrate: the 2011 work plan of the MoH foresees support to SMAGs from GRZ budget resources (e.g., the "scale-up of SMAGs to 10 districts"; supported with approx. 89 million Kwacha (approx. US$ 18,000); other SMAG related activities are to be financed with donor funds); DfID, USAID are utilizing the SMAGs in their maternal health-related interventions in Zambia –see also evaluation questions 3 on "Community involvement/demand orientation and CSO partnerships".
107. The majority of donors were not familiar with the MNH road map.
108. For example, no website exists to make available information on the CARMMA initiatives as such; or on the follow up to the launch, e.g., with regard to the fulfilment of financial pledges; or with regard to other programmes to improve maternal health in Zambia.
109. Information from interviews.
110. An amended version of the MNH Road Map was published in 2011, to reflect implications from new data from the most recent Zambia DHS.
111. The evaluators did not obtain a copy of this plan.

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?[112]

Judgment criteria	Issues to assess
10.1.Linkages established between programmes (Reproductive Health with Gender and Population and Development) established in intervention design	To what extent has UNFPA identified gender constraints as affecting and impeding reproductive health programme objectives at country level?
	How have these gender constraints been addressed in UNFPA programming?
	To what extent has population and development widened the utilization of its data by government, UNFPA and other partners in reproductive health/maternal health interventions?
10.2. Integration of Monitoring and Reporting of UNFPA operations	To what extent has UNFPA country office utilized current reports from cross programme operations at global, regional and country level?

Judgment criterion 10.1

- Linkages established between programmes (Reproductive health with Gender and Population and Development) established in intervention design

The country office has not established deliberate and systematic programmatic linkages between the reproductive health component and the population and development and gender components of the country programme. Only a small number of interventions addressed gender-related challenges to maternal health.

UNFPA maternal health support has addressed a number of gender-related issues over the years.[113] This has included working directly with communities, by supporting the creation of Safe Motherhood Action Groups (SMAGs). With UNFPA support, SMAGs have become a model for creating awareness and demand for maternal health services; and for addressing cultural and other barriers that keep women from accessing the appropriate services in time.[114]

Beyond that, synergies at country office level between the gender component and the reproductive health/maternal health programme component are less apparent. After the previous gender officer resigned, the position remained vacant for eight months; and was only filled in July 2011. UNFPA has supported Gender in Development Division (GIDD) of Zambia.

112. 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)).
113. Also shown by a review of past reproductive health component Annual Work Plans.
114. See evaluation question 3 on community involvement and demand creation for more details.

However, the supported interventions consisted of generic gender awareness-raising and training workshops with gender focal points of different line ministries.[115] The events were not used to discuss and operationalizing specific maternal-health related gender issues.[116]

Deliberate programmatic synergies between UNFPA population and development programme component and the maternal health component have been rare. The UNFPA population and development advisor has made some relevant contributions to the development of the Fifth Zambian National Development Plan (FNDP), e.g., by suggesting the replacement of the indicator for "institutional deliveries" with the more meaningful indicator of "percentage of births attended by skilled personnel". In many ways, however, the population and development component of UNFPA country office has been perceived to operate without strong linkages to other programme components, including that of sexual and reproductive health.[117]

Judgment criterion 10.2

- Integration of Monitoring and Reporting of UNFPA operations

Monitoring and reporting on past UNFPA support is weak. Although the population and development advisor has been named as M&E focal point, he has not received any significant support or training to help him perform this function. No specific monitoring of attempts to create inter-programme synergies has occurred.

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?
11.3. Enhancement/improvement of UNFPA country level programming and interventions through technical and programmatic support from global and regional level	What are specific contributions of regional programmes to supporting integration of maternal health into national frameworks/health system strengthening?

Judgment criterion 11.2

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

The UNFPA country office was not sufficiently staffed to adequately support the implementation of the past country programmes, specifically in the sexual and reproductive health programme component.

115. Including the gender focal point of the Ministry of Health.
116. Information from interviews.
117. Information from interviews (see evaluation question 8 on evidence-orientation of UNFPA work for details).

The country office continues to be understaffed in the area of sexual and reproductive health. Prior to the launch of the MHTF in Zambia, the sexual reproductive health adviser was the only staff member to manage the sexual reproductive health/maternal health portfolio. The recruitment of the Country Midwife Advisor (CMA) and Country Fistula Advisor (CFA) has improved the situation somewhat, as both the CMA and CFA have taken on some responsibilities for the overall maternal health portfolio beyond their main responsibility for midwifery and fistula programming (see also evaluation questions on MHTF below). Nonetheless, the number of staff members is still insufficient to be able to respond to all requirements of the maternal health programming, such as the attendance of all maternal health relevant technical working groups (SWAp structure) and other coordination meetings has not been possible, given the staffing bottlenecks in the country office.[118]

Judgment criterion 11.3

- Enhancement/improvement of UNFPA country level programming and interventions through technical and programmatic support from global and regional level

The Africa regional and sub-regional office has offered on-demand support and has also offered the opportunity to attend workshops on issues such as "results-based management". Although the training opportunity is appreciated, the country office has found it challenging to implement the new concepts after only one such workshop. No follow-up support to accompany the longer-term process of adapting new concepts at country level has been made available by the regional or global offices.[119]

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 MNH; or the willingness of Governments themselves to devote more funds to MNH?

118. Information from interviews.
119. Information from interviews.

Judgment criterion 12.2

- UNFPA leadership of maternal health advocacy campaigns at national level

UNFPA has limited its leadership of maternal health advocacy campaigns to logistical and financial support for the launch of large, government-driven campaigns (e.g., CARMMA) without working with the government to put in place concrete follow-up activities.

In Zambia, UNFPA maternal health support has increased its visibility primarily through its support of initiatives like CARMMA or the longer term support of issues like fistula, through the Campaign to End Fistula. Although UNFPA support of these initiatives has helped to generate a lot of national attention at the time of their launch, UNFPA has not sustained its leadership role in supporting the government with these campaigns during the subsequent follow-up. The UNFPA-supported CARMMA launch has not translated into any significant and concrete new commitments to maternal health. This weakness is also exemplified by lack of any designated staffing for CARMMA in the MoH. UNFPA has so far not worked with the government to improve its weak follow-up to the official launch of CARMMA. [120]

Judgment criterion 12.3

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

UNFPA and the Zambian Government have found it difficult to use the launch of CARMMA or the revision and official launch of the MNH Road Map to leverage additional commitment and resources to support maternal health in Zambia.

By supporting the development of the MNH Road Map, UNFPA helped to develop a useful tool for increasing national attention both on maternal and newborn health and on its own role in supporting these causes. However, the Road Map has not been circulated widely enough to attract support from UNFPA development partners[121] or to encourage increased resource allocations to maternal health by the majority of these partners. This notwithstanding, the government has used the MNH Road Map to document its commitment to maternal health with the government of the United States, in preparation of the US pledge to commit significant resources to reducing maternal mortality in Zambia (see evaluation question 9 for details).

120. Information from interviews.

121. Interviews with development partners (DPs) showed that the road map was hardly known among development partners.

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+ 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?
	To what extent do the MHTF supported needs assessments consider the needs of the most vulnerable groups in the partner countries; and identify the gaps that have prevented the addressing of their needs to that point?
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

In Zambia, the alignment of the MHTF country selection process with the list of H4+ priority countries had not yet fully translated into improved coordination and cooperation among the H4+ partners at the time of the evaluation.[122]

122. Improved coordination and synergies among H4+ partners in MHTF countries had been one rationale of UNFPA globally for focusing MHTF support on H4+ priority countries.

The H4+ group was constituted in Zambia in 2009. However, the group had not really convened any meetings under the H4+ label; and consists largely of UN agencies that had already cooperated as the UNDAF sub-group for health. Cohesion of this group is driven to a large extent by long-standing working relationships of national staff members that pre-date the H4+ concept. Consequently, UN partners started to apply the H4+ label to their cooperation, however, without consciously applying and following global guidance on the envisioned "division of labor" between H4+ partners at country level (see also evaluation question 2 on MHTE above). Instead, the cooperation was guided by the "traditional" division of labor and "added value" of each organization.[123]

This situation notwithstanding, the Zambian H4+ group of UN-agencies has secured funding or has submitted a funding proposal for overall two "joint programmes" in the area of maternal health since the introduction of the H4+ concept to Zambia. One of these joint programmes[124] has received funding from CIDA.[125] It is conceptually linked to another joint programme on Maternal, Newborn and Child Health (MNCH) that has been submitted to the European Union for funding.

