EVALUATION REPORT

EVALUATION OF THE UNFPA SUPPORT TO FAMILY PLANNING 2008-2013

VOLUME II – ANNEXES

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Evaluation of the UNFPA Support to Family Planning Services 2008-2013

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ABBREVIATIONS AND ACRONYMS

APRO	Asia and the Pacific Regional Office
ASRH	Adolescent Sexual and Reproductive Health
ASRO	Arab States Regional Office
AWP	Annual Work Plan
BMGF	Bill and Melinda Gates Foundation
CHAI	Clinton Health Access Initiative
CIP	Costed Implementation Plan
CO	Country Office
CP	Country Programme
CPAP	Country Programme Action Plan
CPD	Country Programme Document
CPR	Contraceptive Prevalence Rate
CSB	Commodity Security Branch
CSO	Civil Society Organisation
DHS	Demographic Health Survey
DP	Development Partner
EC	Emergency Contraception
EECARO	Eastern Europe and Central Asia Regional Office
ESARO	East and Southern Africa Regional Office
FBO	Faith Based Organisation
FGD	Focus Group Discussions
FGM	Female Genital Mutilation
FMoH	Federal Ministry of Health (Ethiopia)
FP	Family Planning
GBV	Gender-Based Violence
GPRHCS	Global Programme for Reproductive Health Commodity Security
HDA	Health Development Army
HEW	Health Extension Worker (Ethiopia)
HIP	High Impact Practices
HQ	UNFPA Headquarters
HRBA	Human rights-based approach
ICPD	International Conference on Population and Development
IDP	International Development Partner
IEC	Information, Education and Communication
IPPF	International Planned Parenthood Federation
ISP	Integrated Service Programme
IUCD	Intra Uterine Contraceptive Device
KI	Key Informant
KII	Key Informant Interview
KM	Knowledge Management
LAC	Latin America and Caribbean

LGBTI	Lesbian, Gay, Bisexual, Transgender, Intersexed people
M&E	Monitoring and Evaluation
MCH	Mother and Child Health
MDG	Millennium Development Goal
MIC	Middle Income Country
MISP	Minimum Initial Service Package
MoH	Ministry of Health
MoHCC	Ministry of Health and Child Care (Zimbabwe)
MoU	Memorandum of Understanding
MSI	Marie Stopes International
MSM	Men who have Sex with Men
NGO	Non-Government Organisation
PGH	The Pledge Guarantee for Health
PHC	Primary Health Care
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission (of HIV)
RA	Rapid Assessment
RH	Reproductive Health
RHCS	Reproductive Health Commodity Security
RMNCH	Reproductive, Maternal, Newborn and Child Health
RO	Regional Office
SIKMB	Strategic Information and Knowledge Management Branch
SIKMB	Strategic Information and Knowledge Management Branch
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health Rights
SuR	State under Review
TA	Technical Assistance
TMA	Total Market Approach
ToT	Training of Trainer
UNDAF	United Nations Development Assistance Framework
UPR	Universal Periodic Review
VMG	Vulnerable and Marginalised Group

Annex 1: Evaluation matrix

<table>
<tr><th colspan="4">Q1: To what extent has UNFPA supported integration of family planning with maternal health, HIV/STI and GBV services in health plans and at primary health care level, in services for adolescents, and in emergency and humanitarian situations?</th></tr>
<tr><th>Assumptions for Verification</th><th>Indicators</th><th>Sources of information</th><th>Methods and tools for the data collection</th></tr>
<tr><td>1.1: UNFPA HQ, RO and CO staff and in-country partners are working towards a common understanding of the meaning and importance of service integration.</td><td>• Knowledge generated and shared regarding nature of and lessons learned from integration interventions.
• UNFPA staff, partners' and users' (women's and men's) perception of meaning and importance of service integration.</td><td>• Documents
• International key informants
• External stakeholder survey respondents
• UNFPA country office survey respondents
• Desk study key informants
• Case study country notes for Bolivia, Burkina Faso, Cambodia, Ethiopia and Zimbabwe</td><td>• Literature review (global and for country notes)
• International key informant interviews
• Desk study key informant interviews
• Focus group discussions
• Group discussions
• Site visits</td></tr>
<tr><td colspan="4">UNFPA developed and/or participated in the development several documents that provide guidance on the definition of sexual and reproductive health rights (SRHR) and integrated services for use by UNFPA staff and programmes include:
• UNFPA Framework on Reproductive health and rights, including priority components and a basic package of SRH services (UNFPA 2010c: 14)
• SRH-HIV Linkages (IPPF, UNFPA et al. 2009, IPPF, UNFPA et al. 2014)
• Reproductive Health for Communities in Crisis (UNFPA 2012l)
• Planning and Implementing an Essential Package of SRH services (Williams, Warren et al. 2010)
• SRH-HIV Linkages Compendium of Indicators and related assessment tools (IPPF, UNFPA et al. 2014)
• Programming Strategies for Postpartum Contraception (WHO 2013)

Global key informants (KIs) indicated that UNFPA has made an important contribution to integration of sexual and reproductive health (SRH) with HIV and AIDS programmes, especially in partnership with other stakeholders. UNFPA collaborated with several partners including the International Planned Parenthood Federation (IPPF), WHO and Young Positives to develop the Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages: A Generic Guide (IPPF, UNFPA et al. 2009). The tool is intended to support the development of country-specific action plans to forge and strengthen linkages between sexual and reproductive health and HIV at the levels of policy, systems and service delivery. UNFPA held five workshops to roll out the assessment guide attended by 66 countries from West Africa, the Arab States, the Caribbean, Asia and the Pacific, Eastern Europe and Central Asia (UNFPA 2008: 20).

Global KIs point to the lack of collaboration and alignment of the technical branches within UNFPA headquarters (HQ), and hence a lack of consensus around the strategies for advancing family planning (FP). The SRH and Global Programme for Reproductive Health Commodity Security (GPRHCS) branches notably do not have a harmonised approach towards FP, with the SRH branch more focused on integration and rights and the Commodity Security Branch (CSB) focused on</td></tr>
</table>

supply side and commodity security with less of a holistic and integrated approach. The CSB is noted for being strong on the supply side, but requires capacity in areas where UNFPA has an important role to play, i.e., in rights and quality. There appear to be tensions about the importance of the current UNFPA focus on FP, especially if it is pursued with an emphasis on "supply side" orientation. For example, in *Ethiopia* the high level of visibility of GPRHCS led partners to think that UNFPA deals with family planning as a separate programme not integrated with SRH as defined in the International Conference on Population and Development (ICPD) programme of action. Other development partners (DPs) considered that the UNFPA practice of responding directly to government requests limited its capacity to promote integration any further than current government initiatives.

1.3: UNFPA support has been effective in stimulating service integration by in-country partners (Government, CSO, private) in policies, plans and actual services.	Number and type of FP/service providers trained on service integration. Number and percentage of SDPs that offer FP integrated with other services (and acknowledge UNFPA guidance for this). Integrated service provision included in provider training programmes (with acknowledgement of UNFPA guidance for this). Inclusion of integrated service provision in government policies and health plans.	• Documents • International key informants • External stakeholder survey respondents • UNFPA country office survey respondents • Desk study key informants • Case study country notes for Bolivia, Burkina Faso, Cambodia, Ethiopia and Zimbabwe	• Literature review (global and for country notes) • International key informant interviews • Desk study key informant interviews • Group discussions • Site visits • External stakeholder and UNFPA CO surveys

The majority of UNFPA staff and global stakeholder respondents from the internet surveys answered the question, "During the period 2008-2013, has **UNFPA contributed to the to the integration of family planning with other SRH services** (maternal health, HIV, youth and adolescent SRH) (tick all that apply)" as follows:

Answer Options	UNFPA Country Offices		External Stakeholders	
	Response Percent	Response Count	Response Percent	Response Count
Policy level	91.2%	52	67.4%	155
In planning	91.2%	52	65.7%	151
In service delivery (government, NGO, private sector)	96.5%	55	75.7%	174
No contribution	0.0%	0	-	-
Not sure	1.8%	1	7.8%	18

UNFPA has reported substantive efforts to develop national strategies and position FP within national health and development plans and to advocate for the integration of FP into other SRH services and primary health care (PHC) settings. Narratives in UNFPA country programme reports are limited; therefore evaluators relied on documentary evidence from country programme evaluations and other reports. Documentary evidence from several evaluations of country

programmes over the period 2008-2013 provided **successful examples of integration**, such as the "innovative approach" to integrate RH in emergencies into the curriculum of national rapid response health teams in *Nepal* (UNFPA Nepal 2011); a collaboration with WHO in *Tajikistan* to ensure integration of the MISP toolkit (REACT) in emergencies (UNFPA Timor Leste 2013); collaboration with Jhpiego to launch a postpartum family planning project in 20 facilities in *Burkina Faso* (FP2020 2014a); the integration of FP into national policies in *Timor Leste* (UNFPA Timor Leste 2013); integration of FP and maternal health in *Kenya* (UNFPA Kenya 2013); and strengthened linkages between HIV and SRH at the policy, system and service levels in *Lao* (UNFPA Lao PDR 2013) and *Malawi* (UNFPA Malawi 2010).

Several country programme evaluations called for enhanced integration efforts. For example, in Mongolia, the linkages were deemed weak (UNFPA Mongolia 2010). In Myanmar, it was observed that there existed a high level of HIV awareness; however, appropriate levels of integration of public and private HIV prevention and SRH services were not readily apparent. In *Sudan*, RH and HIV and AIDS activities had been implemented in isolation in line with the separate management and funding mechanisms in country. Also, while UNFPA incorporated FP into a number of high-level policy documents and organised and conducted training on workshops, these **efforts were deemed too fragmented to make a lasting difference to the capacity of the health system to provide quality FP services** (UNFPA Sudan 2012b).

In a background document prepared for its current strategic plan, UNFPA itself notes that integration is "for Millennium Development Goal (MDG) 5b" and that "**specific problems and obstacles in integration need to be addressed and understood better**. UNFPA has gained experience in integration of FP and HIV services, but implementation remains a challenge" (UNFPA 2014b: 3-4).

External stakeholders surveyed responded that **FP services are integrated with other SRH services (maternal health, HIV/STI, GBV) or development programmes** in their respective countries as follows:

Answer Options	Response Percent	Response Count
In health plans	70.8	172
In government services at PHC level	75.5	183
In NGO or private sector clinics	57.6	140
In services for adolescents	60.1	146
In humanitarian or emergency situations	37.9	92
In other development programmes	53.1	129
No integration	1.6	4
Not sure	2.5	6

When the same survey respondents were asked whether **UNFPA has shown leadership in realising good quality integrated SRHR services** in their country, 70.9 percent responded "yes," 8.9 percent responded "no," and 20.3 percent responded "not sure". This finding is corroborated by key informant interviews (KIIs) at the global and country level which recognise UNFPA for its leadership in advocating for and advancing the concept of integration defined at the 1994 Cairo ICPD and in particular for its extensive work and partnership on SRH-HIV linkages. However, many KIs at the country and global level also found it extremely difficult measure or given an opinion as to **how UNFPA has concretely contributed** to the integration of FP within field programmes and attributed this to an overall **lack of a results orientation within the organisation**.

In the country case and desk studies, progress on **integration is quite varied, as is expected given the different contexts** that shape integration strategies. Highlights from each of the case studies:

Bolivia: UNFPA has stimulated and supported integration at the policy level and in service provision. UNFPA has been a major contributor to the integration of FP into SRH services, adolescent education and services, services for survivors of gender-based violence and humanitarian support through its advocacy and technical support in the development of policies and protocols. Its contribution to implementation has included training in the public sector and financial support to NGOs for service delivery; however the effect is not known given the lack of means for measuring results.
Burkina Faso: Integration is a key feature of the UNFPA youth, humanitarian, and community-based strategies. The CO is partnering with a range of international and national civil society organisations (CSOs) to leverage its resources (human and financial) to take advantage of opportunities to add FP to existing activities and services, thereby extending its reach beyond what it can do on its own through integration. UNFPA leadership has resulted in the development of policies and national plans that promote integration. UNFPA has catalysed FP integration into maternal health, through support of partners to pilot post-partum family planning and to strengthen FP in post abortion care (Burkina Faso Country Note 2015: Section 4.1: 20).
Cambodia: UNFPA has been effective in stimulating integration of FP with other services at policy and strategy level, with the effort skewed towards maternal health services. While UNFPA has supported integration through service provision, results have been limited outside the traditional group of maternal health service clients, i.e., married women. In practice adolescents and unmarried women and men do not have access to adequate, integrated public health services (Cambodia Country Note 2015: Section 4.1: 19-20).
Ethiopia: UNFPA and other DPs have supported the Federal Ministry of Health (FMoH) in development of the policy guideline for linking HIV and AIDS, family planning and maternal health, and at the programmatic level the Development Partners' Forum in which UNFPA takes a leading role integrates FP and HIV and AIDS in its work. UNFPA has provided support for integrated family planning, maternal health, youth, gender and HIV programmes carried out by government and non-government implementing partners. It is currently supporting an integrated reproductive, maternal, newborn and child health (RMNCH) project in 100 woredas (also knows as districts are the third-level administrative divisions of Ethiopia) and has included service integration in its support to health extension worker (HEW) and other health worker training. UNFPA, working with DPs, has been effective in supporting service integration but there are practical limits to integrated service delivery posed by the capacity of HEW and health development army (HDA) staff (Ethiopia Country Note 2015: Section 4.1: 13).
Zimbabwe: UNFPA has contributed to the integration of FP into SRH services through its participation in the Integrated Service Programme (ISP), a partnership supported by several European donors. The ISP is the flagship programme for the CO, and supports RH (including FP), HIV prevention and GBV activities and staff. UNFPA performance has improved and is credited for doing excellent work in strengthening the public sector capacity in GBV prevention and services, HIV prevention and condom programming. The CO has worked to mainstream FP into other SRH technical areas, although country stakeholders noted gaps in addressing opportunities for UNFPA to integrate SRH and GBV in FP training and integrating FP into community based programming (Zimbabwe Country Note 2015: Section 4.1: 14-15).

Selected examples from five desk studies follow (the Nigeria and Rwanda desk studies did not reveal information on this topic):

The ***Tajikistan*** country office found that integration of reproductive health services – including family planning – remains a "complicated matter," since regional health staff and managers have limited knowledge of the on-going primary health care reform.
In ***Nicaragua***, development partners felt that UNFPA support integration to such an extreme that FP sometimes became invisible.

In ***Uganda***, UNFPA supported the National HIV and AIDS linkages and integration strategy and did rapid assessments and supported integration of HIV/RH integration (PMTCT, including FP), MNCH/FP integration; and supported guidelines, tools and integrated registers to collect facility/ client data. In ***Sudan***, work to integrate HIV and SRH began in 2010 in some states (Khartoum, Blue Nile, Gadarif and Kassala) which led to: the creation of a technical working group; enhanced coordination; the development of a SRH-HIV road map and strategy; and improved access to and uptake of SRH/HIV services, including FP, VCT, Care and treatment for PLHIV, condom distribution and other services. However, the project was suspended in 2013 due to lack of coordination, competition over resources and lack of coordination and interest in working with selected NGOs. In ***Viet Nam***, UNFPA worked with the Government, and with partners (MSI, PATH, FHI) on integration, resulting in national guidelines for FP/HIV. UNFPA also addressed adolescents, but it was limited to raising awareness and life skills development, and did not include FP service delivery.			
1.4: Service integration leads to improved user access and quality of services.	Evidence of user consultations. Perception of different user groups (women and men, VMGs, PLHIV) that access and quality has improved by integration.	• Documents • International key informants • External stakeholder survey respondents • UNFPA country office survey respondents • Desk study key informants • Case study country notes for Bolivia, Burkina Faso, Cambodia, Ethiopia and Zimbabwe	• Literature review (global and for country notes) • International key informant interviews • Desk study key informant interviews • Group discussions • Site visits • External stakeholder and UNFPA CO surveys
Evidence exists in the literature to support the notion that **integration is cost-effective, improves access to health care, and increases the financial sustainability of programmes** (Ringheim 2009). Further, there is an expanding evidence base for integrated HIV-FP service delivery, but not without problems as some studies are characterized as having weak programme implementation (Wilcher, Hoke et al. 2013). Regarding family planning/maternal health integration, it is posited that programmatic interventions *may* improve birth spacing and contraceptive uptake; however, larger, well-designed studies are needed to determine the most effective strategies (Sonalkar, Mody et al. 2014). The UNFPA country programme evaluations reviewed and described in Assumption 1.3 above, highlighted activities but did not adequately address the **question of whether UNFPA efforts led to improved user access and quality, especially for FP services**. UNAIDS identified the following issues as warranting rigorous operational research: • Which integration models are optimal in particular settings • Impact of linkages (e.g. on unmet need for family planning, HIV incidence, etc.) • Cost-effectiveness of combining HIV and SRH interventions • How to involve men and boys with regard to HIV and SRH interventions • Impact of linked SRH and HIV services on stigma and discrimination • What are the incentives for service providers in linking services			

- Comprehensive SRH services for people living with HIV, including planning for safe, desired pregnancies and addressing unintended pregnancies, especially in settings where there is limited access to the full range of SRH services
- Optimising reach of services in challenging circumstances, including in humanitarian responses, settings with diverse cultural practices, and for survivors of sexual violence (UNAIDS 2010).

UNFPA uses the following indicators to track integration:

- Number of countries that have integrated SRH services (including FP) into national health policies and plans.
    - 2010 54 (baseline) (n=128)
    - 2011: 57
    - 2012: 57
- Number of countries where UNFPA has supported the development of national health policies and plans with integrated SRH services (including FP)
    - 2010: 10 (baseline)
    - 2011: 49
    - 2012: 54
- Number of countries that have completed an assessment of linkages between SRH and H IV policies, systems and service delivery with support from UNFPA
    - 2010: 9 (baseline) (n=38)
    - 2011: 17
    - 2012: 25 (UNFPA 2013c)

There are no indicators under outcome No. 3 (increased access to and use of quality FP services) related to integration of other SRH issues into FP programmes, and there is an absence of data regarding UNFPA contribution related to FP/SRH integration, making it **difficult to identify or track UNFPA progress on the integration of FP in other SRH activities (or vice versa) over time**.

Four of the five country case studies (*Bolivia, Burkina Faso, Cambodia* and *Ethiopia*) concluded that there is **insufficient evidence to support the assumption that service integration leads to improved user access and quality of services**. In ***Zimbabwe***, it was concluded that access to integrated services had improved, but there was no evidence to support increased quality of care within integrated services. Information existed in *Zimbabwe* because integration was supported through a donor-funded project that conducted external reviews of progress, leading to more robust information available to assess service delivery outputs.

The SRH-HIV rapid assessments provide information about client perspectives regarding integration, however, the evaluation found no evidence in country case or desk studies of explicit follow-up related to these findings. For example, the 2011 RA in ***Burkina Faso*** reported the clients wanted increased availability of information and advice, friendlier services, reduced waiting times and greater availability of medicines and commodities (IPPF, UNFPA et al. 2011). In ***Sudan***, the 2013 CO annual report indicates that there were successful results at health facility and community levels in five localities in four states and planned an evaluation, but this was not conducted.

In ***Haiti***, UNFPA was credited with responding immediately to support Minimum Initial Services Package (MISP) following the earthquake in 2009. The majority of those interviewed reported that free inter-agency RH kits—kits designed to assist MISP implementation—were available within days after the earthquake. This is the result of UNFPA in-country stockpiles and rapid dissemination, combined with early ordering and procurement undertaken by the UNFPA RH coordinator for Haiti. Agencies reported ordering, receiving and using UNFPA-donated kits, including condoms, clean delivery kits, contraceptives, post-rape kits, STI kits, surgical kits and post-abortion care kits (Care, IPPF et al. 2011).

EQ2: To what extent has UNFPA successfully contributed on its own and in coordination with others to strengthening national leadership of family planning and improving sustainability?			
Assumptions for Verification	**Indicators**	**Sources of information**	**Methods and tools for the data collection**
2.1: UNFPA has developed and/or actively supported mechanisms to raise the profile of family planning in coordination with other FP/SRH stakeholders at global, regional and national levels.	Type of existing and emerging coordination mechanisms at each level with evidence of UNFPA support and FP-relevant contents of meetings and initiatives.	• Documents • International key informants • External stakeholder survey respondents • UNFPA country office survey respondents • Desk study key informants • Case study country notes for Bolivia, Burkina Faso, Cambodia, Ethiopia and Zimbabwe	• Document review • Country case studies – visit • Internet surveys 1 and 2 • KIIs

During the evaluation period 2008-2013, there was **increased global attention to repositioning family planning as an important development priority**, after a decade or so of neglect. During this time, there were several important global partnerships to advance FP, notably the Reproductive Health Supplies Coalition, the Maputo Plan of Action, the Ouagadougou Partnership in West Africa and finally FP2020, the latter following the London Summit on FP, which was a watershed global event on repositioning FP. Other global forums with the goal of improving maternal health (with some attention to FP), include the UN initiative *Every Women Every Child*, a global strategy to map out investments, financing and policies to spur progress in women and children's health Every Woman Every Child; and H4+, the technical arm of the global strategy for six UN agencies, related organisations and programmes (UNAIDS, UNFPA, UNICEF, WHO, UN Women and the World Bank).

The perceptions about **UNFPA leadership in family planning differ whether one is speaking pre or post 2011/2012**. Global key informants credited others being at the forefront of efforts to reposition FP more so than UNFPA, such as Bill and Melinda Gates Foundation (BMGF), USAID and DFID. Moreover, KIs widely believe that UNFPA efforts to reposition FP came at the urging of the donors to refocus on FP as the strategic core of its mission (CGD 2011). Even prior to 2011/2012, the major platform for UNFPA advocacy and work in FP was the GPRHCS, the thematic fund created at the behest of donors to support contraceptive security, capacity building and demand creation, with a strong focus on procurement. In 2012, BMGF supported a project grant to strengthen transition planning and advocacy for FP (UNFPA 2012k) which resulted in a the development of a **15-point reform agenda in family planning for UNFPA** aimed at strengthening its position as a global leader in FP and consolidating FP within a broader SRH effort. "*The strategy is part of UNFPA's resolve to prioritize family planning within its broader mandate and is based on the Fund's commitment to a 15-point reform agenda intended to improve business as a global leader in family planning. The reform process is intended to further consolidate ongoing family planning initiatives such as the Global Programme to Enhance Reproductive Health Commodity Security and other activities within a larger reproductive health effort including maternal health, prevention of sexually transmitted infections (STIs) and adolescent outreach"* (UNFPA 2012k).

The reform agenda addresses three major areas – strategy, procurement and metrics/monitoring

UNFPA family planning strategy

- Increase financial commitment for FP by supplementing FP resources with core resources

(for staff)
- Elevate FP leader and management team with direct reporting to the Executive Director (ED)
- Reallocate staff time to FP at global/regional levels.

Procurement process
- Increase number or products procured from southern manufacturers through enterprise resource planning (ERP) approval to decrease prices
- Develop robust local demand forecasts; ensure coordination for supply planning across procurement stakeholders
- Tackle emergency stock-outs through scaling up product availability in AccessRH strategic inventory
- Reduce stock-outs through development of plans for in-country supply chain management and escalation protocol
- Address cyclical funding gaps by creating an interest-free fund that can be used until disbursement occurs.

Metrics and monitoring
- Develop a supplementary scorecard of 10 key metrics for reporting to donors semi-annually
- Introduce performance management for countries by implementing a needs-based and performance-based evaluation funding system
- Track funding/spend across all FP-related activities.

Other reforms
- Up-skill in-country staff responsible for supply chain management, service delivery, monitoring and reporting
- Revamp performance management across all UNFPA FP employees
- Increase external stakeholder involvement by setting up a steering committee chaired by UNFPA together with a donor representative on a rotational basis. Explore a possible role for external stakeholders in UNFPA Executive Board
- Scale up comprehensive support from 46 to 69 countries (Ibid: 9).

This reform plan coincided with the launch of FP2020, in which UNFPA has become an active and important leader, with the ED serving as co-chair of the Reference Group, and with various HQ staff on the different working groups, including: Country Engagement, Rights and Empowerment, Performance Monitoring and Accountability, and Market Dynamics. Most importantly, UNFPA is serving as focal points (with USAID) for obtaining government commitment to FP2020 and for the development of **Costed Implementation Plans** (CIPs). CIPs are implementation and resource maps that help to coordinate the national response for family planning.

As of October 2014, the following countries had made commitments to FP2020:

Bangladesh	Ethiopia	Liberia	Nigeria	Solomon Islands
Benin	Ghana	Malawi	Pakistan	South Africa
Burkina Faso	Guinea	Mauritania	Philippines	Tanzania
Burundi	India	Mozambique	Rwanda	Uganda
Côte d'Ivoire	Indonesia	Myanmar	Senegal	Zambia
DR Congo	Kenya	Niger	Sierra Leone	Zimbabwe

Documents and interviews indicate that **UNFPA played an important coordination role in the development of national FP strategies** in *Burkina Faso*, *Zimbabwe* and *Uganda.* The internet survey among UNFPA country offices (COs) showed that 96.7 percent of the countries have a national FP policy and programme.

UNFPA has supported repositioning by increasing government awareness of the **link between population and development**. Examples include:

- In ***Uganda***, President Museveni endorsed family planning in 2014 as a key pillar for socio-economic transformation (UNFPA Uganda 2014a: 14).
- In ***Tajikistan***, UNFPA was involved in developing the Tajik National Development Strategy and the Tajik poverty reduction strategies, which included integration of gender, population and reproductive health issues, including family planning. At the national level, UNFPA has been actively involved in the making of the Tajik National Development Strategy and the Tajik poverty reduction strategies, resulting in integration of gender, population and reproductive health issues, including family planning (Tajikistan desk study).
- In ***Rwanda***, family planning was included in the "Vision 2020" in 2000 as a means to reduce population growth and as a component in reducing infant and maternal mortality (Ministry of Finance and Economic Planning 2000).

Full data on **national budget allocations** to FP is still only available for a handful of countries. The internet survey showed a difference in the perception between external stakeholders and COs: on the question of whether the government budget for FP procurement and logistics had increased in the period under evaluation, 43.7 percent of the stakeholders and 66.7 percent of COs said yes; 19.3 and 24.6 percent respectively said no; while 37 and 8.8 percent respectively were not sure. Of the respondents who thought government budget had increased, 94.7 percent felt UNFPA had contributed to this change.

Note: It is possible that the higher percentage in the CO survey is due to UNFPA having more information on this theme than some of the external stakeholders who are not specialised SRH and FP organisations.

Progress on repositioning FP at decentralised government level has been mixed. Examples from the country case studies include:

- **Bolivia**: The Constitution of 2009 includes sexual and reproductive rights and this has opened the door for development of laws and policies for FP at national and departmental levels. These developments demonstrate government ownership and leadership at national and departmental levels in the policy and legal environment. There is still however a lack of commitment by all political groups to fully implement the laws and policies with repercussions on government ownership at national and decentralised levels. With administrative decentralisation in *Bolivia*, municipal governments have an important role in resource allocation and funds flow for health services and it is important that they are committed to FP. Municipal mayors and municipality staff who are responsible for the administration of FP services often lack knowledge and experience and sometimes lack political will to promote implementation (Bolivia Country Note 2015: Section 4.2: 19).
- ***Ethiopia***: KIIs with government and civil society respondents showed that at decentralised regional level there is no need for promotion of government ownership of FP programmes, as regional governments have fully subscribed to federal policy. Over-enthusiastic adoption of federal targets for contraceptive prevalence rate (CPR) at regional level has resulted in some unrealistic targets in some places (such as 100 percent FP coverage of women of reproductive age) (Ethiopia Country Note 2015: Annex 3, Assumption 2.2: 54).

In Bolivia and Ethiopia, UNFPA sub-national offices consist of one professional programme staff member with varying levels of support (in some cases only a driver; in others administrative and/or research assistants). This level of capacity is sufficient for liaison work and coordination between sub-national implementing partners and the UNFPA CO, but may not allow development of more substantive work (e.g. FP promotion, advocacy, technical support). The cost-effectiveness of sub-national offices depends on the country size, UNFPA priorities, and degree of decentralisation of

decision-making. The feasibility of expanding at sub-national level also depends on the resources available to UNFPA, as it is expensive to maintain sub-national offices. These considerations are not restricted to FP work.

Increased knowledge and awareness of FP at community level and amongst community leaders was identified in the country case studies. For example in ***Bolivia***, a regional programme implemented by UNFPA in collaboration with AECID raised SRH awareness of indigenous organisations and leaders (UNFPA and FCI 2011); in ***Ethiopia,*** government and NGO work at community level has raised awareness raising and reduced cultural and traditional obstacles for unmarried young people, the key actors in this process being the government *health development army* volunteers, responsible for promotion at community level (Ethiopia Country Note 2015: Section 4.5: 23).

UNFPA is supporting the **inclusion of family planning in comprehensive sexuality education** in a growing number of countries. Progress is being made in ***Uganda*** to integrate sexuality education in secondary school curricular and extra-curricular activities within a supportive socio-cultural, policy and reproductive health services environment (UNFPA Uganda 2010b: 14). In ***Bolivia***, family planning is integrated in the school curriculum on sexuality education (Dirección Departamental de Educación de Chuquisaca 2011), (Bolivia Country Note 2015: Section 4.1: 16-17).

In **emergency and humanitarian work**, KIs indicated that UNFPA has worked with other UN and NGO partners at global level to raise the profile of SRH and family planning in emergency situations at international level and contributed to development of the inter-agency guidelines for SRH in emergencies. UNFPA was key partner in the RAISE initiative (2006-2010) in which UNFPA worked with MSI and Columbia University to promote integration of family planning in emergency and humanitarian relief; UNFPA now has ownership of the emergency RH kits, and is the key player in maintaining RH within the humanitarian response. UNFPA is held to account on this by a group of NGOs that work closely with UNFPA, including Marie Stopes International (MSI), MSF, RHCS members. The key UNFPA role in emergency and humanitarian situations is coordination and advocacy to free up space for NGOs to provide services. UNFPA can and does insist that grantees provide SRH services.

The CO internet survey showed that 98 percent of COs state that they work with partners to **raise the profile of FP**, with 91 percent of COs doing this promotional work within the health sector; 77 percent carry out advocacy and promotion to raise FP profile in other sectors such as education and environment. KIIs with other stakeholders and ministries outside the health sector during case study visits showed that UNFPA works with other government ministries (for example, the ministries of planning and development, education, autonomy in ***Bolivia***; finance and economic development, women children and youth affairs in ***Ethiopia***) (Bolivia Country Note 2015: Section 4.1: 17, Ethiopia Country Note 2015: Section 4.1: 18).

2.2: UNFPA and other donors (including those influenced by UNFPA advocacy) have effectively supported national governments to assume ownership of family planning-related policies and programmes in different national contexts.	• Existence of national FP policy and programme (separate or integrated with other SRH areas). • National budget allocations to FP. • Number of other major donors actively supporting national ownership	• Documents • International key informants • External stakeholder survey respondents • Desk study key informants • Case study country notes for Bolivia, Burkina Faso, Cambodia, Ethiopia and Zimbabwe	• Document review • KII • Country case studies – visit and desk

	of family planning, (on their own account or as a result of UNFPA advocacy).		

The internet survey of COs showed a range of levels of *government commitment* to FP:

Strong	54,4%
Moderate	33,3%
Weak	10,5%
Not sure	1,8%

Results of the internet survey on government policy and *budget commitments* are given in the previous section. National spending on contraceptive procurement in UNFPA focus countries (UNFPA 2014e) shows a total of US$71m allocated in national budgets, and US$52m spent (Ibid: 74). Comparative data is not available for earlier years. Procurement is only part of overall FP spending, which also includes service delivery, infrastructure and human resources.

In ***Ethiopia***, UNFPA reported that "*Family Planning has become a development agenda, not a health sector issue alone, thus the Ministry of Finance and Economic Development is playing a key role in allocation of resources for FP programs in the country*" (UNFPA Ethiopia 2011b). In ***Cambodia***, the government is integrating demographic perspectives in development planning (RGoC 2013). In ***Bolivia***, the Ministry of Education is working on a comprehensive sexuality education curriculum including FP, and is implementing it at sub-national level (Bolivia Country Note 2015: Section 4.1: 16-17).

The evaluation internet survey of external stakeholders showed a high percentage of countries with a range of **coordination mechanisms.** The survey question was phrased in terms of UNFPA participation; there may be additional coordination mechanisms in which UNFPA does not participate.

External stakeholders survey

Does UNFPA participate in government and development partner forums which aim to coordinate and strengthen work in family planning?		
Answer Options	Response Percent	Response Count
Sector-Wide Committees	54,3%	144
Basket funds	17,4%	46
Government led working groups	75,1%	199
NGOs and donor organizations networks	63,4%	168
No	0,4%	1
Not sure	7,9%	21
Other (please specify)		10
Answered question		265
Skipped question		7

The CO internet survey gave similar results, noting a higher percentage of UNFPA participation. This is probably due to external stakeholders having incomplete information on UNFPA activities in the coordination mechanisms.

CO survey

Does UNFPA participate in government and development partner forums which aim to coordinate work in family planning?		
Answer Options	Response Percent	Response Count

Sector-wide committees	61,4%	35
Basket funds	21,1%	12
Government-led working groups	96,5%	55
NGOs and donor organizations networks	75,4%	43
Other	5,3%	3
No	1,8%	1
Other (please specify)		4
Answered question		57
Skipped question		0

Case study data illustrates the range of activities and **effectiveness of coordination mechanisms.** In ***Cambodia***, there is a series of high-level policy forums, technical coordination mechanisms and other partnership platforms. These include, among others, the Joint Partnership Arrangement/ development partner interface group related to the Health Sector Support Program II; the technical working (sub) groups for maternal and child health and family planning; the technical working group contraceptive security and the maternal health fast track initiative (Cambodia Country Note 2015: Section 4.2: 21, Section 4.3: 23). In ***Bolivia***, there are two principal coordinating forums for SRH/MCH and SRHR, together with an additional seven mechanisms which also include FP in their agenda (Bolivia Country Note 2015: Section 4.3: 21). In ***Zimbabwe***, there are coordinating forums for adolescent sexual and reproductive health and reproductive health commodity security (RHCS), amongst others (Zimbabwe Country Note 2015: Section 4.2 and 4.3: 16-18, Section 4.5: 23).

UNFPA has used **joint government-development partner steering committees** to help harmonise donor support to reproductive health commodity security (*Burkina Faso, Cambodia, Ghana* and *Zambia*). UNFPA country offices have initiated the creation of reproductive health commodity security committees in some of the case study countries (*Burkina Faso, Cambodia* and *Zambia*). However, the success of these initiatives varied. In ***Burkina Faso*** and ***Cambodia***, UNFPA supported the creation of RHCS committees as part of a long-term strategy to improve commodity security. The country offices used their staff resources to support the committees with technical assistance and to mobilize support among the governments and development partners (Burkina Faso Country Note 2015: Section 3: 15-18, Cambodia Country Note 2015: Section 4.8: 38-41). In ***Zambia***, staffing shortages made it difficult for UNFPA to maintain its presence in coordination bodies. This reduced the ability of UNFPA to sustain sufficient support for the commodity security committee from among the government and development partners to ensure its continued operation (UNFPA 2012j: 27-28).

The **effectiveness of the forums and their input at strategic level varies**. In ***Nicaragua***, members of the health basket fund committee ("FONSALUD") have some input into government decision-making on allocation of the fund. KIs in ***Zimbabwe*** spoke of there being too many overlapping committees and the need to streamline and clarify authorities and mandates, particularly between the donor initiative steering committees and those that are institutional. Donor initiative steering committees also tend to focus on implementation, rather than the larger strategic issues that need attention (Zimbabwe Country Note 2015: Section 4.3: 16-17). In ***Ethiopia***, KIs spoke of the increased effectiveness of the forums when they have concrete tasks to coordinate, such as programme implementation (Ethiopia Country Note 2015: Annex 3, Assumption 2.1: 51).

There is concurrence in the results of the CO and external stakeholders surveys on the effectiveness of the coordination mechanisms in advocacy, technical assistance, and coordination of funding, with the results showing that both the COs and other stakeholders consider the coordination mechanisms are effective contributors to FP interventions.

CO survey

How have these forums contributed to improving family planning?		
Answer Options	Response Percent	Response Count
Advocacy	98,2%	54
Policy input	90,9%	50
Provision of funds or material resources	80,0%	44
Technical assistance	94,5%	52
Donor coordination	80,0%	44
No significant contribution	3,6%	2
Not sure	0,0%	0
Other	5,5%	3
Answered question		55
Skipped question		2

External stakeholders survey

Have these forums contributed to improving family planning through:		
Answer Options	Response Percent	Response Count
Advocacy	78,6%	151
Policy input	72,9%	140
Provision of funds or material resources	78,6%	151
Technical assistance	83,9%	161
Donor coordination	56,8%	109
No significant contribution	1,0%	2
Not sure	1,6%	3
Other (please specify)		8
Answered question		192
Skipped question		80

Different countries use different entry points to increase national ownership for and to reposition FP. In ***Burkina Faso***, There has existed a strong national commitment by the government, particularly since the mid-2000s, to expand access and use of contraceptive information and services as an essential element of maternal health and, more recently, a factor in economic development. The mother and child health rationale for FP has been a major factor in its increased political and cultural acceptability over the past several years, although an economic rationale is increasingly part of the dialogue at the community level (Burkina Faso Country Note 2015: Section 4.2: 21).

In ***Cambodia***, FP is a sensitive issue, but is introduced through the concept of "birth spacing": after the civil war there was a felt need to have a larger population. But population growth and economic growth need to go together. In the end, the need to reduce the high maternal mortality and save women's and children's lives was the main argument for MoH to promote "birth spacing" – instead of family planning, which had a negative connotation of "limiting the family size" (Cambodia Country Note 2015: Section 4.2: 20-21, Annex 3, Assumption 2.3: 64). In ***Bolivia***, where some political groups still believe that the population should increase, especially amongst small and declining indigenous groups, FP has been positioned as a method to reduce maternal mortality and reduce the high rate of growth of adolescent pregnancy, both of which are key priorities in

Bolivia (Bolivia Country Note 2015: Section 4.2: 19-20). In ***Uganda***, UNFPA has used the country's concern with the demographic dividend as an entry point for FP.

Ethiopia, *Viet Nam* and *Rwanda* provide notable cases in in which government ownership of the leadership role in FP resulted in strong commitment and responses. In 2005, in ***Rwanda***, presidential commitment to addressing population issues triggered the *National Family Planning Policy* (USAID 2009). The Rwanda government took ownership of messages about the advantages of having smaller families in terms of health and education opportunities, and promoted the importance of FP to the Rwandan population (Solo 2008: 12). These initiatives have given the Rwandan government the reputation as one of the most committed to family planning in Africa (Leahy 2011).

UNFPA has undertaken efforts to obtain **government commitments to FP funding** and coordinate donor funding. In ***Nigeria***, for example, the Fund contributed to the introduction of a "basket fund" that pooled together resources from the federal budget, UNFPA and other partners supporting reproductive health commodities (UNFPA Nigeria 2012b: 20). International KIs emphasised the UNFPA role in strengthening country ownership, in coordination with other donors and in getting country commitments to FP: *"UNFPA was and is a key player in FP2020. Its unique contribution is close relationships with family planning champions in priority country governments – UNFPA has been the best of the four FP2020 partners in getting country commitments."* In cases where governments are reluctant or not interested, UNFPA works first with the donors to develop a united front for advocacy with government and to identify the most suitable and appropriate entry points for family planning. This is a special strength of UNFPA, which has access to, and works closely with government in most countries, in part because it has small COs relative to other UN agencies and lacks capacity to implement programmes itself. In ***Burkina Faso***, MoH is interested in having UNFPA provide technical assistance to support its advocacy with the MoF to maintain budget line for commodities (Burkina Faso Country Note 2015: Section 4.7: 23). In ***Cambodia***, UNFPA played a key role towards the inclusion of contraceptive services in the health equity fund scheme and, moreover, used its leverage to achieve adjustments in the health equity fund reimbursement system (to address the bias towards more expensive methods) (Cambodia Country Note 2015: Section 4.2: 20-22).

Humanitarian and emergency situations are common in the UNFPA focus countries and government resources are often stretched to cover them. This can lead to reduction in spending on FP if funds are diverted to cover the emergency. GPRHCS data (UNFPA 2014e) show that in 10 of the 25 countries committing funds for FP commodities, actual spending fell well short of the budgeted amounts. In some cases this is due to national emergencies. In ***Burkina Faso*** for example, two major humanitarian crises occurred during the period of this evaluation – catastrophic floods in September 2009 affected 150,000 people with damage and loss, and rendered 50,000 homeless. In 2012, there was an influx of approximately Malian refugees, which further weakened already vulnerable populations in the northern regions of Burkina Faso (UNFPA Burkina Faso 2014). KIs note that these problems and the political instability as a result of the ouster of the President in 2014 are reasons for the government not coming through on its budget allocation commitments.

The evaluation internet survey shows that 81 percent of external stakeholders consider ***UNFPA has a leading role in the coordination mechanisms***:

Answer Options	Response Percent
Yes	80,5%
No	10,0%
Not sure	9,5%

The ***Ethiopia*** case study shows that UNFPA has taken an active role in coordinating bodies and development partner forums which themselves have supported government leadership in FP. UNFPA is seen as the natural, technical leader for DP and multilateral organisation discussions in

the MoH-led coordinating bodies (Ethiopia Country Note 2015: Section 4.2: 15-17). In ***Cambodia***, "*UNFPA was praised for its management and systems, its support of Royal Government of Cambodia-prompted priority issues, and its promotion of cross-ministry collaboration. Government representatives are particularly enthusiastic about UNFPA contributions, explaining that the UNFPA mandate supports national programmes in a way that fosters their independence and development. Rather than pushing an agenda on ministries, UNFPA listens and responds, identifying feasible solutions and explaining what can and cannot be supported. For this role as advisor and collaborator, UNFPA is much appreciated*" (Shah 2010: 7). International KIs also pointed out that UNFPA responses vary between countries, depending on in-country capacity and the willingness of the CO to expend its political capital on sensitive issues, such as full participation by NGOs or addressing concerns regarding human rights vulnerabilities (see Assumption 6.2). The 2010 UNFPA ***Uganda*** annual report noted the following as the main challenge: "*The relatively better endowed NGOs often take over the leadership of the mechanism thus frustrating the principle of government ownership and leadership of programs. In some instances NGOs have taken dominant role*" (UNFPA Uganda 2010a: 20). In ***Zimbabwe***, donor-initiative steering committees take a leading role in coordinating programme implementation, due to lack of capacity in the public sector (Zimbabwe Country Note 2015: Section 4.2: 16-17). In ***Viet Nam***, the mid-term review of the country programme (CP) assessed the likelihood that national partners will have the **institutional capacity and resources to maintain results over time**. It found that the sustainability of achievements is enhanced by the fact that interventions are embedded in government priorities and systems through high-level government consensus. *Viet Nam* is moving towards sustainable institutional capacity, but will still have to commit more financial resources to reach economic sustainability of reproductive and family planning programmes. This review further states that sustainability is "*greatly enhanced*", since the programme is both designed and implemented with the government, based on its own priorities and strategies, using its own staff and systems. This is backed by solid commitment from all national implementing partners and country implementing partners to "*adopt models, draft legislation, strategies and guidelines*". Also, annual progress reports provide examples of initiatives that have "*a strong likelihood of being sustainable in the future"* (Goss Gilroy 2014: 11). In some countries, UNFPA has sub-offices in decentralised administrative regions (e.g. *Ethiopia* and *Bolivia*). In the country case studies, these sub-offices serve largely as coordinating agents between the CO and implementing partners (including decentralised levels of government) in the sub-national administrative divisions. The capacity of UNFPA sub-offices to carry out a more definitive role in FP is limited by their lack of human resources. In Ethiopia for example, the sub-offices have one member of staff and a driver.			
2.3: Programmes are culturally/ socially, institutionally and economically sustainable in different national contexts.	Trends in mCPR. Percent of FP provided by the public, NGO and private sector. Government spending as percent of total expenditure on FP. Evidence of participation by CSOs (including end user groups, VMGs) and private sector in family planning policy, planning and	• Documents • International key informants • External stakeholder survey respondents • UNFPA country office survey respondents • Desk study key informants • Case study country notes for Bolivia, Burkina Faso,	• Document review • Country case studies – visits • Internet surveys 1 and 2 • KIIs

	accountability mechanisms at national level.	Cambodia, Ethiopia and Zimbabwe	

In ***Bolivia***, although FP policies exist and there is support at central government level, there is **lack of political will** to implement in all the sub-national regions and municipalities, which have control over allocation of funds for FP (Bolivia Country Note 2015: Section 4.2: 19).