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)

In cooperation with other development partners,[126] UNFPA has supported the General Nursing Council of Zambia (GNC), the regulatory agency of the country for nursing and midwifery, in conducting a comprehensive training needs assessment for nurses and midwives. However, this support is not clearly linked to MHTF, as the needs assessment was done before MHTF was officially launched in the country. Nonetheless, this needs assessment forms the basis for comprehensive revisions of training curricula for nurses and midwives, also under the leadership of the GNC that is supported by UNFPA, in terms of financial support for logistics and by providing technical input through the MHTF midwifery advisor and the fistula advisor.[127]

Judgment criteria 1.3

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

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MHTF-resources so far have not been used to influence Zambia maternal health policy agenda and regulatory framework.

A number of donor-supported national initiatives are underway nationally to reform the existing mechanisms for deployment and retention of health staff that have the potential to make the health system more accessible to the most vulnerable groups in Zambia.[128] However, UNFPA, i.e. the MHTF-financed advisors, have not been involved in these initiatives, at least in part due to a lack of adequate financial resources and staffing to support UNFPA involvement.[129]

123. Information from interviews.
124. The programme for "Accelerating Progress Towards Maternal, Neonatal and Child Morbidity and Mortality Reduction in Zambia".
125. In the amount of US$ 9,991,500.
126. Health Sector Support Programme (HSSP) (USAID-funded) and the Clinton Foundation.
127. As explained above, UNFPA has not focused its support on specific vulnerable demographic groups, but has instead used geographic targeting of its three focal provinces.
128. E.g., World Bank-led advocacy to influence policy to increase retention of midwives in remote areas.
129. Information from interview. See also footnote 127.

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?

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?
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?
	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

UNFPA has used the MHTF and the MHTF-funded Country Midwife Advisor (CMA) to establish itself as a partner with acknowledged technical capacity in midwifery in a relevant technical midwifery forum in Zambia and has used its involvement to support a number of initiatives related to midwifery education and training.

MHTF has addressed in particular the following mechanisms that are linked, albeit indirectly, to securing long-term midwifery education funding in Zambia: Firstly, MHTF has started to support the development of organizational capacities in relevant professional associations and government institutions: It is working with the regulatory agency for nursing and midwifery education in Zambia, the General Nursing Council (GNC). It has supported and still is supporting the creation of a professional midwifery association, i.e. the "Midwifery Association of Zambia", which, once fully established, could become an advocate for additional funding for midwifery training and deployment. In particular the support to the GNC has the potential to help improve regulation and oversight of midwifery education in Zambia in the medium- to long-term. In addition, MHTF has provided support for the development of the National Nursing and Midwifery Strategic Plan; and is supporting the development of a corresponding operational plan, to guide midwifery and nursing affairs between 2009 and 2013. Although none of these initiatives necessarily and directly translate into secure, long-term funding, they can provide an important basis for Zambia Government to solicit additional funding for midwifery training and education.

Midwifery and nurses curricula have been standardized across Zambia since 1984; and the curricula have gone through a series of reviews prior to the launching of the ICM-UNFPA midwifery programme in Zambia (MHTF).[130] After the launch of the ICM-UNFPA midwifery programme in June 2009, the GNC initiated another review of the nursing and midwifery curricula, among other things to add components on EmONC. UNFPA used MHTF funds and resources to support this review. Both the Country Midwife Advisor (CMA) and the Country Fistula Advisor (CFA) participated in the working group sessions. In addition the MHTF CMA worked with midwifery tutors to change the midwifery training programme from 12 to 18 to 24 months and to introduce a "direct entry" midwifery training programme.[131]

Judgment criterion 2.2

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

UNFPA has used the MHTF to supervise and support the quality of midwifery services delivered by a new cadre of direct entry midwifes. However, the MHTF has so far not addressed the larger question of how to ensure the needs based deployment of midwifes and their retention, which remains a key challenge for the provision of midwifery services in Zambia.

Although MHTF-funds have not been used to directly work on issues of deployment and retention of midwives and nurses in Zambia,[132] the CMA and CFA have established working relationships with the appropriate institutions[133] to become active in these areas in the future. The National Nursing and Midwifery Strategic Plan that was developed partly with MHTF support can also potentially become a useful tool for rallying support around these issues in the future, with or without UNFPA support. However, at the time of the evaluation, UNFPA, i.e. the MHTF-supported CMA had not yet gotten involved in deployment and retention, at least in part due to time constraints.

To support monitoring and supervision of new trainees, i.e. in particular graduates of the direct entry midwifery programme, UNFPA/MHTF have supported the development of a Mentorship Programme for Direct Entry Midwifery, involving a ten-day training for mentors, who will provide mentoring to graduates of the Direct Entry Midwifery Programme for their first six to 10 months of service. The programme started in March 2010, and has the potential to improve the supervision of the new midwives, and increase the likelihood that new skills are appropriately applied by the graduates.[134] In addition, MHTF is financially supporting joint monitoring visits of the General Nursing Council, the Ministry of Health and other involved partners to follow-up on the implementation of the new curricula; and the application of the new skills in health facilities.[135]

Judgment criterion 2.3

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

The MHTF has kick-started the creation of a separate midwifery association in Zambia, but it is too early to determine what role this association will be able to play, i.e. what added value it will be able to provide with regard to the up-scaling of midwifery services in the country.

130. These reviews were led by the Zambian General Nursing Council (GNC), the regulatory agency in charge of nurses and midwife education. Family planning and gender were formally introduced into the curricula in 2000; in 2004 the curricula were reviewed once more "to meet demands of the Zambian public and new trends in health care" (not specified which demands theses were).
131. Prior to the introduction of this programme, all Zambian midwives first were required to be trained as nurses; and to practice and work as nurses for a number of years. The direct entry programme is meant offer a quicker way for midwives to receive training and to start practicing.
132. Which continues to be a problem.
133. I.e., the General Nursing Council (GNC) and the Nursing Unit of the MoH.
134. No monitoring data for this programme were available.
135. Information from interview; review of Midwifery Annual Work Plan 2011 (Account Description: DSA, x5 people per trip x I trip per quarter, Transport, Fuel, Stationery for monitoring documents).

In promoting the creation of a separate midwifery association (MAZ) in Zambia, UNFPA followed the official credo of the ICM-UNFPA Midwifery Programme, i.e. to pursue "Education, Regulation and Association". The initiative was welcomed[136] by Zambia professional midwives, but was met with more reservations by the already established Union of Zambian nurses (ZUNO) that to date had also represented all Zambian midwives.[137] ZUNO had preferred to represent midwives in an internal group of the existing union, as it feared the division of the nurses/midwives professional community if a separate midwives organization was created. At the time of the evaluation, a meeting was held to resolve this conflict. Up to that point, the differences between the two camps had also affected the CMA effort to organize a national Day of the Midwife in 2009: ZUNO did not support the effort to organize this day, slated to be celebrated on May 5th, as they were already preparing a separate Nurses Day for May 12th, 2009. At that time, suggestions to combine the celebration of nurses and midwives into one day were turned down for fear that the "midwifery cause" would be overshadowed by the celebration of nurses.[138] However, in 2011, ZUNO and the new Midwifery Association of Zambia organized and celebrated the two events jointly in one day on May 5th, 2011, indicating that the two organizations had made progress on coming to an understanding on their complementarity.

It is important to point out that midwifery had been relatively high on the agenda of development partners and the government before the formal launch of UNFPA midwifery programme in Zambia. Most of the above-mentioned initiatives had already been ongoing when the programme was launched. This is not to say that the MHTF has not made valuable contributions to the development of the midwives of the country; however, the programme has not triggered the majority of these initiatives[139], with the exception of the efforts to create a separate midwifery association in Zambia.

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	To what extent organized family planning related training respond to identified needs and priorities?
	Are the capacity development interventions accompanied by interventions ensuring an environment where trained health care providers can practice their newly acquired skills once they are back in their health facilities (equipment, material, and infrastructure)?
	What were the specific family planning activities funded through MHTF?

136. UNFPA interview.
137. Until the introduction of the Direct Entry Midwifery Programme, the only path for being trained as a midwife was to first complete a full nurses training; and to work as a nurse for a number of years.
138. Feedback from UNFPA; Information in the 2009 Annual Report of the Midwifery Programme.
139. E.g., although the midwife who was recruited as CMA by UNFPA (MHTF) participated in the 2008/2009 "Training Needs Assessment" for nurses and midwives, her participation occurred before she started working for UNFPA/MHTF: The respective Training Needs Assessment (TNA) started in late 2008; while the CMA only began working for UNFPA in early 2009. However, as she had been an established member of the midwifery professional community of Zambia well before her recruitment by UNFPA she likely participated in the Training Needs Assessment in one of her other capacities (e.g. board member of the Zambian General Nursing Council (GNC), the organization that formally led the TNA).

Judgment criterion 3.1

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

Due to the fact that the MHTF has so far only been present in Zambia in the form of the UNFPA-ICM Midwifery Programme, the range and number of activities to improve access to family planning services financed with MHTF funds has been limited. MHTF funds have been used in particular to complement the trainings of midwifery tutors with lessons on family planning.

MHTF resources have been used to finance two in-service trainings of midwives in North-Western Province and to support training of midwifery tutors in family planning and other disciplines.[140] The idea of an MHTF-supported "Midwifery Tutor Programme"[141] was the result of an intensive cooperation of the MHTF-funded Country Midwife Advisor (CMA) and Country Fistula Advisor (CFA), a group of development partners and Zambia General Nursing Council, among others.[142] The group had been working on revising midwifery and nursing training curricula, and on introducing a "direct entry" midwifery training programme.

The Midwifery Tutor Programme was conceived to allow appropriate follow-up tutoring of the graduates during their first six to 10 months "on the job", to ensure that they were able to correctly apply their newly acquired skills, including their family planning skills. The closer and more intensive involvement of the CMA and CFA in this effort has allowed UNFPA to make a more visible contribution to shaping this initiative and will enable UNFPA to follow-up more closely on its progress during the first few years of operation.[143]

140. I.e., EmONC, PMTCT, Gender, FGM/C; in 2011, UNFPA had budgeted US$35,000 from MHTF sources for this purpose.
141. That also contained a training component on family planning.
142. Midwifery activities have been done jointly with Jhpiego and the Clinton Health Access Initiative (CHAI) under the umbrella of GNC und MoH Nursing Unit. UNFPA provided Technical Assistance for Five Year Midwifery Curriculum Review, training materials and course syllables. Family planning issues are integrated into the pre-service curriculum and have undergone various reviews.
143. As mentioned elsewhere, the representative of a development partner who had been closely involved in the review of the midwifery curriculum and the other activities with the GNC appreciated the hands-on, practical experience that UNFPA could bring to this intervention.

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 apply to motivate and sustain the Ministry of Health commitment to respond to the bottleneck identified during EmONC needs assessment (including maternal death audits)?
	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	How does the MHTF ensure that its quality control mechanisms (including institutionalizing supportive supervision) are adopted by the partner countries?
	What are the mechanisms MHTF utilizes to address the identified barriers and to increase demand of quality EmONC services?

Judgment criterion 4.1

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

and

Judgment criterion 4.2

- Utilization and access of EmONC services improved through MHTF support

As the MHTF to date had been present in Zambia only in the form of the UNFPA-ICM Midwifery Programme, the issue of EmONC has only been addressed in the context of the general review of Zambia nursing and midwifery training curricula that had received technical support from the MHTF-funded CMA and CFA. In addition, MHTF has also funded a number of fistula-related activities.

MHTF funds were used to finance the integration of EmONC into the nursing and midwifery curriculum. For more details, please see evaluation question 2 on MHTF support for human resources for health. Through the MHTF, UNFPA also supported the fistula repair programme of the Zambian Government that started around 2005; and had been supported by UNFPA already prior to the launch of the MHTF in Zambia.[144] MHTF-funds have been used to produce a documentary on

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

fistula repair,[145] to finance "outreach fistula repair camps",[146] and to conduct supportive visits to satellite sites to assess fistula integration in Gynecology clinics in Luapula and Northern Provinces. The funds have also been used for the sensitization of Health Care Providers on fistula and its prevention.

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 partner 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 supported by the MHTF been translated into national policies (including family planning, skilled care in pregnancy and childbirth, emergency obstetric and neonatal care, obstetric fistula and sexual reproductive health and reproductive health/HIV linkage)?
	Do sexual reproductive health coordination bodies established in countries provide a coordinated framework to address sexual reproductive health/MNH issues? Do the MoH have a strong ownership about sexual reproductive health/MNH coordination?
5.2. National plans consider sustainable funding mechanisms for sexual reproductive health/maternal health through MHTF support	To what extent allow institutional capacities which have been developed through MHTF support systematic and sound costing and budgeting of sexual reproductive health/maternal health interventions?
	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?

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

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

Judgment criterion 5.1

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

As the MHTF in Zambia has so far only supported midwifery, its contribution to the improved positioning of maternal and reproductive health in national policies and strategies so far was also limited to this thematic area. Most significant in this regard has been UNFPA MHTF funded cooperation with the Zambian General Nursing Council, which has led to the development of a National Nursing and Midwifery Strategic Plan.

With the General Nursing Council (GNC), the MHTF has aligned itself and is supporting the Zambian agency in charge of regulating training and education for nurses and midwives in the country. The GNC has led various reviews of training curricula (prior to MHTF and since its involvement has begun), has overseen a recent "Training Needs Assessment" for nurses and midwives, and also has led the development of a "National Nursing and Midwifery Strategic Plan". MHTF-financed UNFPA staff also has established close working relationships with the Nursing Unit of the Ministry of Health that has also been involved in the above initiatives.

Judgment criterion 5.2

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

MHTF support of the General Nursing Council has also helped to provide technical assistance for the development of a national strategic plan for nursing and midwifery, which has the potential for increasing harmonized cooperation of development partners of this sub-sector.

The MHTF has not provided any direct support to improve costing and budgeting of sexual reproductive health/maternal health intervention packages. The most relevant MHTF supported initiative is the development of the National Nursing and Midwifery Strategic Plan (Technical Assistance, finances) that serves as the basis for training, deployment, etc. of nurses and midwives for five years (2009-2013) (see above). In addition, the two MHTF-funded officers (CMA and CFA) have been involved in national EmONC Technical Working Group (TWG), Safe Motherhood TWG and family planning TWGs, thus bolstering the organizational capacity of the UNFPA country office beyond the area of midwifery and fistula.

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?
	To what extent country offices MHTF/Reproductive Health Thematic Fund (RHTF) planning process is facilitated by the review system in place?

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

Technical support facilitated by MHTF helped the country office to set up the UNFPA-ICM midwifery programme in Zambia and to determine its strategic direction. The ICM partnership provided the Country Midwife Advisor and her colleagues with a well appreciated regional professional network.

The launch of the MHTF in Zambia was accompanied by an adequate increase in technical guidance for MHTF planning and implementation in the country office, primarily from the global level and to a lesser extent from the regional level. UNFPA partnership with the International Confederation of Midwives (ICM) is seen to have provided valuable input to the MHTF-financed CMA and the midwifery cause in Zambia overall, not least because governmental partners have accompanied the CMA to regional or global midwifery meetings, which has helped to provide additional guidance to government counterparts as well.[147] However, the launching of the MHTF neither has significantly improved the technical guidance on M&E of maternal health support, nor has it enhanced the actual monitoring and evaluation of MHTF-financed interventions.[148]

The UNFPA country office has also benefitted from the additional guidance in the initial set-up of the UNFPA-ICM Midwifery Programme. The MHTF-funded CMA participated in global inception forum in Ghana in March 2009, where UNFPA staff from the global and regional level laid out the vision for the MHTF; and helped to review the annual work plans for the MHTF. The actual activities implemented in Zambia by the CMA and CFA ultimately corresponded very closely to the guidance given to MHTF country staff during this inception.[149] Activities that were taken on board from the regional suggestions were the "preparation of the International Midwives Day", the "Launch of the Investing in Midwives Programme" and the "desk review to determine what levels of support exist" and "what the gaps are that must be assessed". The UNFPA Zambia country office also hosted the second Capacity Building Workshop for all national and international Country Midwife Advisors in Lusaka, in cooperation with ICM.[150] The AWP review workshops have also been perceived as a positive and generally helpful experience.[151]

147. Information from interview.
148. Information from interview and review of intervention documents.
149. Guidance was given in the form of "activities that should be completed by June 2009" that UNFPA country offices were asked to adopt.
150. For mid-year progress reviews, knowledge sharing, developing standardized strategies for reviewing national midwifery curricula, and strengthening the advocacy skills of the CMAs.
151. One lesson that UNFPA staff had taken away from this workshop was to focus UNFPA support on interventions that allowed the office to retain some "control" over what happened with funds provided. For example, the country office had originally planned to pay Zambian parliamentarians a small grant for organising maternal health sensitisation workshops with their own staff. Upon receiving the above feedback during the Johannesburg workshop, the country office abandoned this intervention.