High staff turnover and the need for continual training is a common theme in all the country studies. Training interventions to increase availability of FP services in ***Burkina Faso*** and ***Zimbabwe*** are focused on in-service training, rather than "upstream" efforts to ensure that FP is integrated within pre-service training (Burkina Faso Country Note 2015: Section 4.7: 32, Zimbabwe Country Note 2015: Section 4.7: 27). In ***Rwanda*** for example, the evaluation of the 6th country programme concludes that sustainability remains a challenge in a country that depends on aid for half its health sector budget and where there is a shortage of skilled and competent labour. Weak ownership is reported in relation to youth programs at district level, to lead government implementing partners, national partners. In particular, the 2009 annual report pointed to the weak government capacity, despite its commitment to own and lead the process. The consequence was that partners were forced to take on roles that ought to be assigned to the government (Abbott, Homans et al. 2012: 54). Staff turnover at decision-making level also affects sustainability when FP policies come up for periodic renewal if new decision-makers are not committed to FP.

The UNFPA focus on **sustainability** in the Asia and Pacific Region **is focused on improving the policy environment and securing national budgets for reproductive health commodities** (UNFPA 2014a). This is also the focus in LACRO countries (*Nicaragua* and *Bolivia*) and in most African countries (*Burkina Faso, Nigeria*). In *Uganda*, the heavy donor dependence is a threat to sustainability of programme activities according to the independent review (UNFPA Uganda 2009: 49). In GPRHCS Stream 1 countries, there is a focus on capacity building in procurement and supply chain management to increase sustainability.

In ***Ethiopia***, UNFPA works with the Ministry of Finance and Economic Development, which is playing a key role in *FP financial allocations*. UNFPA has also worked with the Population and Development Directorate of the National Planning Commission on inclusion of FP in national population plans and increasing male involvement (Ethiopia Country Note 2015: Section 4.3: 18). In ***Uganda***, UNFPA has supported the FP2020 scale up plan, Uganda RMNCH fund action plan, and advocacy by MoH for increased financial commitment to the reproductive health commodity security budget (UNFPA Uganda 2014b: 3-4). At international level, UNFPA works with the Guttmacher Institute to produce the annual report "Adding It Up: The Costs and Benefits of Investing in Family Planning and Maternal and Newborn Health," and it has supported specific studies of the cost-effectiveness of different FP methods in *Ethiopia*. UNFPA has also worked internationally with the RHCS and donor partners to obtain reduced prices for implants through a volume guarantee scheme, which reduces small and irregular purchases and enables manufacturers to plan production and reduce costs, passing the cost reduction on to the procurement agencies. In ***Bolivia***, FP is included in the national maternal child health insurance scheme (*SUMI*). Users have access to free contraceptives, which are financed by municipal budgets. UNFPA worked with the government to promote inclusion of FP in *SUMI*, and has set up a revolving fund within the national commodity supply agency to ensure continuity of supply. As municipal government funding for heath comes directly from central government, this system effectively represents a government contribution to FP supply (Bolivia Country Note 2015: Section 4.2: 19).

Involvement of the private sector and NGOs together with government health services and national insurance schemes in a **Total Market Approach** (TMA) enables a rational segmentation of service provision between sectors according to the capabilities of each and the characteristics of

the groups they serve. With a TMA, the public sector can focus better on the lower income groups and those who need more subsidies and free services, NGOs can focus on hard-to-reach groups and those who can contribute to the cost of services, and the private sector can attend a wide range of all income levels through social marketing and provide clinical services for those with capacity to pay. UNFPA has promoted TMA on a limited basis. For example, in ***Eastern Europe and Central Asia***, the RO, in collaboration with PATH, gathered evidence on why family planning use is so low and subsequently held a high-level consultative meeting with ministries of health and finance in order to place family planning in a wider framework (UNFPA 2013f). The meeting recommended that the RO work on financial sustainability through TMA, and create a learning package on family planning. There is a TMA in each country in the region with participation by ministries of health and finance, NGOs and UNFPA. In ***Bolivia***, on the other hand, lack of joint work between government, NGOs and private sector to advance national procurement and initiate a TMA affects the long-term sustainability of FP programmes, as the national procurement agency needs a larger procurement volume and market in order to obtain cheaper prices and maintain its revolving fund for FP commodities (Bolivia Country Note 2015: Section 4.3: 23).

In ***Cambodia***, UNFPA has supported work with adolescents, garment factory workers and entertainment workers rooted in a rights-based and empowerment approach, which favours the social sustainability of the programmes, implemented among these vulnerable and sometimes marginalised groups. In ***Bolivia***, UNFPA has made an important contribution to **cultural and social sustainability** through its empowerment of indigenous groups and adolescents and has adapted its strategies to variability in the political environment (Bolivia Country Note 2015: Section 4.2: 21). In ***Nigeria***, UNFPA has mobilised and involved reproductive health gatekeepers to overcoming the socio-cultural resistance to family planning and adolescent sexual reproductive health (ASRH) (UNFPA Nigeria 2012b: 55).

There are some examples of **exit strategies**, particularly with respect to reducing the role of UNFPA as a provider of contraceptives for government programmes. In ***Bolivia***, UNFPA made three major contraceptive donations during the evaluation period, the last two (funded by GPRHCS) being used as seed capital to establish a revolving fund for contraceptive purchase in *CEASS*, the national procurement and supply agency. UNFPA has worked with *CEASS* to establish a ring-fenced fund, which will be an important contribution to sustainability. The fund can only be used for contraceptive purchases, and will be replenished by the income resulting from *CEASS* sales to the municipalities (Bolivia Country Note 2015: Section 3: 11-13, Section 4.7: 31-35). In ***Kenya***, UNFPA was lauded for using a participatory and consultative approach to programme design and implementation, however, the design of the 7th CP did not plan for an eventual "hand-over" and no systems or structures were put in place to support hand-over; therefore the level of programme sustainability was considered to be low (UNFPA Kenya 2013).

EQ3: To what extent has UNFPA acted as a broker at global, regional and country levels to promote family planning, acting in partnership with the public, private and non-state sector service providers?			
Assumptions for Verification	**Indicators**	**Sources of information**	**Methods and tools for the data collection**
3.1: At the global and regional level, UNFPA promotes FP repositioning as an essential component of SRHR services through	• Evidence of the role of UNFPA within the RH Supplies Coalition, FP 2020. • Evidence of UNFPA advocacy for FP programming in One-	• Documents • International key informants	• Literature review • International key informant interviews

partnership with state and non-state actors.	UN plans and with other organisations and initiatives		

According to global KIs, there was **a shift in UNFPA efforts to promote FP repositioning midway during the period 2008-2013**. Key points elicited from across several global development partners are below:

- Evidence of a shift towards increased attention to FP is the successful advocacy to ensure there is explicit reference to FP in the Sustainable Development Goals.
- UNFPA was encouraged to participate in FP2020, and to his credit, Dr Babatunde Osotimehin "stepped up to the plate". Donor pressure on UNFPA to support FP in more visible terms was strong. The BMGF provided a "transition grant" of funding to foster support for FP. The Hewlett Foundation funded the CDG to prepare recommendations for the incoming director about strategy and focus moving forward (CGD 2011)
- There is **a difference before/after the appointment of Dr Osotimehin**; before UNFPA support for FP was much more diffuse and some felt it was seen as a "non-priority." Some KIs perceive this to be the long-term consequence of the Cairo agenda and feel it is still a struggle at the heart of things. However, Dr Osotimehin is credited with providing very strong support for FP2020 as a critical priority for UNFPA, although some wonder if he has the power or authority to make it happen at the field level. UNFPA is a bit unwieldy; as one KI put it, "What don't they do?" Since Dr Osotimehin has been there, timing with the London conference, he has done a good job to make a more explicit argument for FP within development and for youth/young generations.
- In the FP2020 universe, UNFPA is seen as followers more than leaders or as one KI put it, "*passengers, not drivers.*" FP2020 is trying to leverage UNFPA, rather than the other way around. The FP2020 theory of action is to support countries to make commitments and then gaps are filled through brokering through focal points (typically, focal points are a team of UNFPA, USAID and government officials). FP2020 is working through the focal points so that wheels of action move. UNFPA interest and engagement is perceived to be keenly dependent on personalities.
- One area where UNFPA should be commended is in their support for the International Conference on FP. For the first three conferences, it has been instrumental in getting ministries and their entourages to the conference and the COs in host countries have helped with logistics. They have been a very good partner and collaborator on this effort, which has contributed a lot to the increased visibility of and commitment to FP globally.
- Data revolution in FP is underway through FP2020 focus on results. UNFPA is behind the curve on this, given **lack of results orientation**. UNFPA must carve out a clear strategic direction and then demonstrate how it makes a contribution and use to see its program – could be an important leader on certain issues, i.e., human rights-based approach (HRBA) in FP, but not without a clear commitment to results monitoring and evaluation.

UNFPA partnerships with USAID: UNFPA signed a memorandum of understanding (MoU) with USAID in 2014 so that both organizations could work together and take advantage of the global momentum for family planning (USAID and UNFPA 2013). USAID and UNFPA have common strengths, including an extensive field presence, long history implementing FP and SRH programmes. Although each organisation responds to different political mandates there can be synergies to advance the mandate and strategic priorities of each organisation. The MoU supports increased collaboration technically at the global level (for example on adolescent RH issues, High Impact Practices (HIPS)) and through increased coordination at the field level. This coordination is enhanced by the FP2020 governance structure where both UNFPA and USAID are country focal points. The March 2015 meeting in Istanbul of country focal points provided the opportunity to work together and KIs say it is beginning to pay off.

- USAID and UNFPA work very differently. USAID does not have the same access to the government; it is more project-focused. Both have strengths – better to collaborate and coordinate. USAID was on the technical advisory group for the UNFPA FGM evaluation; was surprised to see so little operations research.
- On the High Impact Practices (HIP) group: UNFPA is seen as a critical to HIP. UNFPA has provided a strong field perspective, and helped to define HIPs that are practical and applicable to country programmes. UNFPA should be focusing on utilization and dissemination of knowledge and evidence. HIPS are rarely documented by UNFPA. Their contribution is in critical as they fund country and regional staff to attend the technical advisory group (TAG) – they bring a unique field perspective and help to shape the content in ways that the researchers and global technical participants do not.
- The partnership has been useful to both UNFPA and USAID, and has helped to challenge the orthodoxy of certain programme practices through the use of evidence briefs. While USAID is seen as having stronger technical depth overall, UNFPA is seen as stronger of issues related to ARSH. UNFPA, WHO and USAID collaborated on a recent review youth friendly services and co-authored a paper on what doesn't work in ASRH (Chandra-Mouli, Lane et al. 2015). HIP is now part of the UNFPA-USAID MOU as opposed to a separate, parallel activity.

UNFPA-WHO Strategic Partnership Program: UNFPA funded WHO to update guidelines in country. The intent was to get more collaboration than usual at the country level and harness WHO expertise in the guidelines and ability to adapt, since UNFPA does not have the capacity. WHO made significant progress in the development of guidelines yet the work stopped once guidelines were developed.

In 2014, **UNFPA signed an MOU with the BMGF** to outline how to work together in partnership to advance the goals set forth in the London Summit on FP in 2012. Areas of cooperation include supply chain management, expanding access to contraceptive technologies, development and implementation of national costed implementation plans, increasing FP demand and strengthening supply, FP policy and advocacy, advocacy with media and private sector and promoting young women's access and use of FP (UNFPA 2014h).

UNFPA is a key partner along with the BMGF, DFID, USAID, Norad, SIDA and CIFF, in **the "volume guarantee" initiative led by the Clinton Health Access Initiative** (CHAI). This effort was begun in 2012 when DFID requested CHAI assistance to support ongoing discussions with implant producers and to explore reductions in the prices for Jadelle (US$18) and Implanon (US$16.50). Through this programme, CHAI identified guarantors to provide financial backing to share the risk with BMGF in order to negotiate a volume guarantee based agreement with suppliers. This resulted in a reduction in price to US$8.50 per unit by both Bayer and Merck in return for commitments over six years (CHAI 2015).

The **"Pledge Guarantee for Health"** (PGH) is an innovative financing partnership designed to increase the availability and predictability of funding from international donors for health commodities. Through a five-year partial guarantee from the governments of the **United States and Sweden**, PGH is able to leverage $100 million in credit from commercial banking partners, which, in turn, extend short-term credit to traditional donor aid recipients. Recipients are empowered to use committed donor funding in advance of disbursement, resulting in increased buying power, greater value, accelerated procurement and delivery, and, ultimately, more lives saved (UN Foundation 2012). UNFPA cannot participate directly in the PGH scheme because it cannot take out credit; however, UNFPA assisted the Government of Philippines to use the PGH approach of using commercial banks to bridge financial procurement of essential commodities (GHD 2014). KIs from NGOs and other DPs are disappointed that UNFPA has not supported an initiative for large NGO buyers and others supplied by UNFPA to get credit on the basis of pledged donor support to UNFPA.

At the regional level, **UNFPA partnered with PATH** in 2013 to conduct two workshops to develop "road maps" for a **total market approach for SRH and FP** in the Eastern Europe and Central Asia region. These workshops brought together country teams representing FP or RH programming divisions of the ministry of health, UNFPA, financing responsibility for health, and NGOs such as an IPPF affiliate or social marketing group, to develop action plans for implementing a total market approach through the establishment or maintenance of a coordination mechanism for public and private financing for FP services (UNFPA 2013f).

In terms of its reputation as a partner, KIs indicated that **UNFPA can be "bureaucratic and slow to move**, and initiatives work better if UNFPA finances and works with other partners to implement." One KI noted *"UNFPA is involved in all discussions and meetings but slow to move and with high inertia when there are actually things to do. It tends to be too slow and risk-averse, maybe due to its own bureaucracy and unwillingness to step on other people's toes. This inertia can actually hold things up and slow others down (e.g. one example is the lack of support for a pledge guarantee offshoot proposal for NGOs who are supplied by UNFPA to get credit for purchases on the basis of pledges for donor support to UNFPA itself)."*

3.2: At the country level, UNFPA COs brokered partnerships between public agencies, CSOs and private sector entities to promote FP and its integration with other SRH programmes.	• Number and type of partnership agreements, MOUs. • Range of partners (government, CSO, private sector).	• Documents • Desk study key informants • External stakeholder survey respondents • UNFPA country office survey respondents • Case study country notes for Bolivia, Burkina Faso, Cambodia, Ethiopia, Zimbabwe	• Literature review • International key informant interviews • Desk study key informant interviews • Group discussions • Site visits

The **GPRHCS thematic fund has served as a major mechanism** through which UNFPA Country Offices have supported national FP policies and strategies and has improved country level coordination by and capacity within the public sector for securing essential RH supplies and ensuring their use (UNFPA 2014i).

Bolivia: UNFPA plays a role in two major coordination forums whose members give UNFPA credit for linking organisations that would otherwise not have worked together to promote SRH and FP. UNFPA is seen as enabling the voice of CSOs be heard by the government, and has brokered relationships between the MoH and large NGOs (MSI and the Centre for Research Education and Services (*Centro de Investigación Educación y Servicios* - CIES) who now carry out FP training for government health staff. UNFPA has also been a key actor in brokering and fostering joint promotion of FP by the ministries of health, education, justice, autonomy and planning and development; for linking the HIV programme with the FP procurement system; and cooperation between relevant UN agencies (UNFPA, PAHO, and UNICEF), providing the UN agencies more leverage with the government. UNFPA has been selective in its support to NGOs, choosing those which work in its priority areas and which do not prejudice its neutral and apolitical position. KIs felt that the CO could do more to advance a total market approach and broker better coordination among government, NGO and private sector groups to advance national procurement and FP programming (Bolivia Country Note 2015: Section 4.1: 17, Section 4.3: 21-23).

Burkina Faso: Governmental and non-governmental partners consider UNFPA to be a key, strategic actor for FP and SRH issues. UNFPA actively participates in the two major platforms for FP repositioning – the Ouagadougou Partnership and the *Plan de Relance,* the costed implementation plan for FP. CO leadership is somewhat behind the scenes, as it supports the MoH capacity to convene and coordinate its FP programme through various technical and other committees. The current strategy for the 7th Country Programme foresees the strengthening of partnerships with NGOs and CSOs as a means to extend UNFPA geographic and technical reach (UNFPA 2015a). UNFPA is currently supporting 20 capacity-building NGOs, which, in turn support 160 community-based organisations in FP service delivery. By increasing its partnership portfolio, UNFPA is better able to support local approaches across different contexts, but also to increase the voice and engagement of CSOs within the FP programme. NGO and government partners credit UNFPA with successfully advocating for the inclusion of a budget line for contraceptive commodities and for brokering the introduction of Sayana Press, and the approval of pilots to explore social franchising and the delivery of Sayana Press by community health workers. In addition, UNFPA brokered the engagement of CSOs to receive government funding under the *Programme d'Appui au Développement Sanitaire* - PADS). However, partners receiving UNFPA financial support complained about cumbersome and bureaucratic processes as a major weakness that provide a major challenge for expanding and brokering additional partnerships. Partners also noted a gap in UNFPA capacity to convene and broker the exchange of information, data and experiences, leading to duplication of efforts and missed opportunities to collaborate and advance some issue or programme area (Burkina Faso Country Note 2015: Section 4.3: 24).

Cambodia: UNFPA makes good use of its comparative advantage as a policy and advocacy agent, at national as well as at sub-national levels. As a member of the UN system and with its close working relationship with the government, the CO is able to advance partnerships among development partners, NGOs and government stakeholders, sometimes at the programme level but most importantly as a key player in a vast number of coordination forums and working groups. KIs and external evaluators credit UNFPA with having brought partners together from diverse corners and bridged differences between government entities and other partners, including at the 2014 National FP Conference entitled "Choices not Chance" the purpose of which was to promote the government's engagement with and commitment to FP2020. "*UNFPA is credited for having comprehensive approaches to problems, highlighting larger contextual factors, and bridging divides among ministries and partners. UNFPA's success is attributed to a combination of trust, long-term credibility, and close government relationships*" (Shah 2010: 7).

UNFPA played a key role in securing the commitment of the government of Cambodia to establish a first-ever separate budget line for contraceptive procurement in the national budget. This required advocacy with the MoH and assisting the MoH to make its case towards the ministry of Economy and Finance. It also contributed to RH being included in the Health Sector Support Project I (RGoC 2010). Areas where stakeholders want to see stronger UNFPA leadership include awareness creation around availability of safe and legal abortion services in public facilities, especially in light of increased unintended pregnancies among youth; (continued) increased advocacy with parliamentarians; strengthening support to make contraceptive information and services available for youth; and knowledge generation, such as research on user perspective on FP, monitoring progress and identifying challenges to be addressed.

Ethiopia: Given the long-standing nature of technical working groups in Ethiopia, UNFPA is seen as actively participating in, rather than serving as broker of, government and DP partnerships. However, UNFPA has brokered partnerships between the Federal MoH and other ministries to work on determinants of FP demand, including gender work with the Ministry of Women, Children and Youth Affairs (MoWCYA), and programmes for young people with the former Ministry of Youth, Sport and Culture. KIs in government, DPs and civil society all noted opportunities for

UNFPA to broker closer and more horizontal partnerships between the private sector, NGOs and government. This is however hampered by the current context of government restrictions on NGO activities. UNFPA has made a start on brokering partnerships among NGOs, the private sector and government as part of a total market approach to improve the efficiency and cost-effectiveness in commodity supply. UNFPA also supported the 2012 National FP Symposium which was a good opportunity to showcase and promote FP work, and was key in providing support to the government in the hosting of the ICFP 2013 in Addis Ababa (Ethiopia Country Note 2015: Section 4.1: 14, Section 4.3: 18).

Ethiopian NGOs and bilateral DPs would welcome UNFPA taking on a more proactive brokerage role in such areas as: problem-solving between government and NGOs, advocating on behalf of NGO interests and government-private sector partnerships. They also expressed the wish that UNFPA help partners across different directorates and levels within the government, for example between the Federal MoH and Population and Development Directorate of the National Planning Commission to promote male participation in FP which is of interest and strategic importance to both ministries (Ethiopia Country Note 2015: Section 4.3: 18).

Zimbabwe: Stakeholders and partners recognize the comparative advantage of UNFPA with regard to its role in supporting public sector capacity and service provision in FP, and in particular for its support to the Zimbabwe National FP Council (ZNFPC). UNFPA has leveraged this role to support repositioning of FP in partnership with USAID and DFID, and helped to broker involvement by two US technical assistance groups, FHI360 and the Futures Group (now called Palladium), to support the development of a gap analysis, which will inform the development of Zimbabwe's costed implementation plan. DPs are looking to UNFPA to broker a frank dialogue with the government on the revitalization of ZNFPC capacity to lead and coordinate the FP programme and enable it to strategically support the implementation of the National Family Planning Strategy 2015-2020. KIs indicated there is broad consensus that ZNFPC should be restructured to strengthen its training and certification, knowledge management and coordination functions (Zimbabwe Country Note 2015: Section 4.3: 18).

In ***Zimbabwe***, UNFPA also helped to mobilise resources from other donors to complement the USAID contribution for the Demographic Health Survey (DHS) and to identify donors to fund the census. In addition, UNFPA brokered the joint assessment of SRH and HIV linkages with IPPF and the Ministry of Health and Child Care (MoHCC), which fed into the design of the Integrated Support Programme (ISP), discussed in greater depth under EQ 1. One issue raised by KIs was whether there was an inherent conflict in the dual role UNFPA plays as an implementer of programme activities as well as in the coordination of others (Zimbabwe Country Note 2015: Section 4.3: 19).

Uganda: UNFPA helped play a broker role via the FP2020 committee where it brought together partners to support the development of the costed implementation plan. UNFPA is considered by KIs to be influential and has a political role in advocacy, information and convening.

Nicaragua: Promoting collaboration between NGOs and the Government is difficult, due to centralist government policies and the political history of many NGOs. The meetings UNFPA arranged between the Government and NGOs ceased in 2013, according to DPs, UNFPA invests in partnerships at a local, rather than national level, which is easier; however, the Government tries to dictate who they can work with.

Nigeria: As a broker, UNFPA advises the Federal MoH and supports various State MoHs; due to the size of Nigeria making an impact as a whole is unrealistic therefore a more focused effort on various states has been the focus of activities. UNFPA emphasizes the need to broker. For example, UNFPA used advocacy to get an FP basket fund established, to which several donors contribute.

Rwanda: KIs note that UNFPA works with Government and NGOs at a national level and at district level in a Joint Action Development Forum; UNFPA brokerage happens via technical working groups, of which it chairs the group on FP.			
3.3: The visibility of UNFPA is sufficiently high at global, regional and country levels to bring together potential partners to increase commitment to family planning.	• UNFPA and other stakeholders and partners recognise the comparative advantages of UNFPA, its positioning and its potential contribution at global, regional and country levels, and respond to UNFPA initiatives in bringing them together • UNFPA participation and role in policy forums, networks, and other partnership mechanisms.	• Documents • International key informants • Desk study key informants • External stakeholder survey respondents • UNFPA country office survey respondents • Case study country notes for Bolivia, Burkina Faso, Cambodia, Ethiopia, Zimbabwe	• Literature review • International key informant interviews • Desk study key informant interviews • Group discussions • Site visits
On **global leadership to reposition FP**, KIs noted that there is a notable increased in visibility for family planning in general. Due to the increased profile of FP, many multilateral and bilateral organizations and donors in addition to foundations are competing to increase their image in response to FP and to offer leadership and strategic vision. UNFPA co-chairs FP2020 with BMGF. With evolving global set-ups, KIs noted **it is not clear whether UNFPA is appropriately positioned**. Some felt it was important for UNFPA to be a lead actor in FP2020 as it provides a good balance to the foundation from within the UN system. UNFPA should play a complementary role with WHO as the latter is the one that should be generating the basic knowledge and hard-core evidence about what works/what doesn't work. UNFPA should be one of the key recipients and users of that evidence – if they can help to translate that evidence base into guidance for country programs – that would be great for more effective FP. There is a great opportunity from a knowledge management perspective to play this role as WHO doesn't have the same level of programming/infrastructure to do that as UNFPA does. **UNFPA could be an effective knowledge broker for latest and best evidence. However, several KIs noted this is not the case**. Other comparative advantages mentioned by global KIs: • **UNFPA is known for being inspirational, but not results oriented.** Data revolution in FP underway through FP2020 focus on results. There is an opportunity for UNFPA to more effectively participate in generating data and lessons on FP. UNFPA must carve out a clear strategic direction and then demonstrate how it makes a contribution through its programming -- could be an important leader on HRBA in FP, but not without a clear commitment to results monitoring, evaluation to generate and knowledge. • UNFPA is not at the forefront as a leader in rights-based approaches and implementation. They "talk the talk," but **in terms of operationalizing a HRBA, it is not clear "what they are doing about it"** – there is no program or initiative. • One of UNFPA strengths is they have the ear of Ministries of Health – that is who ministries listen to. People familiar with the work of UNFPA see them **as a voice for women's health globally**. Potential to be a convener and advocate with country governments.			

- **UNFPA has a strategic advantage, but they are not using it**. They could do program assessments (using any framework) to support investment in x, y, or z areas, to push on things that are not popular. If UNFPA does not "step up to the plate" then WHO might. WHO is trying to take on FP leadership although they do not have the in-country capacity/networks to do so.

With regard to **UNFPA visibility at the country level** (from country case studies):

Bolivia: UNFPA has a high profile and sufficient visibility at country level to broker relationships among key actors in SRH and FP, and has used its position effectively. The **leadership role played by UNFPA is widely recognised by all members**; they give UNFPA credit for linking organisations that would not otherwise have worked together to promote SRH and FP. NGOs consider UNFPA to be a key organisation to represent the forums, enabling their voice to be heard at government level ("*UNFPA knows how to support government and negotiate*").[1] It has brokered working relations between the MoH and the large FP NGOs (Marie Stopes International (MSI) and Centre for Research Education and Services *(Centro de Investigación Educación y Servicios* (CIES)) who now carry out FP training for government health staff (Bolivia Country Note 2015: Section 3.3: 21).

Burkina Faso: UNFPA has been the **major partner of the MoH and has supported overall coordination of FP and leadership by the MoH** via the (RH) Technical Committee. KIs appreciated UNFPA for allowing the MoH to take the lead and to focus its attention on capacity-building and providing behind-the-scene support. UNFPA is seen as being critical to advocacy efforts, as the CO has the ear of the MoH and the **capacity to broker difficult issues**. UNFPA is highly visible in contraceptive security efforts and for brokering CSO involvement in the FP programme. However, several of the activities it supported (National FP Week, support for mobile services, introduction of Sayana Press) were not explicitly attributed to UNFPA but to the partners it supported on these activities. This may reduce its overall ability to influence. Likewise, given its position and visibility, partners noted that **UNFPA could be more strategic about disseminating results** of their work and the work of others for advocacy and to scale up effective approaches and interventions (Burkina Faso Country Note 2015: Section 4.3: 25)

Cambodia: UNFPA has good visibility ("*even though that is not their intention,"* as one partner said) due to its **strong technical role, position of trust with government and openness to work with both government and civil society**. Partners recognise these comparative advantages, combining key advocacy and technical assistance, generating leverage and influence with government (Cambodia Country Note 2015: Section 4.3: 24). Also, UNFPA gained credibility by developing evidence for debates on reproductive health and by combining activities both at policy and operational levels. "*Government representatives are particularly enthusiastic about UNFPA's contributions, explaining that UNFPA's mandate supports national programs in a way that fosters their independence and development. Rather than pushing an agenda on ministries**, UNFPA listens and responds, identifying feasible solutions and explaining what can and cannot be supported**. For this role as advisor and collaborator, UNFPA is much appreciated*" (Shah 2010: 7).

Ethiopia: UNFPA has contributed to family planning promotion at the East Africa regional level through encouraging and supporting Ethiopia hosting important international and regional events. This has put Ethiopian family planning achievements in the spotlight, which, in turn, has contributed to promoting efforts at national level. UNFPA has **good visibility and a closeness to government (prerequisites for brokerage) at federal level**, largely due to its work in RHCS, but less so at the decentralised regional level. A stakeholder mapping exercise conducted by the USAID project K4Health in 2012 identified USAID, the US Centres for Disease Control and Prevention (CDC) and UNFPA as the major funding bodies, with UNFPA visibility at national rather than the *woreda* (district) level (Hailegiorgis, Harlan et al. 2012). Development partners agree that **there is a**

[1] Interviews with NGOs

need for brokerage of partnerships in FP at the regional level, yet UNFPA regional field offices have only one staff member who is principally engaged to liaise between implementing partners and may not have the skills needed for effective brokerage. Nevertheless, GPRHCS has enabled UNFPA to kick-start a higher level of involvement and partnership with the government; however, this focus has led other DPs and NGOs to think that **UNFPA FP work is concentrated on the supply side and commodity security**. UNFPA comparative advantage and capacity to address issues beyond commodity security, on the demand side or integration, have been less visible within the country (Ethiopia Country Note 2015: Section 4.3: 19).

Zimbabwe: UNFPA global **visibility on key issues related to SRH and HIV linkages and GBV** has supported the CO to serve as a broker and to convene partners and advocates for SRH and rights and for making the case for investment in GBV and adolescent SRH programming, including FP. UNFPA is most **visible on issues of commodity security**, with stakeholders considering UNFPA as a valued partner on commodity security, although USAID is playing the lead role through its support for the JSI Deliver project (Zimbabwe Country Note 2015: Section 4.3: 19, Annex 3, Assumption 3.3: 58).

Uganda: UNFPA is strongly associated with family planning through its participation in the technical working group led by the MoH with strong UNFPA presence. The Government respects and holds UNFPA in high regard while NGOs appreciate UNFPA and recognize its **specific comparative advantage, including the availability of complementary funding** to facilitate processes that other developing partners (DPs) cannot fund.

Tajikistan: the visibility of UNFPA is good; there is recognition from Government and national partners for its **leadership on FP and provision of RH services**. UNFPA is the only organisation (apart from the country IPPF affiliate) that supports FP; without UNFPA there would be major problems with training and implementation of WHO standards. UNFPA is involved in all strategies (via MoH-led working groups) and advocates on issues to which government often agrees; e.g. for 2014 the government agreed to make budget available for contraceptive commodities.

Nicaragua: UNFPA enjoys a strong visibility as a technical agency in FP. It has succeeded to position FP more strongly – e.g. in the **context of adolescent pregnancy and maternal mortality**. Among its successes: cheaper FP methods, sexuality education, attention for GBV, study on early unions. UNFPA is seen as **technically solid, proactive, but necessarily very diplomatic**. UNFPA has defended issues related to its mandate, around poverty, population, and SRH; and succeeded in positioning FP as essential for SRH.

Nigeria: UNFPA is visible and is considered a valued partner for the government at the federal and state levels. It is a major advocate for FP; other partners rely on UNFPA and its prominent position, its professional staff and leadership. **Examples of visible leadership include the task-shifting policy whereby intra uterine contraceptive devices (IUCDs)** can now we inserted by community health workers, a federal level costed implementation plan, and RHCS support for commodity procurement.

Rwanda: UNFPA is **a key partner for government and a leading partner on FP** and co-chairs the FP technical working group. UNFPA is recognised and visible, e.g. via its support for the health sector mid-term review (MTR), the FP strategic plan and the household survey. UNFPA has been visible at national level -- e.g. through support for the elaboration of FP policy documents, strategic plan, guidelines. The GPRHCS programme and UNFPA support for commodity procurement has been important since the London FP2020 summit.

Viet Nam: UNFPA is a **respected technical authority**. Government does not look at UNFPA for funding, but for its role as TA, based on the capacity of its staff and its neutral position. UNFPA can influence government policy, and other DPs and NGOs respect UNFPA for their role in FP.

EQ4: To what extent has UNFPA supported the creation of an enabling environment at national and community levels to ensure family planning information and exercise of rights?			
Assumptions for Verification	**Indicators**	**Sources of information**	**Methods and tools for the data collection**
4.1 UNFPA has identified key enabling factors in different country contexts and developed effective interventions to strengthen these	• Identification of enabling factors in CO annual reports • Interventions in CO plans at the national and community levels designed to strengthen the enabling environment • Evidence of enablers being strengthened at national and community levels (e.g. political commitment, community support) • Evidence of how enablers have facilitated strengthened FP information and services	• Documents • International key informants • Desk study key informants • External stakeholder survey respondents • UNFPA country office survey respondents • Case study country notes for Bolivia, Burkina Faso, Cambodia, Ethiopia, Zimbabwe	• Literature review • International key informant interviews • Desk study key informant interviews • Focus group discussions • Group discussions • Site visits

Enabling environment factors for FP emphasised by the external stakeholder survey participants, included institutional capacity of FP Providers (83 percent), political commitment (69 percent), policy and legal framework (64 percent) and community attitudes (59 percent). To a similar question with a slightly different listing, UNFPA country offices responded: government policy (85 percent), institutional capacity (88 percent), community attitudes (76 percent) and legal framework (58 percent). Both respondent groups thus largely agree on the most important factors.

Examples of a **favourable policy environment and government commitment** can be found across almost all field visit case study countries.

- In ***Burkina Faso***, there is an enabling environment for family planning at the legal and policy levels. The country has many policies and plans that promote access to contraceptive information and services. The new national health policy (*Plan National de Développement Sanitaire* - PNDS), the Strategic Plan to Secure RH Commodities and the Integrated Communication Plan (*Plan Intégré de Communication* - PIC) give priority to promoting FP. The monitoring mechanisms in place to monitor the *Plan de Relance*, including the annual indicators produced by PMA2020 are enabling factors for maintaining the focus on and commitment to FP (Burkina Faso Country Note 2015: Section 4.4: 25).

- In ***Zimbabwe***, the national policy environment for family planning has improved as a result of the re-emergence of FP as a development priority, followed by increased levels of donor

engagement to support the Government of Zimbabwe FP2020 commitment. Moreover, the stabilisation of the economy and of the health sector (following its near collapse during the political crises of 2008/9) has been an important positive factor in the enabling environment (Zimbabwe Country Note 2015: Section 4.4: 20).

- The legal and policy environment in ***Bolivia*** is favourable for FP, but there have been problems in putting laws and policies into practice. During the period under evaluation, the political environment has been complex due to changing levels of support for FP at different governmental levels (central, departmental and municipal) and at different points in time. The political environment has been further complicated by the administrative structure and decentralisation of responsibility for implementation of health programmes including FP to departmental and municipal levels (Bolivia Country Note 2015: Section 4.4: 23, Section 4.7: 31).

However, the **legal environment** is less favourable in several countries.

- In ***Ethiopia***, aspects of the legal and policy framework affect FP programmes in the NGO sector. Advocacy activities of NGOs which receive foreign funds are restricted by the Charities and Societies Proclamation, and discussion of rights-based approaches are limited to supply-side considerations of quality and range of services; this is important in *Ethiopia* where NGOs are significant providers of FP information and services, especially for VMGs and other hard-to-reach groups, and have had an important role in advocating for and supporting FP policy development in the past (Ethiopia Country Note 2015: Section 4.4: 21). In *Cambodia*, the government initiative to pass a law, ultimately adopted in August 2015, to regulate NGO operations, was not received favourably by civil society organisation and development partners (Cambodia Country Note 2015: Section 4.4: 25).

Limitations on family planning policy operationalisation due to community attitudes are encountered in all field visit case study countries, especially with respect to rural and more traditional communities. Despite the progress made in *Burkina Faso* and *Bolivia*, the lack of support or active resistance from community-level political, religious and cultural leaders are a challenge. Although Bolivian national ownership of family planning is embodied in the laws, policies and the basic health package, there are important political groups that actively oppose it at all government levels and in some communities. These include pro-natalist groups who feel that *Bolivia* needs a higher population, and some traditional indigenous leaders in areas where fertility is highly esteemed.
In the other counties, community opposition is aimed at the young and unmarried. In *Cambodia*, unfavourable rural community attitudes make adolescents and unmarried women shy away from seeking contraceptive services. Challenges also exist at the community level in *Zimbabwe*, especially in relation to the needs of adolescents. There is a long-standing stigma against young people's sexual activity and childbearing outside of marriage. Parents and providers fear that providing unmarried teens with SRH information will lead to increased sexual activity, contributing to girls' vulnerability to unintended pregnancy and HIV and STI infections.

Social pressures reported on at community level in *Ethiopia* are two-dimensional. On the one hand, they restrict access for young people. HEWs and Health Development Army (HDA) volunteers are important community leaders and it may be difficult for unmarried young people to approach them if they feel they will risk community disapproval, or wish for privacy. On the other, the work of the HDA leads to more accepting attitudes among community members, although this may be based on ethically questionable strategies: the work of HEWs and the HDA at community level by some is seen as going beyond a reasonable effort to address and change social norms and risks, becoming coercive. There is evidence that women feel there is excess pressure on them to adopt a method, and many receive little or no information about alternatives.

The literature, including external UNFPA country programme and thematic evaluations, offers ample evidence that **UNFPA has invested in identifying key enabling factors** to advance the environment for FP, with reference to policy development and national plans, political commitment, budget allocation, human resources strengthening and improving sustainability (UNFPA Burkina Faso 2009, UNFPA 2011d, UNFPA Bolivia 2011a, UNFPA Niger 2012, MoFA Netherlands 2013). International KIIs confirm this, as do the field visit country case studies.

Evidence of **UNFPA-initiated effective interventions to strengthen enabling factors** abounds. The external stakeholder and country offices surveys (results below) show that both respondent groups emphasise the same type of factors as having been strengthened and also the same factor (legal reforms) as having received less attention.

External Stakeholders' survey

Has UNFPA worked to strengthen enabling factors during the period 2008-2013 through (tick all that apply)?		
Answer Options	Response Percent	Response Count
Support to Government policy development	76,8%	185
Support to Legal reform	31,1%	75
Institutional capacity building	75,1%	181
Community-based work on attitude change	61,0%	147
Other	6,2%	15
None	1,2%	3
Not sure	7,1%	17

Country Office survey

What has UNFPA done to strengthen these enabling factors related to family planning during the period 2008-2013 (tick all that apply)?		
Answer Options	Response Percent	Response Count
Support to government policy development	91,2%	52
Promote or raise the profile of family planning egg through advocacy within the health sector	91,2%	52
Promote or raise the profile of family planning with other sectors beyond health (e.g. education, environment, etc.)	77,2%	44
Support to legal reform	40,4%	23
Institutional capacity building	96,5%	55
Community-based work on attitude change	89,5%	51
Knowledge management (e.g. research, use of evidence, best practice)	82,5%	47
Nothing	0,0%	0
Other	7,0%	4
Answered question		57

The review of documents, including a series of independent external evaluations, confirms that UNFPA has developed and implemented effective interventions to strengthen the enabling environment for FP, in areas such as supply systems, budget allocation, general knowledge on population and rights and community mobilisation (UNFPA Burkina Faso 2009, UNFPA 2011d,

UNFPA 2011e, UNFPA Myanmar 2011, UNFPA 2012d, UNFPA Niger 2012, MoFA Netherlands 2013, UNFPA 2013e, UNFPA Ethiopia 2013).

The UNFPA GPRHCS 2013 report is explicit about the role UNFPA as leading towards an enabling environment: *"[it] contributes to establishing an enabling environment that helps partners to do their good work. For example, advocacy efforts have contributed to stronger policies, strategies and laws; national allocations to procure contraceptives; and the establishment of national coordinating bodies"* (UNFPA 2014e: 49). In addition, it concludes that the GPRHCS-supported countries demonstrate political will and commitment resulting in **establishing budget lines for RH/FP commodities** (Ibid). Other examples of UNFPA contributions include:

- In ***Cambodia***, advocacy efforts were key to ensuring government agreement to establish a budget line for FP commodities in 2014, with relatively modest amounts allocated in 2014 and 2015, but leading to assuming the full cost of annual contraceptive procurement as from 2016 onwards (Cambodia Country Note 2015: Section 4.3: 20).
- In ***Niger***, UNFPA advocacy efforts led to the government establishing a budget line for essential drugs that included RH/FP commodities, with a budget that quadruplicated between 2007 and 2012 (UNFPA Niger 2012).

Interventions related to strengthening the FP-related enabling environment **are largely similar across countries and include advocacy and policy development support**. Examples are:

- In ***Bolivia***, UNFPA has been a leading protagonist of inclusion of FP in health laws and policies and in the social security scheme. It has worked with the MoH to strengthen understanding of FP at all levels and to encourage commitment at municipal level (Bolivia Country Note 2015: Section 4.4: 24).
- In ***Uganda***, UNFPA invested in strengthening the enabling environment for rights-based FP. This was done through revision of relevant policies, support for FP planning and forecasting and for increased government budget allocation for contraceptives (United Nations 2009: 2-3, UNFPA Uganda 2010b: 5, UNFPA 2013a: 13, UNFPA Uganda 2014c: 3-4).
- In ***Burkina Faso***, UNFPA provided technical support and contributed to the development of strong policies by the government. To this end, it conducted advocacy with policy makers, parliamentarians and opinion leaders at central and decentralized levels, to mobilise resources and commitment for FP. The CO aligned its own programme to contribute to implementation of these plans and policies and in an attempt to close the gap between policy and implementation. An example of this alignment was the shift by UNFPA to expand its scope from three regions in the 6th CP to national in the 7th CP. UNFPA adopted a partnership strategy to extend its reach and coverage, which contributed to improving both capacity (supply) and socio-cultural barriers (demand) (Burkina Faso Country Note 2015: Section 4.4: 26).
- In ***Zimbabwe***, UNFPA was instrumental in improving the policy environment for ASRH, through the generation of key data on young people, advocacy campaigns and support for the development of policies that address issues related to parental notification and provider bias against adolescent use of SRH services, including contraception (Zimbabwe Country Note 2015: Section 4.4: 21).

UNFPA country offices opt for different positions **when the legal environment curtails civil society activities**.

- In ***Cambodia***, the government initiative to pass a law on associations and NGOs to regulate their operations generated concerns that it could be used to limit human rights-related NGO activities. UNFPA took a public stance, together with other United Nations organisations, in favour of civil society and critical of the government in the management of the process around the draft law on associations and nongovernmental organisations, especially regarding the lack of transparency and consultation (Cambodia Country Note 2015: Section 4.4: 27).
- In ***Ethiopia***, advocacy activities of NGOs that receive foreign funds are restricted by the Charities and Societies Proclamation and there are also regulatory obstacles to NGO and

private sector service providers, which many consider unnecessarily demanding. UNFPA has not taken a stand on these issues or advocated with government for review of the restrictions of the CSO law or for implementation of a rights-based approach (Ethiopia Country Note 2015: Section 4.4: 21).

- In ***Bolivia***, the number of NGOs has reduced significantly in the last few years due to increasing government restrictions and control over their activities. In this context, UNFPA has been selective in its support to NGOs, choosing those that work in its priority areas, and which do not prejudice its neutral and apolitical position vis-à-vis the government (Bolivia Country Note 2015: Section 4.3: 23).

Burkina Faso and *Tajikistan* are case study countries where UNFPA has contributed to advocacy for increased **engagement of the private sector** in FP provision. In Burkina Faso, this led to approval for MSI to launch a social franchise network to partner with private health providers to offer FP services. UNFPA in *Uganda* focused on the needs of adolescents and other VMGs, in partnership with ministries, civil society and the private sector (UNFPA Uganda 2010b: 14). In the Eastern Europe and Central Asia (EECA) region, international KIIs learned that the RO has taken steps to promote a total market approach (TMA) as a strategy for sustainability ministries, NGOs and the private sector. More broadly, for the years 2008-2013, 20-25 COs (out of 62 surveyed) stated that family planning in the private sector (including social marketing, social franchising) was among the family planning interventions supported by them. At global level, UNFPA in 2014 signed an MoU with the BMGF for cooperation on several areas, including advocacy with private sector on FP-related interventions.

To strengthen the enabling environment for FP, **UNFPA support focused primarily at policy level rather than programmatic level**.

- In ***Burkina Faso***, UNFPA has worked at policy levels, but there remains a gap between policy and implementation, due to a limited capacity to provide quality contraceptive services and information, including a broad method mix, at all levels in the health system (Burkina Faso Country Note 2015: Section 4.4: 27).
- In ***Bolivia***, UNFPA has focused its work on strengthening the enabling environment at policy level, with a limited contribution at programmatic level. UNFPA has supported specific studies such as those of the SRH needs of adolescents and indigenous groups cited earlier. However, UNFPA has not supported development of methods to overcome the lack of reliable data at national level (i.e. major national data bases, such as DHS and census), and information is not available to measure results of this work or its impact on the availability of FP information and the exercise of rights to use services (Bolivia Country Note 2015: Section 4.4: 24-25).
- In ***Cambodia***, interventions were more focused on policy than implementation level; this implied limited attention for increasing the availability of quality SRH and FP service for adolescents and unmarried women and men (Cambodia Country Note 2015: Section 4.4: 27-28).

Regarding **knowledge generation**, for better enabling the FP environment in *Ethiopia,* as an example, UNFPA has contributed to this for specific groups such as young people, through identification of needs and obstacles to access, and has followed up its research with support for programme development. In *Cambodia*, UNFPA is increasingly generating evidence on a number of topics, including FP client needs and satisfaction. This indirectly contributes to insights as to the role of a rights-based approach, and UNFPA has used this to advocate for rights issues with the government and other stakeholders.

4.2 UNFPA has successfully supported partners at country and community levels to	• Identification of enabling factors in CO annual reports	• Documents • International key informants	• Literature review

improve demand creation and access to services, thus enabling people to exercise their rights better	• Interventions in CO plans at the national and community levels designed to strengthen the enabling environment • Evidence of enablers being strengthened at national and community levels (e.g. political commitment, community support) • Evidence of how enablers have facilitated strengthened FP information and services	• Desk study key informants • External stakeholder survey respondents • UNFPA country office survey respondents • Case study country notes for Bolivia, Burkina Faso, Cambodia, Ethiopia, Zimbabwe	• International key informant interviews • Desk study key informant interviews • Focus group discussions • Group discussions • Site visits

Strategies to improve family planning uptake at community-level are similar across several of the field visit case study countries. In *Ethiopia*, UNFPA has worked with other ministries on the social determinants of demand for FP. Commitment by community and institutional leaders is a key factor in creating an enabling environment for take-up of FP services. This is supported through the HDA networks and HEWs. In *Cambodia*, use of modern FP methods has increased in the past decade. This has been the result, in part, of behaviour and awareness raising interventions including media interventions and community-based awareness creation on and distribution of contraceptives. It is worthwhile noting that for this purpose, village health support group volunteers have been engaged by the MoH and NGOs for distribution of FP methods. These volunteers are supposed to be supported and coordinated by public facility health staff – but on average may receive little support or guidance. Incentives are limited or non-existent (Cambodia Country Note 2015: Section 4.4: 26).

For the years 2008-2013, 43-48 COs (out of 62 surveyed) stated that **support to demand creation activities**, through social and behavioural communication, was among the principal CO interventions and usually in the top-3 of top-5. A similar number of COs, over these years, indicated that they supported improved access to family planning services for vulnerable and marginalized groups.

The literature review confirms this and offers a number of evaluation examples of UNFPA support for demand creation and improving access. The UNFPA maternal health thematic evaluation noted that, to improve access and utilisation of FP, several countries received UNFPA support to generate demand in rural and remote areas, employing mobile clinics and voucher schemes to promote access to family planning (UNFPA 2011e). The Arab States Regional Programme 2008-2012 evaluation found that the partnerships with NGOs for VMGs increased demand for SRH/FP services and facilitated experience sharing and support (Thompson, Basil et al. 2013). In Mongolia, "*UNFPA's support (…) [has] improved availability and accessibility of high quality RH services integrated with STI/HIV prevention measures in the remote rural areas for especially disadvantaged groups of people*" (UNFPA Mongolia 2010: xiii). Taking a cost-effectiveness perspective, UNFPA has worked with country governments, such as in *Ethiopia* and *Burkina Faso*, to emphasise the need to stimulate demand for cheaper methods (Chattoe-Brown, Braddock et al. 2010). The UNFPA strategic plan progress report (2013) "affirms that young people's access to SRH services was improved via strengthening of country capacity to scale up youth-friendly services" (UNFPA 2014j).

In case study countries, demand creation support mostly focused on mass media or were community-based; often these strategies were combined:

- In ***Uganda***, "demand creation activities supported by UNFPA including multimedia campaigns and door to door campaigns by [village health teams] and faith based organisations (FBOs) increased awareness about family planning services. Following these efforts, 77,997 new family planning clients were served" (UNFPA 2013a: 11).
- In ***Sudan***, government combined both, as radio and national TV programmes were supported to increase awareness on RH issues, which were then complemented by community awareness sessions. The CO also supported RH advocacy and awareness rising initiatives at the community level in five states, targeting policy makers, religious leaders, media professionals, youth coalition, and teachers (UNFPA Sudan 2008: 20). Also, work towards integration of HIV and SRH in some states improved access to and uptake of SRH/HIV services, including FP and condom distribution.
- In ***Tajikistan***, UNFPA has played a leading role in making family planning available and has supported access to contraception without restriction.
- The CO in ***Burkina Faso*** made a shift in the demand generation and behaviour change communication strategy, from a focus on mass media (through radio, films, information talks) to a community-based strategy, that features interpersonal communication and engagement with local religious and community leaders, addressing socio-cultural barriers to FP utilisation (Burkina Faso Country Note 2015: Section 4.4: 27).
- In ***Cambodia***, UNFPA contributed to socio-cultural sustainability through its support for community-based demand creation and distribution of contraceptives (via NGOs) in a number of provinces (Cambodia Country Note 2015: Section 4.4: 26).
- The FP and SRH programmes that UNFPA has supported through government and civil society implementing partners in ***Bolivia*** have included empowerment, non-discrimination, equity and access to FP as key elements (Bolivia Country Note 2015: Section 4.6: 29).
- UNFPA in ***Zimbabwe*** has made contributions to improved access to services. Within FP, the CO works to improve **method choice** and address access barriers for adolescents and youth (Zimbabwe Country Note 2015: Section 4.6: 26).
- The ***Ethiopia*** CO has made an important contribution to tangible results on access and method mix. Where remote rural and nomadic populations have poor access to all health services, including SRH/FP, this is addressed by UNFPA through a joint outreach programme with the CHAI. It has also supported community mobilisation initiatives through engaging traditional clan and religious leaders in facilitating social change processes to address harmful traditional practices, gender-based violence, SRH, and HIV prevention, but has not focused specifically on FP at community level. Here, as in ***Nigeria***, UNFPA worked with the government on the social determinants of demand for FP and barriers to access (Ethiopia Country Note 2015: Section 4.4: 21-22).

Evidence on the **effect of community-based interventions** is limited and available evidence is contradictory. The UNFPA maternal health thematic evaluation concluded that UNFPA contributed to the scaling up and the increased utilization of and demand for family planning commodities (UNFPA 2012j), through communication, community mobilisation, research and CSO partnerships (UNFPA 2011d). Likewise, other reports and evaluations indicate that most GPRHCS priority countries effectively invested in FP demand generation (UNFPA 2011a, FP2020 2014a, UNFPA 2014e, UNFPA 2014j). Meanwhile, a study in *Zimbabwe* (Valadez and Schwarz 2011) concluded that CBD-served areas performed no better than non-served areas, across a range of indicators. In *Cambodia*, the community-based distribution programme is seen as not being very effective overall (Cambodia Country Note 2015: Annex 3, Assumption 4.2: 73-74). In *Burkina Faso*, the contribution of demand activities to specific results or outcomes was difficult to assess, as UNFPA reports generally provide information at the activity and output level. Meanwhile, partners considered the community-based strategy as promising and likely to address persistent access barriers (Burkina Faso Country Note 2015: Section 4.4: 26).

EQ5: To what extent has UNFPA focused on the family planning needs of the most vulnerable and marginalised groups, including identification of needs, allocation of resources, and promotion of rights, equity and access?			
Assumptions for Verification	**Indicators**	**Sources of information**	**Methods and tools for the data collection**
5.1 UNFPA – globally and at country-level – performs situation analyses to identify needs, challenges and rights violations, and to identify good practices on how to address these	• Evidence of gender-sensitive needs assessment of target groups for UNFPA supported interventions including identification of rights violations • Availability of accurate and sufficiently disaggregated data for targeting most vulnerable and marginalized groups • HQ/RO TA visits to support assessment, design, implementation, monitoring (including results-oriented monitoring) and evaluation of interventions to address the needs of VMGs • Evidence that good practices have been identified and disseminated	• Documents • International key informants • Desk study key informants • External stakeholder survey respondents • UNFPA country office survey respondents • Case study country notes for Bolivia, Burkina Faso, Cambodia, Ethiopia, Zimbabwe	• Literature review • International key informant interviews • Desk study key informant interviews • Focus group discussions • Group discussions • Site visits

Evaluation data sources reflect that KIs and case studies **identified a series of VMGs at global and country level**.

VMGs	KIs	Field visit case study countries					Desk case study countries						
		Bol	Bur	Cam	Eth	Zim	Nic	Nig	Rwa	Sud	Uga	Taj	Vie
Adolescents, young people	X	X	X	X	X	X	X	X	X	X	X	X	X
Urban and/or rural poor	X	X	X		X	X		X	X				
People in remote and rural areas		X	X	X	X					X	X		

Ethnic minorities and indigenous pop. (incl. nomadic people)		X		X	X		X			X			X
Internally displaced pop., other people in humanitarian settings	X		X	X	X			X		X	X		
People living with disabilities			X		X				X		X		X
Migrants, other mobile pop.					X							X	X
PLHIV			X		X	X							
Sex workers					X	X				X	X		
MSM										X	X		
Sexual minorities		X									X		
Survivors of violence												X	
Women at high risk												X	
Military personnel											X		
Married people											X		
Unmarried people					X								
People of African descent							X						
Women with fistula			X										

Sources (field visit countries)
Bolivia (Bol)
Burkina Faso (Bur)
Cambodia (Cam)
Ethiopia (Eth)
Zimbabwe (Zim)

Sources (desk study countries)
Nicaragua (Nic): UNFPA Nicaragua 2012: 99
Nigeria (Nig): UNFPA and NGO staff
Rwanda (Rwa): DP staff
Sudan (Sud): UNFPA staff
Uganda (Uga): UNFPA staff, (UNFPA Uganda 2010b: 3)
Tajikistan (Taj): NGO staff
Viet Nam (Vie): UNFPA and NGO staff

Examples of **needs identification and situation analyses undertaken by UNFPA** abound. Several international UNFPA KIs confirm this and refer to different VMGs (adolescents, people living with HIV (PLHIV)) and issues (equality). Document review generated more evidence, at the EECA, and Asia and the Pacific (AP) regional offices and country levels. The Lebanon CP evaluation found that

UNFPA undertook extensive analyses of population dynamics among vulnerable groups (among people living with disability, female heads of households, older adults) (UNFPA Lebanon 2014). In Kenya, a 2012 evaluation concluded that UNFPA had supported a national sex work situation analysis (UNFPA 2012e).

The case studies almost without exception offered additional examples and **all countries addressed the situation and needs of young people. Other groups received less attention**.

- In ***Bolivia***, UNFPA leads on work with young people and adolescents, notably the National Survey of Youth and Adolescents indicating that 52% of adolescents have received some sexuality education, but 57% of sexually active adolescents do not use any method. When on parental health insurance, parents have to accompany their children and this represents a major barrier for uptake of services by adolescents. UNFPA has done work through NGOs on other VMGs (sex workers and PLHIV). It supported studies with indigenous groups, which have focused on understanding their perceptions of FP and maternal health, and obstacles to their use of services as well as the role of traditional birth attendants with these groups. Understanding and evidence from the studies was used to contribute to formulation of intercultural policies in MoH to improve access of indigenous groups to SRH services. UNFPA supported an MoH study of masculinity and HIV in Bolivia (Bolivia Country Note 2015: Annex 3, Assumption 5.1: 62-63).
- In ***Burkina Faso***, focus of situation analysis is mostly focused on adolescents and youth to address issues of access to services, early marriage, FGM, gender-based violence, the SRH needs of handicapped youth. A study (Guttmacher, 2004) found that though many programs and services exist for adolescents, certain barriers keep adolescents from taking advantage of these services. These include fear of being judged, fear of going to a health clinic where they might be known, insufficient youth friendliness of clinics. Parental restrictions also pose a barrier to adolescent use of health facilities. These findings were confirmed in other documents and an FGD. Other support provided included emergency response, and situation assessment of people living with disabilities (Burkina Faso Country Note 2015: Section 4.5: 29, Annex 3, Assumption 5.1: 66).
- In ***Cambodia***, UNFPA has supported studies on teenage fertility, unmet need for FP and comprehensive sexuality education. Research has been commissioned on the SRHR of migrant garment factory workers and on urban poor, but CO staff indicates that more situation analysis is needed regarding VMGs (Cambodia Country Note 2015: Section 4.5: 30).
- In ***Ethiopia***, a problem is that VMGs are defined differently by different agencies and for different types of interventions and that government implements programmes in support of the whole population based on equity. But an analysis carried out by UNFPA on FP and maternal health needs of VMGs found differences between regions with respect to quality of care, facilities, workforce and commodities. Development partners mention that UNFPA does not share its (global) evidence with government and other stakeholders, although it has showcased best practice in (inter)national meetings (Ethiopia Country Note 2015: Annex 3, Assumption 5.1: 63 and Assumption 5.1: 64).
- In ***Zimbabwe***, the CO is conducting a study on youth fertility to better understand FP needs and has analysed census data to identify trends in child marriage. Support has been given on generating evidence on young people, comprehensive sexuality education, youth friendly service provision, reaching disadvantaged youth and promoting youth leadership and participation. Support for youth friendly corners has not been efficient and effective (Zimbabwe Country Note 2015: Section 4.5: 22-23, Annex 3, Assumption 1.3: 43 and 5.1: 65-66).

In ***Nicaragua***, a qualitative study looked at SRH-related practices and meanings, among indigenous women and youth living in the Caribbean coast; it aimed to determine factors and motivations influencing SRH decisions (UNFPA Nicaragua 2012: 99). Other countries performed needs assessment and studies among youth **(*Sudan*)**.

In a number of countries, **situation analyses focused on themes relevant for VMGs**. In ***Rwanda***, KIIs indicated that research supported by UNFPA asked why contraceptive prevalence rate (CPR) is not increasing while unmet need remains high among VMGs. FP access for VMGs and related barriers were studied in *Nigeria*, according to UNFPA staff; while in ***Sudan***, UNFPA staff indicated that UNFPA in 2013 supported a national knowledge, attitudes and practice study.

The situation analysis mentioned above have resulted in available data on FP needs for targeting VMGs in ***Bolivia*** (especially adolescents and young people, indigenous groups and sexual minorities) which is recognized and used by professional bodies, VMG organisations and widely disseminated in country for advocacy purposes (but not enough to other countries) (Bolivia Country Note 2015: Annex 3, Assumption 5.1: 62-63). In the other countries, data collection focussed mostly on adolescents and youth, but not on other VMGs (Respective Country Notes).

None of the country case studies refers to the **provision of TA visits** to support assessment design, implementation, monitoring (including results-oriented monitoring) and evaluation of interventions to address the needs of VMGs.

Regarding **UNFPA support for the collection and sharing of best practices**, the various evaluation data sources generated few results. In this context it is worthwhile considering the (ASRO) regional programme evaluation 2008-2012, which found, in general (so not specific for FP or VMGs), **a lack of attention for documenting best practices.** "*There is however need to document the advocacy processes employed and the best practices developed and this is not being done in all cases. The lack of adequate documentation compromises ASRO ability to maintain institutional memory in order to build on lessons learned and to adequately trace the impact of the advocacy initiatives within the countries involved*" (Thompson, Basil et al. 2013: 8-9). Also in ***Cambodia***, work on identification of best practices and interventions that have proven to be effective remains underdeveloped (CN/ analysis, Cambodia)

5.2 UNFPA allocates resources to effective and targeted programming for the most disadvantaged groups	• Number and type of program interventions targeted to VMGs • Per cent of total budget allocations to partner activities which focus on VMGs	• Documents • International key informants • Desk study key informants • External stakeholder survey respondents • UNFPA country office survey respondents • Case study country notes for Bolivia, Burkina Faso, Cambodia, Ethiopia, Zimbabwe	• Literature review • International key informant interviews • Desk study key informant interviews • Focus group discussions • Group discussions • Site visits

Evaluation results from all sources (surveys, country case studies, international KIIs and literature review) coincide in terms of bringing **convincing evidence to confirm the assumption that UNFPA has allocated resources for targeted programmes for VMGs**.

- In ***Bolivia***, work with indigenous women has included research on their needs, support for advocacy and activities aimed at empowerment. Work with young people focused on participation and empowerment and promotion and support to the development of differentiated services by the MoH. Other VMGs such as transsexuals are targeted in HIV

programmes implemented by NGOs and also the promotion of VMG rights. There has been no analysis of the effectiveness of programmes for VMGs, although data on access and use of services will be available when analysis of the 2014 DHS is completed. Other stakeholders recognise UNFPA as the leader in work with adolescents (Bolivia Country Note 2015: Section 4.5: 25-27, Annex 3, Assumption 5.2: 64).

- In ***Burkina Faso***, the promotion of SRH among adolescents and youth occupies a prominent place in the annual work plans, but is more focused on advocacy for SRH needs and rights and support to information campaigns (mainly for condom distribution and use) than on actual implementation of youth services. As the CN mentions "UNFPA has made its mark more clearly in the policy and advocacy realm, whereas it is more difficult to determine how access to FP information and services has been improved (in general and for VMGs specifically) as a result of programme implementation" (Burkina Faso Country Note 2015: Section 4.5: 29). UNFPA teamed up with the German GIZ to adapt health facilities to better serve youth, but this did not go beyond pilot phase. A programmes focuses on meeting the SRH needs of youth living with disabilities is still in early stages, but the work plan included training of educators and supervisors of special schools on life skills building, establishment of youth centres and special BCC materials (Burkina Faso Country Note 2015: Section 4.5: 28).
- In ***Cambodia***, UNFPA has invested in programmes to improve services for youth (through the Ministry of Health) and migrant garment factory workers and sex workers (through NGOs). Impact of the youth-friendly services is deemed to be limited, due to persisting socio-cultural issues at community level and quality and provider-attitudes in public facilities. Several stakeholders expressed the view that UNFPA should do more for adolescents – evidenced by CDHS reported increase in teenage pregnancies. UNFPA also supports a programme on comprehensive sexuality education in schools in nine provinces, through the Ministry of Education, Youth and Sport and the *SMARTgirl* programme targeting 16,000 entertainment workers and addresses SRH, rights, HIV and FP, with mixed results - programme monitoring data show that on two out of three key indicators (consistent condom use with clients, abortion), program outcomes are worse than the 2013 behavioural surveillance survey average. The program scored better on the remaining key indicator (consistent condom use with sweetheart or husband). Despite efforts, UNFPA Cambodia itself stresses that "*Insufficient focus has been placed on vulnerable groups – migrants, factory workers, ethnic minorities, entertainment workers, PLWHIV and disabilities."* This is to some extent due to the MoH that UNFPA supports and that is not ready to focus on these groups – though NGOs are and they are also supported (Cambodia Country Note 2015: Section 4.5: 30, Annex 3, Assumption 5.2: 77).
- In ***Ethiopia***, UNFPA has supported FP programmes that focus on VMGs through NGO partners as they have better access to the marginalised groups than the public sector though UNFPA normally focuses on work with the public sector. They have supported work on young people with acute needs, including those in remote rural areas and pastoralist communities as well as urban communities, in four regions and Addis Ababa. The programme included capacity building for duty bearers and empowerment of rights holders (young people) including work with adolescents and pastoralists and support for access to comprehensive HIV services, capacity building for peer education and economic empowerment of sex workers. In all, support has focused on the supply side (strengthening service provision) rather than on the demand and rights to choose/services side (Ethiopia Country Note 2015: Annex 3, Assumption 5.2: 64-65).
- In ***Zimbabwe***, UNFPA has prioritized youth and sex workers (80% of the budget). Support for adolescent SRHR addresses all five prongs of the global ASRHR strategy: evidence based advocacy, comprehensive sexuality education, capacity development for SRH services, reaching disadvantaged youth and promoting youth participation and leadership – aiming for increasing youth voice, establishing a young people's network, building youth capacity in communication and advocacy - but outcomes are not well documented. The establishment of 73 youth-friendly services and staff training was supported but weak supervision and low priority attached to

these services by local health authorities challenged implementation. Another major challenge to monitoring results and contribution of UNFPA and other partners is the duplication of leadership and coordination across various programmes and projects – several KIs mentioned the need for mapping, especially with regard to youth activities. For sex workers, UNFPA supported a national sex worker programme, *Sisters with a Voice*, implemented by an NGO to provide HIV and SRH services to sex workers through a network of clinics (16 clinics as of mid-2013), including STI treatment, voluntary counselling and treatment (VCT), FP, male and female condom provision, primary care and assistance with referral to HIV treatment and care services (Zimbabwe Country Note 2015: Section 4.5: 23, Annex, Assumption 1.3: 44, Assumption 5.3: 68).

The allocation of resources for programming is also mentioned in each of the desk studies, through document review and remote interviews. These references include ***Tajikistan*** (focus on strengthening 21 youth centres and furthermore working with sex workers, MSM and PLHIV), ***Nicaragua*** (focus on indigenous people and adolescent girls (UNFPA 2011: 26), ***Nigeria*** (humanitarian action and focus on young people), ***Sudan*** (HIV work with MSM and sex workers, adolescent awareness programmes) and ***Rwanda*** (programmes for adolescents, international development partners (IDPs), MSM and sex workers). In ***Viet Nam***, the 2014 CP mid-term review concluded the CP is highly relevant to the needs of VMGs, in the context of persisting inequities among ethnic minorities, young people, PLHIV and other vulnerable groups (Goss Gilroy 2014). UNFPA in ***Uganda*** focused on the needs of adolescents, but also worked with uniformed forces, sex workers, displaced populations and disabled persons, in partnership with several Ugandan ministries, civil society and the private sector (UNFPA Uganda 2010b: 14).

Also in the survey, respondents are quite positive about the support for a number of VMGs; COs have a slightly higher opinion of the UNFPA efforts than external stakeholders. The results show that the top-six (any answer options attracting above 40 per cent response rates) are largely similar, i.e. respondents feel that UNFPA, during the period under evaluation, has supported programmes for adolescents, rural communities, the urban poor, unmarried people and sex workers. Internally displaced people and refugees (among COs), and PLHIV (among stakeholders) also score high. Beyond the top-six, also men who have sex with men (MSM), people living with disabilities and indigenous people attract similar response ratings across both respondent groups of 20-30 percent.

CO survey

In the period 2008-2013, has UNFPA allocated resources to support family planning programmes for any of the following vulnerable and marginalised groups (VMG) (tick all that apply)?		
Answer Options	Response Percent	Response Count
Adolescents	89,5%	51
Unmarried young people	64,9%	37
The urban poor	63,2%	36
Rural communities	96,5%	55
Men who have sex with men	29,8%	17
Sex workers	64,9%	37
Injecting drug users	10,5%	6
LGBTI	12,3%	7
Persons living with disabilities	29,8%	17
Indigenous people	26,3%	15
Internally displaced people or refugees	59,6%	34

Not sure	0,0%	0
Others	10,5%	6
None of the above	0,0%	0

External Stakeholders' survey

In the period 2008-2013, has UNFPA supported family planning and SRH programmes for any of these vulnerable or marginalised groups (VMG)? (tick all answers that apply).		
Answer Options	Response Percent	Response Count
Adolescents	82,8%	197
Unmarried people	48,3%	115
The urban poor	50,0%	119
Rural communities	69,3%	165
Sex workers	45,0%	107
People living with HIV	50,4%	120
Men who have sex with men	22,3%	53
Persons living with disabilities	23,5%	56
Indigenous people	20,6%	49
Internally displaced people or refugees	35,3%	84
Minority groups	21,0%	50
Not sure	8,8%	21
No	0,4%	1
Other (please specify)		4

A majority of independent evaluations and UNFPA internal reports, in a number of settings, also contribute evidence for the assumption that **UNFPA has put considerable efforts into effective and targeted programming for VMGs**.

- The Arab States Regional Programme 2008-2012 evaluation found that the regional programme offered technical support to partners for advocacy on SRH rights of vulnerable groups and youth; that partnerships with NGOs for such groups increased demand for SRH services and facilitated experience sharing and support; and that the programme raised awareness on the reproductive rights of vulnerable groups (Thompson, Basil et al. 2013). The 2012 thematic evaluation of adolescent SRH/FP in Humanitarian Settings) identified at least three countries where UNFPA supported adolescent SRH emergency preparedness interventions (Philippines, Tunisia and CAR) (Tanabe, Schlecht et al. 2012).
- A ten-country[2] review of UNFPA CP evaluations found that all CPs "*carried out interventions on young people with different levels of success*", although there was also a critical note. *"UNFPA has been strong in promoting young people's rights and strengthening their individual and institutional leadership capacities. Nonetheless, it is also important to harness this enthusiasm for addressing young people's sexual and reproductive health needs and rights, while not being too limited in our focus when "dealing" with youth issues"* (UNFPA 2014g: 15-16).
- Eight[3] out of 10 UNFPA country evaluations related to the period under evaluation found evidence for UNFPA active programming towards meeting VMGs needs. Groups targeted were

[2] These ten countries were: Bolivia, Costa Rica, Djibouti, India, Jordan, Lesotho, Moldova, Nepal, Sierra Leone and Sri Lanka

[3] These eight evaluations were for Bolivia, India, Kenya, Lao PDR (2), Lebanon, Mongolia, Pakistan, Rwanda and Uzbekistan (UNFPA Mongolia 2010, Seetharam, Sedlak et al. 2011, Thaver, Qureshi et al. 2011, UNFPA Bolivia 2011a, UNFPA India 2011, University of Aberdeen and Institute of Policy Analysis 2012, UNFPA Kenya 2013, UNFPA Lao PDR 2013, UNFPA Lebanon 2014, UNFPA Uzbekistan 2014).

many and varied, including sex workers, indigenous women, poor people, people in emergency situations, PLHIV and, quite often, adolescents and young people. • *"The evaluation concluded that (…) interventions targeting specific and often excluded vulnerable groups (such as sex-workers) were appropriate and timely and reflected the position of UNFPA"* (UNFPA Lebanon 2014: 13). • *"UNFPA's support (…) [has] improved availability and accessibility of high quality RH services integrated with STI/HIV prevention measures in the remote rural areas for especially disadvantaged groups of people"* (UNFPA Mongolia 2010: xiii). • *"A major section of the population that benefits from CP-7 programmes is poor, marginalized and vulnerable"* (UNFPA India 2011: 25). • *"UNFPA's efforts are more sustainable and there is a balance between the demand and services. They also cater to marginalized groups addressing gender and youth issues that are much needed but often neglected"* (Thaver, Qureshi et al. 2011: 340). A minority of evaluations found that **UNFPA did not do enough or achieved poor results**. Albeit not specific for FP, it can be considered significant that one 2013 donor evaluation of its overall support to UNFPA concluded that UNFPA "*does not seem to direct initiatives at key populations*" (MoFA Netherlands 2013: 18), and that it did not make enough efforts to reach VMGs. A 2012 Pacific Islands multi-country evaluation found that UNFPA targeting of vulnerable, at risk and marginalised groups needs to be better articulated in programme development, and that adolescent SRH advocacy wasn't sufficiently matched with concrete actions (UNFPA, SPC et al. 2012: 118). Several country evaluations, in ***India, Afghanistan and Cambodia***, reported disappointing findings, whereby **youth interventions were not successful, youth activities were not youth-driven or not implemented at all**; or no specific or long-term impacts of UNFPA efforts on minorities, marginalised or vulnerable groups were found (UNFPA Cambodia 2011, UNFPA India 2011, Anderson, Panchaud et al. 2014). "*UNFPA has demonstrated effort and activity but not impact for minorities or marginalized groups*" (UNFPA Cambodia 2011: 51). UNFPA reports on progress regarding the implementation of the 2008-2013 strategic plan offer mixed messages. In 2010, UNFPA found that "*UNFPA programmes have supported activities related to indigenous population groups, adolescent girls, HIV-prevention in sex work, migrant and ethnic minorities, and others. However, a systematic programming focus on marginalized and excluded populations is missing in most programme plans*" (UNFPA 2011b: 26). Later reports during 2011-2013 were more positive, yet also the 2011 still warned that "*youth programmes are under resourced and miss reaching marginalized girls (…). Reaching out to women living in rural areas and marginalized groups is challenging in many countries due to prevailing patterns of illiteracy and the lack of tools and resource persons able to work in local languages*" (UNFPA 2012g: 13, 16). One international KI shared that they felt that UNFPA has some good ideas and supports VMGs through several 'small projects', but that overall, **UNFPA has not taken a sufficiently strong leadership position through its own programmes, regarding how to reach and cater for the needs of VMGs**. "*UNFPA should be doing far more*" and, among others, increase scale and address political will (within UNFPA and/or partner countries).		
5.3 UNFPA promotes reproductive rights and supports capacity development to remove barriers and improve access, quality and integration of FP services with other services for	• Rights of, and services for VMGs actively promoted in advocacy strategies with specific attention to gender issues • Type of capacity building interventions to address service	• Documents • International key informants • Desk study key informants • External stakeholder survey respondents	• Literature review • International key informant interviews • Desk study key informant interviews

the most disadvantaged groups	barriers and improve access for, and enable exercise of rights by the most disadvantaged groups	• UNFPA country office survey respondents • Case study country notes for Bolivia, Burkina Faso, Cambodia, Ethiopia, Zimbabwe	• Focus group discussions • Group discussions • Site visits

- In ***Bolivia***, UNFPA has raised the level of awareness of VMG rights to FP services amongst both service providers and VMGs themselves, and has identified better ways to help VMGs exercise those rights (for example, UNFPA has supported programmes which empower adolescents, indigenous women and transgender women and promote informed discussion of their rights). Also, it has been a leading actor in keeping the rights of VMGs high on the public agenda, and in supporting programmes that ensure participation by VMGs in the early stages of design and implementation thereby enabling them to take the lead themselves. UNFPA provided technical support to the development of the National SRH Strategic Plan 2009-15 and the Strategic Plan to Improve Maternal, Perinatal and Neonatal Health 2009-2013 in which the rights of VGMs are firmly integrated. It also provided technical support to MoH to put the international conventions on rights of women and indigenous groups ratified by Bolivia into practice (Bolivia Country Note 2015: Section 4.5: 26, Annex 3, Assumption 5.3: 63).
- In ***Burkina Faso***, UNFPA has supported rights education and training and orientation of teachers, health workers, monitors of special schools and facilitators in literacy centres about the SRH needs of disabled youth. In response to the humanitarian crisis in 2008, UNFPA created an emergency dignity kit, the content of which includes sanitary towels, soaps cloth; an entry point to work on gender based violence. These kits were in high demand (Burkina Faso Country Note 2015: Section 5.3: 68).
- In ***Cambodia***, although UNFPA has made substantial contributions to promoting the sexual and reproductive rights of various groups. Support for capacity building of these groups and their active participation in programmes was still limited (CN analysis, Cambodia).
- In ***Ethiopia***, UNFPA has addressed rights issues on the supply side through GPRHCS and service provider training which aim to improve access to information and quality services and expand the method mix. These activities have been complemented by support for programmes on the demand side with other government ministries and NGOs which focus on determinants of rights, access and demand for family planning, including work on gender and empowerment, adolescents and young people, improved information and focus on VMGs (CN analysis, Ethiopia). However, DP state that UNFPA has not taken a strong stand on these issues although it has access to government which has little interest in a holistic rights based approach for VMGs (Ethiopia Country Note 2015: Section 4.6: 25, Annex 3, Assumption 5.3: 65).
- In ***Zimbabwe***, UNFPA supported a media workshop to train journalists and encourage constructive reporting about sex worker issues and to raise awareness about the 'Sisters with a voice" programme on HIV and STI prevention. The Young People's Network on SRH and HIV operates at national, provincial and district levels, and receives funding and technical support for network activities, including coordination meetings and advocacy. This network provides the "youth voice" to the ARSH coordination forum (Zimbabwe Country Note 2015: Section 4.5: 24.26, Annex 3, Assumption 5.3: 68).

Regarding the **promotion of VMG rights and needs**, the UNFPA CO and external stakeholder surveys results show a similar balance in the responses, across given options, by COs and stakeholders. The top-5 is exactly the same, albeit with COs estimating their own efforts as stronger than their stakeholder counterparts.

Country Office survey

Has UNFPA promoted the rights and needs of VMG in the following ways (tick all that apply):		
Answer Options	Response Percent	Response Count
Removing cultural, legal, geographical or economic barriers to family planning Access	82,5%	47
Addressing discrimination and stigma	64,9%	37
Improving quality	80,7%	46
Integrating family planning with other services	87,7%	50
Social mobilization and empowerment	71,9%	41
Other	3,5%	2
None of the above	8,8%	5
Answered question		57
Stakeholder survey		
Removing barriers to family planning access	63,0%	150
Addressing discrimination and stigma,	45,8%	109
Improving quality,	62,6%	149
Integrating family planning with other services	71,4%	170
Social mobilization and empowerment	50,8%	121
Not sure	10,9%	26
Other (please specify)	1	

Document review findings that found **VMG rights and capacity development interventions were mostly not FP-specific**. A Kenya CP evaluation found that UNFPA supported life skills and entrepreneurship building for adolescents and youth 'as a vulnerable group' (UNFPA Kenya 2013). The 2008-2013 strategic plan review identified UNFPA support for several relevant interventions, including girl rights (Loaiza and Liang 2013), capacity building to scale up youth-friendly services (the number of countries with this type of UNFPA support increased from 77 in 2011 to 101 in 2013) (UNFPA 2014k) and capacity building for sex workers to express their needs and 'have a voice' (UNFPA 2013c).

5.4 UNFPA actively encourages VMGs to participate in programme planning, implementation and monitoring and VMGs receive capacity building to this end	• Evidence for gender sensitive participation by VMGs • Evidence for UNFPA support for training in participation	• Documents • International key informants • Desk study key informants • External stakeholder survey respondents • UNFPA country office survey respondents • Case study country notes for Bolivia, Burkina Faso, Cambodia, Ethiopia, Zimbabwe	• Literature review • International key informant interviews • Desk study key informant interviews • Focus group discussions • Group discussions • Site visits

Many of the country case studies found that **UNFPA engaged with interventions to promote VMG participation and capacity development**.

- In ***Bolivia***, UNFPA was a pioneer and lead agency in supporting the active participation of VMGs in all stages of design and implementation, enabling them to take the lead themselves. It also contributed to the empowerment and agency of social movements and, specifically, indigenous women, towards public policy participation (UNFPA Bolivia 2011b). UNFPA invested considerably in capacity building for young people, transsexual women and other VMGs such as indigenous groups, focusing on leadership skills, programme design and resource mobilization (CN/ Evaluation Matrix, Bolivia).
- In ***Burkina Faso***, UNFPA does not have a consistent approach for proactively encouraging participation, including that of VMGs, in programming; however, some work through community-based and civil society partners includes participation and capacity-building (Burkina Faso Country Note 2015: Section 4.5: 28-29).
- In ***Cambodia***, UNFPA only indirectly (via implementing partners) supported VMG capacity development and participation in programme planning, but this is still limited in analysis. (Cambodia Country Note 2015: Section 4.5: 32). This is similar to the situation in ***Viet Nam***, as indicated by UNFPA staff interviewed. More directly, support was given towards empowering entertainment workers through their active participation and dialogues in national and sub-national forums.
- In ***Ethiopia***, there is no evidence that VMGs participate in the project cycle, but neither do any other users. At regional level, the government considers that no-one is marginalised as the target is 100 percent coverage of women of reproductive age (including adolescents, disabled, etc.) resulting in marginal attention to VMGs - UNFPA has not raised this issue with the government (Ethiopia Country Note 2015: Annex 3, Assumption 5.1: 64).
- In ***Zimbabwe***, UNFPA is supporting the set up of sex worker drop in centres where peer educators are trained and there is a new initiative to train FSW peer educators as paralegals, which is building up towards the FSW network doing their own outreach and support work around human rights and GBV independent of the host organization. There is little indication of active building capacity of youth beyond support for youth participation in advocacy, young people's networks and establishing a meaningful young people's voice in forums, as well as for workshop on communication and project management (Zimbabwe Country Note 2015: Annex 3, Assumption 5.4: 69-70).

Findings in the desk studies are:

- In ***Uganda***, VMGs were involved in a 2013 process that assessed the link between SRH policies, systems and service delivery (UNFPA 2013a: 14).
- UNFPA staff in ***Tajikistan*** indicated that UNFPA encouraged VMG participation via peer groups and 'Youth Voice' contests, but that resources were limited and more could be done.

The literature review offers a number of findings **for UNFPA encouragement of VMG participation in programmes and support for capacity development**, at global, regional and country level. The 2008-2013 Latin America and Caribbean (LAC) regional programme evaluation found that young people had received capacity building in order to enable them to participate in advocacy, policy dialogues and the programme cycle, so as to incorporate their rights and needs in national strategic plans (UNFPA 2013e). The Investing in Young People evaluation across ten CPs identified that young people were usually involved in 'participation mechanisms' (UNFPA 2014g). Through the Global Network of Sex Work projects, UNFPA supported strengthening their capacity to participate in the development of policies and programmes (UNFPA 2013c). Two independent 2011 CP evaluations (for ***Cambodia*** and ***Bolivia***) concluded that UNFPA had encouraged active participation of indigenous peoples (UNFPA Bolivia 2011a, UNFPA Cambodia 2011).

In ***Rwanda*** and also ***Sudan*** **young people were often targeted**, for capacity development on management via youth networks at national and State level (UNFPA staff interviews). Young

people in ***Nicaragua*** were offered capacity development activities, including young leaders training on leadership and social skills and personal growth training camps with university students, to strengthen young people's capacity to contribute to dialogue and programmes and negotiate the approval of youth plans with local authorities (UNFPA 2012a: 4, 15).

Sex workers are a second VMG that received more attention than others in terms of participation/empowerment and capacity building. This is mentioned for ***Rwanda*** and ***Nicaragua***, ***Cambodia***, where they participated in trainings to enhance their active participation in national and other forums. Such special attention for sex workers is confirmed by the 2013 strategic plan 2008-2013 progress report, which states that "*meaningful participation of sex workers in the development of policies, guidance, tools and programmes*" (UNFPA 2013c, Annex 7: 3). In ***Nicaragua***, other groups offered capacity strengthening were LGBTI people and PLHIV (UNFPA 2010a: 15).

5.5 Access to and utilization of services by VMG, according to their sexual and reproductive health intentions, has improved.	• Documented evidence on improved VMG access and utilization of services (link with area 1 - integration) • VMG user (women and men) satisfaction with service access and quality	• Documents • International key informants • Desk study key informants • External stakeholder survey respondents • UNFPA country office survey respondents • Case study country notes for Bolivia, Burkina Faso, Cambodia, Ethiopia, Zimbabwe	• Literature review • International key informant interviews • Desk study key informant interviews • Focus group discussions • Group discussions • Site visits

- In ***Bolivia***, There is no quantitative data available on access to FP services for different VMGs, although it is well documented that access for adolescents and young people is restricted by social attitudes as well as service provider bias. Access for indigenous women is also limited by cultural factors including their perception of the need for outside support in childbirth and their unwillingness to leave their families to travel to health facilities (Bolivia Country Note 2015: Section 5.5: 66-67). In the absence of reliable data, the impact of programmes on service use and user satisfaction for VMGs cannot be measured. However, information from interviews and focus groups suggests that access has improved, but UNFPA, NGOs and the MoH recognise that there are still major obstacles to overcome on the supply side, including poor availability of appropriate services and trained staff in the public sector facilities (Bolivia Country Note 2015: Section 4.5: 27).
- In ***Burkina Faso***, UNFPA has not developed information on improvements in access and utilization of services by VMGs, but information collected in this evaluation suggests that access has improved for youth and rural populations in general (Burkina Faso Country Note 2015: Section 4.5: 28-29).
- In ***Cambodia***, for youth-friendly services, the impact on uptake seems to be limited (except for married young women), due in part to persisting issues related to socio-cultural community and service quality (staff attitude). Impact on uptake of services for factory workers and entertainment workers is unclear. Many stakeholders interviewed, however, including several multilateral and bilateral development partners, do not see public services having the

comparative advantage to effectively provide adolescent-friendly services, and this may also apply to other VMGs (Cambodia Country Note 2015: Section 4.5: 29-31).

- In ***Ethiopia***, UNFPA has not supported monitoring of FP services by government and NGO service providers to ensure users are offered full information and to ensure there is no undue pressure to adopt any FP method. Government maintains that access has increased for the population in general, but there has not been any evidence generated for this (Ethiopia Country Note 2015: Section 4.6: 25-26).
- In ***Zimbabwe***, UNFPA has limited data to demonstrate improvements in access and utilisation of services; however, narrative reports indicate that programmes supported by UNFPA are reaching some VMGs with relevant and appropriate services. This applies to GBV services and sex worker services, but no evidence that measures increases in uptake of services (Zimbabwe Country Note 2015: Section 4.5: 23-24).

In several of the desk case studies, NGO, DP and UNFPA staff interviewed provided **some affirmation that access for VMGs has improved**. In ***Sudan*** this was said for young people and people in humanitarian situations, in ***Viet Nam*** for sex workers ("*but not much analysis has been done on whether the access has improved for VMGs overall*"), in ***Rwanda*** and ***Nigeria*** for VMGs in general.

Also literature review did **not yield much evidence to support the assumption that VMG access to and utilization of FP services improved**. One global evaluation concluded that young people's use of FP methods had increased, although unmet need had not declined (MoFA Netherlands 2013). In one state in ***India***, the 2011 CP evaluation found that, while UNFPA had supported adolescent-friendly health clinics, as part of government-run primary health care services, these had seen limited access and service quality; "*the intervention did not have much success*" (UNFPA India 2011: 8). To improve access and utilisation of FP, several countries received UNFPA support to generate demand in rural and remote areas, employing mobile clinics and voucher schemes to promote access to family planning (UNFPA 2011e). More broadly, the 2013 UNFPA strategic plan progress report "*affirms that young people's access to SRH services was improved via strengthening of country capacity to scale up youth-friendly services*" (UNFPA 2014a). **The scarcity of evidence of increasing access and uptake of FP services generated or shared by UNFPA** for the general population and specifically for VMGs, was also highlighted by one international KI.

EQ6: To what extent has UNFPA implemented a human rights-based approach to family planning, in particular regarding access to and quality of care, and through support from HQ and RO for a rights-based approach in country?			
Assumptions for Verification	**Indicators**	**Sources of information**	**Methods and tools for the data collection**
6.1 UNFPA staff and key partners have a shared understanding of the meaning and importance of a rights-based approach to FP	• Identification of definitions/descriptions of rights-based approaches • Perception of UNFPA and partners' staff of the meaning and importance of a rights-based approach	• Documents • International key informants • Desk study key informants • External stakeholder survey respondents • UNFPA country office survey respondents • Case study country notes for Bolivia, Burkina Faso, Cambodia,	• Literature review • International key informant interviews • Desk study key informant interviews • Group discussions • Site visits

		Ethiopia, Zimbabwe	

In 2003, the UN developed a **"Common Understanding" on how the UN system could mainstream the HRBA in its policies and practices** in development cooperation. In 2011 the UN developed a handbook on how to incorporate rights programming which serves as one of the main references on human rights programming in development activities (UNEG 2011). UNFPA mentions human and reproductive rights in the 2008-2013 strategy and supports the "*building of capacity to implement a rights-based approach in programming and policies at all levels from an ICPD perspective"* (UNFPA 2007: 10). Human rights is one of three principles in UNFPA sexual and reproductive health rights (SRHR) Framework (the other two are equity and participation, both critical to a rights-based approach) (UNFPA 2010c). The UNFPA 'Choice not Chance' strategy provides the most comprehensive and detailed articulation by UNFPA of a rights-based approach to FP, including the tenet that *"governments should monitor for and eliminate any use of incentives, targets or fee structures that incentivize health care providers to advocate for adoption of specific method, or for incentives to use contraception"* (UNFPA 2012c: 99).