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?
	To what extent does MHTF support in promoting sexual reproductive health/maternal health policies, strategies and plans including M&E plans (with specific indicators) allow to integrate obstetric fistula?
7.3. Integration of Midwife programme strategic directions in MHTF plans in countries	What is the role of ICM regional advisor in supporting country offices?
	Is partnership with ICM sufficient to boost midwifery in partner countries? Are there other potential partners that can contribute to this aim?
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 delivery plans have an integrated sexual reproductive health/HIV component?
	Do the revised midwifery curricula include PMTCT in country supported by MHTF with high HIV prevalence?

Judgment criterion 7.1

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

and

Judgment criterion 7.3

- Integration of Midwife programme strategic directions in MHTF plans in countries

and

Judgment criterion 7.5

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

The MHTF has been relatively well integrated into UNFPA overall portfolio in Zambia, which became evident by shared responsibilities of MHTF-funded and regular technical staff for interventions funded by core funds as well as by the MHTF. Integration also extended to the field of fistula.

The CMA and CFA have worked together closely, including in particular on the General Nursing Council-led curriculum review for training of nurses and midwives. Although the review was formally under the auspices of the CMA, the fistula advisor shared responsibilities with the CMA, and also worked to ensure that fistula prevention and identification was adequately covered in the revised curriculum.

The involvement of UNFPA at community level in three provinces;[152] and its support of SMAGs in those provinces, has been used as an opportunity by the fistula advisor to integrate the sensitization of communities on fistula into the SMAG trainings and outreach activities.[153] Also, two documentaries that had been produced with UNFPA/fistula funds were used in UNFPA-funded trainings of nurses and midwives in three provinces of UNFPA, to ensure that these were sensitized on fistula. Finally, the fistula outreach camps were used as a training opportunity for midwives and nurses to assist in fistula repairs.[154]

UNFPA partnership with ICM has provided the Country Midwife Advisor with a number of opportunities to participate in regional capacity development activities and workshops, i.e. the initial "inception meeting" of the programme in Ghana, and a subsequent mid-year review workshop with all African CMAs that was held in Lusaka. An ICM regional advisor has visited Lusaka during the first year of the programmes operation and has provided feedback to the CMA on the set-up of the programme. As mentioned above (evaluation questions 6), ICM input during these meetings was directly translated into activities in Zambia, i.e. with regard to the launch of the International Midwives Day"[155] and the creation of a "Midwives Association of Zambia" (MAZ). Also, the guiding principle of the ICM-UNFPA programme, "Education, Regulation, and Association" has been acknowledged as a guiding principle for the set-up and operation of the programme in Zambia.[156]

No integration of HIV activities into MHTF funded interventions has been observed.

152. Under the "Integrated reproductive health programme".
153. Information from fistula Annual Work Plans and annual reports; as well as UNFPA interviews.
154. More information on fistula support is presented in evaluation question 4 for MHTF above.
155. Which failed, because of conflicts with the Zambian Nurses Union Organisation (ZUNO).
156. Feedback from UNFPA staff interviews.

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?

Judgment criterion 8.1

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

and

Judgment criterion 8.2

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

The MHTF has helped UNFPA to translate its involvement in global and regional maternal health campaigns and partnerships (CARMMA, Maputo Plan, H4+) into national level awareness raising campaigns under its leadership. However, in most cases, high profile launches have not been used sufficiently to leverage additional resources to support maternal health in Zambia, neither from government nor from development partners.

Potential MHTF contributions to an increased visibility of UNFPA in matters of maternal health in Zambia are primarily linked to the H4+ initiative, to CARMMA and the MNH Road Map, and finally, to the increased presence of UNFPA staff in national technical fora, i.e., the General Nursing Council-led review of training curricula for midwives and nurses.

Although the H4+ concept has not yet been firmly established in the working relationships of the respective partners in Zambia (see evaluation question 2 on the thematic evaluation above), the H4+ initiative provided a focal point for the partners at country level to submit two maternal health-relevant proposals for funding, i.e. to CIDA and to the European Union. The submitted budget for the CIDA-funded intervention alone was US$ 9,991,500. Implementation of neither of the programmes had started at the time of the evaluation.

The two regional policy initiatives, CARMMA and the MNH Road Map that were linked to the Maputo Plan of Action, created visibility for UNFPA and maternal health in the short-term, in particular through the well-publicized and MHTF-supported launch of the CARMMA initiative in Zambia. However, follow-up to either of these initiatives has been relatively weak. As stated above (evaluation questions 2 and 9 for the thematic evaluation), neither the MNH Road Map, nor CARMMA have been used to systematically advocate for maternal health support in Zambia SWAp forums in the wake of the official launch. Development partners who tried to find information on the operational dimensions of CARMMA were discouraged by the fact that no information was readily available[157] and, as a result, decided not to pursue CARMMA any further.[158]

MHTF-support has allowed UNFPA to become more visible in technical forums surrounding maternal health, specifically in the General Nursing Council-led review of training curricula, as mentioned above. The participation of the MHTF-funded CMA and CFA raised the profile of UNFPA in this group, as both development partners and Governmental partners acknowledged their contributions.[159]

157. There is, for example, no website with CARMMA-related information for Zambia. Staffing in the Ministry of Health to provide follow up, e.g. on pledges made during the launch or to solicit more financial contributions is limited.
158. Feedback from interviews with several development partners.
159. Feedback from interviews with development partners and governmental partners.

5. Conclusions

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 Zambia only, and as such do not provide a judgment on the quality of UNFPA country programme in Zambia overall, which would only be provided by a comprehensive country programme evaluation. The conclusions cover the overall maternal health interventions of UNFPA in Zambia and also the specific added value of MHTF in the country.

5.1 Conclusions on UNFPA overall maternal health portfolio in Zambia

1. UNFPA overall contribution to maternal health in Zambia has been limited by a lack of strategic direction in the programming and implementation of its maternal health support[160]

    - UNFPA in Zambia has established itself as a close development partner of the Zambian government. However, in doing so, it has lost sight of the need to not only provide supplementary funding to fill small scale funding gaps of the government, but instead to tie its financial and technical support to an open and evidence-based dialogue that aims at increasing the overall consistency of Zambia maternal health support strategy and implementation capacity.
    - UNFPA has made a number of valuable contributions to improving maternal health in Zambia, such as to the training of nurses and midwives. However, it has not addressed related challenges of incorrect deployment and insufficient retention of staff, although these challenges have directly limited the impact of its support for training health cadres. Similarly, it has not invested in finding appropriate models for improving access to maternal health services in districts with low population density, which include some of UNFPA own focal districts.
    - Although UNFPA has acknowledged these challenges, it has been slow to respond to them in its programming. For example, UNFPA did not invest significantly in the focused collection of data to document the extent and precise nature of the remaining challenges.

2. UNFPA has an insufficient number of staff to be able to implement the country programme in Zambia[161]

    - Insufficient numbers of technical staff have been at least one of the contributing factors for UNFPA insufficient strategic positioning in the maternal health community in Zambia. UNFPA difficulties to assign sufficient staff time to attend and substantively contribute to the key maternal health coordination forums, i.e. the Technical Working Groups and the other higher level forums demonstrates how understaffing has limited UNFPA performance in this area. Until the arrival of the Country Midwife Advisor (CMA) and the Country Fistula Advisor (CFA), the UNFPA sexual reproductive health advisor alone would have been responsible for attending these technical working groups, to prepare any technical input UNFPA would have wanted to provide, conduct preparatory and follow-up negotiations with government and development partners, prepare, administer and supervise the implementation of UNFPA

160. Based on: Chapters 4.2.1 (Relevance), 4.2.2 (Harmonization), 4.2.4 (HRH), 4.2.7 (EmONC), 4.2.8 (Evidence), 4.2.9 (Frameworks)).
161. Based on Chapters 4.2.2 (Harmonization), 4.2.4 (HRH), 4.2.11 (Internal Coherence), 4.3.1. (Relevance – MHTF), 4.3.2 (HRH – MHTF).

sexual reproductive health programming, supervise its monitoring, carry out administrative tasks[162] and to fill out the intended technical leadership role of UNFPA in the area of maternal health. The addition of the CMA and the CFA to UNFPA staff in Lusaka has improved the situation somewhat; however, staffing levels are still not systematically linked to an estimation of the workload associated with the respective country programme.