UNFPA has defined a HRBA for programming and has conducted training for UNFPA staff and partners and has conducted training for UNFPA staff and partners from regional human rights NGOs. UNFPA reports that between 62 and 69 percent (in 2007 and 2010 respectively) of countries have incorporated reproductive rights in national human rights protection systems (UNFPA 2011b). In this manual, rights-based programming:

- Emphasizes the process as well as the outcomes of programming
- Draws attention to the most marginalized populations
- Works toward equitable service delivery
- Extends and deepens participation of those targeted by programs
- Ensures local ownership of development processes
- Strengthens accountability of all actors (Ibid).

The UNFPA Culture, Rights and Gender Branch developed a background paper for the 2014-2017 UNFPA Strategic Plan that put forward the evidence that the quality and effective implementation of policies and programmes for gender equality and human rights/reproductive rights contribute to the success of development programmes and have a direct impact on SRH outcomes. The paper called for **a "dual strategy" that mandates a HRBA and requires that gender equality be integrated across all disciplines and thematic areas and results** (UNFPA nd).

With the advent of FP2020 there has been an increase in concern among rights activists that international family planning would revert to days of quantitative "population" goals and that would have the effect of compromising human rights and contraceptive choice (Hardee, Kumar et al. 2014). WHO held a consultation in 2013 to review evidence to guide recommendations on HRBA in contraceptive programmes including a set of indicators and a framework (WHO 2014a, WHO 2014b). Other frameworks include the Voluntary Rights-based FP Framework (Hardee, Kumar et al. 2014) and FP2020 Rights and Empowerment Principles for Family Planning (FP2020 2014b).

WHO and UNFPA recently collaborated on guidance on how to operationalize human rights within contraceptive services, which was disseminated within UNFPA in 2015. The resulting document takes human rights standards as set out in WHO guidelines and identifies a set of program actions that can be used to operationalize these rights within FP programs. These action points (and the corresponding human rights principles) are noted below, along with some key questions gleaned from the document:

1. Ensuring access for all (non-discrimination)
    - What has been done to ensure equal access for all, including the poor, adolescent and youth, and other vulnerable populations (analysis, assessment, services, etc.)?

2. Commodities, logistics and procurement (availability)
    - Has information about unmet need, discontinuation, barriers to access and potential demand for different methods been used for forecasting?
    - What has been done to expand the method mix, address stockouts, improve provider capacity, and ensure political and financial commitment in support of a routine and sustainable logistics and procurement?
3. Organization of health facilities (accessibility)
    - Outreach for hard to reach populations (support for mobile teams)
    - Integration:
        i. With HIV
        ii. With antenatal and postpartum care
    - Youth-friendly/men friendly services
4. Quality of care (acceptability, quality, informed decision-making, privacy and confidentiality)
    - How does UNFPA monitor issues of quality (both clinical quality and informed choice) and/or support its implementing partners to do so?
    - What activities have been undertaken to support improved quality of care in contraceptive service delivery? (training, supervision, QI)
    - Is there a protocol in place about when/how to address and manage serious problems identified (especially regarding coercion, mortality)?
5. Comprehensive sexuality education (accessibility)
    - What has UNFPA done to advocate for and strengthen capacity to offer age-appropriate CSE?
6. Humanitarian context (right to accessible services)
    - What has been done to assess the demand for and access to contraceptive information and services and the extent of sexual violence in each setting and to respond to identified needs?
7. Participation by potential and actual users (participation)
    - To what extent has UNFPA conducted dialogues with relevant stakeholders, including community leaders; are there regular mechanisms in place for regular participation by communities? (UNFPA and WHO 2015).

Global key informants spoke about how UNFPA is in a unique position as the main champion of the ICPD agenda and of the sexual and reproductive rights enshrined within the Plan of Action. However, they also spoke of how **the reality of programmes does not match the human rights rhetoric** advocated at the global level. While UNFPA is a strong advocate for HRBA in international forums, at country level UNFPA sometimes shies away from addressing rights (e.g., *Ethiopia* - see assumption 6.2), although it was noted that UNFPA showed excellent leadership in pursuing rights in China, where the human rights and family planning context can be seen as challenging (see Assumption 6.2).

The vast majority (89.5 percent) of UNFPA CO staff surveyed stated that UNFPA implemented a rights based approach to FP. When asked about the focus of the rights-based work, CO staff provided the following responses, indicating that **access, quality and expanding choice (supply side interventions) are predominant foci**.

Country Office survey

What has been the focus of this rights-based work (tick all that apply)?		
Answer Options	Response Percent	Response Count
Improving access	100,0%	51
Improving quality of care	90,2%	46

Providing information and expanding contraceptive options	96,1%	49
Strengthening participation	72,5%	37
Strengthening accountability mechanisms	62,7%	32
Addressing stigma and discrimination	74,5%	38
Other	3,9%	2

The survey responses are consistent with an evaluation in 2011 of how UNFPA mainstreams gender and an HRBA in programming. "*Consulted **UNFPA staff members in the field had varying degrees of awareness of the corporate guidance** note on integrating gender equity, human rights and culture. However, all consulted staff members were generally familiar with the UNFPA corporate dedication to culturally sensitive programming, and its commitment as a UN agency to integrating gender equality and taking a human rights-based approach*" (Universalia 2011: vi).

The survey responses track with the findings from the country case studies, which indicate that there is a mixed understanding of the definition and/or importance of a rights-based approach to FP. Highlights of perceptions from case studies are below:

- ***Bolivia***: Discussion of a rights-based approach has emerged in the last ten years; previously, FP was considered a health service rather than a right. However, UNFPA has worked with civil society partners to advocate for a rights-based approach within the constitution. UNFPA has supported government publications to explain SRH rights (Bolivia Country Note 2015: Section 6.1: 67-68).
- ***Burkina Faso***: CO and partners staff gave varied definitions of what constitutes a HRBA, which were often associated with concepts such as quality of care, gender equality, and universal access and access to safe abortion (Burkina Faso Country Note 2015: Section 4.6: 31).
- ***Cambodia***: UNFPA and partners share a similar understanding of what a rights-based approach towards FP entails, focusing on equity, proper information, quality counselling and free choice from an expanded range of methods. This approach is well reflected in key public policies, towards all of which UNFPA has actively contributed involving both duty bearers and rights holders (Cambodia Country Note 2015).
- ***Ethiopia***: There is no explicit consensus among UNFPA staff, DPs, the Government of Ethiopia (GoE) and CSOs on the meaning and importance of a rights-based approach to family planning in Ethiopia. The government considers rights in FP mainly in terms of the right of access to effective, long-acting FP services for all. UNFPA supports this approach mainly through its supply side activities aimed at strengthening service provision (Ethiopia Country Note 2015: Section 4.6: 33-34).
- ***Zimbabwe***: Staff and partners working in GBV and HIV prevention activities were more likely to talk about the elements of a rights-based approach, particularly as it related to addressing the needs of adolescents and other vulnerable populations (sex workers) than staff working on RH/FP activities. For the latter, human rights are about expanding method mix and increasing access (Zimbabwe Country Note 2015: Section 4.6: 25).

Highlights from selected desk studies:

- ***Uganda***: UNFPA staff defines HRBA as focusing on accessibility, acceptability, affordability and quality of care. There is still work needed for the other stakeholders to understand it. Development partners noted that rights-based approach is about voluntarism, or voluntary choice, such that all individuals have the right to access FP services, with full information/ informed consent, without discrimination.
- ***Sudan***: UNFPA staff see HRBA as ensuring access to information, safe and confidential services.
- ***Viet Nam***: UNFPA defines HRBA in the context of FP as voluntary, autonomous decisions, informed choice, avoiding incentives, and coercion.

• ***Rwanda***: UNFPA defines HRBA in FP as ensuring choice, without restriction and no discrimination. According to development partners, the Rwandan government defines FP as a free choice, with good information; not "pushing people". Through its policies and programmes, the government tries to "convince" people to benefit from FP, but this also includes information about side effects. NGOs define HRBA as the right for all to FP, without discrimination, e.g. by age or sex, and respecting the rights of clients. • ***Nigeria***: UNFPA and interviewed partners see the HRBA as ensuring FP is voluntary, without coercion, well-informed decisions; involving qualified providers; choice from a range of methods; without major stock-outs. • ***Tajikistan***: UNFPA staff and development partners have a shared understanding of the meaning and importance of a HRBA to FP. HRBA is seen in terms of acceptability, access, quality, equality; and comprehensive services, free of charge services, with full information, and including a focus on rights of women. In the country, HRBA is seen as not limiting anybody's rights to FP services. The 2002 Law on RH (revised in 2014) allows all women to decide on children, services, fertility, although in reality, rights in terms of access has not been achieved.			
6.2 UNFPA programming incorporates human rights principles in the assessment, design, implementation and evaluation of FP programme interventions	• Evidence of a rights-focused needs assessment, quality assurance mechanisms, participatory processes and accountability mechanisms within programmes • Evidence of attention to barriers and protocols for addressing coercion • User satisfaction with family planning access and quality (women and men, VMGs)	• Documents • International key informants • Desk study key informants • Case study country notes for Bolivia, Burkina Faso, Cambodia, Ethiopia, Zimbabwe	• Literature review • International key informant interviews • Desk study key informant interviews • Group discussions • Site visits
In several country programme evaluations reviewed (*Afghanistan, Jordan, Zimbabwe*, Dutch speaking Caribbean countries), the terms of reference included attention to a human rights-based approach; however the **evaluation reports themselves included scant mention regarding whether and how the CO applied a HRBA approach** (Russell-Brown and Ramautarsing 2010, UNFPA Zimbabwe 2010, Excel Consulting Associates 2011, Anwari, Coupal et al. 2013). Other evaluations (e.g., *Lao* and *Pakistan*) noted progress in advancing a rights-based approach, but without further articulating the actions that led to this conclusion (Seetharam, Sedlak et al. 2011, Thaver, Qureshi et al. 2011). Evaluations of the UNFPA Egypt programme and of ARO capacity building efforts, taking a rights-based approach was associated with gender activities, such as the prevention of FGM/FGC, child marriage and other harmful practices (UNFPA Egypt 2011, The Bassiouni Group 2013). In *Nigeria*, evaluators summed up the issue well, e.g., *"operational dimensions of human rights based approach to programming were missing from AWPs, annual reports and similar documents and iconic **elements of HRBA** (evidence of training, use and or accent on the principles, norms and standards as well as support for the roles and responsibilities of duty bearers and claim holders, etc.) **were not commonly found in programme documents beyond the copious declarations found in the CPAP**"* (UNFPA Nigeria 2012: 17). The aforementioned (section 6.1) evaluation of UNFPA the mainstreaming of gender further stated, "Country Offices are obliged to work on all three of UNFPA priority areas, including gender,			

and to use a human rights-based approach, but **beyond this general expectation there are no corporate guidelines or standards regulating how this is put into practice**" (Universalia 2011: ix).

Regarding whether UNFPA sufficiently mainstreams HRBA in its work, 55 per cent of survey respondents for the Multilateral Organisations Performance Assessment Network (MOPAN)[4] rated the organisation strong or very strong overall, citing the 2010 training tool developed in collaboration with the Harvard School of Public Health, which provides guidance (supported by case studies) on how to implement/apply a HRBA in UNFPA programming in the areas of population and development, reproductive health and gender (UNFPA 2014i).

Regarding the UNFPA supported Asian Forum of Parliamentarians on Population and Development (AFPPD), an evaluation found that while AFPPD has a strong commitment to gender equality, its attention to human rights is mixed, due to the sensitivity among some Asian governments. Therefor the forum is not comfortable raising human rights in conference agendas or publications, thus missing an opportunity to address the issue. UNFPA, as the major financial supporter of the forum, is not getting a return on its investment regarding an issue of importance achieving the ICPD vision (Tobin and Wilkinson 2011).

In ***India***, evaluators called for UNFPA to urgently increase its advocacy against single method programming -- in this case, female sterilisation. *"It is imperative that UNFPA uses a farsighted, comprehensive and constructive advocacy programme to bring balance into the system. There is a need to gather, analyse and present national and international data that shows it is possible to achieve high contraceptive coverage and consequent maternal and child health objectives through provision of services that delivery a basket of choices suitable for all age groups and parities. Advocacy on this potentially sensitive issue is needed urgently"* (UNFPA India 2011: 38).

Some global KIs (development partners) opined that **it is difficult to have UNFPA move beyond human rights rhetoric and to operationalise and integrate HR principles and approaches within FP programmes**. UNFPA was seen as not doing enough to implement and document how to advance rights programming for FP specifically.

The following are highlights from country case studies on how UNFPA incorporates a human rights-based approach within FP programmes:

- ***Bolivia***: UNFPA has worked on **keeping rights issues high on the public agenda** through promotion and advocacy. UNFPA has contributed leadership and direction in rights promotion by working from both sides, empowering users to demand their rights, and strengthening the capacity of service providers to respond. It has used a holistic strategy, including FP within SRH rights, and has also contributed specifically to a rights-based approach to FP through financial support, production of materials and technical input to service provider training both directly and through training of trainers (ToT). The FP and SRH programmes that UNFPA has supported through government and civil society implementing partners have included empowerment, non-discrimination, equity and access to FP as key elements, in particular in projects with VMGs (e.g. indigenous populations) (Bolivia Country Note 2015: 4.6: 29-30).

- ***Burkina Faso***: Language about human rights is found within most of UNFPA plans and documents and is linked to the "Cairo Agenda", i.e. the ICPD in 1994. **UNFPA uses a rights frame in its programmes and advocacy**, e.g., SRH for disabled youth, SRH for adolescents and youth, fistula, humanitarian assistance, outreach to rural and underserved areas. Rights principles of empowerment, non-discrimination and equity underpin UNFPA activities, especially in its work with VMGs. However, **the CO has not undertaken a systematic effort to**

[4] MOPAN members included in the survey included HQ staff, donors, in-country and UNFPA direct partners.

assess and address the factors that support or hinder a HRBA for FP, except in its efforts to improve contraceptive choice by expanding the method mix. For example, there isn't systematic attention to quality assurance or voluntary choice, particularly in the context of results-based financing which include provider incentives for increasing FP uptake (Burkina Faso Country Note 2015: Section 4.5: 28-30).

- ***Cambodia***: Various UNFPA Cambodia programming documents and reports show **attention for a range of HRBA issues**, such as regarding the principles of reproductive choice and rights; accountability and responsiveness towards the needs and rights of all people; reproductive rights of sex workers; and human rights standards such as freedom from discrimination, coercion and violence. UNFPA supports interventions for a number of VMGs, with a focus on young people, migrant garment factory workers, entertainment workers and, increasingly, people living in poverty. UNFPA furthermore **flanks this with on-going empowerment strategies for women and young people**. However, the strong emphasis on long-acting methods results in a latent tension between method-specific promotion and ensuring voluntary choice Braddock, 2015 #4440: Section 4.6: 32-35}.

- ***Ethiopia***: High government FP targets at all service delivery levels, related to the overall goal of 66 percent CPR by 2015, and a focus on 'switching' users to long-acting methods, raise **concerns about possible pressure on users to adopt FP and/or opt for specific methods**. UNFPA has made an important contribution to tangible results on access and method mix, which are important aspects of a rights-based approach on the supply side; however, it has not contributed to the debate or alerted the government to evidence of pressure, despite its comparative advantages and close working relationship with the Federal Ministry of Health. **UNFPA has not taken a strong stand on SRH rights as discussions with the government** on human rights issues in Ethiopia are carried out jointly by the UN system, and other UN agencies have been nominated to take the lead (Ethiopia Country Note 2015: Section 4.6: 24, Annex 3, Assumption 2.6: 6970).

- ***Zimbabwe***: UNFPA is leading efforts in Zimbabwe at national, service and community levels to address gender-based violence and has **explicitly framed its gender work within a human right-based approach**. UNFPA has worked and made contributions to address sexual violence and exploitation, harmful traditional practices such as child marriage, improved access to services, and prevention and response to GBV. Programming for **SRH and HIV linkages includes components that address participation, empowerment and addressing stigma and discrimination**. Within FP, the CO works to improve method choice (adding long-acting methods and female condoms) and by addressing **access barriers for adolescents and youth**; however, there is little attention to other rights issues, such as quality assurance or monitoring voluntarism within the technical assistance provided to the public sector programme (Zimbabwe Country Note 2015: Section 4.6: 25-26).

The following are highlights from selected country case studies on whether and how UNFPA incorporates a human rights-based approach within FP programmes:

- ***Uganda***: UNFPA provided support to the ministry of health to incorporate human rights language into the FP costed implementation plan. This explicit language supports FP service availability within a rights frame that includes full, free and informed choice, respect for privacy and confidentiality, equality and non-discrimination, equity, quality, client-centred care, participation and accountability. HRBA is infused upstream in national documents, strategies and training manuals, but not seen as having been operationalised in practice.

- ***Rwanda***: Per CO staff, UNFPA supports a HRBA by working on the supply side to make a range of methods available. It also contributes to HRBA by improving quality via capacity

development, establishing youth-friendly services and strengthening monitoring and evaluation (M&E).

- ***Viet Nam***: The mid-term review of the 8th country programme looked at cross-cutting issues from a human rights-based approach, examining the steps taken by the Vietnamese government with the support of UNFPA to be inclusive of vulnerable groups and in realizing their rights. Moreover, it also noted persisting inequities, particularly in maternal health, family planning and contraceptives, among ethnic minorities, young people, people living with HIV and AIDS, and other vulnerable groups (Goss Gilroy 2014). With specific regard to FP, both KIs noted that UNFPA and partners have addressed issues with Government and MoH around the "draconian two-child policy" and it is currently leading the review of this, bringing partners together to address challenges in putting a more rights-based approach into practice at national and province/district levels.

- ***Tajikistan***: According to UNFPA and the government, UNFPA has played a leading role in making family planning available and increasing service quality in Tajikistan. In 2014, the Tajik government reiterated its commitment to the ICPD, and UNFPA has supported updates to the RH law, support for adolescent SRH and access to contraception without restriction.

- ***Sudan***: According to the 5th Country Programme Evaluation (UNFPA Sudan 2012b), UNFPA followed the HRBA in working with the government and development partners to define specific population issues and to design the RH, Population and Development (P&D) and Gender programme, mainly through its focus on gender. The report talks about monitoring United Nations Development Assistance Framework (UNDAF) implementation, progress towards implementing the ICPD PoA and other outcome reports as the main evidence of UNFPA advancing and operationalising human rights.

6.3 UNFPA is developing a body of evidence and lessons learned regarding human rights-based approaches for FP	• Identification of evaluation and research and/or briefs on lessons learned related to human rights-based programming	• Documents • International key informants • Desk study key informants • Case study country notes for Bolivia, Burkina Faso, Cambodia, Ethiopia, Zimbabwe	• Literature review • International key informant interviews • Desk study key informant interviews • Group discussions • Site visits

UNFPA conducted its first **Universal Periodic Review** (UPR) in 2006 with the intention to conduct it every five years (UNFPA 2014c). The UPR is a mechanism established by the UN General Assembly to review the fulfilment by each UN Member State of its human rights obligations. The UPR is **a good measure of the gap between the commitment to rights and actions taken to fulfil them**. The outcome of the UPR is a set of recommendations made to the State under Review (SuR) and the response of the SuR to each recommendation. Of the 22,000 human rights recommendations made, only 25% relate to SRHR, and within these, only a handful related to FP, despite the relevance of the topic within SRHR (presentation by Luis Mora, Chief of Culture, Rights and Gender Branch, October 2014). *"A total of 13 recommendations made specific reference to contraception or family planning. Ten recommendations were accepted and three rejected. Of the 10 accepted recommendations, two focused on increasing access to contraception, three on providing family planning information and education, and four on both; one recommendation encouraged the SuR to 'ensure that programmes for family planning duly take into account the traditions and physical*

obstacles faced by women in rural areas'" (UNFPA 2014c: 27). It is worth noting that none of the recommendations mentioned issues related to choice or coercion.

Highlights from country case notes regarding UNFPA efforts to build an evidence base regarding a HRBA for FP:

- ***Bolivia***: Per KIs, UNFPA has designed and supported projects and programmes, which have empowered VMGs, including adolescents, sexual minorities and indigenous women, and supported them in understanding their rights to FP. This has led to better access to services for adolescents, higher levels of participation in and ownership of processes of programme design and implementation by transsexuals, and better access to FP services for indigenous women. UNFPA has carried out some important studies of a HRBA for specific groups, and has opportunities to do more on its own and through its IPs that work with young people, indigenous groups, sexual minorities and survivors of GBV. Per UNFPA CO staff, these studies include FP and the results are used in programme design and advocacy. However, UNFPA has not yet developed a substantial evidence base, which can be used for rights promotion (Bolivia Country Note 2015: Section 4.5: 25-27).

- ***Burkina Faso***: Human rights entries in country office reports pertain to issues related to female genital mutilation (FGM), working with men and boys on gender norms, gender mainstreaming, and advocacy for legal frameworks, but not specifically related to human rights in FP. UNFPA has contributed to the evidence base, mainly via assessments to support advocacy regarding SRH needs for different groups (Burkina Faso Country Note 2015: Section 4.6: 32).

- ***Cambodia***: UNFPA is increasingly generating evidence on FP client needs and satisfaction, hence indirectly contributing to insights as to the role of a rights-based approach. The CO has used this to advocate for rights issues with the government and other stakeholders and intends to use it to strengthen its programmes targeting young people and factory and entertainment workers; however a substantial evidence base to be used for rights promotion is as yet missing. See below re studies co-commissioned by UNFPA (Cambodia Country Note 2015: Section 4.6: 34).

    - Cockcroft, M. 2014. Literature review on sexual and reproductive health and rights of migrant garment factory workers in Cambodia. Phnom Penh, United Nations Population Fund Cambodia
    - Loun, M., C. Phan and S. Mao. 2013. Levels and Trends of Contraceptive Prevalence and Unmet Need for Family Planning in Cambodia: Further Analysis of the Cambodia Demographic and Health Survey. Phnom Penh, National Institute of Statistics, Ministry of Planning and Directorate General for Health, Ministry of Health
    - Meng, K., M. Po and C. Thiep. 2013. Teenage Fertility and its Socio-Demographic Characteristics and Risk Factors: Further Analysis of the Cambodia Demographic and Health Survey. Phnom Penh, National Institute of Statistics, Ministry of Planning and Directorate
    - Sovannarith, E. 2014. Family planning thematic evaluation report. Phnom Penh, United Nations Population Fund Cambodia
    - UNFPA Cambodia. 2014. Situational Evidence Review Report. Sexual and Reproductive Health and Rights, Gender Equality and Women's Empowerment, Population and Development. Phnom Penh, United Nations Population Fund Cambodia
    - Westoff, C., K. Bietsch and R. Hong. 2013. Reproductive Preferences in Cambodia. DHS Further Analysis Reports No. 87. Calverton, Maryland, ICF International.

• ***Ethiopia***: KIs (development partners and NGOs) think that UNFPA is the organisation best placed to use evidence to work with the government and generate discussion on the relationship between access to rights-based FP, population growth and economic development. However, UNFPA has not taken a stand on support for contraceptive choice nor has it systematically gathered information on good practice in HRBA or supported monitoring of FP services by government and NGO service providers to ensure there is no undue pressure to adopt FP or specific long-term methods (Ethiopia Country Note 2015: Section 4.6: 26). • ***Zimbabwe***: UNFPA has not documented results or lessons related to taking a HRBA overall even though UNFPA programming explicitly incorporates human rights principles in HIV prevention, GBV and ASRH, (but less so for mainstream FP interventions) (Zimbabwe Country Note 2015: Section 4.6: 26). The Chinese experience in promoting a HRBA in a difficult context through the development of evidence from successful pilots that were then scaled up, is an important example of what UNFPA can do in sensitive political contexts; however, this result has not been widely disseminated within UNFPA and externally.			
6.4 Country offices receive and put into practice technical guidance from HQ and ROs to support rights-based FP	• Number, frequency and type of TA provided • RO plans address the capacity gaps and support needs of COs and ROs provide timely support • CO strategies and programmes reflect current technical guidance and best practices for rights-based FP	• Documents • International key informants • Desk study key informants • Case study country notes for Bolivia, Burkina Faso, Cambodia, Ethiopia, Zimbabwe	• Literature review • International key informant interviews • Desk study key informant interviews • Group discussions • Site visits
See 9. HQ, RO and CO coordination.			
6.5 Rights holders consider that duty bearers understand their rights to family planning and SRH	• User satisfaction with FP availability and quality (men and women, VMGs)	• Documents • International key informants • Desk study key informants • Case study country notes for Bolivia, Burkina Faso, Cambodia, Ethiopia, Zimbabwe	• Literature review • International key informant interviews • Desk study key informant interviews • Group discussions • Site visits
Information collected from the country case studies is highlighted below: • ***Bolivia***: Focus group discussions (FGDs) with users identified the following issues: users in rural health facilities do not feel they receive sufficient counselling and consider that FP is not promoted; while users in urban areas say they are satisfied with the level of information and counselling they receive at facilities and feel that health staff understand their rights to FP with freedom of method choice. In addition, adolescents and young people feel they are disadvantaged by lack of information and service provider bias, as well as community and			

family level taboos on discussion of sexuality and FP (Bolivia Country Note 2015: Annex 3, Assumption 6.5: 28-30).

- ***Burkina Faso***: FGD participants (young, unmarried women) who were clients of an NGO programme expressed their satisfaction with the services, i.e., they had a right to quality FP services, they were treated with dignity and respect, their confidentiality was assured and they were provided with information about what to expect in terms of side effects. Participants from FGDs who were clients of government services were less aware that they were entitled to access quality services and suggested that the health providers were not concerned about privacy and confidentiality (this was a particular issue and barrier for youth). Further, many participants reported that they did not receive information about potential side effects. Within FP settings, observations yielded consistent findings regarding lack of counselling regarding side effects, provider biases for/against specific methods, and lack of privacy or confidentiality -- all areas that could impact HRBA in FP (Burkina Faso Country Note 2015: Annex 3, Assumption 6.5: 73).

- ***Cambodia***: FGDs with female service users noted that users were happy with provider attitudes and know the community based distribution system. They were able to mention all available methods for FP. At a footwear factory visit, some young women workers said that health centre staff are friendly and explain all methods; others indicated that not all health workers are friendly and that explanations were inadequate (Cambodia Country Note 2015: Annex 3, Assumption 6.5: 87).

- ***Ethiopia***: In FGDs, users indicated they appreciate the increased choice of methods, although not all methods are available in facilities they access. They also noted that they do not complain or make an issue when duty bearers do not respect their rights; if services are poor quality, they would go to a NGO provider. KIs expressed concern about service provider bias and pressure to reach targets, which affects voluntary choice (Ethiopia Country Note 2015: Annex 3, Assumption 6.5: 71).

- ***Zimbabwe***: The evaluation team was unable to conduct FGDs during the case study country visit. A donor review of the Integrated Support Programme[5] recommended that UNFPA conduct analyses of target groups with unmet need for FP, to better understand needs and to support advocacy for expanding the reach of FP and for increasing uptake of long-acting and permanent methods of contraception. These studies will be done in the future (DFID 2014).

EQ7: To what extent has UNFPA adapted its mode of engagement to evolving country needs in different settings, using evidence and best practice?			
Assumptions for Verification	**Indicators**	**Sources of information**	**Methods and tools for the data collection**
7.1: HQ and ROs provide support and TA to COs to identify and adapt to changing needs over time.	• Number of visits and TA input from RO and HQ to changing needs in FP engagement.	• International key informants • Desk study key informants	• Document review • KII • Internet survey 2

[5] Integrated Support Programme (ISP) on SRH and HIV Prevention was launched with funding from the UK, Irish and Swedish governments to address the SRH challenges faced by women and girls in Zimbabwe, such as unsafe abortions, unplanned pregnancies, increased sexual violations and new sexually transmitted infections (STIs) and HIV infections. It is a four-year, US$95 million initiative to provide integrated services in SRH, HIV prevention and gender-based violence (GBV) prevention and response. UNFPA is one of several implementing partners for the ISP and its role is to support the government's capacity to coordinate and deliver comprehensive reproductive health (RH) services.

	• Other activities (staff workshops, training, etc.) conducted by HQ and R) to support program innovation and/or incorporation of best practices into programmes.	• External stakeholder survey respondents • UNFPA country office survey respondents	
In 2012, UNFPA established a new procedure to strengthen input from HQ and ROs to the Country Programme Document. A **Programme Review Committee**, chaired by the Executive Director and comprised of peers, including regional advisors (from and outside the relevant region), and Technical Division staff, provides input for the Country Programme Document (CPD), the strategic document, describing the next programme cycle. There are 29 criteria to govern the peer review. This is the only opportunity for systematic review by HQs of the CPD. The CPD is a broad document upon which the Country Programme Action Plan (CPAP) and annual work plans (AWP) are based. The CPD is backed up by other more detailed plans, including resource mobilisation, M&E, human resource plans. The RO provides the quality assurance of the underlying analytical work prepared by the CO for the CPD; the Operational Support and QA Branch does a sample review of annual work plans. According to UNFPA HQ staff, the review process is generally timed too late for substantive input to be included in final plans. To address this issue, discussions are underway for COs to submit early concept notes to allow for more strategic input from HQ and other internal stakeholders. Further, technical input is dependent on who is selected to participate in the peer review, so it is not possible to ensure that input provided is aligned with best practices in specific content areas. From the CO perspective, they conduct analysis of the changing environment and propose the overall strategy and programme design while RO/HQ "support" is generally in the form of questions to which the CO must respond. ESARO is including the *Zimbabwe* CO in an assessment of youth friendly services support future strategy and programme development; **however, there isn't an on-going, overall effort by the RO to identify needs and promote the use of different strategies** or modes of engagement in the CP (Zimbabwe Country Note 2015: Section 4.7: 27). Similarly, in *Ethiopia* and *Burkina Faso*, **the COs perceive they have similar or higher technical skills and a greater in-depth understanding of the country context** (Burkina Faso Country Note 2015: Section 4.7: 33, Ethiopia Country Note 2015: section 4.9: 31). In *Cambodia*, technical support from APRO is conducted mostly through trainings and updates, **though this is not frequent. While this office is seen as having adequate technical capacity, staff time is limited;** however, this CO has acknowledged receiving support for family planning programme formulation (Cambodia Country Note 2015: Section 4.9: 42). Regarding HQ and RO support for best practices, HQ has been working to strengthen knowledge management overall, given its importance if UNFPA is to move upstream in its modes of engagement (UNFPA 2013i). To identify good practices from within the organisation, UNFPA has instituted an annual good practices "contest" through which COs can submit practices for consideration to be widely shared throughout the organisation via the database. HQ also oversees a centralised roster of consultants. The roster is administered by ROs; however the Programme and Technical Divisions oversee the process and ensure quality control of the database.		
7.2: UNFPA COs monitor changes in country context and needs over time and adapt their mode of engagement and	• Evidence of continued monitoring of country context and needs. • Appropriateness of the mix and change of	• International key informants • Desk study key informants	• Document review • KII • Country case studies – visit and desk

programme development accordingly.	engagement modes used over time. • Existence and frequency of coordination on engagement modes with national stakeholders and development partners.	• External stakeholder survey respondents • UNFPA country office survey respondents • Case study country notes for Bolivia, Burkina Faso, Cambodia, Ethiopia, Zimbabwe	• Internet surveys 2

The current business model described in the UNFPA Strategic Plan 2014-2017 identifies **four modes of engagement: Advocacy and policy dialogue/advice; Knowledge management; Capacity development; and Service delivery**. The business model also indicates which are most appropriate for different settings, and it locates programme countries within four quadrants defined on the basis of country need and ability to finance interventions. Resource allocation is categorized in four quadrants, with countries in the red quadrant (highest level of need and lowest national capacity to finance) to receive the lion's share of resources in 2016 and 2017. The table below illustrates the four quadrants (UNFPA 2013j: 13):

Ability to Finance	Need			
	Highest	High	Medium	Low
Low	A/P, KM, CD, SD	A/P, KM, CD, SD	A/P, KM, CD	A/P, KM
Lower-middle	A/P, KM, CD, SD	A/P, KM, CD	A/P, KM	A/P
Upper-middle	A/P, KM, CD	A/P, KM	A/P	A/P
High	A/P	A/P	A/P	A/P

Key:
A/P = Advocacy and policy dialogue/advice
KM = Knowledge management
CD = Capacity development
SD = Service delivery

The business model was in response to concerns that UNFPA was trying to do everything everywhere, and to better respond to the needs of its clients. It also responds to calls for the entire UN system to shift from delivering "things" to delivering "thinking," or to move more upstream and focus on advocacy and policy dialogue as well as on south-to-south cooperation for the purposes of knowledge management and to create opportunities for sharing. "*The [above] matrix is intended to be used as a starting point for thinking critically about how UNFPA should engage in different settings rather than as a straitjacket. It cannot replace country-level dialogue about national priorities and needs. Thus,* ***UNFPA will preserve the flexibility to respond to the diverse challenges encountered****. For example, if a country office in the yellow band (which would normally be focusing on advocacy and policy dialogue/advice and knowledge management) in collaboration with national partners determines that the most effective way to achieve impact given the resources at its disposal would be via capacity development, then it simply needs to provide a justification in the form of a robust business case"* (UNFPA 2013j: 13).

UNFPA monitors changing needs and adapts its *programme interventions*. This does not necessarily involve changing *the mode of engagement* (e.g. interventions can change focus to special need groups, or can react to a specific need such as advocacy on particular themes) (UNFPA 2013e). Country context is a key feature of all intervention design, including GPRCHS (UNFPA 2012k).

Middle-income countries (MICs) are seeking more upstream involvement of UNFPA, as the countries themselves develop technical capacity and skills. However, they often still need downstream support for capacity-building and service delivery (UNFPA 2013h). UNFPA has tended to focus on the needs of the government sector, and adaptation in its mode of engagement reflects the priorities and needs of the public sector rather than the NGO or private sector (Solo 2011).

In the survey of COs, there was stability across modes of engagement over the period of evaluation, with some increase in advocacy and knowledge management.

What have been the principal modes of engagement for family planning work in your country during the period 2008-2013 (tick all that apply each year):							
Answer Options	2008	2009	2010	2011	2012	2013	Response Count
Support to service delivery	51	52	52	51	50	51	55
Capacity building	51	51	54	55	54	56	56
Advocacy	48	49	49	53	53	54	54
Knowledge management	35	38	42	44	45	50	50
Commodity procurement and RHCS	49	51	50	50	50	50	53
Other	5	5	6	6	7	7	7
Not sure	1	1	1	1	1	1	1
						Answered question	57
						Skipped question	0

Out of the 57 CO teams responding to the survey, 55 reported that the CO identified changing needs in support for FP, and 89.1 percent noted that this led to different modes of engagement. Factors that led to changes in the modes of engagement are noted below, with UNFPA policies, fund availability and alignment of government priorities as the top three factors driving change. Evidence from evaluation and technical support from RO or HQ were rated among the lowest factors.

Did any of these other factors lead to changes in the mode of engagement (tick all that apply)?		
Answer Options	Response Percent	Response Count
UNFPA policies and priorities	78.9%	45
Availability of funds for specific programmes	80.7%	46
Government priorities	87.7%	50
Emergency or humanitarian situations	70.2%	40
Availability of skilled staff in CO	68.4%	39
Technical support and promotion by RO or HQ	52.6%	30
Activities of other development partners	59.6%	34
Evidence from evaluation of CO activities	66.7%	38
Other	5.3%	3
Answered question		57
Skipped question		0

External stakeholders surveyed, support the notion that family planning needs have changed in their countries, citing the growth in both general demand for FP and demand for different methods. This is accompanied by a perception among two-thirds of these stakeholders that UNFPA

increased overall in engagement in capacity building, service delivery, advocacy, donation of methods, and knowledge management. The perception of increased donation of FP methods and capacity building may be related to the rise of GPRHCS during the same time period.

In the period 2008-2013, have family planning needs changed in any of the following ways in your country (tick all that apply)?		
Answer Options	Response Percent	Response Count
Overall demand for family planning has grown	67.1%	112
Overall demand for family planning has stagnated or reduced	18.0%	30
Demand for different family planning methods has changed	52.7%	88
There are new demands from different groups (e.g. rural women, unmarried youth, others)	37.7%	63
Reduced ability to pay for family planning services	9.6%	16
	Answered question	167
	Skipped question	16

Has the type of support provided by UNFPA for family planning changed in any of the following ways in this period (tick all that apply)?				
Answer Options	More	Less	Same	Response Count
Service delivery	96	14	25	135
Capacity building	99	9	29	137
Advocacy	96	13	21	130
Knowledge management	56	17	29	102
Donation of family planning methods	80	13	26	119
Not sure	10	5	13	28
Other (please specify)				7
			Answered question	167
			Skipped question	16

Of the country case studies developed for this evaluation, four countries are in the red quadrant (*Burkina Faso, Cambodia, Ethiopia* and *Zimbabwe*) and one in the orange quadrant (*Bolivia*). Six of the seven desk study countries are in the red quadrant (*Nicaragua, Nigeria, Rwanda, Sudan, Uganda,* and *Viet Nam*) and one is in the orange quadrant (*Tajikistan*). Findings on the modes of engagement used and shifts for each of the case country studies follow:

- ***Bolivia***: UNFPA has had to adapt to a volatile political environment in the period under evaluation, with large fluctuations in political and central government support for FP and phases of stagnation with little progress in SRH and FP. **UNFPA has monitored changing needs and adapted its modes of engagement as necessary**. It has moved away from its earlier role as a principal supplier of FP methods to focus more on capacity building, advocacy and technical support. Capacity building and strengthening in procurement and the supply chain has included diagnostic studies and technical support to *Central de Abastecimiento y Suministros de Salud* (Central Health Supplies Organisation) (CEASS) and to *Unidad de Medicamentos y Tecnología en Salud* (Unit for Medicines and Health Technology) UNIMED. CEASS was set up in 1998 to carry out procurement and distribution of essential medicines. UNFPA helped to create the CEASS rotating fund for contraceptive purchase, support to service provider training in the public sector, and training for municipal governments in FP (Bolivia Country Note 2015:

Section 4.8: 35). Advocacy has been carried out at all government levels. **UNFPA is currently moving further upstream into knowledge management.** Examples include research studies on the SRH and FP needs of indigenous groups and young people for input into programme design, and cooperation with the MoH in implementation of the national stocktaking of contraceptives and logistic processes as a response to problems of availability of FP methods in health facilities Braddock, 2015 #4444: Section 4.7: 31}.

- ***Burkina Faso***: The major change in the country context for *Burkina Faso* during the period under evaluation was an increase in political support and commitment at the national level for family planning as a national development priority. UNFPA shifted its programme to align and support the goals of the revitalised FP programme. The major shift undertaken by UNFPA was to **move from a geographic focus that concentrated efforts in three regions, to a national focus** in support of the ambitious contraceptive prevalence goal of the government. To effectively manage a national focus without a concomitant increase in the amount of resources, UNFPA adapted its partnership strategy and expanded the number of civil society partners it supported to conduct service delivery and build the capacity of community-level organizations. It continued to maintain its focus on and to play a major leadership role in contraceptive security, and strengthened its approach through the application of good practices and support from GPRHCS (such as the adoption of CHANNEL software for monitoring contraceptive commodities) (Burkina Faso Country Note 2015: Section 4.7: 32).

- ***Cambodia***: UNFPA has gradually started to move away from the more traditional downstream modes, as the country situation and stable political commitment to FP allowed this, and as other modes appear as more strategic and sustainable. This meant slowly changing from an emphasis on commodity provision and direct service delivery support to more upstream modes involving policy advocacy, capacity development and knowledge management. UNFPA convinced its implementing partners they could assume costs of most activities. For a number of years UNFPA has not used core funds for regular contraceptive procurement, partly in response to other development partners (i.e. USAID and DFID) assuming a strong role in the area (Cambodia Country Note 2015: Section 4.7: 35).

  UNFPA will pursue a change in modes of engagement in the new country programme (United Nations 2005). These changes imply an increasing need for CO competencies for and focus on policy advocacy, negotiation over sensitive issues and service quality and innovation. They also imply further **investing in quantitative knowledge generation, among others to show impact** and increasingly complementing this with qualitative research. Research is a regular component of the CO approach to interventions, as evidenced by a series of studies conducted or commissioned. Several stakeholders also suggested UNFPA could put more emphasis on knowledge generation and its application to policies and programming (Cambodia Country Note 2015: Section 4.7: 37).

- ***Ethiopia***: UNFPA has monitored changes in the context informally rather than systematically, and its response has been tempered by the need to work within the national context and align its programme to government criteria of needs, priorities and programmes. Changes in modes of engagement have been a response to changes in the context and availability of resources (e.g. the focus on supply-side work when GPRHCS funds became available) rather than a planned evolutionary process of moving upstream. Within the country there are important differences between the decentralised regional contexts which affect needs for different modes of engagement – for example, service delivery support may be a priority in some regions where service quality and coverage are still poor, and knowledge management may be a higher priority in regions where immediate service delivery needs are already well covered. An emphasis on support for service delivery and procurement at the start of GPRHCS funding (in 2007) is now moving towards capacity building in quality control and regulation in the

supply chain. Demand-side work is carried out through broader projects related to the determinants of demand, with limited input to the Federal Ministry of Health demand creation programmes through the health extension workers (HEWs) and the health development army (HDA) network. HEWS and HDA are the principal agents for FP demand creation at the community level under the national health extension programme of the MoH (Ethiopia Country Note 2015: Section 4.7: 26-28).

- ***Zimbabwe***: During the economic and political crisis in 2008, Zimbabwe experienced hyperinflation, a humanitarian crisis situation and a complete breakdown of social services and the health system. Urgent measures were needed to shore up the health system to halt the rising rates of maternal and child mortality. For example, UNFPA supported a "top up" salary scheme and procurement of vital RH commodities to ensure that maternity wards remained open during the crisis. Donor support had the aim to re-build the capacity of and financing for the health system. The situation has improved although the country context is still considered fragile. During this time UNFPA modes of engagement remained "downstream", and the CO continued to focus its efforts on support for capacity building and service delivery, rather than shifting to "upstream" modes more characteristic of a national programme farther along in the sustainability continuum. The situation did not allow for a change in engagement modes. UNFPA investments in capacity building, service delivery and demand creation, and support for coordination posts within the MoHCC are likely to be needed for the foreseeable future, given the fragility in the country context (Zimbabwe Country Note 2015: Section 4.7: 27-28).

In the desk country studies, with much of the information coming from UNFPA programme documents, the evaluation team found little explicit evidence about the process used to monitor changes in environment and hence, modes of engagement. However, in several countries, shifts in programming have occurred:

- ***Nicaragua***: UNFPA modes of engagement have shifted over time, and presently there is less emphasis on FP service provision and **greater effort on knowledge, capacity and advocacy**. Advocacy is not easy and politically complex; therefore, UNFPA uses quality of care issues within service delivery as an entry point to address other issues.

- ***Tajikistan***: the RHCS coordination team is responsible for monitoring the FP situation, specifically access to and availability of contraceptives. Until 2012, UNFPA provided contraceptives to respond to country needs, but was successful in advocating for the government to budget for commodities.

- ***Sudan***: There was little information from documents and interviews to support the finding that the CO consciously and deliberately monitors changes and needs, and adapts its programme design and modes of engagement accordingly (UNFPA Sudan 2012b). A recurrent theme is the absence of documentation and qualitative assessments of UNFPA activities. A key recommendation in the *Evaluation of the Government of Sudan/UNFPA Country Program (2009-2012)* pleads with the CO to invest in an impact study covering the past decade, pointing to the need for a systematic examination of the results of UNFPA activities, implicitly to adapt its modes of engagement and programmed development.