3. UNFPA in Zambia has not yet utilized its presence on the ground to promote the maternal health agenda at national level[163]

- UNFPA has established good working relationships with local authorities, especially in the North-Western and Western Provinces where the two sub-offices are located. Aided in part by its physical presence, UNFPA has been able to identify initiatives like the Safe Motherhood Action Groups (SMAGs) as a worthwhile model for replication in other provinces; and has been able to provide relevant training to SMAGs in its area of influence, allowing these groups to target cultural and other barriers to maternal health.
- However, the positive example of the SMAGs is not sufficient to justify diverting scarce staff resources from the national to the provincial level. To put scarce financial and staff resources to optimal use, the two provincial sub-offices have to be used to enhance UNFPA maternal programming overall, not just to support maternal health service delivery in these two specific provinces.
- UNFPA has not taken advantage of its potential strength of "piloting" new approaches, i.e. by identifying promising initiatives; and promoting them on a wider scale[164]
- With the exception of the promotion of Safe Motherhood Action Groups (SMAGs), where UNFPA support has helped to turn the SMAGs into a widely supported approach for community mobilization in Zambia, UNFPA has not made full use of its potential for testing new approaches and promoting them for up-scaling and replication at the national level. The attempt to introduce a Reproductive Health Commodity Security Committee to Zambia was at least in part unsuccessful because UNFPA did not utilize the full range of options it had used in connection with the SMAGs. These included targeted, intensive advocacy at different levels for the concept and technical inputs, based on UNFPA past successes in Zambia or beyond. UNFPA partners who feel that they have achieved considerable successes in their work perceive that UNFPA has not taken these successes as an opportunity to systematically identify contributing factors and to publicize the findings as a way to encourage others to adopt similar approaches.

4. UNFPA has not fully taken advantage of the possibility to strengthen the evidence-base on maternal health challenges in Zambia through monitoring, evaluation and research to document the full extent of the outstanding problems [165]

- UNFPA has supported the generation and use of demographic and research data and information from monitoring and e valuation to improve the focus on maternal health by the government and development partners and to improve the performance of its own programmes. It also has established stable and long-term relationships with relevant partners, i.e. the Central Statistical Office or the University of Zambia.
- However, UNFPA has made insufficient use of these partnerships to strategically generate data, e.g. to support targeted and evidence-based advocacy for possible "best practices" in its own portfolio or the portfolios of its implementing partners. UNFPA also made too little use of the available data – or its potential to generate more and better data – for its own programming and to adjust its interventions in response to new information from the field.

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162. The sexual reproductive health advisor has so far not had any administrative support from an assistance or secretary.
163. Based on Chapters 4.2.3 (Community & demand), 4.2.6 (Family planning), 4.2.8 (Results/evidence orientation), 4.2.9 (Frameworks), 4.3.3 (Family planning – MHTF).
164. Based on Chapters 4.2.2 (Harmonization), 4.2.3 (Community), 4.2.8 (Evidence), 4.2.9 (Frameworks).
165. Based on Chapters 4.2.1 (Relevance), 4.2.2 (Harmonization), 4.2.6 (Family planning), 4.2.7 (EmONC), 4.2.8 (Evidence & results); 4.2.9 (Frameworks), 4.2.10 (Internal coherence), 4.2.12 (Visibility).

5. UNFPA has not sufficiently used its potential for strategic and sustained policy advocacy at the highest level to influence the maternal health policy agenda in Zambia[166]

   - Initiatives like the CARMMA campaign or the support of the MNH Road Map have helped to direct public attention to the issue of maternal health. Also, UNFPA has successfully used targeted and intensive advocacy to promote specific approaches, like the SMAGs, to help with their integration into national development frameworks. However, in the cases of CARMMA and the MNH Road Map, the advocacy was neither sufficiently sustained, nor backed by targeted and evidence-based technical contributions to help the government to develop a sound operational follow-up plan to serve as the basis for increased and harmonized support from the development partners of Zambia.

5.2 Conclusions on the added value of MHTF in Zambia

6. The MHTF has added some strategic direction to the area of midwifery and fistula as part of UNFPA maternal health support[167]

   - 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 that, for the rest of UNFPA budget, have left the strategic direction of UNFPA funding choices somewhat unclear and diffuse.
   - The guiding principle of "education, regulation, association" gave a concise template against which the country office could identify worthwhile areas of support. In the case of Zambia, this happened to be the creation of a separate midwifery professional association, although it is yet to be determined if the creation of an independent professional association for midwives will in fact be an advantage for the combined representation of health staff in Zambia.
   - The partnership with ICM provided UNFPA and the CMA 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 interventions have remained too isolated from UNFPA overall maternal health support to bring about an overall more strategic approach to maternal health support in Zambia and to thereby safeguard its own short-term achievements in midwifery[168]

   - The positive contributions of the MHTF to the operations of UNFPA country office in Zambia; and the overall good working relationships between MHTF-financed and UNFPA core staff notwithstanding, the MHTF-funded operations have in the end remained relatively separate from the rest of UNFPA maternal health support. The stronger emphasis on midwifery, for example, has not prompted UNFPA to address the closely related challenges of weak deployment and retention of trained midwifes and nurses. 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 in Zambia.

166. Based on Chapters 4.2.2 (Harmonization), 4.2.4 (HRH), 4.2.8 (Evidence & results), 4.2.9 (Frameworks), 4.2.12 (Visibility).
167. Based on Chapters 4.3.1 (Relevance – MHTF), 4.3.2 (HRH – MHTF), 4.3.4 (EmONC – MHTF), 4.3.5 (Planning), 4.3.8 (Leveraging & visibility).
168. Based on Chapters 4.3.1 (Relevance-MHTF), 4.3.2 (HRH – MHTF), 4.3.6 (Management – MHTF).

8. The MHTF provided the country office with much-needed staff capacity by allowing for the placement of the CMA and the CFA in the office[169]

    - Adding the Country Midwife Advisor and the Country Fistula Advisor to the staff of UNFPA country office has allowed the organization to become more active in relevant technical forums and groups, such as the GNC-led collaborative group for the review of training curricula for nurses and midwives. In addition, since both MHTF-funded staff members have taken on other responsibilities in the country office as well, their presence also alleviates the strain on the single sexual reproductive health advisor that so far has managed UNFPA sexual reproductive health programme.

9. The MHTF has so far not sufficiently addressed the persisting challenges in UNFPA monitoring system, which means that evidence on results for MHTF-funded interventions is as scarce as it is for interventions financed with UNFPA core funds[170]

    - Although it has been one of the core tenets of the MHTF to apply a results- and evidence-based approach, the Fund has so far not succeeded in improving the results-based monitoring of MHTF-financed initiatives in Zambia. The joint annual report for thematic funds provides mostly information on process, activities and outputs. Also, since the MHTF has not provided any separate country-level resources for monitoring and evaluation, the monitoring of MHTF-funded activities is affected by the same weaknesses as UNFPA overall

169. Based on Chapters 4.3.1 (Relevance-MHTF), 4.3.2 (HRH – MHTF), 4.3.6 (Management – MHTF), 4.3.8 (Leveraging & visibility).
170. Based on Chapters 4.3.1 (Relevance-MHTF), 4.3.2 (HRH – MHTF), 4.3.6 (Management – MHTF).

6. Annexes

6.1 Key data of Zambia

ZAMBIA		
Summary statistics		
Region	2000	Eastern Africa
Currency	2008	Kwacha (ZMK)
Surface area (square kilometers)	2008	752612
Population (estimated, 000)	2008	12620
Population density (per square kilometer)	2008	16.8
Largest urban agglomeration (population, 000)	2007	Lusaka (1328)
Economic indicators		
GDP: Gross domestic product (million current US$)	2008	14441
GDP: Gross domestic product (million current US$)	2005	7272
GDP: Growth rate at constant 1990 prices (annual %)	2008	6.3
GDP per capita (current US$)	2008	1144.3
GNI: Gross national income per capita (current US$)	2008	1053.0
Gross fixed capital formation (% of GDP)	2008	25.1
Exchange rates (national currency per US$)	2008	4832.26
Balance of payments, current account (million US$)	2008	-1336

CPI: Consumer price index (2000=100)	2008	341
Industrial production index (2005=100)	2008	115
Agricultural production index (1999-2001=100)	2007	117
Food production index (1999-2001=100)	2007	115
Unemployment (% of labor force)	2000	12.9*
Employment in industrial sector (% of employed)	2000	5.8*
Employment in agricultural sector (% of employed)	2000	71.6*
Labor force participation, adult female pop. (%)	2008	60.3
Labor force participation, adult male pop. (%)	2008	80.7
Tourist arrivals at national borders (000)	2008	812
Energy production, primary (000 MT oil equivalent)	2007	1005
Telephone subscribers, total (per 100 inhabitants)	2008	28.8
Internet users (per 100 inhabitants)	2008	5.6
Exports (million US$)	2008	5098.7
Imports (million US$)	2008	5060.5
Major trading partners (% of exports)	2008	Switzerland (49.8), South Africa (10.4), Egypt (7.5)
Major trading partners (% of imports)	2008	South Africa (42.6), Dem. Rep. of Congo (10.6), Kuwait (10.2)
Social indicators		
Population growth rate (avg. annual %)	2005-2010	2.4
Urban population (%)	2007	35.2
Population aged 0-14 years (%)	2009	46.2
Population aged 60+ years (women and men, % of total)	2009	5.2/4.4

Sex ratio (men per 100 women)	2009	99.5
Life expectancy at birth (women and men, years)	2005-2010	45.6/44.6
Infant mortality rate (per 1 000 live births)	2005-2010	94.6
Fertility rate, total (live births per woman)	2005-2010	5.9
Contraceptive prevalence (ages 15-49, %)	2006-2009	40.8
International migrant stock (000 and % of total population)	mid-2010	233.1/1.8 (incl. refugees)
Refugees and others of concern to UNHCR	end-2008	83542
Education: Government expenditure (% of GDP)	2005-2008	1.4
Education: Primary-secondary gross enrolment ratio (w/m per 100)	2005-2008	91.9/96.9
Education: Female third-level students (% of total)	2000	31.6 est.
Seats held by women in national parliaments (%)	2009	15.2
Environment		
Threatened species	2009	44
Forested area (% of land area)	2007	55.9
CO2 emission estimates (000 metric tons and metric tons per capita)	2006	2470/0.2
Energy consumption per capita (kilograms oil equivalent)	2007	127.0

Source: UN World Statistics Pocketbook

Figure 2: Map of Zambia

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[171]	Beneficiaries	Data collection methods
1. Relevance	▲ O	▲ O	▲			▲		Document analysis (strategic and planning documents), interviews
2. Harmonization, coordination, partnerships	▲ O	▲			▲ O	▲		Document analysis (e.g. joint programmes, documentation of coordination structure), interviews
3. Community involvement and demand orientation	▲ O	▲ O	▲ O	▲	▲	▲	▲	Document analysis (e.g., gov. strategies), interviews capital, field visit (focus groups, interviews)
4. Capacity development – Human Resources in Health (HRH)	▲ O	▲ O	▲ O		▲ O	▲	▲	Data and document analysis (strategic documents, needs analyses), interviews, field visits (focus groups, interviews)
5. Maternal Health in humanitarian contexts	▲ O	▲			▲			Data and document analysis, interviews
6. Sexual and reproductive health services – family planning	▲ O	▲ O	▲	▲	▲	▲	▲	Data and document analysis, interviews, field visits (focus groups, interviews)
7. Sexual and reproductive health services – EmONC	▲ O	▲ O	▲		▲ O		▲	Data and document analysis (e.g., scale up plan, Annual Work Plans (AWPs)), interviews, field visit (interviews, focus groups)
8. Results/evidence orientation	▲ O	▲	▲			▲		Document analysis (monitoring reports, tools), interviews
9. Integrating maternal health in national policies and frameworks	▲ O	▲ O		▲	▲			Document analysis (policies and frameworks), interviews
10. Coherence of maternal health support with Gender and Population and Development	▲ O	▲			▲	▲ O		Document analysis (review of AWPs, Country Programme Document (CPD)), interviews
11. Coherence between country, regional, global programmes	▲ O	▲				▲		Document analysis (technical documents, AWPs), interviews
12. Visibility	▲ O	▲	▲	▲	▲	▲		Interviews, document analysis (visibility tools and strategies)

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

171. 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 [172]	Beneficiaries	Data collection methods
1. Relevance	▲O	▲O			▲	▲		Document analysis (strategic and planning documents), interviews
2. Capacity Development – HRH	▲O	▲O			▲	▲		Document analysis (e.g., curricula, strategic documents), interviews
3. Sexual and reproductive health services – family planning	▲O	▲					▲	Document analysis, interviews capital, field visit (focus groups)
4. Sexual and reproductive health services - EmONC	▲O	▲O	▲			▲		Document analysis, interviews, field visits (interviews)
5. Health planning, programming and monitoring	▲O	▲O		▲	▲	▲O		Data and document analysis, interviews
6. Management of MHTF	▲O					▲		Document analysis, interviews
7. Coordination and Coherence	▲O					▲		Document analysis, interviews
8. Leveraging and Visibility	▲O	▲		▲	▲	▲		Document analysis, interviews

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

172. 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+[173]) at global, regional and country level
	2.2. Harmonization of maternal health support through partnerships at country and South-South/regional

173. 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 (CSO) 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 the MHTF contributed to improve planning, programming and monitoring to ensure that maternal and reproductive health are priority areas in program 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

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.
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?[174]	
Judgment criteria	10.1. Linkages established between programmes (reproductive health with gender and population and development) in intervention design
	10.2. Integration of monitoring and reporting of UNFPA operations

174. 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
	11.3. Enhancement/improvement of UNFPA country level programming and interventions through technical and programmatic support from global and regional level
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 (SRH)/maternal health planning and programming priorities the most vulnerable groups and underserved areas
Evaluation question 2 To what extent has the MHTF contributed towards strengthening human resources planning and availability (particularly midwives) for maternal health and newborn health?	
Judgment criteria	2.1. Partner countries midwifery education upgraded based upon International Confederation of Midwives (ICM) essential competencies through MHTF support
	2.2. Strategies and policies developed to ensure the quality of midwifery services provision in partner countries through MHTF support
	2.3. Midwifery associations able to advocate and support scaling up of midwifery services through MHTF support

Evaluation question 3 To what extent has the MHTF contributed towards scaling-up and increased access and use of family planning?	
Judgment criteria	3.1. Creation of enabling environment to facilitate scale-up of quality family planning services in priority countries through MHTF support
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
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

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-ICM175 Midwives Programme and HIV-PMTCT[176] 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
	7.3. 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
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)

175. International Confederation of Midwives.
176. Preventing Mother-to-Child Transmission.

6.4 Focus Group report template

<table>
<tr><td rowspan="3">FOCUS GROUP</td><td>Evaluation team member</td><td></td><td>Date</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td colspan="2">Topic/issues to be addressed</td><td>Place</td></tr>
<tr><td colspan="2"></td><td></td></tr>
<tr><td colspan="4">Participants (type, number, etc.)</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td colspan="4">Issues discussed</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td colspan="4">Findings</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td colspan="4">Other Observations by evaluator</td></tr>
</table>