- ***Uganda***: The Uganda CO monitors changes in country context and needs over time to adapt its mode of engagement and programme development accordingly, according to UNFPA programme documents. UNFPA employs all modes of engagement – service delivery (incl. demand creation, outreach), procurement and logistics, capacity building and policy dialogue; however, KM is seen by DPs as a weakness. UNFPA staff query if and when 'poor' countries should 'move upstream'. One DP is not sure whether UNFPA is moving, or should move, upstream. Another feels that the four UNFPA modes of engagement are constant and still

important. Within each mode, there have been changes, e.g. advocacy (addressing new topics); service delivery (more attention for long-term methods). Change is lacking, however, in the area of capacity building, in that UNFPA has for many years supported the same districts and trained the same people there, with unclear results.			
7.3: UNFPA interventions and engagement modes support country moves towards increased sustainability of FP and SRH interventions.	• Evidence of change in engagement modes supporting moves towards sustainability • Percent of overall family planning financial needs covered by national budget. • Allocation of funds to FP in medium and long-term health sector plans.	• International key informants • Desk study key informants • Case study country notes for Bolivia, Burkina Faso, Cambodia, Ethiopia, Zimbabwe	• Document review • Country case studies – visit and desk • KIIs

In the current UNFPA strategic plan 2014-2017, strengthened evidence-based national policies is an important element of sustainable development. The strategies that UNFPA uses to achieve this outcome are heavily focused on the modes of engagement of advocacy and policy dialogue/advice, knowledge management, and capacity development (UNFPA 2013j). All of the case study countries included these modes of engagement and contributed to **sustainability through the improvement of the policy environment for family planning and RHCS** in particular.

"UNFPA has contributed to policy development, the setting up of logistical systems for commodity purchase and distribution at the country level, and improved availability of family planning methods, thus facilitating the use of family planning" (MoFA Netherlands 2013: 16). **UNFPA considers the GPRHCS thematic fund as a cornerstone of sustainable development** via the mechanism for commodity procurement and capacity development to ensure access and use of essential supplies for RH. As noted below in highlights from *Burkina Faso, Cambodia* and *Ethiopia*, UNFPA has contributed to sustainability through its efforts to increase government budgetary commitments and allocations for contraceptives. Through GPRHCS, UNFPA reports in 2013 that 27 countries *(countries not specified)* have *"increased national budget allocations for reproductive health commodities and expended as planned"* (UNFPA 2014e: 80).

- ***Bolivia***: UNFPA work to promote inclusion of FP in the basic health insurance package has been an important contribution to sustainability, as the government now covers the cost of FP supplies through reimbursement of contraceptives purchases by municipal governments. UNFPA has contributed to social sustainability of programmes through its pioneering work to develop horizontal relationships with FP users, treating them and the community as participants rather than beneficiaries. Programme participants, NGOs and the MoH recognise that empowerment is a key to social sustainability. Participants and NGO implementing agencies are now advocating wider use of this approach. UNFPA contributions to capacity building in the public sector through service provider training are less sustainable due to high staff rotation (Bolivia Country Note 2015: Section 4.7: 31-32).

- ***Burkina Faso***: UNFPA has contributed to sustainability through its work to build the capacity of public and civil society partners in service delivery and demand creation. UNFPA effectively advocated for the government to include a budget line for commodities, a major step in ownership of FP programme responsibility (although there is an issue with meeting the commitments in the resulting budget line). UNFPA also advocated for a change in the fee structure for contraceptive commodities, to reduce fees by half, effective in 2015. While this will generate less revenue for the government, the losses expect to be offset by increases in

number of paying users who can now afford the price of methods. The removal of economic barriers is also expected to contribute to an increased and more sustainable demand for contraceptive services in the long run. UNFPA also contributed to sustainability through its participation in the common basket fund and its successful advocacy to secure contracts for CSO partners to expand FP services. Inclusion of NGOs and the private sector in the procurement, planning and supplies distribution system is also an important contribution to sustainability in Burkina Faso (Burkina Faso Country Note 2015: Section 4.7: 32-33).

- ***Cambodia***: UNFPA made an important contribution to the institutional sustainability of FP programmes through its dedicated efforts to strengthen national leadership, ownership and political commitment. It also contributed to some degree of social sustainability through its support for community-based distribution and demand creation (albeit with some reservations as some groups may benefit while others may feel left out). Family planning programming, or at least its contraceptive commodity security component, is also set to become more financially sustainable with increased national budget support since 2014 as decided on by the government, to which UNFPA advocacy greatly contributed. UNFPA successfully worked towards inclusion of contraceptives in the pro-poor health equity fund schemes. This enables people identified as poor to access FP services free of charge and contributes to sustainability, as government has indicated it will continue to sustain the health equity funds even if development partners no longer support them (Cambodia Country Note 2015: Section 4.4: 27, Section 4.7: 37, Section 4.8: 40).

- ***Ethiopia***: UNFPA has been a leading player in moving upstream in commodity security work, supporting Ethiopia in moving away from reliance on UNFPA and other donors to fill the gaps in commodity purchase towards strengthening national capacity for its own procurement and supply chain management. This was a rational and sustainable approach by UNFPA whose resource availability for procurement is relatively limited in comparison with other donors. The national procurement and distribution system is strong and growing rapidly, and UNFPA has made an important contribution. It has also helped to establish regional RHCS coordinating mechanisms in states supported by the UNFPA country programme. As the government of *Ethiopia* and the FMoH further develop their leadership role in family planning, more upstream engagement will be the most appropriate type of support from UNFPA and other development partners. UNFPA has started this process in its supply-side work, and there are opportunities to do the same on the demand-side through development and use of evidence bases for analysing and improving family planning programmes and their sustainability (Ethiopia Country Note 2015: : Annex 3, Assumption 7.1: 72-73, Assumption 7.2: 74).

- ***Zimbabwe***: UNFPA has sought to contribute to the sustainability of FP in the public sector through its support to ZNFPC and MoHCC, and to SRH interventions in the public and non-government organisation (NGO) sector. However, sustainability is compromised by the challenges that exist with the coordination, implementation and quality of FP interventions in the public sector, particularly given the dominance of the public sector in FP service delivery.

  UNFPA has contributed to re-establishing a basically functional system which is still highly dependent on external financing through the development of key policies and strategies, refurbishment of facilities, support the DHS and census, and to a lesser extent through training. Until the national situation substantially improves, the current modes of engagement will continue to be maintained “downstream” and focused on direct support for services and capacity. Any gains made thus far in these areas are unlikely to be sustained without external support (Zimbabwe Country Note 2015: Section 4.7: 27).

- ***Sudan***: The documents reviewed provide numerous examples on how the UNFPA Sudan country office supports service delivery, capacity building, advocacy and knowledge

management but without giving an in-depth discussion of the issue in relation to reproductive health in general and to family planning in particular. In other words, there is weak evidence to support the assumption that UNFPA interventions and engagement modes support country moves towards increased sustainability of FP and SRH in Sudan (UNFPA Sudan 2012b).

- ***Tajikistan***: A recent evaluation of the country programme indicated that sustainability is a weak aspect of the planning, monitoring and reporting by the CO (UNFPA Tajikistan 2014). Tajikistan remains dependent on external resources for financing its social sectors, making country ownership and domestic financing unlikely in the foreseeable future.

- ***Uganda***: UNFPA supported sustainability through the development of resource mobilisation plans to support CP implementation and assist government and partners to advocate for additional resources (UNFPA Uganda 2010b).

7.4: UNFPA identifies and applies good practice at country, regional and global levels.	• Evidence of good practices identified with attention for rights and gender issues. • Examples of application of good practice at country, regional, global level.	• International key informants • Desk study key informants • UNFPA country office survey respondents	• Document review (CO annual reports) • KII • Internet survey 1

UNFPA has been working to strengthen its knowledge management system and is currently working on an updated knowledge management strategy for 2015. In HQ Programme Division, the Knowledge Sharing Branch was established in 2001, and is now called the Strategic Information and Knowledge Management Branch (SIKMB). Its mandate is to guide and promote the generation and use of strategic information and knowledge to support programming and management. For programming, the major means for identifying lessons learned is **the annual good practice competition**, which supports learning across the organisation on topics of interest. In 2012, the competition focus was on adolescents and youth, followed by results-based programming in 2013 and effective partnering with IPs in 2014 (UNFPA 2015b). In 2015, the compilation of lessons learned for the 2015 Executive Director annual report to the Executive Board is focused on the themes of integrated SRH services, gender equality, data and policy, humanitarian response and organizational effectiveness and efficiency (handout provided at 11/30/15 meeting between evaluation team and representatives from SIKMB). In this way, UNFPA pulls information on topics that are relevant to the organisation and selects some for use in reports. However, it is insufficient as a major component of a KM system.

However, **there does not appear to be an attempt to critically evaluate or synthesize what is reported and the information generated through this process lacks the guidance that would enable others to use the information strategically**, i.e. in what contexts would it make sense for other programmes to apply the practice? For example, a key informant cited the husband school in *Niger* (UNFPA 2011c) as an example of a widely disseminated best practice. However, dissemination lacked critical information about how it should be promoted or applied given that the practice is not aligned with UNFPA values on gender equality. Therefore, it should be considered a starting or entry point for engaging men in FP but not considered an end in itself.

There are presently 250 programme practices in the **MyUNFPA Good Practices database**. The database is searchable by key word and country. A search for *Burkina Faso* led to 6 separate good practices, two of which were focused on FP. Practices submitted by COs are vetted first at the regional level and then by a global panel in HQ. The SIKMB has created a simple template making it

easier for CO staff to submit practices for consideration. In a guidance note on good practices (UNFPA 2014f). **UNFPA defines a good practice as "*a programme, technical or operational component that is pertinent to UNFPA's work, and exhibits innovation, sustainability, results and opportunity for replication in other contexts.*** *It must be* ***relevant*** *(in an area that speaks to UNFPA's mandate, either in a programmatic, technical or operational area);* ***innovative*** *(brings about new and creative approaches or ideas to solve a problem or achieve better results);* ***sustainable*** *(the observed benefits of the practices that demonstrate long-term returns);* ***results-oriented*** *(efficient by showing cost reduction and better service quality; and effective in terms of proven contributions to programmatic outputs and outcomes); and* ***replicable*** *(can be adopted, with appropriate adjustment, in other organizational units within UNFPA)* (Ibid: 2). The document further describes the review process, how the practices are shared, and roles and responsibilities. **Nowhere in the document is a standard put forward to further define the type or quality of documentation needed to objectively support the criteria (e.g., relevance, innovation, sustainability, result-oriented and replicable) in the above definition, nor is there a requirement to link the UNFPA good practice to what is already known in the existing literature.**

GPRHCS identifies and disseminates best practices in family planning at its annual meetings and within its annual reports (UNFPA 2010a, UNFPA 2011a, UNFPA 2014e). In 2012, it produced a document to highlight ten best practices across a range of issues, including reaching underserved communities, strengthening supply management and mobilising political will and financial resources (UNFPA 2012i). The purpose of this report shares numerous examples of programme activities from GPRHCS Stream 1 countries, providing the background and rationale for each practice, along with a description of the approach and results achieved. ANY LIMITATIONS To this reports in their function to identify and actually disseminate best practices

Input from global KIs indicate that **UNFPA is an important partner in the USAID-UNFPA-WHO collaboration on high impact practices** by bringing to the table important perspectives on what is useful for country programme implementation. Within this forum, UNFPA field staff is highly valued participants for the review of the evidence and input on its applicability in programs; however, KIs do not see UNFPA as a significant contributor of evidence itself.

Respondents from both the CO and External Stakeholders surveys indicate that UNFPA has supported best practices in FP, although the response from external stakeholders is not as strong as that reported by CO staff.

Country Office Survey

How has the CO helped apply best practice in family planning? (tick all that apply)		
Answer Options	Response Percent	Response Count
Advocacy with government and other partners	94,7%	54
Technical support to implementing partners	91,2%	52
Dissemination through conferences, publications, web sites	71,9%	41
Other	12,3%	7
No support for application of good practice	0,0%	0
Not sure	1,8%	1
	answered question	57

External Stakeholders' survey

Has UNFPA disseminated examples of good practice in family planning from within your country or from elsewhere?		
Answer Options	Response Percent	Response Count

Yes	66,4%	158
No	8,8%	21
Not sure	24,8%	59

Findings from the country case studies indicate that UNFPA has identified best practices and lessons learned for a range of interventions across many different topic areas, depending on the focus of interventions implemented in each country. For FP, engagement in **GPRCHS** has resulted in bringing innovations (new service approaches or new methods) to countries, such as in *Burkina Faso,* indicating **the important role a thematic fund can play in transferring knowledge and supporting innovation in country programmes**. Highlights from each of the country case studies follow:

- ***Bolivia***: UNFPA has identified and implemented some best practices in FP and SRH work with adolescents and young people which can be applied nationally, such as differentiated services for adolescents, and the Committee for Prevention of Adolescent Pregnancy (CAJPEA), which started at departmental level and has been scaled up to national level. Best practices for work with indigenous groups have also been identified, documented and implemented successfully in different departments. The CO has taken advantage of its access to best practices from other countries, with support from the LACRO. The **most effective learning method has been through visiting staff from LACRO** who have shared experiences from elsewhere and discussed with CO staff how they can be adapted and applied in the Bolivia environment. The CO has also sent people from user groups and implementing partners on study trips outside Bolivia to learn about best practices elsewhere, and participants in the evaluation's focus groups indicated that these experiences are often put into practice.

- ***Burkina Faso***: UNFPA has contributed to the application of global or regional best practices including, but not limited to, the introduction of postpartum contraception in partnership with Jhpiego and the piloting of Depo-provera in Uniject (Sayana Press), with the plan to eventually task shift its delivery by lower level health workers. Both innovations have the **potential to increase service access and use**. The information collected during the evaluation points to a strong drive by the CO staff to be strategic and on the lookout for new approaches to apply and adapt, coupled with the capacity to partner effectively in order to get them implemented. The GPRHCS meetings organised by HQ have served as an important means for sharing knowledge on best practices and personal visits from RO advisors have supported the CO to adapt approaches to the local context. In addition the CO is making efforts to generate knowledge through the implementation of facility surveys and monitoring the adoption of CHANNEL as a best practice (Burkina Faso Country Note 2015: Section 4.7: 33, Section 4.8: 35).

  The CO routinely identifies lessons learned on an annual basis as part of its routine reporting requirements for its annual progress report, although the **descriptions tend to be general, retrospective in nature and lacking data review and analysis**. The CO also provides technical and financial support to the MoH for an annual RH good practices workshop as a step in identifying, documenting and sharing best practices. However, the CO receives little feedback on the information they share from either the RO or HQ and have a knowledge management agenda that could assist in being strategic about where to invest scarce resources for research and dissemination efforts (Burkina Faso Country Note 2015: Section 4.7: 33).

- ***Cambodia***: UNFPA has identified several good practices and lessons learned regarding contraception and SRH work, which can be applied elsewhere. One is the *Love9* show multi-media strategy, involving the TV airing combined with a telephone hotline, social media communication, and school-based comprehensive sexuality education, which led to enthusiastic participation. Another example is the support to the MoH regarding sharing of evidence on the economic benefits of investing in FP, which enabled the ministry to present

and win its case with the ministry of economy and finance. Furthermore, the *SMARTgirl* programme experience shows the **effectiveness of using peers as group leaders and outreach workers to reach younger entertainment worker**s. There is no evidence of UNFPA having brought best practice experiences from elsewhere to adapt and apply in *Cambodia* (Cambodia Country Note 2015: Section 4.7: 37-38).

- ***Ethiopia***: There is both need and opportunity to move into knowledge management, developing an evidence base in Ethiopia itself and bringing in more experience from outside. UNFPA has already done some important work in this field through its support for important events such as the Third International Conference on Family Planning (ICFP 2013) in Addis Ababa where experiences and good practices from *Ethiopia* and other countries were presented, stimulating interchange of ideas. However there is **not a systematic approach to identifying, sharing and applying relevant good practices f**rom other contexts or using evidence, which is available in *Ethiopia* for advocacy work. UNFPA has made a start on development of evidence bases on good practice in FP programming and support, an important element of knowledge management and an essential input for effective advocacy. The international and regional family planning events, supported in part by UNFPA and hosted by Ethiopia, have been excellent opportunities for showcasing this national work and enabling exchange of experiences with other (Ethiopia Country Note 2015: Section 4.7: 27).

- ***Zimbabwe***: Examples of best practices applied by the CO based on technical guidance and input provided by the UNFPA HQ and the ESARO include the programme design for the gender-based violence and SRH and HIV Linkages programmes, a workshop and technical assistance on how to develop advocacy for increasing investment in youth based on the demographic dividend rational, and the upcoming assessment of youth friendly and in-service/pre-service training strategies. The work to scale up the Sisters with a Voice intervention has demonstrated significant results in reaching female sex workers and uptake in HIV Testing and Counselling (HTC), STI treatment, condom use and contraception. The programme includes **operations research to measure outcomes and an innovative programme to address GBV and human rights** of sex workers, and has been acknowledged as a best practice (UNFPA Zimbabwe 2012). However, the CO does not have the capacity to undertake operations research, which affects the availability of data for analysis of results across the range of programme interventions, and it does not allow for evidence-based documentation of lessons learned for contributing to best practice discussions (Jackson, Njovana et al. 2014). Implementing partners also called for technical assistance from UNFPA to support monitoring and evaluation that goes beyond counting outputs (such as persons reached, materials distributed, and providers trained) and helps to document outcomes (Zimbabwe Country Note 2015: Section 4.7: 27-28).

- ***Nigeria***: UNFPA creates knowledge by commissioning studies e.g. on barriers to FP uptake, annual survey on FP access, acceptability and affordability; trend analysis of MHF indicators 2003-2013.

- ***Sudan***: A best practice identified by the CO was the public-private partnership to introduce implants within the public sector through training of 230 senior health care providers in over 200 facilities across the country. NGO and private sector partners provided financial support and UNFPA support to coordinate the RCHS Strategic Plan sensitised partners to contribute to the role of FP (UNFPA Sudan 2012a).

- ***Tajikistan***: The CO uses the MyUNFPA Good Practices database for knowledge sharing on best practices. Examples of practices reported included a “new approach” for procurement of essential RH commodities through advocacy and policy dialogue with authorities regarding allocation of budget for FP activities and RH commodities (UNFPA 2013b); and advocacy to draw the attention of high ranking officials to the problems of access to information and basic

RH services as an effective method and good practice to support FP interventions (UNFPA 2012b). While these may have been effective approaches to achieve a result, but the documentation of these practices does not explicitly deal with an effort to identify, communicate or generalize a good or best practice.

- ***Uganda***: Best practices applied include the implementation of the Minimum Initial Service Package in humanitarian situations (UNFPA Uganda 2012) and using a multisectoral approach to gender-based violence to engage a range of partners and improve coordination (UNFPA Uganda 2009, UNFPA Uganda 2010a).

EQ8: To what extent has UNFPA support for supply-side activities promoted rights-based and sustainable approaches and contributed to improved access to quality voluntary family planning?

Assumptions for Verification	Indicators	Sources of information	Methods and tools for the data collection
8.1: Provider training supported by UNFPA is client-centred, quality-focused and promoting rights and freedom of choice in FP.	• Nature of training programmes offered by MoH and other partners. • Behaviour change communication and client counselling included in training including gender perspectives.	• Documents • International key informants • Desk study key informants • External stakeholder survey respondents • UNFPA country office survey respondents • Case study country notes for Bolivia, Burkina Faso, Cambodia, Ethiopia, Zimbabwe	• Document review • Country case studies – visit and desk • KII • Internet survey 2

The GPRHCS strategy (UNFPA 2014d) **is based on the assumption that provision of commodities must be complemented by training in all aspects of supply**, from planning and procurement to community-based distribution, as well as on the demand side. GPRHCS training has been focused on supply but there has also been support for culturally appropriate and client-friendly service provider training. This is continued in GPRHCS II. RBA in FP provision is a key element of GPRHCS strategy. The GPRHCS reports are an example of use of HRBA language without full follow-through. They focus on method mix as an element of HRBA, but there is less definite activity around other elements related to rights.

The CO and external stakeholders' internet surveys show that over 98% of **COs have supported different types of training related to FP**. CO responses are higher than those of external stakeholders

CO survey

Has the CO supported capacity building for family planning service providers?

Answer Options	Response Percent	Response Count

External Stakeholders' survey

Has UNFPA supported capacity building for family planning service providers?

Answer Options	Response Percent	Response Count

Yes	98,2%	56
No	1,8%	1
Not sure	0,0%	0

Yes	89,1%	212
No	2,9%	7
Not sure	8,0%	19

Country Office survey

If yes, has capacity building included training or material support for (tick all that apply):		
Answer Options	Response Percent	Response Count
Counselling on different family planning methods	96,5%	55
Provision of different family planning methods	93,0%	53
Gender perspectives	80,7%	46
Quality of family planning services	93,0%	53
Community-based family planning interventions	84,2%	48
Other	8,8%	5

Country Office survey

If yes, has capacity building included training or material support for (tick all that apply):		
Answer Options	Response Percent	Response Count
Counselling on different family planning methods	96,5%	55
Provision of different family planning methods	93,0%	53
Gender perspectives	80,7%	46
Quality of family planning services	93,0%	53
Community-based family planning interventions	84,2%	48
Other	8,8%	5

External Stakeholders' survey

Has capacity building included training or material support for (tick all that apply):		
Answer Options	Response Percent	Response Count
Counselling on different family planning methods	79,1%	167
Provision of different family planning methods	86,3%	182
Improving quality of care and exercise of rights	73,5%	155
Gender perspectives	59,2%	125
Not sure	5,2%	11
Other (please specify)		5

Examples of the range of training provided include:

- Capacity building in the supply chain and in quality of supplies in ***Ethiopia***, (Ethiopia Country Note 2015: Section 4.8) and in procurement and logistics systems in ***Bolivia*** (Bolivia Country Note 2015: Section 4.8).
- Training for service providers in all aspects of FP at facility level, through development of a unified FP training package based on WHO recommendations and guidelines on modern contraceptive methods in ***Tajikistan*** (UNFPA Tajikistan 2014: 49)
- Training for community-based distribution of FP, and training of service providers at primary health care facility level in Nicaragua (UNFPA 2013a: 10, 14, 18, 22)

- Training for service providers at all levels in ***Burkina Faso*** (Burkina Faso Country Note 2015: Section 4.8).

- In ***Ethiopia***, UNFPA support has been catalytic in stimulating capacity building of the supply chain, together with other partners. UNFPA has supported capacity building in the procurement and distribution agency the Pharmaceuticals Fund and Supply Agency (PFSA) and is now moving towards support for quality control (the Food Medicine and Health Care Administration and Control Authority (FMHACA)) through secondment of qualified personnel to both agencies. There has also been support from HQ for capacity building in quality UNFPA has also contributed indirectly to service provider training through support for development of courses for midwifery training which include family planning (Ethiopia Country Note 2015: Section 4.8). In ***Bolivia***, service provider training supported by UNFPA has included some programmes with a client-centred approach, service quality and promotion of rights and method choice (Bolivia Country Note 2015: Section 4.8).

- In ***Ethiopia***, UNFPA has supported training for HEWs in implant insertion at health post level, but removal is only possible at health centres which may compromise clients' ability to exercise their right to choose (Ethiopia Country Note 2015: Section 4.8). In ***Bolivia***, according to public sector protocols family planning consultations should be provided by a doctor. In practice this is generally observed for the first visit, and in follow-up visits pills, condoms and injectables are administered by nurses or auxiliaries. UNFPA has promoted task-shifting to enable *obstetrices* (qualified midwives) to provide first consultations and has successfully supported inclusion of family planning in the professional curriculum in three universities. The first group of graduates is about to finish their course (Bolivia Country Note 2015: Section 4.8).

One of the GPRHCS II objectives is to strengthen access to FP services through, for example, policy, guidance and training to enable lower level heath workers to provide a wider method mix, including underused methods such as implants (DFID 2013a).

- In ***Zimbabwe***, training for IUCDs has been unsuccessful to date, as there is not a sufficient client caseload to support provider training. Moreover, the TOT strategy was hindered because the individuals trained as trainers had no training skills (Zimbabwe Country Note 2015: Section 4.8). In ***Bolivia***, UNFPA was the prime mover in introduction of three more methods (female condoms, implants and emergency contraception) through the public sector procurement and distribution system. These methods are now available in health facilities but uptake is still low. This is partly because they are still new, but there are also political obstacles for emergency contraceptives, technical obstacles for implants (insufficient service provider training in insertion and removal), and social obstacles for female condoms, which are associated with sex work (Bolivia Country Note 2015: Section 4.8).

- In ***Tajikistan***, UNFPA provides ToT in several areas: peer education of volunteer to provide sexuality education for young people; provision of RH services for sex workers; promotion and protection of reproductive heath and rights; insertion and removal of implants and IUCD insertion and removal (UNFPA Tajikistan 2014: 49). In ***Nicaragua***, ToT was carried out in development of comprehensive sexuality education courses (UNFPA 2013a).

- In ***Bolivia***, GPRHCS funding has enabled a larger contribution to service provider training in family planning and strengthening of the procurement and logistics systems and the supply chain (Bolivia Country Note 2015: Section 4.8). At global level, UNFPA KIs indicated that GPRHCS sees quality of care as the most important way of promoting rights; the service provider training provided by GPRHCS is quality-focused and promotes choice.

- In ***Cambodia***, some KIs indicated that not enough training is happening and that many midwives did not receive (refresher) training on IUCD insertion and "*therefore do not offer the service to clients*". Also, there is a considerable shortage of secondary midwives, who are the only ones who can provide long-term methods (IUCDs and implants) at health centre level (Cambodia Country Note 2015: Section 4.8). In ***Zimbabwe***, KIs expressed concern about the quality of training, the lack of outcome data, inadequate monitoring and follow-up and high cost of training (Zimbabwe Country Note 2015: Section 4.8).

The **lack of evidence on the effectiveness and impact of training on service quality or on increased user satisfaction** was a recurrent theme in all the country case studies.

- In ***Burkina Faso***, beyond numbers of individual trained, there is no information on longer-term results regarding the use of skills or the quality of information or services provided, particularly from the perspective of the individual user (Burkina Faso Country Note 2015: Section 4.8).
- In ***Ethiopia***, the impact of UNFPA-supported training on service quality has not been identified, making it difficult to claim a positive contribution for UNFPA in this respect. While UNFPA has supported provider training, the GOE has emphasized service access over service quality and there is insufficient information to determine if training is client centred, quality focused and promoting rights and freedom of choice in FP (Ethiopia Country Note 2015: Section 4.8).
- In ***Zimbabwe***, UNFPA has supported extensive provider training, but without adequate follow-up of quality and access outcomes; therefore it is not evident how training has affected (or not) service quality and access, nor whether it is client-centred and quality focused (Zimbabwe Country Note 2015: Section 4.8).
- In ***Bolivia***, there has been no evaluation of the impact of training on user perspectives of service quality, but anecdotal evidence from interviews and FDGs suggests that service providers' counselling skills are weak, many are unable to provide full information to clients and they do not fully understand clients' rights to choose a method (Bolivia Country Note 2015: Section 4.8).

KIs indicated that as needs differ widely between countries, and country programmes are aligned to needs, no overall strategy for capacity building has been developed in UNFPA. UNFPA has recognized that there is **little catalytic effect of the service provider training** it supports (UNFPA 2012h).

8.2: UNFPA support to procurement promotes availability of a wider method mix.	• Range of methods procured by UNFPA, development partners and national governments • Range of methods available at service delivery points for all user groups.	• Documents • International key informants • Desk study key informants • External stakeholder survey respondents • UNFPA country office survey respondents • Case study country notes for Bolivia, Burkina Faso, Cambodia, Ethiopia, Zimbabwe	• Document review • Country case studies – visit and desk • KII • Internet survey 2
GPRHCS I covered the period 2007-2012. Stream 1 countries which received most support were:			

Burkina Faso, Ethiopia, Haiti, Lao PDR, Madagascar, Mali, Mongolia, Mozambique, Nicaragua, Niger, Nigeria, Sierra Leone.

The GPRHCS 2012 Annual report (p. 17) shows the percentage of service delivery points (SDPs) offering at least three modern methods of contraception in GPRHCS Stream 1 countries, 2009 to 2012. In 2012, five countries, (*Burkina Faso, Lao PDR, Madagascar, Mali,* and *Niger*) showed improvements in the availability of contraceptives at the primary SDP level (Table 7) and nine countries showed improvements at secondary level.

Improved availability of method mix and the contribution made by UNFPA was identified in all the country case studies. In *Burkina Faso,* facilities that offered at least three modern contraceptive methods increased from 69.9 percent in 2009 to 95 percent in 2013. In *Cambodia,* by 2014 all of nearly 1,100 health centres provided at least three FP methods. In *Zimbabwe* the focus of UNFPA support is to increase access to long-acting contraception (IUCDs and implants), whilst other donors provide pills and injectables (UK) and condoms (USAID) (Burkina Faso Country Note 2015: Section 4.8, Cambodia Country Note 2015, Zimbabwe Country Note 2015).

A range of FP methods was procured by UNFPA in the large majority of countries responding to the internet survey. The figures suggest an increase in the range procured during the period under evaluation, with **more countries procuring a wider range of methods**. Procurement of materials and inputs for surgical sterilisation occurred in very few countries.

If UNFPA has procured family planning commodities for your country in the period 2008-2013, which were they (tick all that apply)? If UNFPA has not procured any, leave this question unanswered.							
Answer Options	2008	2009	2010	2011	2012	2013	Response Count
Pills	42	43	43	42	43	46	48
Injectables	41	42	43	42	44	47	49
Condoms	40	43	43	42	42	44	50
Female condoms	25	25	31	27	28	34	41
Implants	19	20	26	29	30	36	39
IUCD	36	37	38	39	40	40	45
Emergency contraceptives	20	19	22	24	27	30	34
Materials for tubal ligation or vasectomy	8	6	8	9	9	11	15
Other	1	1	2	2	3	2	3

Source: *CO internet survey*

IERG-2014-388 describes the **leading role, which UNFPA has played in promotion of new FP methods at international level**. Methods include the new injectable Sayson, emergency contraceptives, female condom and cheaper implants.

In *Bolivia* there are **political obstacles** for emergency contraceptives (conservative elements at all levels of government oppose emergency contraception (EC), and this is also reflected in the health sector). There are **technical obstacles** for implants (insufficient service provider training in insertion and removal), and social obstacles for female condoms which are associated with sex work (Bolivia Country Note 2015: Section 4.8).

Misoprostol is one of the methods recommended by WHO for first trimester medical abortion (WHO 2015). Its availability and use has reduced the need for low-income women to risk unsafe

abortion, as well as reducing the need for safer methods including menstrual regulation. KIs recognise the **contribution of UNFPA in gaining acceptance of misoprostol** as an essential medicine.

The **contribution of UNFPA to broadening method mix**:

- It was recognized by KIs in ***Cambodia***, who said that UNFPA was a driving force behind the expansion of the FP method mix and its roll-out in health facilities. However, issues around implants, IUCDs, emergency contraceptives, the female condom and availability of permanent methods imply that the method mix is still not optimal and availability of long-term and permanent methods are limited (Cambodia Country Note 2015: Section 4.8).
- In ***Ethiopia***, UNFPA has supported widening the method mix during the evaluation period through promotion of access to new methods such as emergency contraceptives (EC) and the female condom, and through support to the government strategy to up-scale access to implants and IUCDs (Ethiopia Country Note 2015: Section 4.8).
- In ***Zimbabwe***, the focus of UNFPA support on the supply side is to increase access to long-acting contraception to support an expanded method mix that is better able to meet the different client needs and reproductive intentions (Zimbabwe Country Note 2015: Section 4.8).
- In ***Bolivia***, UNFPA was the prime mover in introduction of three more methods (female condoms, implants and emergency contraception) through the public sector procurement and distribution system (Bolivia Country Note 2015: Section 4.8).

"A breakdown of family planning demand satisfied and method mix given in the 2011 and 2012 GPRHCS annual reports provide useful insights to interpret country progress and highlight the importance of taking ***a more strategic approach to achieving optimum method mix*** *(which in turn will enable progress in improving CPR and addressing unmet need)"* (DFID 2013b: 12).

"More analysis of appropriate contraceptive method mix is needed…. Staff need to be able to support policy making that addresses the balance between long term and short term family planning methods and the relative costs of methods and brands and which promotes the selection of financially sustainable, as well as appropriate options…… suitability and acceptability varies according to country context and users, but… where considerable proportions of GPRHCS funds are spent on large
quantities of expensive methods the Programme is effectively limiting access to any family planning method for large percentages of the population who fall outside the limited group who have access to those few more expensive ones" (Chattoe-Brown, Weil et al. 2012: 7).

In ***India***, surgical sterilization is still the most widely used method, with little use of hormonal or barrier methods. The most recent DHS data available for 2007/8 shows 34 percent of MWRA using surgical sterilization, whilst 4 percent use pills, 2 percent IUs and 6 percent condoms (Sikdar nd). Data for the 2014-15 DHS is still not available, but the surgical sterilization camps and incentives are still a cause of controversy (see for example: Venkatram 2014). KIs in UNFPA are aware of the problem of insufficient method mix in India. In contrast, country case studies showed that in *Cambodia, Ethiopia* and *Burkina Faso,* access to long-term and permanent methods is poor (Burkina Faso Country Note 2015, Cambodia Country Note 2015, Ethiopia Country Note 2015: Section 4.8). ZZZ

Reasons for **inequality in accessibility and slow take-up** were noted in several of the country studies. Remote rural and nomadic populations in *Ethiopia* have poor access to all health services including SRH, a situation that is being addressed by UNFPA through a joint outreach programme with the CHAI. Cultural norms restrict access for young people in *Cambodia*. Service provider bias due to lack of training or information about specific methods was noted in *Bolivia*, particularly for newly introduced methods. Lack of infrastructure and facilities for IUCD insertion and provision of

permanent methods was noted in both *Burkina Faso* and *Cambodia* (Burkina Faso Country Note 2015, Cambodia Country Note 2015, Ethiopia Country Note 2015: Section 4.8) ZZZ

KIs recognise that **UNFPA played a leading role in integration of family planning into emergency and humanitarian kits**, and continues to do so. UNFPA now has ownership of the emergency RH kits, and are the key player in maintaining RH within the humanitarian response. UNFPA is held to account on this by a group of NGOs who work closely with UNFPA and use the kits extensively, including MSI, MSF and RHCS members. However, evaluators noted that none of the kits include misoprostatin for medical abortion, which should be a standard item. UNFPA is not bold about including safe abortion and post-abortion care in essential health services although this could be done under the "sexual violence" umbrella at no risk to UNFPA. Formerly, the kits included male and female condoms, emergency contraceptives. In *Bolivia* recent humanitarian crises have been due to natural disasters. In these situations, women are more likely to need the methods they usually use, specifically hormonal methods, rather than methods aimed at preventing unwanted pregnancy in a situation of high risk of sexual violence. In *Bolivia,* the CO has adjusted the content of the supplies ordered for emergency kits to take this into account (Bolivia Country Note 2015: Section 4.8).

UNFPA sponsors the annual Guttmacher Institute review of the cost-effectiveness of SRH services. The 2014 edition provides the following information on the **cost of different methods**: *"Long-acting and permanent methods such as the IUCD and sterilization incur higher costs up front than short-acting methods, but they offer protection from pregnancy for many years. Thus, for each user, average annual direct costs are lowest for IUDs ($0.58), male sterilization ($0.88) and female sterilization ($1.84). Annual costs per user are substantially higher for condoms ($4.07) and are highest for hormonal methods ($7.51–7.90).*

The average annual cost per current user in the developing world in 2014 is $3.18 in direct costs and
a total of $6.35 when indirect costs are factored in. These costs vary widely by region: *The average total cost per user is lowest in Asia ($4.76), where more than half of users are located; it is $10.65 in Africa and $13.44 in Latin America and the Caribbean. These differences are due to variations in method costs, the mix of methods used and indirect costs. Costs are lowest in Asia, primarily because of the high prevalence of female sterilization and IUCD use, especially in India and China. The costs of commodities and personnel are generally higher in Latin America and the Caribbean than in other regions, but costs are also high in Sub-Saharan Africa, where a higher proportion of women use hormonal methods, compared with other regions"* (Singh, Darroch et al. 2014: 12).

8.3: Strengthened procurement and logistics systems and related health system improvements are designed to be financially sustained by national governments.	• Trend in FP methods as % MoH budget. • Trends in contributions by other development partners. • Value-for-money in method mix, which meets user needs (men and women, adolescents, VMGs).	• Documents • International key informants • Desk study key informants • External stakeholder survey respondents • UNFPA country office survey respondents • Case study country notes for Bolivia, Burkina Faso, Cambodia,	• Document review • KII • Country case study – visit and desk • Internet surveys 1 and 2

		Ethiopia, Zimbabwe	

Support for RHCS policy development has been carried out in all the case study countries, with particular success in *Burkina Faso, Cambodia, Bolivia* and *Nicaragua* (Bolivia Country Note 2015, Burkina Faso Country Note 2015, Cambodia Country Note 2015: Section 4.8, Nicaragua Desk Study 2015: Section 8). In *Burkina Faso* for example, UNFPA supported the government in development of the Strategic Plan for Reproductive Health Commodity Security 2009-2015, which includes policies for funding and sustainability of commodities. UNFPA recognises that it is important for health professionals and those who allocate resources to and within the health sector to understand that the short-term costs of an increased FP programme will generate large cost savings in the future as spending is reduced on curative interventions (EOC, post-abortion care, STI adolescent HIV/AIDS treatment etc.) (Chattoe-Brown, Braddock et al. 2010).

Strategy development during GPRHCS I highlighted the importance of working with government to **promote rational demand which is compatible with the country's ability to cover the costs of supply in the long term**. Early in GPRHCS I, some country governments carried out heavy promotion of implants, which at that time were an expensive option. In *Ethiopia* for example, much of the GPRHCS commodity budget in the first 3 years was spent on implants. UNFPA has worked at international level to reduce the cost of implants, but at the same time has worked with country governments to emphasise the need to stimulate demand for cheaper methods. Cost-effectiveness studies have been carried out in *Ethiopia*, for example. As mentioned in the previous section, in *Burkina Faso* UNFPA worked with MSI and the IPPF affiliate to stimulate demand for IUCDs, which are the cheapest option (Chattoe-Brown, Braddock et al. 2010).

When donor funding is confirmed on an annual basis, it is difficult for country governments to develop the medium-term plans and budgets needed to achieve RHCS, which need funding over a span of several years. Investments are needed in infrastructure and training as well as material supplies (UNFPA 2014d). UNFPA has worked with country governments and development partners to **ensure RHCS is included as a spending option in SWAps and basket funds**, thus integrating it with institutional budgets whilst retaining a certain degree of donor input. These mechanisms have enabled UNFPA to leverage its relatively small financial contributions. Although these financing mechanisms do not normally earmark funds for specific purposes, UNFPA has been able to obtain commitment to spend at least its own contributions on FP commodities (Chattoe-Brown, Weil et al. 2012, UNFPA 2012i, UNFPA 2014d).

The CO and the external stakeholders internet surveys showed that **government budgets have increased in the majority of focus countries**. The external stakeholders survey showed a lower percentage identifying budget increases, but the percentage identifying no increase is similar to that of the CO responses, suggesting the many of the large group of "don't knows" correspond to countries where there have been positive government budget increases, although the respondent stakeholders may not have direct knowledge of this if they are not working in the RHCS field.

Country Office survey

Has the government budget for family planning procurement and logistics increased in the period 2008-2013?		
Answer Options	Response Percent	Response Count
Yes	66,7%	38
No	24,6%	14
Not sure	8,8%	5
If yes, did UNFPA contribute to this change?		

External stakeholders' survey

Has the government budget for family planning procurement and logistics increased in the period 2008-2013?		
Answer Options	Response Percent	Response Count
Yes	43,7%	104
No	19,3%	46
Not sure	37,0%	88

Answer Options	Response Percent	Response Count
Yes	94,7%	36
No	0,0%	0
Not sure	5,3%	2

In order **to increase the sustainability of commodity supply**, UNFPA ***Bolivia*** carried out successful advocacy to include family planning in the national insurance scheme. The insurance scheme provides family planning methods free to users, and municipalities purchase replacement stocks. Under the decentralised national financing system municipalities receive budgets from the central government for health infrastructure and supplies; the system is therefore equivalent to having a central government budget for contraceptive purchase, provided the municipalities allocate their funds to family planning supplies. UNFPA donations of contraceptives were used as seed capital for setting up a revolving fund for contraceptive purchases in the national procurement and distribution systems in order to increase sustainability (UNFPA Bolivia, 2015).

The CO and the external stakeholder surveys both showed a high level of recognition for the **UNFPA contribution to strengthening the commodity procurement and logistics systems**.

Country Office survey

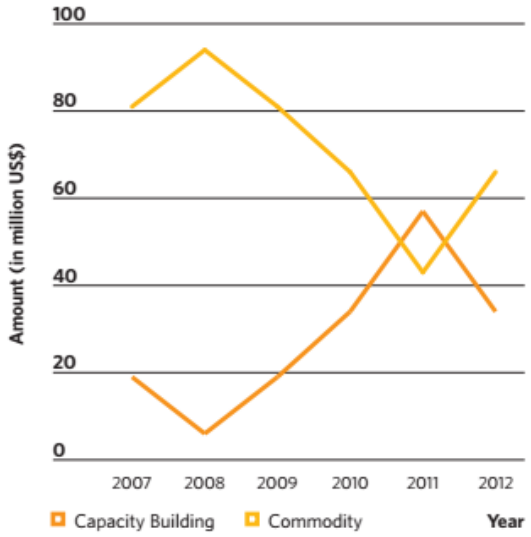
Has UNFPA worked to strengthen the national family planning commodity procurement and logistics systems?		
Answer Options	Response Percent	Response Count
Yes	98,2%	56
No	1,8%	1
Not sure	0,0%	0

External stakeholders' survey

Has UNFPA worked to strengthen the national family planning commodity procurement and logistics systems?		
Answer Options	Response Percent	Response Count
Yes	79,8%	190
No	5,0%	12
Not sure	15,1%	36

In ***Ethiopia***, UNFPA support has been catalytic in stimulating capacity building of the supply chain, together with other partners. UNFPA has supported capacity building in the procurement and distribution agency (the Pharmaceuticals Fund and Supply Agency (PFSA)) and is now moving towards support for quality control (the Food Medicine and Health Care Administration and Control Authority (FMHACA)) through secondment of qualified personnel to both agencies. There has also been support from HQ for capacity building in quality assurance. The procurement and distribution system is now generating its own margins and is likely to be sustainable. Full sustainability of supply however will require more financial commitment from government, which still relies on external aid for purchase of family planning commodities. UNFPA has participated in successfully lobbying government for allocation of a family planning budget line in the national health budget, which is a first step towards a higher national financial commitment (Ethiopia Country Note 2015: Section 4.8).

The GPRHCS annual report for 2012 traces the split between **expenditure on commodities and on capacity building** during the period under evaluation (see graph). Expenditure on commodities was high (around 80 percent) at the start of the programme in 2007 and 2008, but dropped steadily until 2011. Increased spending on commodities in 2012 was a response to donor requirements. In GRHCS II, the percentage spending on capacity building has also been reduced, at the request of the donors.



In ***Zimbabwe***, donor agencies procure 100 percent of the contraceptives used in the Zimbabwean FP programme. The UK provides the pills and injectables, USAID provides condoms and UNFPA provides implants and IUCDs. Distribution of contraceptives happens within one coordinated logistics and supply chain through the delivery team topping-up (DTTU) System, implemented by ZNFPC with technical support from Crown Agents (funding through the ISP) and JSI DELIVER (with USAID support) (Zimbabwe Country Note 2015: Section 4.8).

EECARO has taken steps to promote a **TMA as a strategy for sustainability**. The RO has worked on TMA in each country of the region, in partnership with ministries of health and finance, and large NGOs. The work has resulted in national action plans in each country and inclusion of NGOs and the private sector in planning and distribution systems (KII).

The GPRHCS 2012 annual report presented **progress on reduction of stock-outs**: *"Seven out of 12 countries (Ethiopia, Lao PDR, Madagascar, Mongolia, Mozambique, Nicaragua and Niger) experienced no stock-out of contraceptives in 60 percent or more SDPs in 2012 (Table 10). This is an increase of one country from 2011. Ethiopia (97.6 percent), Niger (97.1 percent) and Madagascar (88.9 percent) have very high 'no stock-out' rates"* (UNFPA 2012f: 23).

8.4: At global level UNFPA has developed an improved and efficient procurement system to deliver quality contraceptives to countries.	• Percentage of TPP by UNFPA. • Cost per CYP for contraceptives procured and delivered to countries by UNFPA.	• Documents • International key informants • Desk study key informants • Case study country notes for Bolivia, Burkina Faso, Cambodia, Ethiopia, Zimbabwe	• KII with GPRHCS HQ staff • Review of GPRHCS financial documentation

The **Reproductive Health Supplies Coalition** (RHCS) was formed in 2004. Its objective is *"to bring together a diversity of partners and mobilize their collective strengths to increase access to a full range of affordable, quality reproductive health supplies in low- and middle-income countries"* (Reproductive Health Supplies Coalition 2015). It has a 348 member organisations including multilateral and bilateral organizations, private foundations, low- and middle-income country governments, civil society, inter-governmental and non-governmental organisations, and the private sector.

AccessRH was developed by the RHCS Systems Strengthening Working Group at the same time as the Pledge Guarantee system (2006/7). AccessRH was passed to UNFPA together with the RHInterchange data base, which is used by 99 percent of stakeholders (RHInterchange is a website for coordination of contraceptive shipments and orders). UNFPA launched the MyAccessRH.org web portal in 2011, **providing access to the RHInterchange, as well as to AccessRH Catalog** products and pricing, quality assurance policies, standard lead times, and manufacturer contact information. KIs consider that the RHInterchange system needs to be kept more up to date in both structure and content.

The Pledge Guarantee scheme is designed to overcome the non-alignment of procurement and funding cycles. Procurers can obtain credit on the basis of pledged future income from donors.

KI described a new initiative which was proposed for large NGO buyers and others supplied by UNFPA to get credit on the basis of pledged donor support to UNFPA. This is a similar proposal to the Pledge Guarantee scheme, designed to overcome the problem that UNFPA is unable to take out credit itself. The reasons why UNFPA was unwilling to support the scheme are not clear.

9. Cross-cutting theme: Support to country offices from UNFPA headquarters and regional offices			
Assumption for Verifications	**Indicators**	**Sources of information**	**Methods and tools for the data collection**
1.2: Country offices receive and put into use practice technical guidance from HQ and ROs to support partners in delivering quality, integrated services.	Number, frequency and type of TA provided RO plans address COs needs for support in promoting service integration where appropriate. CO plans and programmes reflect current technical guidance and best practices for integrated services. Evidence-based guidance developed to support the integration of FP or more in the following SRH services (in policies, plans, actual service delivery): • Maternal health • HIV/STIs • Gender-based violence • Level of emergency preparedness to address FP needs in emergency situations • Adolescent SRH (girls and boys).	• Documents • International key informants • External stakeholder survey respondents • UNFPA country office survey respondents • Desk study key informants • Case study country notes for Bolivia, Burkina Faso, Cambodia, Ethiopia and Zimbabwe	• Literature review (global and for country notes) • International key informant interviews • Desk study key informant interviews • Focus group discussions • Group discussions • Site visits

UNFPA developed and/or participated in the development several **documents that provide guidance on the definition of SRHR, and integrated services** for use by UNFPA staff and programmes include:

- UNFPA Framework on Reproductive health and rights, including priority components and a basic package of SRH services (UNFPA 2010c)
- SRH-HIV Linkages (IPPF, UNFPA et al. 2009, IPPF, UNFPA et al. 2014)
- Reproductive Health for Communities in Crisis (UNFPA 2012l)
- Planning and Implementing an Essential Package of SRH services (Williams, Warren et al. 2010)
- SRH-HIV Linkages Compendium of Indicators and related assessment tools (IPPF, UNFPA et al. 2014)
- Programming Strategies for Postpartum Contraception (WHO 2013)
- The UNFPA manual on HRBA (Human Rights-based Approach to Programming: Practical Implementation Manual and Training Materials, 2010) is available to the CO, but no specific guidance has been provided for Ethiopia UNFPA (UNFPA 2010b)

Examples of **support for integration consisted of invitations to conferences, training and meetings**, such as a regional MCH/FP meeting in 2015 *(Sudan)*; on-line webinars *(Nicaragua)*; assistance for the rapid assessment of SRH-HIV linkages *(Uganda, Burkina Faso, Zimbabwe).* In

Bolivia, technical support has included technical and advocacy materials on key programme areas, training for both the CO and the MoH in communications skills and in RHCS, information exchange between offices in the region, and information on best practices discussed in GPRHCS annual regional planning meetings and in visits from LACRO staff to *Bolivia*. This technical support takes into account the national context. In *Cambodia*, technical support regarding family planning has included sharing of technical and advocacy materials, support for country programme formulation, suggestions for consultants, training for country staff on commodity security, information exchange between offices in the region, and information on best practices (Cambodia Country Note 2015: Section 4.9: 41).

Documentary evidence provided information about support offered by HQ and selected regional offices (ROs) for **integration**. For example, an evaluation of the UNFPA Africa regional offices found that they are closely aligned with many regional and global initiatives, and they have advanced the UNFPA mandate in the region on many fronts, including advocacy and policy reform, partnership and capacity building, and progress in thematic areas such as SRH/HIV integration and HIV prevention, reproductive rights, youth advocacy, and gender-based violence (GBV) (The Bassiouni Group 2013: 14). UNFPA organized a meeting for COs to support incorporating the integration of SRH and HIV in Global Fund proposals (Ibid: 62).

UNFPA also provided **technical support for action toward SRH/HIV integration** (Prongs I and II of prevention of mother to child transmission *(of HIV)* (PMTCT)) in 13 countries of the East and Southern Africa sub-region in 2012. Support was provided to seven countries in Southern Africa to allow full linking of HIV and AIDS and SRH in national and broader development strategies, plans and budget. UNFPA has also completed and endorsed the rapid assessments (RAs) (Ibid: 71).

UNFPA has implemented **the minimum initial service package** (MISP) in the Africa region and has been a stalwart in advocating for the inclusion of FP within the package of services offered by non-government organisations (NGOs) working in emergencies. For example, UNFPA *Sudan*, with the help of partnerships with national organisations, established a series of trainings to trainers on the MISP for improved coordination, implementation and monitoring. Further, in late February 2013, UNFPA supported relief to the flood victims in *Nigeria* by implementing the MISP for RH in three different, severely affected states. Twenty-nine health facilities received various kits, which targeted at least 600,000 people. In the annual work programmes for the Arica RO, UNFPA organised two training of trainers (ToTs) workshops for reproductive health RH coordinators in crisis situations for selected country offices (COs) and national and regional institutions (Ibid: 71-72).

In 2012, UNFPA has **mainstreamed and integrated GBV** into its HIV prevention programmes for young people and behavioural prevention programmes. GBV has also been integrated in the joint UNFPA-UNAIDS programme on SRHR/HIV integration implemented in seven countries (Ibid: 74).

On **integration of FP with maternal health**, UNFPA has provided assistance through the thematic fund for maternal health to anchor family planning more firmly within their policy frameworks (UNFPA 2012j: xii). Family planning has been one of three pillars of UNFPA support for reducing maternal mortality and morbidity. The UNFPA approach was to help develop the capacity of health systems in programme countries to provide quality family planning services. Support in maternal health evaluation case study countries (Ibid) included trainings for managers and service providers in family planning, as well assistance in the establishment of appropriate regulatory frameworks and quality assurance systems (Ibid: 26).

The evaluation team (Arab States Regional Programme) reported the **tendency of technical personnel to work in *silos;*** however, this is now reported as being mitigated by a strategy that integrates work plans focusing on common objectives and achievement of outputs rather than

activities (Thompson, Basil et al. 2013: 40). This finding was echoed in the Zimbabwe country case study where stakeholders felt that UNFPA was missing opportunities to effectively integrate FP within gender and HIV prevention programmes.

In the country case studies (field and desk studies), interviews with CO staff about HQ and RO support for integration included the following:

- ***Bolivia***: FP is integrated within postpartum and post abortion services, following guidance from HQ and RO (Bolivia Country Note 2015: Section 4.1: 16).
- ***Burkina Faso***: The CO receives strategic guidance from both HQs and the RO: guidance from HQ on integration and other matters comes in the form of documents, evaluations, and feedback on reporting (although this was not considered substantive, but rather more of a back and forth to clarify information in the reports). An example of RO guidance is a workshop conducted recently by the RO on the integration of FP, GBV and human rights held in Bamako to review what has been working, identify commonalities across countries and develop different proposals on integration. Staff indicated that plans are being developed to reinforce the capacity of partners in gender and human rights programming (Burkina Faso Country Note 2015: section 4.1: 19).
- ***Cambodia***: There has been little support or funding from HQ, apart from regular sharing of technical papers, and there have been some missed opportunities, such as not inviting government officials to participate in the London FP Summit in 2012. RO provides support via workshops, technical assistance (TA) and sharing best practices; however, they are very busy (Cambodia Country Note 2015: Section 4.9: 42).
- ***Ethiopia***: HQ and RO provide handbooks and guidelines on integration, such as the UNFPA/Population Council publication on "Planning and Implementing an Essential Package of SRH services". The RO proposed to carry out an SRH-HIV linkages survey but the government did not agree. HQ supports CO by setting overall policy and developing tools that COs can adapt to their needs, and opening doors to international resource mobilisation. The RO plays a role in transmitting these elements to the CO; however, the CO feels it has a good level of technical skills and so technical support is not required from the RO. The RO role is to keep COs up to date with innovation, share experiences, identify resource mobilisation opportunities, and recommend TA providers when necessary (Ethiopia Country Note 2015: Section 4.1: 19).
- ***Zimbabwe***: The CO identified a few instances of support for integration from the RO, such as support for a learning tour of centres of excellence in SRH-HIV linkages in Kenya for staff from ministry RH and HIV units, support for the RA of SRH-HIV linkages, and more recently an invitation to participate in a review of adolescent sexual and reproductive health practices (Zimbabwe Country Note 2015: Section 4.7: 27-28).
- ***Nicaragua***: RO provides support but from a distance. HQ engages even less with the CO, with only a few visits in the past eight years. Webinars are appreciated to share new information. The CO would like more political support from HQ.
- ***Uganda***: HQ and RO supported integration through the provision of guidance and support for the Rapid Assessment
- ***Sudan***: CO uses guidance and appreciates support from HQ and TA, which has included invitations to conferences, trainings, workshops, and GPRHCS support. Two specific workshops mentioned were a regional mother and child health (MCH)/ FP meeting in 2015 and a FP workshop in 2014.
- ***Viet Nam***: HQ and RO staff have good management and coordination skills, but are not necessarily technical experts. In addition, they are not always available to support the CO although the RO has good networks of experts through universities and from countries such as China, Japan, Korea and Malaysia.

AV 6.4: Country offices receive and put into practice technical	• Number, frequency and type of TA provided	• Documents • International key informants	• Literature review

guidance from HQ and ROs to support rights-based family planning	• RO plans address the capacity gaps and support needs of COs and ROs provide timely support • CO strategies and programmes reflect current technical guidance and best practices for rights-based FP	• Desk study key informants • Case study country notes for Bolivia, Burkina Faso, Cambodia, Ethiopia, Zimbabwe	• International key informant interviews • Desk study key informant interviews • Group discussions • Site visits
Global key informants point to the **lack of collaboration and alignment of the technical branches within HQ**, and hence a lack of consensus around the strategies for advancing family planning. The SRH and GPRHCS branches notably do not have a harmonised approach towards FP, with the SRH branch more focused on integration and rights, and the Commodity Security Branch (CSB) focused on supply- side and commodity security. With GPRHCS becoming the UNFPA "flagship" family planning effort, KIs noted that the CSB has less of a holistic and integrated approach than other areas of the Technical Division whose role in FP has been reduced. The CSB is noted for being strong on the supply side, but requires capacity in areas where UNFPA has an important role to play, i.e., in human rights and quality of care. There appear to be tensions about the importance of the current UNFPA focus on FP, especially if it is pursued with an emphasis on "supply side" orientation. Key informants were in agreement that just sending **guidelines from HQ to COs is not enough to ensure COs incorporate them in their programming**. HQ Technical Division has developed a technical guideline on HR and family planning with participation from WHO and other stakeholders and experts within and outside UNFPA. Implementation has been carried out through regional workshops. Changes in strategy are implemented through regional workshops. HQ intervention is limited as they only have core funds to work with, whereas thematic funds have resources to mount regional workshops. KIs also considered that transmission of documents has not been enough to disseminate best practices and promote their adaptation to other country contexts and their implementation. Personal contacts, regional meetings and discussions, expert technical assistance, interchanges and exchange visits have been more effective than sharing documentation. UNFPA staff from the CS and Gender, Human Rights and Quality (GHRC) Branches conducted a workshop for participants from WCARO and ESARO in October 2015 for integrating human rights into family planning services. The workshop aimed to identify human rights gaps in strengthening access to and quality of FP services and support countries to strengthen accountability mechanisms and capacities of National Human Rights Institutes to assess the fulfilment of human rights. Country action planning was also conducted in the context of on-going FP strategies and CIPs. There is intended to be a follow-up effort in select countries to conduct pilot programming (presumably on the basis of the action plan). KIs report important experiences working with the Chinese government to develop evidence in support of modification of the one-child policy. This information is also available on the China CO website. The experience was not widely disseminated to other countries although **experience-sharing** may have helped others working in a challenging human rights environment.		
AV 7.1: HQ and ROs provide support and technical assistance to	• Number of visits and TA input from ROs and HQ to collection	• Documents • International key informants	• Document review

COs to identify and adapt modes of engagement to changing needs over time	and analysis of evidence on changing needs in FP engagement • Other activities (staff workshops, training, etc.) conducted by HQ and ROs) to support program innovation and/or incorporation of best practices into programs.	• Desk study key informants • Case study country notes for Bolivia, Burkina Faso, Cambodia, Ethiopia, Zimbabwe	• Key Informant Interviews (KII) • Focus Group Discussions (FGD) • Site visits

The ***Bolivia*** CO considers that it has had constant and high quality technical support from the LACRO since the Regional Office was set up in 2008. Needs for support are identified by the CO and discussed with LACRO for planning purposes, with additional on-going dialogue on needs and input required from the RO (Bolivia Country Note 2015: Section 4.9: 36). In ***Cambodia***, most technical support is provided by the nearby regional office, APRO. The CO feels it receives quality technical support from APRO, even though this is not frequent. Needs for support are identified on an annual basis by the CO and discussed with APRO for planning purposes, with additional on-going dialogue on needs and input required from the regional office (Cambodia Country Note 2015: Section 4.9: 42).

Responses to the internet survey are shown In the following tables:

Country Office survey

Has your Country Office requested, received and put into practice technical guidance from Headquarters in any of the following areas (tick all that apply)?

Answer Options	Requested	Received	Put into practice	Respon e Count
Support for partners in delivery of quality integrated family planning services	12	19	21	24
Identification of family planning needs	10	16	18	20
Creating an enabling environment	7	14	14	17
Promoting family planning demand	9	17	16	20
Promoting family planning access	7	14	15	17
Rights-based family planning	8	15	13	18
Adapting your mode of engagement to changing needs over time	2	9	10	12
Capacity building in RH commodity security	21	31	30	34
Knowledge management (e.g. operations research, situation analysis and/or knowledge sharing)	12	24	19	25
Other areas	0	2	2	3
No support or guidance	6	7	6	9
Not sure	8	6	5	9

Country Office survey

Has your Country Office requested, received and put into practice technical guidance from Regior Office in any of the following areas (tick all that apply)?

Answer Options	Requested	Received	Put into practice	Response Count
Support for partners in delivery of quality integrated family planning services	12	16	18	19
Identification of family planning needs	14	18	17	20
Creating an enabling environment	11	15	16	18
Promoting family planning demand	11	14	15	16
Promoting family planning access	12	16	17	18
Rights-based family planning	10	14	16	19
Adapting your mode of engagement to changing needs over time	6	9	9	10
Capacity building in RH commodity security	34	34	35	40
Knowledge management (e.g. operations research, situation analysis and/or knowledge sharing)	17	21	22	24
Other areas	2	4	4	6
No support or guidance	2	3	4	5
Not sure	7	7	7	8

APRO has actively supported COs in *India* and *Indonesia* in getting country commitments to FP2020, and is developing evidence bases for use in negotiations. ESARO has supported a learning tour in 2012 for the *Zimbabwe* Ministry of Health and Child welfare officials to increase their awareness of the importance of integration of FP with HIV/AIDS services.

LACRO has a system of "environmental scanning" which identifies changes in country contexts and brings them to the attention of the COs. APRO identifies changing needs during field missions and base their training sessions on the those needs. EECARO identifies different country needs and contexts in order to tailor its support – for example the FP context in Muslim countries is variable and understanding of the country context is essential for programme development. South-South technical assistance and experience exchange is often the most effective.

EECARO has been active in investigating the need for new models and approaches and adapting them to country contexts. In 2011, the RO gathered evidence on the low use of family planning methods, then held high-level consultative meetings with ministries of health and finance to get family planning out of solely health framework. As a result, RO started to work on financial sustainability through TMA, and to create a learning package on family planning. As of 2013, both are now in place. To support implementation of the TMA, the RO and CO together in each country worked with the ministries of health and finance and NGOs to develop national action plans. A regional workshop was held with PATH on policy advocacy in 2013 (UNFPA-2013-309). There has been good progress, and countries are now including NGOs and private sector in planning and distribution systems. The Armenian government, for example, has put FP in the state budget, even though it is a low priority for the country where there is no population growth. EECARO has also been instrumental in developing public private partnerships through COs in the region. A learning package was developed by the Health Institute of Romania for service providers and medical schools, based on WHO eligibility criteria. Pilot countries pass action plans to EECARO who are developing tools on public-private partnership. EECARO both planned and funded this initiative; most COs now use the tools in their implementation

The ***Bolivia*** CO considers that it has had constant and high quality technical support from **LACRO** since the regional office was set up in 2008. Needs for support are identified by the CO and discussed with LACRO for planning purposes, with additional on-going dialogue on needs and input required from the RO. Technical support has included technical and advocacy materials on key programme areas, training for both the CO and the MoH in communications skills and in RHCS, information exchange between offices in the region, and information on best practices discussed in

GPRHCS annual regional planning meetings and in visits from LACRO staff to *Bolivia*. This technical support takes into account the national context.

APRO has developed partnerships and has carried out advocacy at regional level with the Association of South East Asian Nations (ASEAN) and AFPPD (Asian forum for parliamentarians for population and development). APRO attends and focuses on specific issues each year at annual meetings. Feedback is positive on the results of advocacy with parliamentarians. CO representatives always attend, financed by the regional programme fund.

APRO has developed an e-group of RH focal points in each country office, and fortnightly they send them a summary of latest research and findings; e-discussions are held on important topics, and other CO staff participates. The method was started in 2009 as an APRO innovation. They have had very positive feedback from COs.

AV 8.5: HQ provides appropriate support to CO level in capacity building for supply-side activities	• Effective monitoring of CO needs by HQ • Number and type of TA and other support inputs	• Documents • International key informants • Desk study key informants • Case study country notes for Bolivia, Burkina Faso, Cambodia, Ethiopia, Zimbabwe	• Literature review • International key informant interviews • Desk study key informant interviews • Group discussions • Site visits

Note: Points referred to in these annex entries are not limited to support for supply-side capacity building.

APRO has identified that quality of care is an important issue in many countries of the region, often constituting a more important obstacle than physical access to services. On the basis of this observation, the RO organised regional workshops on service quality and counselling in the period 2010-2012. Seven countries in the region adopted the guidelines on quality of care provided in the training, which were based on WHO guidelines, and translated them into their own languages. Regional GPRHCS meetings also identified quality of care as a priority issue in the region. The RO has received feedback from participating COs on the impact of the workshops. *India, Bangladesh* and *Nepal* revised national guidelines to include quality of care and counselling in basic training for service providers. The workshops were attended by government, CO staff and other stakeholders.

In ***Bolivia***, there has been training and support from HQ through the RO for strengthening results frameworks at country level, including the development of stronger indicators of results and better definition and monitoring of results in FP. The CO has had support in development and use of the results framework, and in alignment of results and indicators of the strategic plan with the Country Programme Action Plan products, baseline information, targets and means of verification (Bolivia Country Note 2015: section 4.9: 36).

In ***Ethiopia***, the RO proposed to carry out an SRH-HIV linkages survey but the government did not agree to the exercise (Ethiopia Country Note 2015: Section 4.9: 31).

LACRO has contracted specialist regional organisations such as PRISMA (a Peruvian NGO) to carry out training and technical support for supply-side activities when it has insufficient capacity to do

the work itself. LACRO has also offered additional support to the government on supply-side activities but this was not accepted.

KIs from UNFPA HQ indicated that **the principal contact between HQ and COs is through results-framework reporting** which is not enough to enable HQ to understand the country perspective. KIs in country offices also felt that the frameworks do not convey sufficient information to understand the richness of programme activities in-country.

Annex 2: Terms of Reference

Evaluation Office

TERMS OF REFERENCE

Evaluation of the UNFPA Support to Family Planning 2008-2013

New York

May 22, 2014

Table of contents

List of acronyms

CO	Country Offices
EQA	Evaluation Quality Assessment
EO	UNFPA Evaluation Office
GPRHCS	Global Programme to Enhance Reproductive Health Commodity Security
HIV AND AIDS	Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
ICPD	International Conference on Population and Development
MDG	Millennium Development Goal
M&E	Monitoring and evaluation
MISP	Minimum Initial Service Package
NGO	Non-governmental organization
OECD DAC	Organization for Economic Co-operation and Development - Development Assistance Committee
PMCT	Prevention of mother-to-Child transmission
RHCS	Reproductive health commodity security systems
RO	Regional Office
SBCC	Social Behaviour Change Communication
SRHR	Sexual and reproductive health and rights
STIs	Sexually Transmitted Infections
ToR	Terms of reference
UN	United Nations
UNAIDS	Joint United nations Programme on HIV AND AIDS
UNEG	United Nations Evaluation Group
UNFPA	United Nations Population Fund

1. Introduction

Evaluation at the United Nations Population Fund (UNFPA) serves three main purposes: (a) demonstrate accountability to stakeholders on performance in achieving development results and on invested resources; (b) support evidence-based decision-making; (c) contribute key lessons learned to the existing knowledge base on how to accelerate implementation of the Programme of Action of the 1994 International Conference on Population and Development (ICPD).[6]

The Evaluation Office (EO) will conduct an independent evaluation of the UNFPA support to family planning (2008-2013) to inform decision-making and policy formulation as per the Transitional Biennial Budgeted Evaluation Plan, 2014-2015 (UNFPA 2013g) approved by the UNFPA Executive Board in 2014.

This evaluation will commence in May 2014 and will be presented to the Executive Board in September 2016. It will be managed by the Evaluation Office, UNFPA, and conducted by a team of external specialists.

These terms of reference were prepared by the evaluation manager based on a document review and initial consultations with stakeholders. They will be finalized based on further comments and discussion with the evaluation reference group. The evaluation team shall conduct the evaluation in conformity with the final terms of reference and under overall guidance from the Evaluation Office and the evaluation reference group.

2. Rationale

The independent evaluation of UNFPA support to family planning is a matter of corporate strategic significance that contributes to the assessment of progress against the current and past strategic plans. It is expected that its results will provide an overall independent assessment of UNFPA interventions in the area of family planning and identify key lessons learned for the current and future strategies. The particular emphasis of this evaluation will be on learning with a view to informing the implementation of the UNFPA family planning strategy *Choices not chance* 2012-2020, as well as other related interventions and programmes, such as the Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS 2013-2020). The evaluation will constitute an important contribution to the mid-term review of UNFPA strategic plan 2014-2017.

As an integral part of sexual and reproductive health and rights, family planning covers a wide range of interventions which overlaps with other recent, ongoing or future UNFPA evaluations. With view to avoiding duplication, the evaluation will be based on a focused scoping and will **build upon key issues identified in previous evaluations and reviews**.

3. Users of the evaluation

The evaluation will serve programming and management purposes and will generate important findings, lessons and recommendations that will be of use to a variety of stakeholders. The main users of the evaluation include UNFPA (at the global, regional and country level), programme countries and civil society organizations, diverse stakeholders (including NGOs) as well as other agencies in the UN system in countries where UNFPA has supported family planning interventions.

4. Context

Demand for family planning in developing countries is projected to increase from 818 million (2008) to 933 million women (2015). It is estimated that currently, 222 million sexually active women in developing countries are not using any modern method yet want to avoid pregnancy,

[6] See UNFPA evaluation policy (revised, 2013) - DP/FPA/2013/5 (United Nations 2013b)

which means that they have an unmet need for modern contraceptives. Unmet need increased in the 69 poorest countries from 153 million in 2008 to 162 million in 2012. Serving all women in developing countries that currently have unmet need for modern contraceptives would prevent an additional 54 million unintended pregnancies, including 21 million unplanned births, 26 million abortions (of which 16 million would have been unsafe) and seven million miscarriages; this would also prevent 79,000 maternal deaths and 1.1 million infant deaths.[7]

Fewer unintended pregnancies also mean fewer infants born to mothers living with HIV, thus resulting in a smaller number of potentially HIV-positive infants. Preventing HIV and unintended pregnancies for the 16 million women currently living with HIV would also lead to reductions in maternal morbidity and mortality, and would generate additional benefits for women. Yet, ensuring that family planning is available to women and young people who use or want to use contraceptives entails addressing challenges such as strengthening all aspects of health systems, overcoming issues such as lack of data, unavailability of health care providers, eliminating contraceptive stock-outs, as well as issues of access, quality of care with human rights standards and equity. It also requires countries to take ownership of, and leadership in family planning financing and accountability.

UNFPA is the United Nation lead agency on family planning programming and reproductive health commodity security. UNFPA is committed to delivering a world where every pregnancy is wanted, every childbirth is safe and every young person's potential is fulfilled. The support provided by UNFPA aims to fulfil the **Programme of Action of the 1994 International Conference on Population and Development** (ICPD) which secured reproductive rights as the basic right of *all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so* (family planning services), as well as t*he right to attain the highest standard of reproductive health*. The ICPD Programme of Action also includes *the right to make decisions concerning reproduction free of discrimination, coercion and violence* (Para.7.12).

The ICPD agreed that, in order to achieve reproductive rights, couples and individuals need to have access to integrated, comprehensive, and quality sexual and reproductive health services, including family planning. Family planning thus became **an integral part of sexual and reproductive health and reproductive rights** (SRHR). Effective family planning is achieved when all individuals can *effectively exercise their right* to choose the number, spacing and timing of their children and have access to affordable, quality reproductive health commodities of their choice when they need them. This, in turn, requires a well-functioning health system to provide equitable access to a necessary mix of contraceptives for all populations, and national capacity to procure and manage its supply chain.

The **Millennium Development Goals** (MDGs) 5a and 5b on improving maternal health and universal access to reproductive health (which includes contraceptive prevalence) are the central focus of UNFPA work. The benefits of family planning range from improved maternal and new-born health to increased education and empowerment for women, to more financially secure families, to stronger national economies. Furthermore, family planning services provide an important entry point to prevent HIV infections (dual protection) in women, men and adolescents and reduce potential HIV infection in children (MDGs 4, 5 and 6). Access to contraception is also integral to efforts to reduce recourse to unsafe abortion and is essential if girls and women are to fully enjoy their rights to education, employment and political participation (MDGs 1, 2, and 3).

[7] See *Choices not chance*, UNFPA Family Planning Strategy 2012-2020 (UNFPA 2013d: 4-6).

5. Strategic frameworks

UNFPA is committed to, and active across the full scope of family planning interventions: advocating and supporting strategies, policies and intersect oral interventions to empower and engage communities and improve access to contraceptive information and services, mobilizing global and national resources, strengthening health systems, ensuring reproductive health commodity security. In the recent years, UNFPA is a key player for the promotion of family planning at the global level, most notably through playing a leadership role in the recent *Family Planning 2020* goal of expanding access to contraceptives to an additional 120 million women and girls with unmet needs in the poorest countries by 2020.

UNFPA reproductive health and rights approach seeks to support integrated reproductive health services, including interventions to address maternal mortality, gender-based violence, harmful practices, sexually transmitted infections including HIV, adolescent reproductive health, as well as family planning. **UNFPA strategic plan 2008-2011** provided guidance at the level of outcomes, which country offices should aim to achieve. Specifically, the strategic plan's reproductive health and rights focus was organized around 5 outcomes, including *access to and utilization of quality voluntary family planning services by individuals and couples increased according to reproductive intention*. A more detailed delineation of UNFPA support to family planning was set out in the **Reproductive rights and sexual reproductive health framework (2008-2011)**. The framework proposed a series of three strategies, which, in turn, were further broken down into a list of key activities, and with indicators to measure progress.

In line with the strategies, UNFPA also launched the **Global Programme to Enhance Reproductive Health Commodity Security** (GPRHCS) to move towards more predictable, planned and sustainable country-driven approaches for securing essential reproductive health supplies, as well as ensuring their effective use. The GPRHCS (2007-2012) aimed to promote the prioritisation and mainstreaming of RHCS by: (i) providing reproductive health commodities (procurement, product and technologies for family planning, condom programming); (ii) strengthening health information management system (HIMS for forecasting and logistics); and (iii) building governments' capacities **in 46 countries** as well as in countries facing commodity stock-outs and humanitarian needs. The GPRHCS has now entered its second phase (2013-2020).

In 2011, UNFPA launched the **Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive**. The Global Plan focuses on **22 countries** where nearly 90% of pregnant women living with HIV are in need of services. The **Preventing HIV and Unintended Pregnancies: Strategic Framework 2011-2015**provides guidance for preventing HIV infections and unintended pregnancies (which are both essential strategies for improving maternal and child health) and eliminating new paediatric HIV infections.

In 2011, the midterm review of UNFPA Strategic Plan[8] presented a revised strategic direction to help strengthen the focus of the organization and prioritize key issues in a streamlined set of outcomes and outputs. Outcome 3 of the **Development Results Framework** (DRF) -- *Increased access to and utilization of quality family planning services for individuals and couples according to reproductive intentions*, strengthened UNFPA focus on family planning, and included its integration within comprehensive reproductive health services as well as linkages with maternal health care and HIV prevention. This priority was reinforced at the London Summit on Family Planning in July 2012 with the commitment by UNFPA to increase the proportion of its programme funds for family planning **from 25 per cent to 40 per cent**.

[8] UNFPA Strategic Plan 2008-2011 (DP/FPA/2007/17) was extended until 2013.

As part of the UNFPA resolve to prioritize family planning within its broader mandate, the Fund designed a **family planning strategy, *Choices not chance*2012-2020**with a specific focus on the 69 low income countries that have the highest levels of unmet need for family planning and low contraceptive prevalence rates (CPR) and with the overarching goal of *accelerating delivery of universal access to rights-based family planning as part of efforts to achieve universal access to sexual and reproductive health and reproductive rights*. This new strategy sets out a framework for five results:

(1) Enabling environment for human rights-based family planning at national, regional and global levels as part of sexual and reproductive health and reproductive rights (incorporating strengthened political and financial commitment);
(2) Increased demand for family planning according to clients' reproductive health intentions;
(3) Improved availability and reliable supply of quality contraceptives;
(4) Improved availability of good quality, human rights-based family planning services;
(5) Strengthened information system pertaining to family planning.

These objectives are aligned with the orientation set out in **UNFPA Strategic Plan 2014-2017**.Family planning is identified as one of three major pillars of UNFPA work in sexual and reproductive health (together with maternal health and HIV). A specific output of the Strategic plan seeks *increased national capacity to strengthen enabling environments, increase demand for, and supply of modern contraceptives and improve quality family planning services that are free of coercion, discrimination and violence*.[9]The Strategic Plan states that UNFPA will be active across the full range of interventions needed to ensure quality of care: increasing supply of services, generating demand and improving the enabling environment. This approach builds on the key concepts of *not trying to do everything everywhere* and of better addressing the changing needs of programme countries. It reflects the United Nations system shift away from *delivering things* to *delivering thinking* or moving upstream to focus on advocacy and policy dialogue/advice while limiting service delivery to a limited number of countries.[10] This shift is reflected in UNFPA business model phased in during 2014-2015. It acknowledges the organization's limited budget and should allow the Fund to build on its strongest comparative advantage with a view to improving efficiency and effectiveness.[11]

[9] Output 2 under outcome 1 on: *Increased availability and use of integrated sexual and reproductive health services (including family planning, maternal health and HIV) that are gender-responsive and meet human rights standards for quality of care and equity in access* (United Nations 2013c).

[10] See the Quadrennial comprehensive policy review (A/Res/67/226) (United Nations 2013a)

[11] UNFPA Strategic Plan 2014-2017 - Annex 3: Business Model (DP/FPA/2013/12) (UNFPA 2013k)

Strategic Plan 2008-2011
Outcome 3 - Access to and utilization of quality voluntary family planning services by individuals and couples increased according to reproductive intentions
Output 1 - Strengthened national systems for reproductive health commodity security
Output 2 - Strengthened national capacity for community-based interventions for family planning

Reproductive Rights and Sexual and Reproductive Health Framework 2008-2011
Priorities **Unmet needs :** • Will be addressed by demand creation; emphasis placed on disadvantaged groups and availability of a broad range of FP methods. • Family planning services need to be an integrated part of relevant SRH services. **Capacity Development:** • Will focus on those cadres of service providers who deliver outreach services. • Offer of a wide range of safe and effective modern methods; ensure a sufficient supply of commodities through a reliable logistics system.
Strategy 1 Undertaking advocacy and policy support for quality family planning as part of SRH services
Strategy 2 Developing capacity within health systems, particularly among providers, for the provision of quality family planning services.
Strategy 3 Integrating family planning within SRH services

Global Programme to Enhance Reproductive Health Commodity Security 2007-2012
Outcome Increased availability, access to and utilization of reproductive health commodities for voluntary family planning, HIV/STI prevention and maternal health services in the GPRHCS focus countries.
Output 1 Country RHCS strategic plans developed, coordinated and implemented by governments with their partners.
Output 2 Political and financial commitment for RHCS enhanced
Output 3 Capacity and systems strengthened for RHCS.
Output 4RHCS mainstreamed into UNFPA core business.

Preventing HIV and Unintended Pregnancies – Strategic Framework 2011-2015
Prong 2 Prevention of unintended pregnancies in women living with HIV (as part of rights-based sexual and reproductive health of people living with HIV.

Strategic Plan 2014-2017
Outcome 1 - *Increased availability and use of integrated sexual and reproductive health services (including family planning, maternal health and HIV) that are gender-responsive and meet human rights standards for quality of care and equity in access*
Output 1 - *Increased national capacity to strengthen enabling environments, increase demand for, and supply of modern contraceptives and improve quality family planning services that are free of coercion, discrimination and violence.*

6. Evaluation purpose, objectives and scope

6.1 Purpose

The purpose of the evaluation is to assess the performance of UNFPA in the field of family planning during the period covered by the Strategic Plan 2008-2013 and to provide learning to inform the implementation of the current UNFPA Family Planning Strategy *Choices not chance* (2012-2020). The evaluation will also inform other relevant programmes such as the GPRHCS (2013-2020) and the HIV/Unintended pregnancies framework (2011-2015). Finally, the evaluation results will feed into the mid-term review of UNFPA current Strategic Plan 2013-2017.

6.2 Objectives

The primary objectives of the evaluation are to:

1. Assess how the framework as set out in UNFPA Strategic Plan (and revised DRS) 2008-2013 and further specified in the Reproductive rights and sexual and reproductive health framework (2008-2011) as well as in the GPRHCS (2007-2012) and the HIV/Unintended Pregnancies framework (2011-2015), has guided the programming and implementation of UNFPA interventions in the field of family planning;
2. Facilitate learning and capture good practices from UNFPA experience across a range of key programmatic interventions in the field of family planning during the 2008-2013 period to inform the implementation of both outcome 1 of UNFPA current Strategic Plan[12] and the *Choice not chances 2012-2020* strategy; inform the GPRHCS (2013-2020) and the HIV/Unintended pregnancies framework (2011-2015) as well as future programming of interventions in the field of family planning.

6.3 Geographical and temporal scope

The evaluation will cover UNFPA programmatic interventions in the field of family planning during the period 2008-2013. For the coverage of intended effects, and whenever necessary, 2014 data will be presented in the analysis. The evaluation will be forward-looking and will take into account the most recent strategy and UNFPA programming orientations in the field of family planning. Evaluators will provide lessons and recommendations for UNFPA continued support to quality family planning services within the present context and relevant strategic orientations, as well as taking into consideration the current programming and implementation processes within the Fund.

The geographical scope should include all countries where family planning interventions were undertaken and will particularly focus on countries, which can illustrate UNFPA support to availability of quality family planning. This includes programme countries in UNFPA six regions of operation: Western and Central Africa; Eastern and Southern Africa, Asia and the Pacific, Arab States, Eastern Europe and Central Asia, Latin America and the Caribbean.

In consultation with the evaluation manager and the reference group, the evaluators will propose a sample of countries from which to collect data and a list of countries where detailed country case studies will be conducted. To identify both sample countries and country case studies, the evaluators will take into consideration the different national contexts, as well as diverse needs and range of capacities when it comes to strengthening family planning. In particular, the 69 poorest countries[13] with low rates of contraception and the highest unmet need experience significant challenges in quality family planning provision. On the other hand, middle-income countries are often characterized by high degrees of inequality in access to health care, and must

[12] See footnote 5.

[13] Defined as having a per capita gross national income less than or equal to $2,500 in 2010.

manage diverse population dynamics ranging from high to low fertility, ageing and migration. Evaluators will also take into consideration those countries affected by fragility and conflict and which face severe development challenges (weak institutional capacity, poor governance systems, political instability and continuing violence or the effects of its legacy).

6.4Thematic scope

UNFPA support to quality family planning services refers to an overall concept encompassing the full set of UNFPA programmatic interventions in the area of family planning. Therefore, the evaluation team will examine the family planning outcomes, outputs, strategies as well as key activities as outlined in the UNFPA Strategic Plan (including its revised DRS) 2008-2013,and further specified in the Sexual and reproductive health framework, the GPRHCS and, more recently, in the Preventing HIV/Unintended pregnancies framework. The evaluation will examine primarily the results presented in the diagram below (see also annex 4 and selected bibliography) and review, inter alia, the overall consistency of the set of interventions implemented to support family planning during the period 2008-2013.

The evaluation will cover interventions directly relevant to family planning services financed from core and non-core resources, in particular resources channelled through the GPRHCS and other funds. Relevant activities undertaken by other institutions or donors active in the field of family planning are to be looked at under the angle of coherence as well as coordination and eventual partnerships, but are not assessed as such. In order to clearly define and delineate the field of study, the evaluators will **analyse the theory of change** (represented in the intervention logic). The focus of the evaluation will be specifically identified with the **choice of a set of evaluation questions**.

7. Evaluation criteria and indicative areas of investigation

The evaluation will be informed by criteria endorsed by the OECD DAC as well as other criteria relevant to the present evaluation.

Relevance	to both national needs, programme country government priorities and UNFPA policies and strategies, and how they address different and changing national contexts – e.g. diverse cultural/individual practices; large disparities between regions and within countries (related to poverty, age, gender, geographical location and marital status, etc.)
Effectiveness	the extent to which intended results were achieved
Efficiency	in terms of how funding, personnel, administrative arrangements, time and other inputs contributed to, or hindered the achievement of results
Sustainability	the extent to which the benefits from UNFPA support are likely to continue, after it has been completed, while taking into account the institutional capacity required for maintaining consistent levels of access to, and delivery of quality family planning services
Coordination	with other national partners and other prominent actors in the area of family planning with a view to creating synergies and partnerships

The above criteria are translated into indicative areas for investigation, referred to **as evaluation questions** in the ToR, and each question may address one or more of the criteria in its intent. The evaluation questions are intended to give a more precise form to the evaluation criteria and articulate the key areas of interest to stakeholders, thereby optimising the focus and utility of the evaluation. The evaluation manager, in consultation with the Technical Division at UNFPA, developed the following indicative areas of investigation:

(1) Extent and scope of UNFPA support to the **integration of family planning with other sexual and reproductive health services** in health plans and at the primary health care level, including condoms for dual protection, prevention of mother-to-Child transmission (PMTCT), as well as emergency contraception. *Particular attention to*: programming guidance and technical support provided by UNFPA regional offices and headquarters to country offices. *(Relevance, effectiveness)*

(2) Extent of UNFPA efforts for the **coordination** of actions, resources and leadership on family planning to ensure **national ownership** of family planning policies/programmes and **institutionalization of their implementation**, and to establish approaches that safeguard achievements and extend/improve gains in a sustainable manner. *(Coordination, sustainability)*

(3) Extent of UNFPA efforts as a **broker** to promote family planning as an essential part of SRHR in programme countries. *Particular attention to*: UNFPA **partnerships** with public sector, private sector and other non-state service providers. *(effectiveness, sustainability)*

(4) Extent of UNFPA support to the creation of an **enabling environment at the national and community levels** allowing for communication to, and information of individuals and couples on the availability of family planning programmes so they can effectively exercise their rights to choose the number, spacing and timing of their children. *Particular attention to*: communities support (including the engagement of men and boys) towards demand for, access to, and use of SRH and HIV services. *(relevance, effectiveness)*

(5) Level of focus on the needs of the **most vulnerable groups and marginalized populations** (e.g. adolescents, unmarried people, the urban poor, rural communities, sex workers and people living with HIV, persons living with disabilities, indigenous people). *Particular attention to*:(I) UNFPA analysis of country situations and needs of population groups facing a combination of access barriers (including gender inequalities) and rights violations in relation to family planning with a view to identifying the most disadvantaged groups; (ii) UNFPA strategic allocation of resources to reach these groups/populations and ensure efficient achievement of results; (iii) UNFPA promotion of reproductive rights and ensuring access to rights-based family planning for a number of disadvantaged groups.*(relevance, effectiveness, efficiency)*

(6) Extent of implementation of a **human-rights based approach** in UNFPA supported family planning interventions. *Particular attention to*: (i) UNFPA support to human rights values in access, quality of care (i.e. provision of the widest possible range of contraceptive choices; adequate facilities and equipment; application of evidence-based clinical protocols; technical, managerial and interpersonal skilled staff), integration of family planning with other SRH services, outreach and communication activities to those with unmet need for family planning, quality assurance mechanisms and knowledge management; (ii) UNFPA **regional offices and headquarters technical support for country offices** to effectively apply a human-rights based approach to the design, programming and implementation of family planning interventions.*(relevance, effectiveness)*

(7) UNFPA **choice and use of different modes of engagement in different settings** to respond to evolving country needs and context (low/lower-middle/upper-middle income countries) through approaches ranging from provision of goods and services to upstream work on advocacy and policy dialogue/advice. *Particular attention to*: (i) UNFPA responsiveness to local circumstances in determining the most appropriate **programming strategies**; (ii) UNFPA use of evidence-based information to identify good practices and **scale-up" what works" and innovative approaches** based upon reliable data and information collected through monitoring and evaluations. *(Relevance, efficiency, sustainability)*

The **wording of evaluation questions** (including rationale; assumptions to be assessed; and corresponding qualitative and/or quantitative indicators) **will be performed during the inception phase** when the evaluation team will have acquired a clear understanding of UNFPA intervention logic/rationale in the field of family planning during the period under review. The evaluation team will also take into account issues raised by key informants. The **potential usefulness as well as feasibility of each proposed question will be assessed** in close collaboration with the reference group with a view to determining the final set of evaluation questions.

Note: the specific issues related to the access of **young people (including adolescents)** to contraception services and how their specific needs are addressed within UNFPA interventions will be analysed within the scope of a **thematic evaluation of UNFPA support to adolescents and youth (2008-2014)**, which will be launched contemporaneously by UNFPA Evaluation Office. Coordination between the two thematic evaluations will be ensured in order to seek synergies and avoid duplication.