6.5 List of documents consulted

TITLE	YEAR	TYPE OF DOCUMENT
GRZ/African Union: Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA) – Advocacy Kit	2010	Planning Document
GRZ: Road Map for Accelerating the Attainment of the Millenium Development Goals Related to Maternal, Newborn and Child Health in Zambia	2010	Planning Document
GRZ/Ministry of Finance and National Planning: Zambia Poverty Reduction Strategy Paper 2002-2004	2002	Planning Document
GRZ/Ministry of Finance and National Planning/UNFPA: 6th National Development Plan 2011-2015. Executive Summary	2011	Planning Document
GRZ/Ministry of Finance and National Planning/UNFPA: 6th Country Programme. Joint Government of the Republic of Zambia and UNFPA 2007-2010. Evaluation Report	2010	Evaluation Report
GRZ/Ministry of Finance and National Planning/UNFPA: 5th National Development Plan 2006-2010	2006	Planning Document
GRZ/MOH: 2011 Action Plan	2011	Planning Document
GRZ/MOH: National Health Policy	2011	Planning Document
GRZ/MOH: National Health Strategic Plan 2011-2015	2011	Planning Document
GRZ/MOH: The Zambia National HIV and AIDS Commodity Security Strategy 2011-2015	2010	Planning Document
GRZ/MOH: Annual Health Statistical Bulletin	2009	Annual Report
GRZ/Ministry of Finance and National Planning/UNDP: Zambia Millennium Development Goals – Progress Report	2008	Progress Report
GRZ/MOH: Integrated Reproductive Health Supervisory Tool	2007	Planning Document
GRZ/MOH: Maternal Deaths Situation in Chongwe District from January 2006 to November 2009	2009	Assessment Report
GRZ/MOH: National Health Strategic Plan 2006-2010	2005	Planning Document
GRZ/MOH: Human Resources for Health Strategic Plan 2006-2010	2005	Planning Document

GRZ/MOH/Zambia National Formulary Committee: Standard Treatment Guidelines, Essential Medicines List, Essential Laboratory Supplies for Zambia	2008	Report
GRZ/UNFPA : Country Programme Action Plan (CPAP)	2007-2010, 2011-2015	Planning Document
GRZ/UNFPA : Country Programme Documents (CPD)	2007-2010	Planning Document
GRZ/UNFPA: 5th GRZ/UNFPA Country Programme. Evaluation Report	2007	Evaluation Report
National AIDS Council: Comprehensive Condom Programming Strategy	2009	Planning Document
National AIDS Council: National Strategy for the Prevention of HIV and STIs in Zambia	2009	Planning Document
UN: Development Assistance Framework for the Republic of Zambia (UNDAF) 2011-2015	2011	Planning Document
UNDP: Millenium Development Goals - Progress Report 2011; Zambia	2011	Progress Report
UNFPA: Annual Work Plans with implementing partners	2007, 2008, 2009, 2010, 2011	Planning Document
UNFPA: MHTF Annual Report 2010	2011	Annual Report
UNFPA: MHTF Results Frameworks, Indicators, Baselines and Targets	2009-2011	Management Report
UNFPA: Mid-Term Reporting for the Thematic Funds	2011	Evaluation Report
UNFPA: Zambia Mid-Year RHCS Report for the Reproductive Health Thematic Funds	2011	Evaluation Report
UNFPA: "Am here to stay because I want to help my people" - Report on the Assessment of the UNFPA-funded enrolled Nurse Training Programme in North-Western Province	2010	Assessment Report
UNFPA: Annual Work Plan for Midwifery and Fistula Programs	2010	Planning Document
UNFPA: Country Annual Joint Reporting for the Thematic Funds: Midwifery	2010	Management Report
UNFPA: Country Annual Joint Reporting for the Thematic Funds: RHCS	2010	Management Report

UNFPA: Country Annual Joint Reporting for the Thematic Funds: RHCS, Midwifery and Fistula	2010	Management Report
UNFPA: Country Annual Report for Thematic Funds – Fistula	2010	Annual Report
UNFPA : Country office Annual Report (COAR)	2004-2010	Management Reports
UNFPA: Expenditure Report for funds allocated by TD under MHTF, UBW and GPRHCS funds: Fistula	2010	Management Report
UNFPA: Expenditure Report for funds allocated by TD under MHTF, UBW and GPRHCS funds: Midwifery	2010	Management Report
UNFPA: MHTF Review Annual Reports 2009/AWP 2010	2010	Annual Report
UNFPA: Midwifery Programme – Annual Report 2009	2010	Annual Report
UNFPA: Southern Sudan Midwifery Report	2010	Assessment Report
UNFPA: 2009 Expenditures Report for Activities Against Thematic Trust Funds	2009	Management Report
UNFPA: Condom Destination Audit	2009	Management Report
UNFPA: Country Annual Joint Reporting for the Thematic Funds	2009	Management Report
UNFPA: Country Annual Joint Reporting for the Thematic Funds: RHCS and MHTF; Obstetric Fistula and Midwifery Interventions	2009	Management Report
UNFPA: Expenditure Details Report for Funds Allocated by Commodity Security Branch for RHCS Activities Implementation	2009	Management Report
UNFPA: Luapula Province Maternal Death Review (MDR) Orientation and Training of Trainers	2008	Assessment Report
UNFPA/International Confederation of Midwives: Annual Report for ICM/UNFPA Programme for Investing in Midwives and Others with Midwifery Skills to accelerate progress towards MDG five	2009	Annual Report
USAID: Zambia: Reproductive Health Commodity Security Assessment	2010	Assessment Report

6.6 List of people interviewed

Organization/Unit	Name	Position
Governmental partners - Lusaka		
Central Statistical Office (CSO	Sheila Shimwambwa-Mudenda	Head - Demography
Division of Gender and Development (GIDD)	Ms Christine Kalamwina	Director
Division of Gender and Development (GIDD)	Mr. Butola	Gender Analyst
Ministry of Health	Dr Elizabeth Chazema Kawesha	Director Public Health
Ministry of Health	Dr Max Bweupe	Deputy Director PH
Ministry of Health	Dr Reuben Kamoto Mbewe	Director Technical Services and support
Ministry of Health	Dr. Ruth Bweupe	Family Planning Officer
Ministry of Health/UNFPA	Abraham Cingalika	RHCS Coordinator
Ministry of Finance	Mainga Lowabelwa	Chief Planner
Ministry of Finance	Francis Mpampi	Principle Planner
Ministry of Finance	Pamela Kauseni	Principle Planner
Ministry of Finance	Belinda Lumbula	Principle Planner
Ministry of Sports Youth and child development	Mr Toddy Mulonga	Permanent Secretary
Ministry of Sports Youth and child development	Collins A. Mulonda	Director Youth
Ministry of Sports Youth and child development	Abigail Malikutila	Senior Youth Development Officer
Ministry of Sports Youth and child development	Muma K. Mukupa	Chief Youth Development Officer
Ministry of Sports Youth and child development	Ivy Mbangu	Chief Youth Development Officer

National Aids Council	Dr Ben Chirwa	Director General
Governmental partners – Northwestern Province		
Kasempa District Health Office	Mr Shikelenge	Public Health Officer
Kasempa District Health Office	Joyce Kamwana	Reproductive health focal point person
Solwezi Provincial Health Office	Dr George Llabwa	Provincial Health Officer
Solwezi Provincial Health Office	Dr Winard Mumba	Clinical Specialist
Other implementing partners – Lusaka (Governmental and Non-Governmental)		
Breastfeeding Association of Zambia	Ruth Muzumara	Programme Officer
Mwansa Young Women's Action	Ms. Loindsay	Programme Officer
NGOCC	Nalucha Nganga Ziba	Communication and Advocacy Coordinator
Planned Parenthood Association of Zambia (PPAZ)	Henry Kaimba	Programme Manager
Planned Parenthood Association of Zambia (PPAZ)	Edford Mutuna	Programme Manager
Society for Women and Aids	Kombe Mutale	Programme Officer
University Teaching Hospital	Dr Lackson Kasonka	Managing Director
University Teaching Hospital	Sr Masopela	Sister in Charge – Fistula Ward
University of Zambia - School of Population studies	Dr Namuunda Mutombo	Head
University of Zambia - School of Population studies	Mr Vesper H. Chisumpa	Lecturer
Other implementing partners – Northwestern Province (Governmental and Non-Governmental)		
Solwezi School of Nursing	Ngambo Mushikula	Principal Tutor
Solwezi School of Nursing	Martha Mushi	THET (Tropical Health Education Trust)
Solwezi Urban Clinic	Mulomba M.M. Chilumbu	Clinical Instructor
Solwezi Urban Clinic	Doris Mpatisina	Nurse/Midwife
Solwezi Urban Clinic	Charity M.N. Libwa	Nurse/Midwife MCH