8. Evaluation methodology and approach

The evaluation will be **transparent, inclusive, participatory, as well as gender and human rights responsive**. The evaluation will utilize mixed methods and draw on quantitative and qualitative data. These complementary approaches will be deployed to ensure that the evaluation:

a) responds to the needs of users and their intended use of the evaluation results;
b) integrates gender and human rights principles throughout the evaluation process including participation and consultation of key stakeholders (rights holders and duty-bearers) to the extent possible;[14]
c) utilizes both quantitative and qualitative data collection and analysis methods to provide credible information about the extent of results and benefits of support for particular groups of stakeholders, especially vulnerable and marginalized groups.

Data will be disaggregated by relevant criteria (age, sex, etc. wherever possible). The evaluation will also be sensitive to fair power relations amongst stakeholders.

The evaluation will follow the guidance on the integration of gender equality and human rights principles in the evaluation focus and process as established in the UNEG Handbook, Integrating Human Rights and Gender Equality in Evaluation - Towards UNEG Guidance. The evaluation will follow UNEG Norms and Standards for Evaluation in the UN system and abide by UNEG Ethical Guidelines and Code of Conduct and any other relevant ethical codes.

The evaluation will utilize a **theory of change approach** to the evaluation of UNFPA support to the availability of quality family planning services -- its intended outcomes, the activities implemented to achieve those outcomes, and the contextual factors that may have had an effect on implementation of UNFPA interventions and their potential to bring about desired outcomes. Where outcome-level data is lacking, evaluators will assess the extent to which programmes and interventions have contributed to the achievement of results foreseen in UNFPA strategies.

The evaluation team will design **evaluation methods and tools** that will allow the evaluation to answer the questions and to come up with an overall assessment backed by clear evidence. The methodological design will include: an analytical framework; a strategy for collecting and analysing data; a series of specifically designed tools; and a detailed work plan.

The evaluation team will propose a provisional methodological design within the bid (including cost estimates). The main elements of the methodology will be further developed during

[14] See UNEG Handbook on *Integrating Human Rights and Gender Equality in Evaluation - Towards UNEG Guidance*.

inception phase in line with the agreed evaluation questions and related analytical framework; they should include the following:

Documentary review and secondary data: A preliminary list of relevant documentation (together with electronic copies) including key documents related to UNFPA activities, reports from other stakeholders and existing literature in the theme has been prepared by the Evaluation Office in consultation with UNFPA technical experts (see selected bibliography in annex). Access to these documents will be made available to interested bidders on request.

A full set of available documents will be shared with the evaluation team during the inception phase. It will include global/regional-level resources that are already available in headquarters such as strategic documents, annual reports, portfolio analysis containing financial information, thematic papers, related studies, evaluations, etc.

Previous thematic, country, or programme evaluations, reviews, audits and assessments carried out by UNFPA and key partners should be used to inform the present exercise. The evaluators will also take into account documentation produced by other donors, experts, and international institutions. In addition, evaluators will be responsible for identifying and researching further information (both qualitative and quantitative) at global, regional and country levels. The available documentation will be reviewed and analysed during the inception phase to determine the need for additional information and finalisation of the detailed evaluation methodology.

During the preparatory phase, The Evaluation Office will undertake a review of the UNFPA portfolio of interventions to inform the inception phase. This will constitute a basis for in-depth analysis to be performed by the evaluation team during the inception phase.

Interviews with key informants: Interviews will be conducted by the evaluation team. Key staff from programme countries and global/regional advisors/experts will be interviewed during the inception phase. During the field phase, interviews will be conducted with experts and staff involved in managing family planning interventions. Additional interviews will be conducted with policy makers and actors in the field of family planning in the programme countries as well as with beneficiaries. Interviews will also be held with staff of other agencies that contribute to, and partner in UNFPA family planning interventions at global and/or national levels.

Group interviews and focus groups: with selected UNFPA staff, family planning programme participants/beneficiaries, service providers, and decision/policy makers as well as other actors in the field of family planning. The specific plans for focus group discussions will be developed during the inception phase. When organising focus group discussions and interviews, attention will be given to ensure gender balance, geographic distribution, cultural sensitivity, representation of population groups and representation of the stakeholders/duty bearers at all levels (policy/service providers/target groups/communities).

Survey: An internet-based survey to assess achievements, adequacy of guidance and technical support, challenges and needs, etc. will be designed and implemented to generate additional information from a sample of programme countries for the evaluation. The justification, scope and timing of such a survey will be provided in the inception report.

Country and regional case studies: the evaluation team will assess UNFPA support at global, regional and country level. The team will conduct between five to six country case studies (involving field visits) to provide an in-depth assessment and illustrate UNFPA support at country level as well as analysing to what extent UNFPA headquarters and regional offices support country offices in terms of guidance and technical support. The evaluation team will

propose a sample of countries spanning the six UNFPA regions of intervention. It is anticipated that this will include at least two-three case studies covering WCARO and ESARO, one- two case studies in APRO, one case study in LACRO.

In addition, for a balanced approach, the team will undertake between five to ten desk-based country and/or regional case studies (no field visits involved) to supplement the field visits and inform the synthesis report. Methodology for the desk cases will involve documentary review and interviews.

In selecting country case studies, much attention will be paid to the large disparities between regions -- e.g. sub-Saharan Africa is marked by the lowest CPR of modern methods of all region (at 20%) and the highest unmet need for family planning (at 25%), as well as the disparities attached to cultural and political issues related to access to rights-based family planning and other sexual and reproductive health services. The criteria to identify and select country case studies will be developed by the evaluation team at the inception phase in close collaboration with the evaluation manager and the reference group.

9. Evaluation process and deliverables

The evaluation will consist of six phases, subdivided in subsequent methodological stages and/or related deliverables. All **evaluation deliverables will be drafted in English** (see Annex 1.e) to the exception of: (I) the *executive summary* of the final evaluation report and of the *evaluation brief* which will be produced in English, French and Spanish versions.

Evaluation Phases	Methodological Stages	Deliverables
1. Preparatory	➢ Drafting of terms of reference ➢ Setting-up of reference group	➢ Final terms of reference (UNFPA Evaluation Office)
2. Inception	➢ Structuring of the evaluation	➢ ***Inception report***
3. Data collection	➢ Data collection, verification of hypotheses	➢ ***Presentation of the results of data collection***
4. Reporting	➢ Analysis ➢ Judgments on findings ➢ Recommendations	➢ ***Country case studies notes*** ➢ ***Final report***
5. Management response	➢ Response to recommendations	➢ Management response (UNFPA Technical /Programme Divisions)
6. Dissemination	➢ Dissemination seminars	➢ ***Executive Summary*** *(French and Spanish versions)* ➢ ***Evaluation briefs*** *(English, French and Spanish)* ➢ ***PowerPoint presentation of the evaluation results***

I. Preparatory phase

The EO evaluation manager leads the preparatory work. This phase includes:

- Initial documentary review
- drafting of terms of reference
- selection and recruitment of the external evaluation team;
- constitution of an evaluation reference group.

II. Inception phase

The evaluation team will conduct the design of the evaluation in consultation with the EO evaluation manager. This phase includes:

- A **documentary review** of all relevant documents available at UNFPA headquarters, regional office and country office levels
- a **stakeholder mapping**. The evaluation team will prepare a mapping of stakeholders relevant to the evaluation indicating the relationships between different sets of stakeholders
- a reconstruction of the **intervention logic** of the UNFPA support, i.e. the theory of change meant to lead from planned activities to the intended results of the UNFPA support;
- the **development of a list of evaluation questions** addressing the main topics/issues identified (section 4.5 above), the identification of the assumptions to be assessed and the respective indicators, sources of information and methods and tools for the data collection
- the development of a **data collection and analysis strategy** as well as a concrete work plan for the field and reporting phases
- the selection of the **case studies** and **desk notes**
- the **pilot field mission**(10 working days) to test and validate core features such as the evaluation approach, evaluation questions, tools in addition to collecting and analysing the data required in order to answer the evaluation questions as agreed upon at the design phase
- Following the pilot country case study, the evaluation team will produce an **inception report**, displaying the results of the above-listed steps and tasks. The evaluation team will submit the final inception report and present it to the reference group. The inception report will be considered final upon approval by the evaluation manager.

The inception report will follow the structure as set out in **Annex 1.a**

III. Data collection phase

At data collection phase, the evaluation team will conduct an in-depth documentary review, interviews at global, regional and country levels, desk-based country studies and a survey. The evaluation team will also conduct fieldwork in the programme countries selected for the case studies in the final inception report. Each in-country mission will last a minimum of eight working days.

At the end of each mission, the evaluation team will provide the country office with a **debriefing presentation** on the preliminary results of the case study, with a view to validating preliminary findings and testing tentative conclusions to feed in the synthesis report

The evaluation team will present to the reference group the **results of the data collection** including the case study findings, the results of the survey, desk review results as well as interviews at regional and global levels.

For each country case study, the evaluation team will proceed to prepare a case study note. These notes will be annexed to the final report.

The country case study notes will follow the structure as set out in Annex 1.b

IV. Reporting Phase

The reporting phase will open with a **two-day analysis workshop** bringing together the evaluation team and the evaluation manager to discuss the results of the data collection phase including the case study findings. The purpose of this analysis workshop is to generate substantive and meaningful comparison between the different case studies. The objective is to help the various

team members to deepen their analysis with a view to identifying the evaluation's findings, main conclusions and related recommendations. The evaluation team then proceeds with the drafting of the report.

This **first draft final report** will be submitted to the evaluation manager for comments. The evaluation manager will control the quality of the submitted draft report. If the quality of the draft report is satisfactory (form and substance), the manager will circulate it to the reference group members. In the event that the quality is unsatisfactory, the evaluators will be required to produce a new version of the draft report.

The report will be presented by the evaluation team during a meeting with the reference group. On the basis of the comments expressed, the evaluation team should make appropriate amendments and submit the **final report**. For all comments, the evaluation team will indicate in writing how they have responded ("trail of comments").

The final report should clearly account for the strength of the evidence on which findings are made so as to support the reliability and validity of the evaluation. The report should reflect a rigorous, methodical and thoughtful approach. Conclusions and recommendations should build upon findings.
The report is considered final once it is formally approved by the evaluation manager in consultation with the reference group.

The final report will follow the **structure as set out in Annex1.c**

V. Management response

During this phase, the Programme Division will coordinate the preparation of the **management response** to the evaluation report for presentation to the Executive Board. The management response will be published on the UNFPA evaluation webpage.

VI. Dissemination

The **evaluation report**, the **executive summary** and the **evaluation brief** (in English, French and Spanish) will be published on the UNFPA evaluation webpage.
The evaluators will be required to assist the evaluation manager during the dissemination phase. In particular, they will present the results, the conclusions and recommendations of the evaluation during a **stakeholder workshop** to be held at UNFPA headquarters in New York City. The evaluation report will also be presented by the Director of the Evaluation Office to the September 2016 **UNFPA Executive Board session**.

10. Management and governance of the evaluation

The responsibility for the management and supervision of the evaluation will rest with the Evaluation Office. The **evaluation manager** will have overall responsibility for the management of the evaluation process, including hiring and managing the team of external consultants. The evaluation manager is responsible for ensuring the quality and independence of the evaluation (in line with UNEG Norms and Standards and Ethical Guidelines – see Annex 2).The main responsibilities of the evaluation manager are to:

- prepare the terms of reference
- lead the hiring of the team of external consultants, reviewing proposals and approving the selection of the evaluation team
- chair the reference group and convene review meetings with the evaluation team
- supervise and guide the evaluation team all through the evaluation process

- participate in the data collection process both at inception and field phases
- review, provide substantive comments and approve the inception report, including the work plan, analytical framework, methodology, and selection of countries for in-depth case studies
- review and provide substantive feedback on the country notes, as well as draft and final evaluation reports, for quality assurance purposes
- approve the final evaluation report in coordination with the reference group
- disseminate the evaluation results and contribute to learning and knowledge sharing at UNFPA

The evaluation manager will be supported by a **research assistant** during the inception phase of the evaluation. Under the guidance of the evaluation manager, the researcher will carry out selected analytical work on:

- the collection of key internal documentation and preparation of an initial literature
- the portfolio of UNFPA interventions including a financial analysis
- the preliminary review of the portfolios of the specific countries once identified for desk or field case studies
- the stakeholder mapping

The researcher will also set up, populate and maintain a dedicated web/drop box site to share the collected data with the evaluation team.

The progress of the evaluation will also be followed closely by the **reference group** consisting of members of UNFPA services and selected external experts who are directly interested in the results of this thematic evaluation. The reference group will support the evaluation at key moments of the evaluation process. Staff from UNFPA relevant administrative units will be represented in the reference group. They will provide substantive technical inputs, will facilitate access to documents and informants, and will ensure the high technical quality of the evaluation products. The main responsibilities of the reference group are to:

- contribute to the preparation and scoping of the evaluation including the finalization of evaluation questions and the selection of countries for field and desk case studies
- provide feedback and comments on the inception report as well as country notes, and on the overall technical quality of the work of the consultants
- provide comments and substantive feedback from a technical expert perspective on the draft and final evaluation reports
- actas the interface between the evaluators and the UNFPA services (in headquarters, regional and country offices), notably to facilitate access to informants and documentation
- assist in identifying external stakeholders to be consulted during the evaluation process
- participate in review meetings with the evaluation team as required
- play a key role in learning and knowledge sharing from the evaluation results, contributing to disseminating the results of the evaluation as well as to the completion and follow-up of the management response

11. Quality assurance

Since the evaluation team is expected to be hired through a company, the latter will conduct quality control of all outputs prior to submission to the Evaluation Office. They will be expected to dedicate specific resources to quality assurance efforts, and must consider all time, resources, and costs related to this in their technical and financial bid. The bidder must present the quality

assurance mechanisms, which will be applied throughout the evaluation process as part of the technical offer.
UNFPA Evaluation Office quality assurance system, based on the UNEG norms and standards and good practices of the international evaluation community, defines the quality standards expected from this evaluation. A key element is the evaluation quality assessment grid (EQA (see Annex 3), which sets out processes with in-built steps for quality assurance and outlines for the evaluation report and the review thereof. The EQA will be systematically applied to this evaluation.
The first level quality assurance of evaluation reports will be conducted by the Evaluation Office evaluation manager. The second level quality assurance will be conducted by the Evaluation Office internal reviewer. To further enhance the quality and credibility of this evaluation, the evaluation reference group will also comment on the reports, notably to verify accuracy of facts presented and validity of interpretations of evidence. The Director of the Evaluation Office maintains an oversight and quality assurance of the final evaluation report.

12. Indicative time schedule

Evaluation Phases and Stages	Deliverables(*)	Dates	Meetings
PREPARATORY PHASE			
Consultations and documentary research with a view to drafting the Terms of Reference	Terms of reference	May 2014	
Tendering Process		May-June 2014	
Review of technical proposal (Evaluation Office/UNFPA)		July 2014	
Review of financial proposal (PSB/UNFPA)		July 2014	
Contracts Review Committee		July 2014	
Contract award		July 2014	
INCEPTION PHASE			
Structuring stage Desk study	**Inception report (*draft*)**	August-November 2014	Reference group meeting(team leader + at least one team member)
Pilot mission (Country case study #1)	**Debriefing presentation** to country office(PowerPoint)	December 2014	Exit meeting in country office (team leader + team members)
Reporting stage	**Final Inception report**	December 2014	
DATA COLLECTION PHASE			
	Pilot country case study note (*draft*)	January 2015	
	Presentation of the Inception report (incl. findings from Pilot case study) to the reference group (PowerPoint)	February 2015	Reference group meeting - (Video conference with team leader + team members)
	Final Pilot country case study note	February 2015	
Field missions to four UNFPA programme countries	**Debriefing presentations** to country offices (PowerPoint)	February - June 2015	Exit meetings in country offices (team leader + team members)
Reporting stage	**Four country case study notes (*draft*)**	September2015	
	Presentation of the results of the data collection and preliminary findings to the reference group (PowerPoint)	October 2015	Reference group meeting (team leader + core team members)
	Analysis workshop (2 days)	October2015	Evaluation team with evaluation manager (in UNFPA headquarters)
REPORTING PHASE			
	***Draft* final report**	Oct-Dec 2015	
	Presentation of the Draft final report to the reference group (PowerPoint)	February 2016	Reference group meeting (team leader + at least one team member)

	Final report	April 2016	
MANAGEMENT RESPONSE			
	Management response	May 2016	Coordinated by the Programme Division
DISSEMINATION			
	Evaluation briefs (English, French, Spanish) **French and Spanish versions of the Executive summary** of the final evaluation report	May-June 2016	
	Presentation of the evaluation results (PowerPoint) to the stakeholder workshop	May 2016	Presentation by team leader and evaluation manager
	Presentation of the evaluation results	September 2016	Presentation to the Executive Board

(*) *in bold*: *deliverables to be produced by the evaluation team - for payment modalities, see Section 11.*

13. The evaluation team

This evaluation is to be carried out by a multi-disciplinary team hired through a company. The company and the evaluation team members will not have been involved in the design, implementation or monitoring of UNFPA family planning interventions during the period under review, nor will they have other conflict of interest or bias on the subject.

The evaluation will follow UNEG Norms and Standards for Evaluation in the UN system and abide by UNEG Ethical Guidelines and Code of Conduct and any other relevant ethical codes (see Annex 2).

The core team is expected to be composed of three to four internationally recruited members, including the team leader. The core team should draw upon specialized technical expertise, research and editorial assistance as necessary. It will be complemented by national expertise for the country case studies and should include women and men of mixed cultural backgrounds. The team members must be able to communicate clearly in English and must have excellent analytical and drafting skills. A working knowledge of French and Spanish will be an advantage, in particular for the field phase.

The **team leader** must have an extensive experience in leading evaluations of a similar size, complexity and character, as well as technical expertise in areas related to sexual and reproductive health and rights. His/her primary responsibilities will be:

- guiding and managing the team throughout the evaluation phases
- setting out the methodological approach
- leading the pilot mission
- reviewing and consolidating the team members' inputs to the evaluation deliverables
- liaising with the UNFPA Evaluation Office and representing the evaluation team in meetings with stakeholders
- delivering the inception reports, and evaluation report (including the country case study notes) in line with the requested outlines and quality standards (see Annexes 1 and 3)

The **team members** will bring together a **complementary and balance combination of the necessary technical expertise in the thematic areas directly relevant to the evaluation** (e.g. family planning, sexual and reproductive health and rights, developing countries health systems, gender equality and women's empowerment, human rights, behaviour and social change, community empowerment). They must also have experience in applying evaluation methods in their respective areas of expertise. Team members will:

- contribute to the design of the evaluation methodology
- undertake in-depth documentary review
- conduct field work to generate additional evidence from field visits and consultations of a wide range of stakeholders
- participate in team meetings, including with stakeholders
- prepare inputs and make contributions to the evaluation deliverables

14. Specification of tender, cost of the evaluation and payment modalities

The bidder should submit a proposal consisting of two separate components: technical and financial. The technical proposal will be assessed by the Evaluation Office while the financial proposal will be assessed by UNFPA procurement services.
In responding to the present terms of reference, the technical proposal should detail the services offered, and should contain at least the following (suggested number of pages is indicated):

- Technical profile of the company (2 pages).Information associated with financial stability should be presented in the annexes
- The bidder's understanding of the terms of reference(2 pages max)
- The approach and methodology (7 pages max)
  a. Present the approach and methods for the thematic evaluation
  b. Present how the country case study approach will be combined with desk studies, questionnaires and other methods.
  c. Comment on any challenges or difficulties, which might arise in structuring and conducting the evaluation, suggesting solutions when applicable.
  d. Quality assurance mechanisms, which will be applied throughout the evaluation process, including reference to EQA in Annex 5.

- The proposed composition of the evaluation team (1 page max). Curriculum vitae of each team member should be annexed to the offer.
- A detailed time and work plan for fulfilment of the assignment including:
  a. the roles, functions and responsibilities of the different team members;
  b. estimates of the time required for the different tasks of the assignment, and
  c. a staffing schedule that specifies the tasks performed by the team members and the time allocated to each of them (3 pages max)

The contract will be awarded to the firm who will provide UNFPA with the most competitive technical and financial proposals.

The budget range for the overall cost of the evaluation is **USD 400,000 -USD 440,000**. The costs of the evaluation include:

- The evaluation as defined in the Terms of Reference
- The cost of translation of dissemination products
- The travel costs for participation in the reference group meetings, as well as to the analysis and stakeholder workshops, and all field missions.

Travel Expenses
The Vendor will be responsible for full cost of all travel, accommodation to/from during the full assessment period(s) of the evaluators/consultants. The destination countries at this moment are not known and the exact locations will be determined by UNFPA and the selected firm as part of the initial phase of the evaluation once the contract is in effect.

Travel related expenses will be reimbursed based on the actual values up to, but not exceeding the amount offered by the firm in their financial bid and also in line with maximum expenditure reimbursable limits as per UN travel rules and regulations.

Payment Modalities

The payment modalities will be as follow:

- **30%** on acceptance of the **Final inception report** (December 2014)
- **15%** on acceptance of the **Draft country notes** (September 2015)
- **35%** on acceptance of the **Draft final report** (December 2015)
- 3%on presentation of the evaluation results (PowerPoint) at the stakeholder workshop (May 2016)
- **17%** on acceptance of the **Final report** *including* the **French and Spanish versions of the Executive summary**, as well as the **Evaluation briefs** (English/French/Spanish) (June 2016)

Note that no payment will be processed until the corresponding deliverables are formally approved by the evaluation manager.

Selected bibliography

UNFPA strategic documents

Programme of Action of the 1994 International Conference on Population and Development (ICPD), 1994
https://www.unfpa.org/public/home/publications/pid/1973

ICPD Review Report, 2014
http://issuu.com/shiralevine/docs/icpd_review_global_report_a_69_62_e

UNFPA Strategic plan 2008-2011 (DP/FPA/2007/17)
http://www.unfpa.org/exbrd/2007/secondsession/dpfpa_2007_17_eng.pdf

UNFPA Strategic Plan - Midterm review of the UNFPA strategic plan, 2008-2013(DP/FPA/2011/11)
https://executiveboard.unfpa.org/execDoc.unfpa?method=docDetail&year=2011&sessionType=SRS

UNFPA strategic plan 2014-2017 (DP/FPA/2013/12)
http://www.unfpa.org/public/home/about/strategic-direction

UNFPA Annual reports 2008 through 2013
https://www.unfpa.org/public/cache/offonce/home/publications/annual_reports

Relevant documents on family planning and SRHR

UNFPA - Making reproductive rights and sexual and reproductive health a reality for all. Reproductive rights and sexual reproductive health framework (2008-2011)
http://www.unfpa.org/webdav/site/global/shared/documents/UNFPA_SRH_Framework_Final Version.pdf

UNFPA - Choices not Chance: UNFPA Family Planning Strategy 2012-2020
https://www.unfpa.org/webdav/site/global/shared/documents/publications/2014/UNFPA%20CHOICES%20NOT%20CHANCE_final.pdf

UNFPA, Guttmacher Institute, Adding it up: Costs and benefits of contraceptive services, June 2012
https://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/AIU%20Paper%20-%20Estimates%20for%202012%20final.pdf

Family Planning High Impact Practices. High-impact practices (HIPs), when scaled up and institutionalized, will maximize investments in a comprehensive family planning strategy, 2012
https://www.fphighimpactpractices.org/

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http://www.unfpa.org/webdav/site/global/shared/documents/publications/2013/UNFPA%20GPRHCS%20Annual%20Report%202012_web%20final.pdf

Key Results of the GPRHCS 2007 – 2012
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Mid-term Review of GPRHCS 2007-2012
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UNFPA - Increasing Access to Reproductive Health Key Results of the Global Programmed to Enhance Reproductive Health Commodity Security 2007-2012
http://www.unfpa.org/public/home/publications/pid/14325

UNFPA Maternal Health Thematic Fund – Business Plan 2008-2011, UNFPA Contribution to the Joint United Nations Accelerated Support to countries in Maternal and Newborn Health
http://www.unfpa.org/webdav/site/global/shared/documents/publications/2009/mhtf_business_plan.pdf

UNFPA, How universal is access to reproductive health? A review of the evidence, 2010
http://www.unfpa.org/webdav/site/global/shared/documents/publications/2010/universal_rh.pdf

UNFPA Global Programme to enhance reproductive health commodity security. The Bill & Melinda Gates Foundation project "Strengthening Transition Planning and advocacy at UNFPA" with the GPRHCS, June 2012
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Family planning 20202 – Partnership in action
http://advancefamilyplanning.org/sites/default/files/resources/FP2020_PartnershipInAction_2012-2013_lores.pdf

UN Commission on life saving commodities for women and children – Commissioners report, September 2012
http://everywomaneverychild.org/images/UN_Commission_Report_September_2012_Final.pdf

UNFPA - Preventing HIV and Unintended Pregnancies: Strategic Framework 2011 – 2015
http://www.unfpa.org/public/cache/offonce/home/publications/pid/10575

UNICEF – Towards and AIDS-free generation - Children and AIDS: Sixth stocktaking report, 2013
http://www.childrenandaids.org/

UNFPA and Harvard School of Public Health-- *A Human Rights-Based Approach to Programming*: *Practical Information and Training Materials,* 2010
http://www.unfpa.org/webdav/site/global/shared/documents/publications/2010/hrba/hrba_manual_in%20full.pdf

UNFPA - *Engaging Men and Boys*: *A Brief Summary of UNFPA Experience and Lessons Learned,* 2013
https://www.unfpa.org/webdav/site/global/shared/documents/publications/2013/UNFPA%20Engaging%20men%20and%20boys_web-2.pdf

WHO - *Ensuring human rights in the provision of contraceptive information and services*: *Guidance and recommendations,* 2014
http://www.who.int/reproductivehealth/publications/family_planning/human-rights-contraception/en/

UNFPA Office of Audit and Investigation Services. Audit of the Governance and Strategic Management of UNFPA Supplies, 2016
http://www.unfpa.org/internal-audit-reports-listing-page

Evaluation Reports

UNFPA – Evaluation Office, Thematic evaluation of UNFPA support to maternal health (2000-2011)
http://www.unfpa.org/webdav/site/global/shared/documents/Evaluation_branch/Thematic%20Evaluations%20-%20Sept%202013/MHTE%20-%20Sept%202013/MHTE_12_12R.pdf

UNFPA – Evaluation Office, Mid-term evaluation of the Maternal Health Thematic Fund contribution to maternal health, 2012
http://www.unfpa.org/webdav/site/global/shared/documents/Evaluation_branch/Maternal_health_report/MHTF%20evaluation%20report%2001.02.2013.pdf

UNFPA, UNICEF Evaluation Offices - Evaluation of the UNFPA-UNICEF joint programme on female genital mutilation/cutting (FGM/C): Accelerating change, 2013

http://www.unfpa.org/webdav/site/global/shared/documents/Evaluation_branch/Joint%20Evaluation%20-%20Sept%202013/Main%20Report/FGM-report%2012_4_2013.pdf

UNFPA – Evaluation Office, Independent Country Programme Evaluations: Lebanon (2014); Madagascar (2012); Cameroon (2012); Bolivia (2011)
http://www.unfpa.org/public/home/about/Evaluation/EBIER/CPE

UNFPA - Evaluations of UNFPA country programmes managed by UNFPA country offices are also available at:
http://web2.unfpa.org/public/about/oversight/evaluations/

The following evaluation reports were assessed (EQA – see Annex 3) as of good quality:

- Evaluation of UNFPA/Bosnia Herzegovina Country Programme (2013)
- Evaluation of UNFPA/Cambodia 3rd Country Programme (2011)
- Evaluation of the UNFPA/Jordan 7th Country Programme (2011)
- Evaluation of the UNFPA/Mexico Country Programme (2013)
- Evaluation of the UNFPA/Thailand 9th Country Programme (2011)
- Evaluation of the UNFPA/Togo Country Programme (2013)

Note: *over 50 country programme evaluations are currently available within UNFPA evaluation database. Each evaluation report is accompanied by a quality assessment (EQA) which evaluators should consult prior to using the information provided in the reports. The overall poor or unsatisfactory quality of a report does not preclude the possibility that some sections of a report could be of good quality and may provide reliable information. Detailed guidance is provided in each EQA.*

Second independent evaluation of UNAIDS, 2011
http://www.unaids.org/en/media/unaids/contentassets/documents/pcb/2011/12/20111122_PCB%2029%20SIE.pdf

Evaluation guidance

UNFPA Evaluation Office, **Handbook on How to design and conduct a country programme evaluation at UNFPA**, 2013 http://www.unfpa.org/public/home/about/Evaluation/Methodology

Note: *this handbook was specifically designed as a guide to help evaluation managers and evaluators apply methodological rigor to evaluation practices in UNFPA country offices. The handbook presents a set of evaluation tools and templates for (i) structuring information; (ii) data collection; and (iii) data analysis. A number of those* ***tools and templates*** *can be used for the present thematic evaluation, in particular*: *Evaluation matrix; Effects diagram; List of Atlas projects by CPAP outputs and Strategic Plan Outcome (notably for country case study notes); Stakeholder map, etc.*

UNEG, Integrating Human Rights and Gender Equality in Evaluation - Towards UNEG Guidance, 2011
http://www.unevaluation.org/HRGE_Guidance

Annex 1. Structure for evaluation reports and country case study notes

Inception report

Table of Contents
List of Acronyms
List of Tables (*)
List of Figures

1 Introduction
Should include: objectives of the evaluation; scope of the evaluation; geographical scope; overview of the evaluation process; purpose of the inception report

2 The Global Context of Family Planning Support
Should include: uneven progress in family planning across the world; the global family planning response; the analysis of the UNFPA strategic framework for family planning; the intervention logic, based on official documentation.

3 UNFPA Strategy and Intervention Logic
Should include: overview of UNFPA family planning framework -- incl. UNFPA Strategic Plan and DRS (2008-2013); Sexual and Reproductive Health (SRH) Framework (2008 – 2012); GPRHCS (2007-2012); HIV/Unintended pregnancies framework (2011-2015); logical reconstruction of UNFPA family planning strategic framework

4 Methodology
Should include: methodology for data and information collection from UNFPA headquarters and decentralized units, international bodies, experts and other actors working in the field of family planning. This proposal will include: (i) a sample of countries to be surveyed; (ii) case studies identified as relevant with a view to respond to the evaluation questions (including criteria and rationale for each country case study); (iii) suitable methods of data collection within the case studies -- incl. data collection plan; preparation of interview and issues guides for interviews and focus groups; harmonization of approaches across country case studies; limitations; preparation process and logistics; recruitment of field teams.

5 Proposed Evaluation Questions
Should include: a set of evaluation questions with the explanatory comments associated with each question; overall approach for answering the evaluation questions; detailed proposed evaluation questions (including: rationale; method/chain of reasoning; assumptions to be assessed and corresponding qualitative and/or quantitative indicators; feasibility); coverage of theme/issues stated in the ToR by each Evaluation Questions (table). The aim is to adequately focus the evaluation taking into consideration the usefulness of the questions, available information, limitations and constraints;

6 Next Steps
Should include: a detailed work plan for the next phases/stages of the evaluation, including detailed plans for the visits in programme countries, including the list of interventions for in-depth analysis in the field (explanation of the value added for the visits); team composition and distribution of tasks; the contractor's approach to ensure quality assurance of all evaluation deliverables.

7 Annexes

Should include: portfolio of UNFPA family planning interventions; evaluation matrix; stakeholder map; template for survey; bibliography; list of persons met; terms of reference

(*) *Tables, graphs and diagrams should be numbered and have a title.*

Country case study notes

Table of Contents
List of Acronyms
List of Tables (*)
List of Figures

1. Introduction

Should include: scope of the thematic evaluation; purpose and structure of the country case study

2. Methodology of the Country Case Study

Should include: the selection of country case studies (process and criteria); justification for selecting Country X; scope of the country case study; data collection and analysis during the country case study incl. limitations and restrictions

3. Short description of Family Planning in [name of Country]

Should include: country background; country health sector; health indicators; UNFPA response in the country

4. Findings of the Country Case Study

Should include: findings corresponding to the issues/themes corresponding to the evaluation questions (note: the purpose is not to answer to the evaluation questions in the case studies).

5. Conclusions

6. Annexes

Should include: key data of country X; overview of UNFPA interventions in country X (2008-2013); data triangulation; data collection result matrix; focus groups report template; list of documents consulted; list of people interviewed;

(*) *Tables, graphs and diagrams should be numbered and have a title.*

Final report

Table of Contents
List of Acronyms
List of Tables (*)
List of Figures

Executive Summary

1. Introduction
Should include: purpose of the evaluation; mandate and strategy of UNFPA in the field of family planning

2. Methodology
Should include: overview of the evaluation process; methods and tools used in evaluation design; analysis of UNFPA strategic framework; evaluation questions and assumptions to be assessed; the typology of UNFPA-funded activities; staged sampling to define the geographical scope of the evaluation; methods and tools used for data collection; desk review; survey; country case studies; limitations to data collection; methods and tools used for data analysis; methods of judgment; the approach to triangulation

3. Main findings and analysis
Should include for each response to evaluation question: assumptions to be assessed; evaluation criteria covered; summary of the response; detailed response

4. Conclusions
Should include for each conclusion: summary; origin (which evaluation question(s) the conclusion is based on); evaluation criteria covered; related recommendations(s); detailed conclusion

5. Recommendations
Should include for each recommendation: summary; priority level (very high/high/medium); target (administrative unit(s) to which the recommendation is addressed); origin (which conclusion(s) the recommendation is based on); operational implications. Recommendations must be: linked to the conclusions; clustered, prioritized and targeted at specific business units; accompanied by timing for implementation; useful and operational; if possible, presented as options associated with benefits and risks.

The final version of the evaluation report will be presented in a way that enables publication without need for any further editing (see section e below).

Annexes will be confined to a separate volume
Should include: country case study notes; evaluation matrix duly completed; portfolio of interventions; methodological instruments used (survey, focus groups, interviews etc.); bibliography; list of people interviewed; terms of reference.

(*) *Tables, Graphs, diagrams, maps etc. presented in the final evaluation report must also be provided to the Evaluation Office in their original version (in Excel, PowerPoint or word files, etc.).*

See examples of evaluation reports at: http://unfpa.org/public/home/about/Evaluation

Reports cover
UNFPA logo (there should be no other logo/ name of company)

Title of the evaluation:
Evaluation of the UNFPA Support to Family Planning Services 2008-2013

Title of the report (example: Inception Report)

Evaluation Office
New York
Date

The following information should appear on page 2:

- Title of the evaluation
- Title of the report
- Name of the evaluation manager
- Names of the members of the reference group
- Names of the evaluation team

Any enquiries about this Report should be addressed to:
Evaluation Office, United Nations Population Fund
E-mail: evb@unfpa.org - Phone number: +1 212 297 2620

See examples of evaluation reports at: http://unfpa.org/public/home/about/Evaluation

Editing guidelines
Evaluation reports and notes are formal documents. Therefore they will be drafted in a language and style which is appropriate and consistent and which follows UN editing rules, in particular:

Acronyms: In each section of the report, words will be spelt out followed by the corresponding acronym between parentheses. The authors must refrain from using too many acronyms; acronyms or abbreviations should be used only when mentioned repeatedly throughout the text. In tables and figures, acronyms should be spelt out in a note below the table/figure.

Capitalization: Capitalize high ranking officials' titles even when not followed by a name of a specific individual. Capitalize national, political, social, civil etc. groups –e.g. Conference for Gender Equity, Committee on HIV AND AIDS, Commission on Regional Development, Government of South Africa.

- Capitalize common nouns when they are used as a shortened title, for example, the 'Conference' (referring to the Conference on Gender Equity) or the 'Committee' (referring to the Committee on HIV AND AIDS). However, do not capitalize when used as common nouns – e.g. 'there were several regional conferences.'
- Some titles/names corresponding to acronyms are *not capitalized* – e.g. human development index (HDI), country office (CO).
- Use lower case for: UNFPA headquarters; country office; country programme; country programme evaluation; regional office, country programme document; results framework; results-based monitoring framework; monitoring and evaluation system.

Numbers: Spell out single-digit whole numbers. Use numerals for numbers greater than *nine. Always spell out simple fractions and use hyphens with them (e.g. one-half of…, a two-thirds majority).*Hyphenate all compound numbers from *twenty-one* through *ninety-nine*. Write out a number if it begins a sentence. Do not use any symbols such as # and & in the text.Use % symbol in tables and “per cent” in the narrative portion of the text

Terminology: Do not give possession to acronyms, abbreviations or inanimate objects. For example, do not write UNFPA’s, UNDP’s, UNICEF’s, the Government’s, the country’s, etc. Such usage does not comply with United Nations editorial guidelines. Instead, write: the UNFPA programme, the government programme, the UNICEF programme, etc. Do not use the word ‘agencies,’ except in the expression, ‘funds, programmes and specialized agencies of the United Nations system’. Instead, use the correct term, ‘United Nations organizations’. Do not use ‘sister agencies’. Instead, use ‘partner organizations.

Bibliography
Author (last name first), *Title of the book*, City: Publisher, Date of publication.
Author (last name first), "Article title," Name of magazine (type of medium). Volume number, (Date): page numbers, date of issue.
URL (Uniform Resource Locator or WWW address).author (or item's name, if mentioned), date.

List of people consulted

- should include the full name and title of people interviewed as well as the organization to which they belong
- should be organized in alphabetical order (English version) with last name first
- should be structured by type of organization

Before submitting draft country notes and evaluation reports, please check them for grammar, spelling, punctuation, and perform a thorough editing.

See United Nations Editorial Manual Online at: http://dd.dgacm.org/editorialmanual/

Annex 2.Code of conduct and norms for evaluation in the UN system

Evaluations of UNFPA-supported activities need to be independent, impartial and rigorous and evaluators must demonstrate personal and professional integrity. In particular:

1. To avoid **conflict of interest** and undue pressure, evaluators need to be **independent.** The members of the evaluation team must not have been directly responsible for the policy/programming-setting, design, or overall management of the subject under evaluation, nor should they expect to be in the near future. Evaluators must have no vested interest and should have the full freedom to conduct impartially their evaluative work, without potential negative effects on their career development. They must be able to express their opinion in a free manner.
2. The evaluators should protect the anonymity and **confidentiality of individual informants**. They should provide maximum notice, minimize demands on time, and respect people's right not to engage. Evaluators must respect people's right to provide information in confidence, and must ensure that sensitive information cannot be traced to its source. Evaluators are **not expected to evaluate individuals**, and must balance an evaluation of management functions with this general principle.
3. At times, evaluations uncover **evidence of wrongdoing**. Such cases must be reported discreetly to the appropriate investigative body.
4. Evaluators should be **sensitive to beliefs, manners and customs** and act with integrity and honesty in their relations with all stakeholders. In line with the UN Universal Declaration of Human Rights, evaluators must be sensitive to, and **address issues of discrimination and gender equality**. They should avoid offending the dignity and self-respect of those persons with whom they come in contact in the course of the evaluation. Knowing that evaluation might negatively affect the interests of some stakeholders, evaluators should conduct the evaluation and communicate its purpose and results in a way that clearly respects the dignity and self-worth of all stakeholders.
5. Evaluators are responsible for the **clear, accurate and fair** written and/or oral presentation of study limitations, evidence based findings, conclusions and recommendations.

A **declaration of absence of conflict of interest must be signed by each member of the team and will be annexed to the offer.** No team member should have participated in the preparation, programming or implementation of UNFPA family planning interventions during the period under evaluation.

See **Code of conduct for evaluation in the United Nations System** at:
http://www.unevaluation.org/search/index.jsp?q=UNEG+Ethical+Guidelines

See Norms for evaluation in the United Nations System at:
http://www.unevaluation.org/papersandpubs/documentdetail.jsp?doc_id=21

Annex 3.Quality assurance of the evaluation report

The Evaluation Office recommends that the evaluation quality assessment grid (below) is used as an element of the proposed quality assurance system.

The main purpose of the evaluation quality assessment grid is to ensure that the evaluation report complies with professional standards while meeting the information needs of the intended users. The assessment of the strengths and weaknesses of the evaluation report gives an indication of the relative reliability of its results.

The quality assurance assessment of the ***draft evaluation report*** must be performed by the contractor. Based upon the results of this assessment, the evaluation team leader will revise and make all necessary corrections (form and substance) to the draft final report prior to submitting the report to the review of the evaluation manager (Evaluation Office/UNFPA).

The contractor should also apply the quality assessment grid to the ***final evaluation report***.

1. Structure and Clarity of the Report
To ensure report is user-friendly, comprehensive, logically structured and drafted in accordance with international standards

Does the report clearly describe the evaluation, how it was conducted, the findings of the evaluation, and their analysis and subsequent recommendations? Is the structure *logical*? Is the report *comprehensive*? Can the information provided be *easily understood*?

Checklist of minimum content and sequence required for structure:

- (I) Acronyms; (ii) Executive Summary; (iii) Introduction; (iv) Methodology including Approach and Limitations; (v) Context; (vi) Findings/Analysis; (vii) Conclusions; (viii) Recommendations.
- *Minimum requirements for Annexes (to be presented in a separate volume)*: Country case study notes; Evaluation matrix duly completed/edited; Portfolio of interventions; Methodological instruments used (survey, focus groups, interviews etc.); Bibliography; List of People Interviewed; Terms of reference.

2. Executive Summary
To provide an overview of the evaluation, written as a stand-alone section and presenting main results of the evaluation.
Does it read as a stand-alone section, and is a *useful* resource in its own right? Is it brief yet *sufficiently detailed*, presenting the main results of the evaluation, and including *key elements* such as methodology and conclusions and recommendations?

Structure: (i) Purpose and scope of the evaluation; (ii) Background of the evaluation; (iii) Methodology; (iv) Main findings; (v) Conclusions; (v) Recommendations
Maximum length 6-7 page

3. Design and Methodology
To provide a clear explanation of the methods and tools

Is the *methodology* used for the evaluation clearly described and is the rationale for the methodological choice justified? Have cross-cutting issues (vulnerable groups, youth and gender equality) been paid specific attention in the design of the evaluation? Are key processes (tools used, triangulation, and consultation with stakeholders) discussed in sufficient detail? Are *constraints* and *limitations* made explicit (including limitations applying to interpretations and extrapolations; robustness of data sources, etc.) and discussed?

Minimum content and sequence:

- Explanation of methodological choice, including constraints and limitations;
- Techniques and Tools for data collection provided in a detailed manner;
- Triangulation systematically applied throughout the evaluation;
- Details of participatory stakeholders' consultation process are provided;
- Specific attention to cross-cutting issues (vulnerable groups, youth, gender equality) in the design of the evaluation.

4. Reliability of Data

To clarify data collection processes and data quality

Are *sources* of data clearly stated for both primary and secondary data? Is it clear why case studies were selected and what purpose they serve? Are all relevant materials related to case studies, interviews (list of interviewees, questionnaires) etc. annexed to the report? Are the limitations, and methods to address them, discussed? What other *data gaps* are there and how have these been addressed?

- Sources of qualitative and quantitative data have been identified;
- Credibility of primary (e.g. interviews and focus groups) and secondary (e.g. reports) data established and limitations made explicit.

5. Findings and Analysis

To ensure sound analysis and credible findings

Findings: Is there a *clear pathway* from data to findings, so that all findings are *evidence-based*? Are *biases* stated and discussed? Are *unintended* findings reported and discussed?

- Findings stem from rigorous data analysis;
- Findings are substantiated by evidence;
- Findings are presented in a clear manner.

Analysis: Are *interpretations* of the findings understandable? Are *assumptions* clearly stated and extrapolations well explained? Are their *limitations* (or drawbacks) discussed? Does the analysis respond to *all* evaluation questions? If not, are *omissions* (of both evaluation criteria and questions) recognized and explained? Has the analysis examined *cause and effect* links between an intervention and its end results? Are *contextual factors* identified and their influence discussed?

- Interpretations are based on carefully described assumptions;
- Contextual factors are identified;
- Cause and effect links between an intervention and its end results (including unintended results) are explained.

6. Conclusions

To assess the validity of conclusions

Are the conclusions organized in priority order? Do the conclusions amount to a reasonable *judgment* of the findings and are their links to evidence made clear? Are there any limitations and are these made clear? Do they present an *unbiased* judgment by the evaluators of the intervention or have they been influenced by preconceptions or assumptions that have not been discussed?

- Conclusions are based on credible findings;
- Conclusions are organized in priority order;
- Conclusions must convey evaluators' unbiased judgment of the intervention;
- Conclusions include: Summary; Origin (which evaluation question(s) the conclusion is based on); Evaluation criteria covered; Related recommendations(s); Detailed conclusion.