Solwezi Urban Clinic	Mable Muyupi	Nurse/Midwfe
Solwezi Urban Clinic	Makwala Sandra	2nd Year student nurse
Solwezi Urban Clinic	Mercy Mataliro	2nd Year student nurse
Development partners (UN and Others)		
Clinton Health Access Initiative	Tracy Rudne Hawry	Programme Manager, HRH
Clinton Health Access Initiative	Chikusela Sikazwe	Programme Manager, Male Circumcision
DfID	Angela Spilsbury	Human and Social Development Team Leader
European Union	Paul Kalinda	Health Advisor
SIDA/Swedish Embassy	Veronica Perzanowska	First Secretary
UNICEF	Christine Muntungwa Lambwe	Maternal Child Health Advisor
USAID	Dr. Susan Brems	USAID Zambia - Mission Director.
USAID	Dr. George Sinyangwe	Senior Health Advisor
USAID	Dr. Musuka Mussunali	Health Advisor
WHO	Patricia Kananga	Safe Motherhood Officer
UNFPA Country office - Lusaka		
UNFPA	Dr. Duah Owusu-Sarfo	Country Representative
UNFPA	Dr. Sarai Malumo	National Programme Officer – Reproductive Health
UNFPA	Charles Banda	National Programme Officer – Population and Development
UNFPA	Elizabeth Kalunga	Country Midwifery Advisor
UNFPA	Jenipher Mijere	Country Fistula Advisor

UNFPA	Andrew Kumwenda	National Programme Officer – HIV and AIDS
UNFPA	Precious Zandonda	National Programme Officer – Gender
UNFPA Sub-Office - Solwezi		
UNFPA	Carnet Mulenga	Safe Motherhood Officer
UNFPA	Clara Mwala	ASRH/Team Leaders
UNFPA	Wilson Mumba	Officer Assistant
UNFPA	Mercy Kazungula-Ngandu	Finance/Admin Assistant
UNFPA	Mary Kate Bwalya	Reproductive health Officer/ Acting PNO

6.7 Overview of UNFPA interventions in Zambia (2007-2011)

Annual Work Plans (AWP)

Component of CP	Implementing partner	Project/intervention/ programme titles	Volume in US$ (contracted) from UNFPA	Year
Reproductive health	Medical Stores Limited	Logistics Management Support (focus on capacity development for condom distribution)	265,039	2009
Reproductive health	Ministry of Health	(Fistula Prevention and Treatment); (focus on Midwifery and Fistula)	300,000	2011
Reproductive health	Ministry of Health	(Integrate maternal health in national health system) (focus on Capacity Building of health service providers)	642,000	2011
Reproductive health	Ministry of Health	Integrated Reproductive Health (Luapula Province) (focus on EmONC, Family Planning, YFS)	581,594	2010
Reproductive health	Ministry of Health	Integrated Reproductive Health (focus on EmONC, Midwifery, Family Planning, YFS)	1,145,934	2010
Reproductive health	Ministry of Health	Procurement and Logistics Management (focus on Legislation)	30,000	2010
Reproductive health	Ministry of Health	Integrated Reproductive Health (focus on Midwifery, Family Planning, YFS)	827,330	2009
Reproductive health	Ministry of Health	Procurement and Logistics Management (focus on technical assistance and procurement)	370,500	2009
Reproductive health	Ministry of Health	Procurement and Logistics Management (focus on procurement)	23,150	2009
Reproductive health	Ministry of Health	Integrated Reproductive Health (focus on EmONC)	1,335,874	2008

Reproductive health	Ministry of Health	Support to Scaling-Up HIV Prevention	156,000	2008
Reproductive health	Ministry of Health	HIV Prevention Mechanisms (focus on Family Planning)	385,863	2007
Reproductive health	Ministry of Health/General Nursing Council and Professional Association	Increased Capacity to Integrate maternal health (focus on Midwifery and Fistula)	200,000	2010
Reproductive health	Ministry of Health/General Nursing Council and Professional Association	Increased Capacity to Integrate maternal health (focus on Midwifery)	407,000	2010
Reproductive health	Ministry of Health/General Nursing Council and Professional Association	Increased Capacity to Integrate maternal health (focus on Midwifery)	59,920	2009
Reproductive health	Ministry of Health/ University Teaching Hospital	(Fistula Prevention and Treatment)	271,500	2010
Reproductive health	MSYCD	HIV Prevention Mechanisms (focus on YFS)	96,300	2009
Reproductive health	National AIDS Council	Support to Scaling-Up HIV Prevention	27,700	2009
Reproductive health	UNFPA/Ministry of Health	Procurement and Logistic Management RHCS Plan (focus on technical assistance and Capacity Building)	105,500	2009
Reproductive health	Zanis	Behavioral Change Communication (focus on family planning/YFS)	126,000	2010
Reproductive health	Zanis	Behavioral Change Communication (focus on family planning/YFS)	134,500	2009
Reproductive health	Zanis	Behavioral Change Communication (focus on family planning/YFS)	834,000	2007

Source: Annual Work Plans, Zambia

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

Time period	Project ID	Project Title	Budget	Expenditure
2004-2007	ZAM02P06	ADMIN SUPPORT	596500	579602,5
2008-2009	GRP6R21A	CD to integrate maternal heath	51427,86	19229,63
2007-2010	ZAM6R101	CONDOM PROMOTION	1882193,93	845534,55
2008-2010	ZAM6R42B	CONDOM PROMOTION - ZHECT	458153,45	301339,54
2009-2010	ZAM6R24C	FISTULA PREVENTION AND TREATME	440750	394656,94
2007-2010	ZAM6G102	FRAMEWORK FOR STATE PARTY REPO	224440,28	168763,43
2008	CMB5R2H1	Global Programme to enhance Reproductive health	147682	0
2008-2010	ZAM6R42D	HIV PREVENTION AND CONDOM PROM	539064,49	220089,37
2007-2010	ZAM6R208	HIV PREVENTION MECHANISMS	702177,3	631393,26
2008-2010	ZAM6R42E	HIV PREVENTION MECHANISMS - LU	83971,26	19485,63
2008-2010	ZAM6R42G	HIV PREVENTION MECHANISMS - NA	301021,07	255372,54
2006-2010	ZAM6R209	HIV/AIDS HUMAN RESOURCE CAPACI	312219,87	272992,16
2007-2010	ZAM6P203	IMPROVED INSTITUTIONAL CAPACIT	1813232,06	1648052,16
2009	ZAM6R20A	INCREASED CAPACITY TO INTEGRAT	59920	59216,13
2007-2010	ZAM6R201	INTEGRATED REPRODUCTIVE HEALTH	6454191,97	6145871,6
2009-2010	ZAM6R31A	MATIONAL REPRODUCTIVE HEALTH C	517450	323772,63

2007-2009	ZAM6R202	NATIONAL FISTULA TREATMENT CEN	156260,77	132928,45
2004-2010	ZAM02P05	POP COM	406266,18	381743,16
2007	ZAM02P09	POPULATION TRAINING & RESEARCH	9386,62	-1383,33
2005-2008	ZAM02P10	PREVENTION AND TREATMENT OF FI	519425,88	228153,99
2007-2010	ZAM6R204	PROCUREMENT AND LOGISTICS MANA	290943,87	299811,19
2004-2010	ZAM02P02	REFUGEE REPRODUTIVE HEALTH	159569,52	116998,23
2007-2010	ZAM6R301	Reproductive health BEHAVIOURAL CHANGE COMMUNIC	499210,43	465492,78
2004-2010	ZAM02P03	Reproductive health SERVICES	1796763,47	1535580,16
2004-2010	ZAM02P04	SAFE MOTHERHOOD	544135	545590,91
2007-2010	ZAM6G101	STRENGTHENED GBV RESPONSE	687444,08	605002,23
2008-2010	ZAM6R33A	SUPPORT RHCS AND HUMAN RESOURC	211988,19	173293,99
2007-2010	ZAM6R106	SUPPORT SCALING UP HIV PREVENT	315775,2	204508,83
2010	ZAM6R24B	Tackling Poverty Together (TPT	15000	15806,7
2007-2008	CMB5R201	THEMATIC TRUST FUNDS FOR RHCS	23447,31	36641,35
2008-2010	ZAM6R42C	YOUTH BCC MALE CIRCUMCISION CO	736839,27	324266,2
2004-2007	ZAM02P07	YOUTH REPRODUCTIVE HEALTH	621608,15	605831,09
2008-2010	ZMBM0809	ZMB BSB MANAGEMENT	2340975	2467110,53
		Total	**23919434,48**	**20022748,53**

Source: ATLAS data