7. Recommendations

To assess the usefulness and clarity of recommendations

Is there a *logical flow* from the conclusions to recommendations? Are they strategic and clearly presented in a priority order, which is consistent with the *prioritization* of conclusions? Are they *useful* – sufficiently detailed, targeted and likely to be implemented and lead to *further action*? How have the recommendations *incorporated* stakeholders' views and has this affected their i*mpartiality*?

- Recommendations flow logically from conclusions;
- Recommendations must be strategic, targeted, realistic and operationally-feasible;
- Recommendations must take into account stakeholders' consultations whilst remaining impartial;
- Recommendations should be presented in priority order
- Recommendations include: Summary; Priority level (very high/high/medium); Target (administrative unit(s) to which the recommendation is addressed); Origin (which conclusion(s) the recommendation is based on); Operational implications.

8. Meeting Needs

To ensure that Evaluation Report responds to requirements (scope and evaluation questions) stated in the ToR

Does the report adequately address the information needs and responds to the *requirements stated in the* ToRs? In particular, does the report respond to the evaluation questions identified in the inception report?

Annex 4. UNFPA strategic frameworks for family planning

Strategic Plan 2008-2011
Outcome 3
Access to and utilization of quality voluntary family planning services by individuals and couples increased according to reproductive intentions
Focus
▪ The urgent need to re-energize family planning programmes including their integration within comprehensive reproduction health services; ▪ Dual protection with condoms to prevent STIs and HIV infection and pregnancy; ▪ Greater access to a range of modern contraceptives, including among the most vulnerable, such as women living in poverty and people living with HIV, including young people; ▪ Improving services, particularly counselling, to facilitate informed choice; ▪ Ensuring a reliable and consistent supply of reproductive health commodities; ▪ Demand generation strategies such as strategic communication and community mobilization

Development Results Framework 2012-2013
Outcome 3
(8) Increased access to and utilization of quality family planning services for individuals and couples according to reproductive intentions
Outputs
1. Strengthened national systems for reproductive health commodity security
2. Strengthened national capacity for community-based interventions for family planning
Outputs related to: Family planning in humanitarian settings
1. Increased capacity to implement the minimal Initial Service Package (MISP) in humanitarian settings *(output 7 under outcome 2)*
2. Strengthened national capacity for addressing gender-based violence and provision of quality services, including in humanitarian settings *(output 13 under outcome 5)*

Reproductive Rights and Sexual and Reproductive Health Framework 2008-2011
Outcome 3
Access to and utilization of quality voluntary family planning services by individuals and couples increased to their reproductive intentions
Priorities
1. Unmet need: ▪ will be addressed and complemented by demand creation with SBCC and community mobilization ▪ Emphasis will be placed on disadvantaged groups (poor people, youth, refugees, IDPs, person with disabilities, and ethnic minorities) ▪ Family planning services must ensure availability of a broad range of methods that meet reproductive health needs and intentions ▪ Family planning services need to be an integrated part of relevant SRH services
2. Capacity development: ▪ Will focus on those cadres of service providers who deliver outreach services ▪ Quality of care (incl. counselling for method selection and switching) is an important component of capacity development ▪ Offer of a wide range of safe and effective modern methods to enable individuals and couples to choose the method that best suit their perceived needs ▪ Need to ensure a sufficient supply of commodities through a reliable logistics system within the health system ▪ R&D as a long-term venture that needs investment to produce both male and female controlled new methods of contraception
Strategy 1: Undertaking advocacy and policy support for quality family planning as part of SRH services
Key Activities: ▪ Promoting the development, strengthening and sustainability of family planning information and services, including commodities, with an emphasis on their preventive nature, incl. emergency contraceptives; ▪ Developing and supporting strategies (e.g. social marketing, community mobilization) to address the population access barriers by reducing out-of-pocket payments and by focusing on target groups;

- Promoting consistent and sustainable access to, and correct use of, male and female condoms;
- Building partnerships and advocating for research on new methods of contraception
- Undertaking advocacy and partnerships with faith-based organizations, religious leaders and parliamentarians.

Strategy 2: Developing capacity within health systems, particularly among providers, for the provision of quality family planning services

Key Activities:

- Supporting technical assistance for including or updating family planning modules as part of the basic professional training of nurses, midwives and medical practitioners;
- Supporting capacity development for improved management of family planning information and services
- Strengthening national systems for RHCS to ensure the availability of a comprehensive range of contraceptive methods, especially underutilized methods such as emergency contraception
- Developing strategies for improved access for disadvantaged groups such as poor people, youth, single women and refugees and IDPs through multiple settings such as clinics, health posts, workplaces, schools and colleges, camps, community outreach programmes and other community spaces, private-sector providers, pharmacists and other retail outlets;
- Supporting demand creation using strategic communications through the application of innovative communication strategies and audio-visual technology that is easily adaptable at field level;
- Meeting needs in emergency, humanitarian and displacement situations through rapid assessments, the distribution of emergency supplies and equipment, training and capacity development, incl. the Minimum Initial Service Package.

Strategy 3: Integrating family planning within SRH services

Key Activities:

- Establishing coordination mechanisms among SRH programme components, especially service provision for HIV-positive women, prevention and management of GBV, and youth-friendly services;
- Applying the results of operations research for innovative approaches to service delivery.

Global Programme to Enhance Reproductive Health Commodity Security 2007-2012
Outcome
(9) Increased availability, access to and utilization of reproductive health commodities for voluntary family planning, HIV/STI prevention and maternal health services in the GPRHCS focus countries
Outputs
1. Country RHCS strategic plans developed, co-ordinated and implemented by governments with their partners
2. Political and financial commitment for RHCS enhanced
3. Capacity and systems strengthened for RHCS
4. RHCS mainstreamed into UNFPA core business

Preventing HIV and Unintended Pregnancies – Strategic Framework 2011-2015
Prong 2
Prevention of unintended pregnancies in women living with HIV (as part of rights-based sexual and reproductive health of people living with HIV
Key interventions
1.Information and counselling to support reproductive rights, including preventing unintended pregnancies
2. Clinical management of HIV -- including treatment as prevention (offering antiretroviral to HIV-positive partners contributes to primary prevention – e.g. HIV-positive partners of HIV-negative pregnant women)
3. Rights-based family planning counselling and services
4. STI screening and management
5. Gender-based violence prevention and impact mitigation
6. Stigma and discrimination eradication
7.* HIV counselling and testing (particularly for pregnant, postpartum, and breastfeeding women and their male partners) and referral for, or on-site treatment
8.* Condoms (female and male): promotion, provision and building skills for negotiation and use
* Key interventions 7 and 8 pertain to *Prong 1 on Primary prevention of HIV*: *rationale and package of essential services;* they are listed here given their high level of complementary with Prong 2 key interventions

Annex 3: Bibliography for the evaluation matrix

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Annex 4: Portfolio of UNFPA Family Planning Interventions 2008-2013

*Total budget and expenditure for all outcome codes **versus** budget and expenditure for Family Planning (U3) and GPRHCS(ZZT05)*

U3: Increased access to and utilization of quality family planning services for individuals and couples according to reproductive intentions.
ZZT05: Global Programme to Enhance Reproductive Health Commodity Security, GPRHCS

Blue box	Sum total of budget and expenditure: the UNFPA country program in each of the UNFPA regions
Red box	Sum total of budget and expenditure: core Family Planning FP (coded as U3) and GPRHCS (coded as ZZT05)
Orange box	Some of the GPRHCS budget/expenditure figures are double-coded with the core U3 code for Family Planning, FP. This must be subtracted to avoid double-counting
Green box	Sum total of budget and expenditure of core Family Planning, FP (U3) and GPRHCS (ZZT05): the sum (FP+GPRHCS) minus the GPRHCS figures coded as FP

All figures: 000 US $		UNFPA BUDGET/EXPENDITURE		FAMILY PLANNING BUDGET/EXPENDITURE((FP + GPRHCS) – GPRHCS coded as FP)							
		TOTAL		FP only		GPRHCS only		GPRHCSasFP		(FP+GPRHCS) – GPRHCSasFP	
Year	Country	BUDGET	EXPENDITURE	BUDGET	EXPENDITURE	BUDGET	EXPENDITURE	BUDGET	EXPENDITURE	BUDGET	EXPENDITURE
Eastern and Southern Africa											
2008-2013	**Angola**	22,926	19,916	2,549	2,007	377	262	377	262	2,549	2,007
2008-2013	**Botswana**	16,707	15,234	0	0	1,056	736	0	0	1,056	736
2008-2013	**Burundi**	34,181	29,742	3,168	2,888	1,999	1,748	1,989	1,749	3,178	2,887
2008-2013	**Comoros**	10,294	8,951	523	468	290	255	290	255	523	468
2008-2013	**Dem Republic of Congo**	103,977	88,134	4,308	2,791	6,077	4,762	3,102	1,925	7,283	5,628
2008-2013	**Eritrea**	25,891	22,686	176	8	175	125	37	14	314	119
2008-2013	**Ethiopia**	111,698	89,152	6,123	4,896	9,709	7,242	2,760	1,912	13,072	10,226
2008-2013	**Kenya**	50,036	43,438	0	0	338	282	0	0	338	282
2008-2013	**Lesotho**	18,714	16,165	0	0	2,095	1,471	0	0	2,095	1,471
2008-2013	**Madagascar**	43,826	40,003	8,984	8,176	7,768	7,203	7,597	7,034	9,155	8,345
2008-2013	**Malawi**	70,657	58,379	9,811	6,379	914	760	454	379	10,271	6,760
2008-2013	**Mauritius**	545	459	0	0	0	0	0	0	0	0
2008-2013	**Mozambique**	85,125	70,990	1,873	1,626	6,623	5,214	1,504	1,383	6,992	5,457
2008-2013	**Namibia**	19,968	17,982	0	0	798	783	0	0	798	783
2008-2013	**Rwanda**	43,449	39,162	5,412	5,013	626	511	526	411	5,512	5,113
2008-2013	**Seychelles**	518	411	0	0	0	0	0	0	0	0
2008	**South Africa Johannesburg**	574	294	237	0	100	62	0	0	337	62
2008-2013	**South Africa Pretoria**	19,807	17,505	32	24	529	472	0	0	561	496
2008-2013	**South Sudan**	81,798	54,928	0	0	660	565	0	0	660	565
2008-2013	**Swaziland**	15,827	14,645	2,475	2,354	1,810	1,748	1,581	1,522	2,704	2,580
2008-2013	**Tanzania**	65,647	51,877	0	0	325	149	0	0	325	149
2008-2013	**Uganda**	107,333	94,464	24,580	21,723	1,348	1,217	1,103	961	24,825	21,979
2008-2013	**Zambia**	39,155	32,019	4,423	1,876	1,720	1,201	1,572	1,201	4,571	1,876

2008-2013	**Zimbabwe**	114,925	85,184	20,730	19,104	1,941	1,761	0	0	22,671	20,865
Subtotal ESARO		**1,103,578**	**911,720**	**95,404**	**79,333**	**47,278**	**38,529**	**22,892**	**19,008**	**119,790**	**98,854**
West and Central Africa											
2008-2013	**Benin**	27,394	25,055	2,379	1,785	2,379	1,785	2,379	1,785	2,379	1,785
2008-2013	**Burkina Faso**	60,796	51,808	19,805	17,750	15,557	13,628	15,557	13,756	19,805	17,622
2008-2013	**Cameroon**	33,689	27,897	1,757	1,410	194	118	0	0	1,951	1,528
2008-2013	**Cape Verde**	11,707	11,390	0	0	0	0	0	0	11,707	11,390
2008-2013	**Central African Republic**	33,823	29,944	484	464	710	635	162	146	1,032	953
2008-2013	**Chad**	60,468	53,782	2,757	2,639	4,125	3,925	2,198	2,164	4,684	4,400
2008-2013	**Congo**	25,842	22,480	186	79	1,526	1,210	110	35	1,602	1,254
2008-2013	**Côte d'Ivoire**	64,227	56,197	2,451	1,913	4,087	3,535	1,366	1,018	5,172	4,430
2008-2013	**Equatorial Guinea**	10,918	8,731	0	0	0	0	0	0	10,918	8,731
2008-2013	**Gabon**	11,228	10,011	114	99	1,541	1,347	0	0	1,655	1,446
2008-2013	**Gambia**	12,281	11,383	262	242	2,579	2,363	0	0	2,841	2,605
2008-2013	**Ghana**	33,214	27,347	0	14	1,347	878	0	0	1,347	892
2008-2013	**Guinea**	34,176	27,998	6,177	5,783	3,178	2,742	3,178	2,742	6,177	5,783
2008-2013	**Guiné-Bissau**	20,887	19,065	44	18	502	466	14	3	532	481
2008-2013	**Liberia**	42,492	35,710	2,014	1,558	1,774	1,417	1,616	1,256	2,172	1,719
2008-2013	**Mali**	36,773	31,587	0	-15	6,268	5,058	0	0	6,268	5,043
2008-2013	**Mauritania**	29,682	26,737	1,094	752	1,279	937	569	260	1,804	1,429
2008-2013	**Niger**	70,589	56,405	0	0	10,694	7,965	0	0	10,694	7,965
2008-2013	**Nigeria**	139,239	94,954	53,955	32,749	7,338	6,182	6,683	5,615	54,610	33,316
2008-2013	**São Tome & Príncipe**	5,416	5,190	0	0	343	318	0	0	343	318
2008-2013	**Senegal**	42,129	30,093	0	0	4,821	3,844	0	0	4,821	3,844
2008-2013	**Sierra Leone**	74,226	61,204	5,824	3,338	12,223	11,620	1,241	1,202	16,806	13,756
2008-2013	**Togo**	21,166	19,511	2,267	2,053	2,746	2,444	1,505	1,384	3,508	3,113
Subtotal WCARO		**902,362**	**744,479**	**101,570**	**72,631**	**85,211**	**72,417**	**36,578**	**31,366**	**172,828**	**133,803**
Asia and the Pacific											
2008-2013	**Afghanistan**	89,480	64,691	5,157	4,605	210	164	210	164	5,157	4,605
2008-2013	**Bangladesh**	106,332	67,277	1,141	1,030	10	0	0	0	1,151	1,030
2008-2013	**Bhutan**	8,810	7,901	0	0	0	0	0	0	0	0
2008-2013	**Cambodia**	39,403	36,121	3,985	3,384	0	0	0	0	3,985	3,384
2008-2013	**China**	35,177	33,831	361	334	0	0	0	0	361	334
2008-2013	**Dem Republic of Korea**	16,630	12,662	1,101	944	0	0	0	0	1,101	944
2008-2013	**India**	86,105	75,504	8,408	7,157	0	0	0	0	8,408	7,157
2008-2013	**Indonesia**	44,761	39,892	2,328	2,123	0	0	0	0	2,328	2,123
2008-2013	**Iran**	13,462	13,058	499	486	0	0	0	0	499	486
2008-2013	**Lao**	21,984	19,963	4,744	4,500	2,684	2,421	1,052	980	6,376	5,941
2008-2013	**Malaysia**	2,643	2,456	187	179	0	0	0	0	187	179
2008-2013	**Maldives**	4,967	4,371	713	675	0	0	0	0	713	675
2008-2013	**Mongolia**	24,220	21,746	2,301	2,104	1,981	1,738	757	641	3,525	3,201
2008-2013	**Myanmar**	66,611	59,546	0	0	0	0	0	0	0	0

2008-2013	**Nepal**	48,112	36,557	0	0	264	29	0	0	264	29
2008-2009	**Fiji**	3,968	3,322	454	373	17	24	1	0	470	397
2008-2013	**Pakistan**	27,756	26,325	2,167	1,813	0	0	0	0	2,167	1,813
2008-2013	**Papua New Guinea**	22,565	19,125	1,027	749	447	228	407	191	1,067	786
2008-2013	**Philippines**	81,035	58,915	2,369	1,143	25	0	0	0	2,394	1,143
2008-2013	**Sri Lanka**	22,073	19,528	0	0	253	210	0	0	253	210
2008-2013	**Thailand**	16,960	14,684	0	0	0	0	0	0	0	0
2008-2013	**Timor Leste**	23,880	20,392	3,352	2,201	342	233	278	180	3,416	2,254
2008-2013	**Vietnam**	46,005	43,342	5,963	5,808	0	0	0	0	5,963	5,808
Subtotal APRO		**852,939**	**701,209**	**46,257**	**39,608**	**6,233**	**5,047**	**2,705**	**2,156**	**49,785**	**42,499**
Latin America and the Caribbean											
2008-2013	**Argentina**	5,160	4,703	0	0	0	0	0	0	0	0
2009/2012	**Belize**	23	18	0	0	0	0	0	0	0	0
2008-2013	**Bolivia**	21,349	19,848	5,221	4,872	2,256	2,008	2,256	2,008	5,221	4,872
2008-2013	**Brazil**	23,330	21,223	0	0	32	31	0	0	32	31
2008-2013	**Chile**	1,830	1,573	0	0	0	0	0	0	0	0
2008-2013	**Colombia**	46,324	44,302	0	0	0	0	0	0	0	0
2008-2013	**Costa Rica**	7,228	7,094	26	26	0	0	0	0	26	26
2008-2013	**Cuba**	1,090	745	154	47	0	0	0	0	154	47
2008-2013	**Dominican Republic**	12,885	11,966	0	0	56	56	0	0	56	56
2008-2013	**Ecuador**	18,989	16,972	1,924	1,650	2,590	2,043	1,236	1,132	3,278	2,561
2008-2013	**El Salvador**	16,247	14,229	352	354	400	389	0	0	752	743
2008-2013	**Guatemala**	48,367	40,481	0	0	0	0	0	0	0	0
2008-2013	**Haiti**	66,183	54,135	4,956	3,827	4,270	3,521	1,793	1,629	7,433	5,719
2008-2013	**Honduras**	22,492	20,810	977	817	466	327	417	279	1,026	865
2008-2013	**Mexico**	23,752	22,889	2,562	2,463	0	0	0	0	2,562	2,463
2008-2013	**Nicaragua**	49,841	42,297	6,537	5,197	3,756	3,315	1,732	1,586	8,561	6,926
2008-2013	**Panama**	8,096	7,434	1,706	1,417	424	405	233	230	1,897	1,592
2008-2013	**Paraguay**	8,108	7,827	0	0	0	0	0	0	0	0
2008-2013	**Peru**	28,540	26,857	1,036	1,034	498	507	186	187	1,348	1,354
2011-2013	**Uruguay**	2,493	1,551	1,805	1,118	98	98	98	98	1,805	1,118
2008-2013	**Venezuela**	27,859	22,189	5,954	4,281	0	0	0	0	5,954	4,281
Subtotal LACRO		**440,186**	**389,143**	**33,210**	**27,103**	**14,846**	**12,700**	**7,951**	**7,149**	**40,105**	**32,654**
Arab states											
2008-2013	**Algeria**	7,846	5,131	0	0	0	0	0	0	0	0
2008-2013	**Djibouti**	11,347	8,749	827	357	577	383	527	333	877	407
2008-2013	**Egypt**	22,508	21,445	2,377	2,712	0	0	0	0	2,377	2,712
2008-2013	**Iraq**	50,563	35,513	4,281	3,408	0	0	0	0	4,281	3,408
2008-2013	**Jordan**	14,011	11,498	4,147	3,758	0	0	0	0	4,147	3,758
2008-2013	**Lebanon**	16,628	13,101	0	0	0	0	0	0	0	0
2012-2013	**Libya**	2,466	1,450	0	0	0	0	0	0	0	0
2008-2013	**Morocco**	25,293	18,342	3,890	998	0	0	0	0	3,890	998

2008-2013	**Palestine**	34,116	29,749	0	0	250	268	0	0	250	268
2008-2013	**Oman**	6,191	4,697	0	1	0	0	0	0	0	1
2012-2013	**Qatar**	26	0	0	0	0	0	0	0	0	0
2008-2013	**Somalia**	46,933	36,411	0	0	530	458	0	0	530	458
2008-2013	**Sudan**	113,171	94,518	5,680	4,879	1,203	1,091	1,054	942	5,829	5,028
2008-2013	**Syria**	37,697	30,976	2,808	1,242	0	0	0	0	2,808	1,242
2008-2013	**Tunisia**	6,318	5,020	0	0	0	0	0	0	0	0
2008-2013	**Yemen**	46,629	33,403	1,373	1,067	0	0	0	0	1,373	1,067
Subtotal ASRO		**441,743**	**350,003**	**25,383**	**18,422**	**2,560**	**2,200**	**1,581**	**1,275**	**26,362**	**19,347**
Eastern Europe and Central Asia											
2008-2013	**Albania**	11,236	8,568	2,734	2,039	0	0	0	0	2,734	2,039
2008-2013	**Armenia**	6,110	5,552	3	3	0	0	0	0	3	3
2008-2013	**Azerbaijan**	7,789	7,087	391	383	0	0	0	0	391	383
2008-2013	**Belarus**	3,726	3,538	0	0	0	0	0	0	0	0
2008-2013	**Bosnia & Herzegóvina**	6,131	4,928	77	75	0	0	0	0	77	75
2008-2012	**Bulgaria**	985	716	0	0	0	0	0	0	0	0
2010-2011	**Cyprus**	148	0	0	0	0	0	0	0	0	0
2008-2013	**Georgia**	12,314	11,741	624	604	54	53	0	0	678	657
2008-2013	**Kazakhstan**	5,808	5,380	543	530	0	0	0	0	543	530
2008-2013	**Kosovo**	5,694	5,047	214	152	0	0	0	0	214	152
2008-2013	**Kyrgyzstan**	7,280	6,904	0	0	141	141	0	0	141	141
2009-2010	**Lithuania**	29	0	0	0	0	0	0	0	0	0
2008-2013	**Moldova Republic**	4,509	4,321	1,007	951	0	0	0	0	1,007	951
2008	**Poland**	16	16	0	0	0	0	0	0	0	0
2008-2012	**Romania**	3,520	3,470	0	0	0	0	0	0	0	0
2008-2013	**Russian Federation**	10,992	10,170	0	0	0	0	0	0	0	0
2008-2013	**Serbia**	1,325	1,059	95	67	0	0	0	0	95	67
2008-2013	**Tajikistan**	7,424	7,230	1,110	1,083	149	148	149	148	1,110	1,083
2008-2013	**Macedonia**	3,164	2,606	204	198	0	0	0	0	204	198
2008-2013	**Turkey**	22,201	20,157	42	41	0	0	0	0	42	41
2008-2013	**Turkmenistan**	5,250	5,035	209	236	123	121	0	0	332	357
2008-2013	**Ukraine**	8,453	9,695	666	662	160	159	160	159	666	662
2008-2013	**Uzbekistan**	10,620	9,995	671	655	88	86	88	86	671	655
Subtotal EECARO		**144,724**	**133,215**	**8,590**	**7,679**	**715**	**708**	**397**	**393**	**8,908**	**7,994**

000 US $	UNFPA BUDGET/EXPENDITURE		FAMILY PLANNING BUDGET/EXPENDITURE							
	TOTAL		FP only		GPRHCS only		GPRHCS as FP		(FP+GPRHCS) – GPRHCS as U3	
Region	BUDGET	EXPENDITURE	BUDGET	EXPENDITURE	BUDGET	EXPENDITURE	BUDGET	EXPENDITURE	BUDGET	EXPENDITURE
Eastern and Southern Africa	1,103,578	911,720	95,404	79,333	47,278	38,529	22,892	19,008	119,790	98,854
West and Central Africa	902,362	744,479	101,570	72,631	85,211	72,417	36,578	31,366	172,828	133,803
Asia and the Pacific	852,939	701,209	46,257	39,608	6,233	5,047	2,705	2,156	49,785	42,499
Latin America and the Caribbean	440,186	389,143	33,210	27,103	14,846	12,700	7,951	7,149	40,105	32,654
Arab States	441,743	350,003	25,383	18,422	2,560	2,200	1,581	1,275	26,362	19,347
Eastern Europe and Central Asia	144,724	133,215	8,590	7,679	715	708	397	393	8,908	7,994
TOTAL WORLD	**3,885,532**	**3,229,769**	**310,414**	**244,776**	**156,843**	**131,601**	**72,104**	**61,347**	**417,778**	**335,151**

Period covered: 2008-2013. Data not available for the entire period: this is indicated in the left column.

Annex 5: Theory of Change

The theory of change (ToC) is a representation of the organisation's concept of how change occurs, and underlies intervention design(UNEG 2011). Although UNFPA did not explicitly established a theory of change when defining its strategies and programmes for family planning during the evaluation period under review, the evaluation team has developed a reconstruction of the key elements of a ToC found in UNFPA documentation to help focus the evaluation questions and carry out the contribution analysis. This reconstruction must be seen as a working tool to help integrate elements of the different strategic documents and to identify the type of strategies and modes of engagement which were proposed by UNFPA during the evaluation period. The reconstructed ToC helps to focus the evaluation questions on the processes of change, the linkages between the areas of investigation, the cross-cutting themes and the external factors and risks. It helps the evaluators to identify the contribution of UNFPA to these elements and to achievement of change. Being a reconstruction and a working tool to provide a graphical representation of the expected processes of change, it will be reviewed and revised during the course of the evaluation when necessary.

The elements of UNFPA ToC for family planning and its evolution through time can be identified from the key strategic documents referred to earlier and listed in Table 2 below. During the evaluation period 2008-2013, the strategies and policies of UNFPA have consistently included family planning as part of the core business. However, there have been changes in emphasis and focus, particularly with the advent of GPRHCS Phases I and II and the *Choices not Chance* strategy. The nature of expected family planning outputs have not changed significantly over the period, but ways of defining and measuring them have become more specific. The reconstruction of the UNFPA ToC for family planning has taken into account these changes in focus and process.

In the first years of the evaluation period (Phase 1, 2008-2011) the interventions of UNFPA followed the ICPD programme of action, integrating family planning into SRH and rights as part of a holistic approach. The GPRHCS commenced at the start of the evaluation period with a strong focus on family planning within a rights-based approach, and contributing important additional resources to mainly supply-side activities.

The MTR of the UNFPA strategic plan in 2011 recommended a clearer definition of supply and demand-side family planning outputs. The London Family Planning Summit of 2012 also led to a repositioning of family planning and commitments to resource allocation specifically for family planning both within and outside UNFPA, whilst continuing to emphasise the rights-based approach and maintain consistency with the ICPD Programme of Action. The response of UNFPA to these changes included more emphasis on the supply side and commodity security within a rights-based approach, which included attention to service quality and community-based family planning interventions.

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The representation of the ToC was used to identify pathways of change related to each of the eight areas of investigation included in the evaluation, basing the pathways on the activities and interventions specified in the policy and programme documents. For each area of investigation the pathways were traced on the ToC diagram. The principal questions related to these pathways were then identified and developed into assumptions to be tested in the evaluation process (see evaluation matrix in next section), bearing in mind the linkages between the areas of investigation as well as the cross-cutting themes and the external factors which affect each one of them.

An example of the process is shown below for the first area of investigation (integration of family planning with other SRH services). The principal strategy area associated with this theme is "Integration of FP in SRH". This area is related to activities in all four modes of engagements:

- In the **Advocacy** cluster there are activities at policy level and at community level, expected to lead to outputs of national ownership and integrated services, which in turn lead to improved quality and increased demand.
- In the **Support for Service Delivery** cluster there are activities at policy, service delivery and user level, with a particular focus on vulnerable and marginalised groups. Again, these activities are expected to lead to integrated services and improved quality.
- The **Capacity Building** cluster is expected to lead to increased demand from users together with increased capacity to meet that demand.
- The **Knowledge Management** cluster is associated with situation analysis and knowledge sharing, both expected to lead to more service integration and hence to increased demand.

There is necessarily some overlap between these pathways, reflecting the inter-relationships between activities, strategies and outputs mentioned above. External factors and cross-cutting issues have not been traced on the diagram since they are specific to each country context. However, they were analysed in the next stage which consisted in "unpacking" the principal evaluation questions and developing assumptions for testing during the evaluation.

Initial sketches of pathways of change have been developed for the other seven evaluation areas, and are shown in Annex 1. The diagrams show the complex inter-relationships and multiple pathways between modes of engagement and outputs.

The draft ToC figure and the pathways of change for each evaluation area will serve as working tools throughout the evaluation. In this first stage they have been used to develop the evaluation matrix. They will be reviewed and checked during the data collection and analysis phases, and are expected to change as the evaluation identifies how proposed interventions were put into practice, the contribution of UNFPA to change, the effect of external factors and the risks, the cross-cutting issues and the influence of progress in other related areas of work covered by other elements of the evaluation matrix.

Diagram 1: Theory of Change to trace pathways of change – Investigation Area 1: INTEGRATION

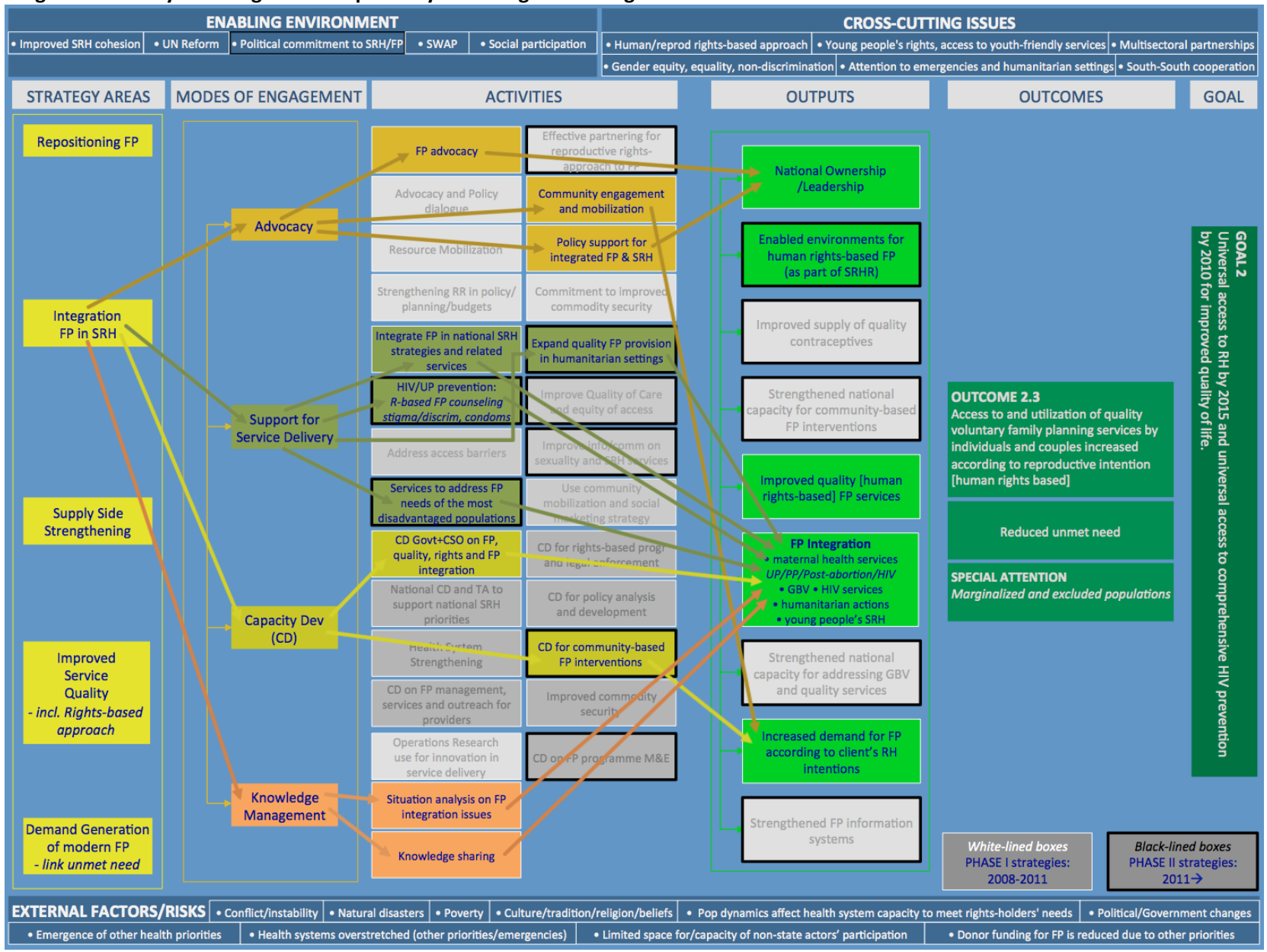


Diagram 2: Theory of Change to trace pathways of change –Investigation Area 2: COORDINATION

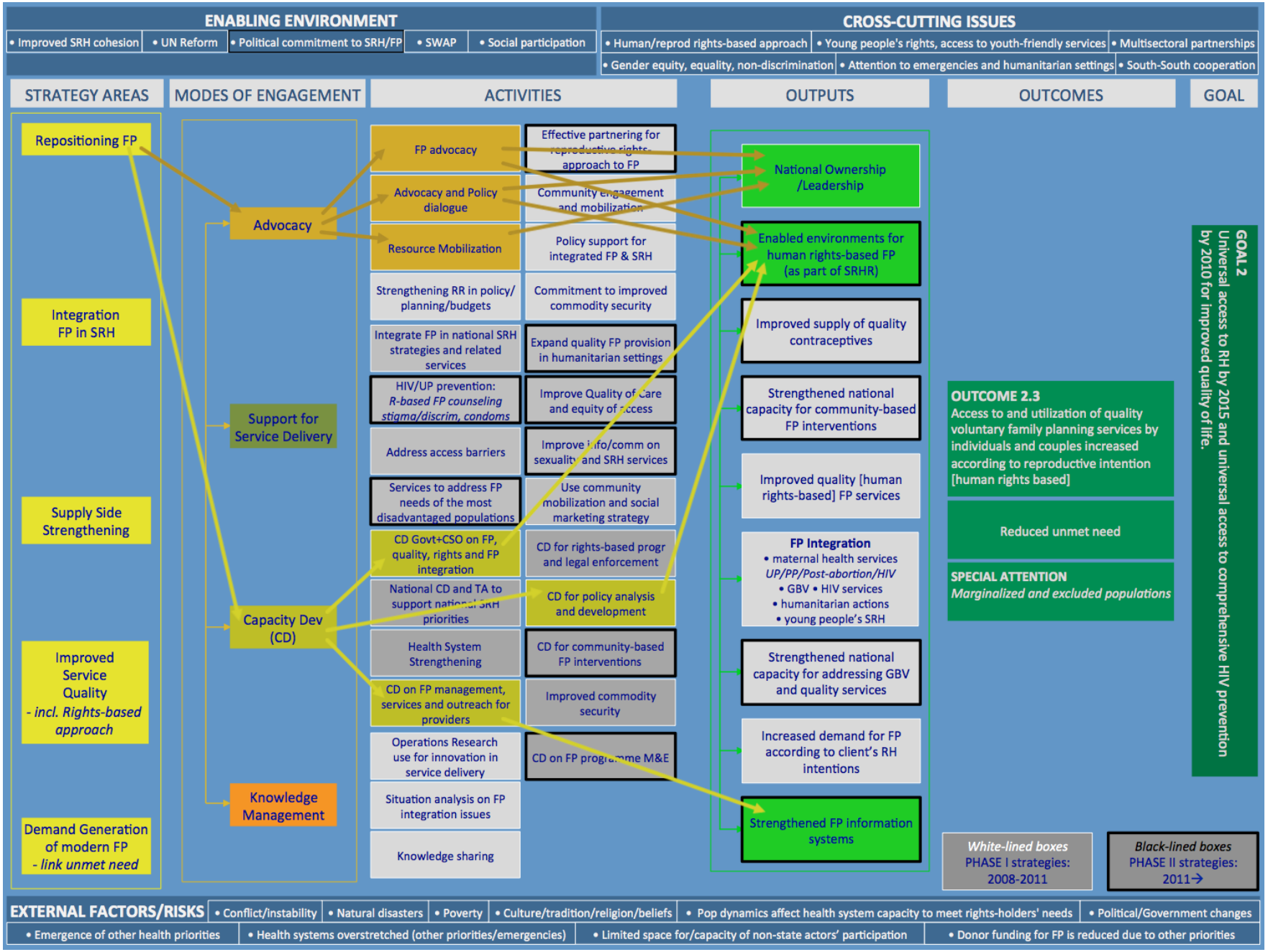


Diagram 3: Theory of Change to trace pathways of change – Investigation Area 3: BROKERAGE AND PARTNERSHIP

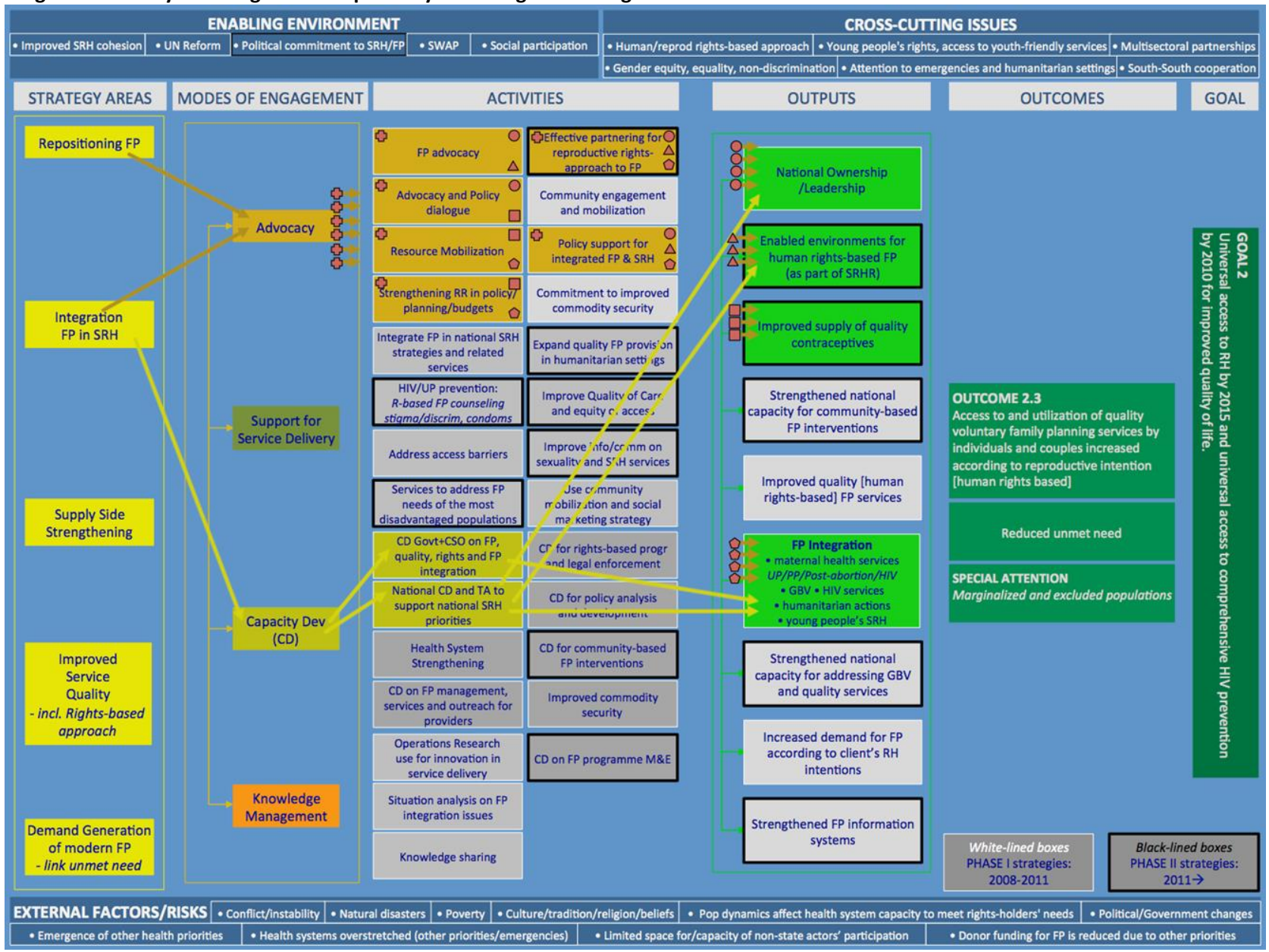


Diagram 4: Theory of Change to trace pathways of change – Investigation Area 4: ENABLING ENVIRONMENT

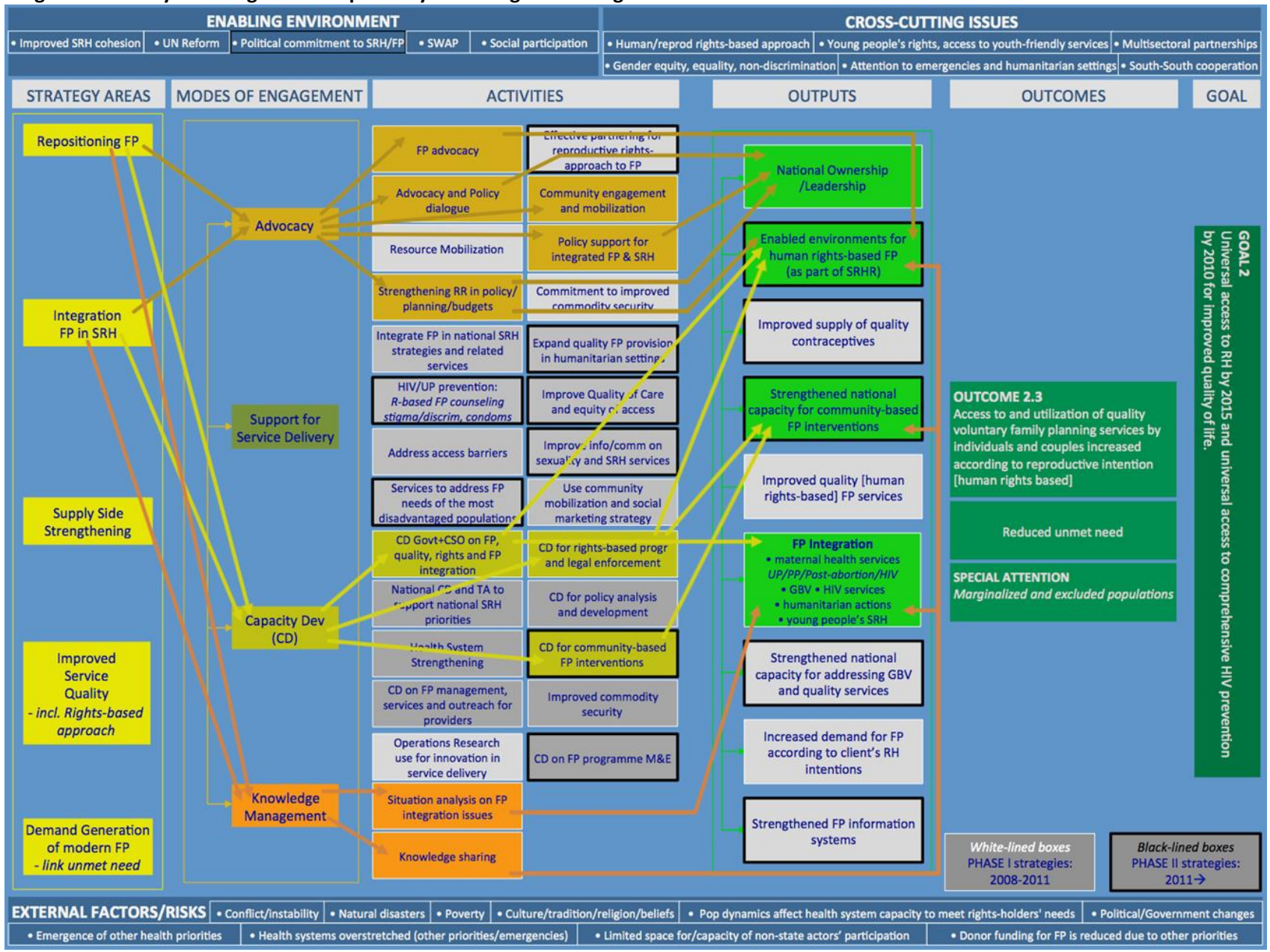


Diagram 5: Theory of Change to trace pathways of change – Investigation Area 5: VULNERABLE AND MARGINALISED GROUPS

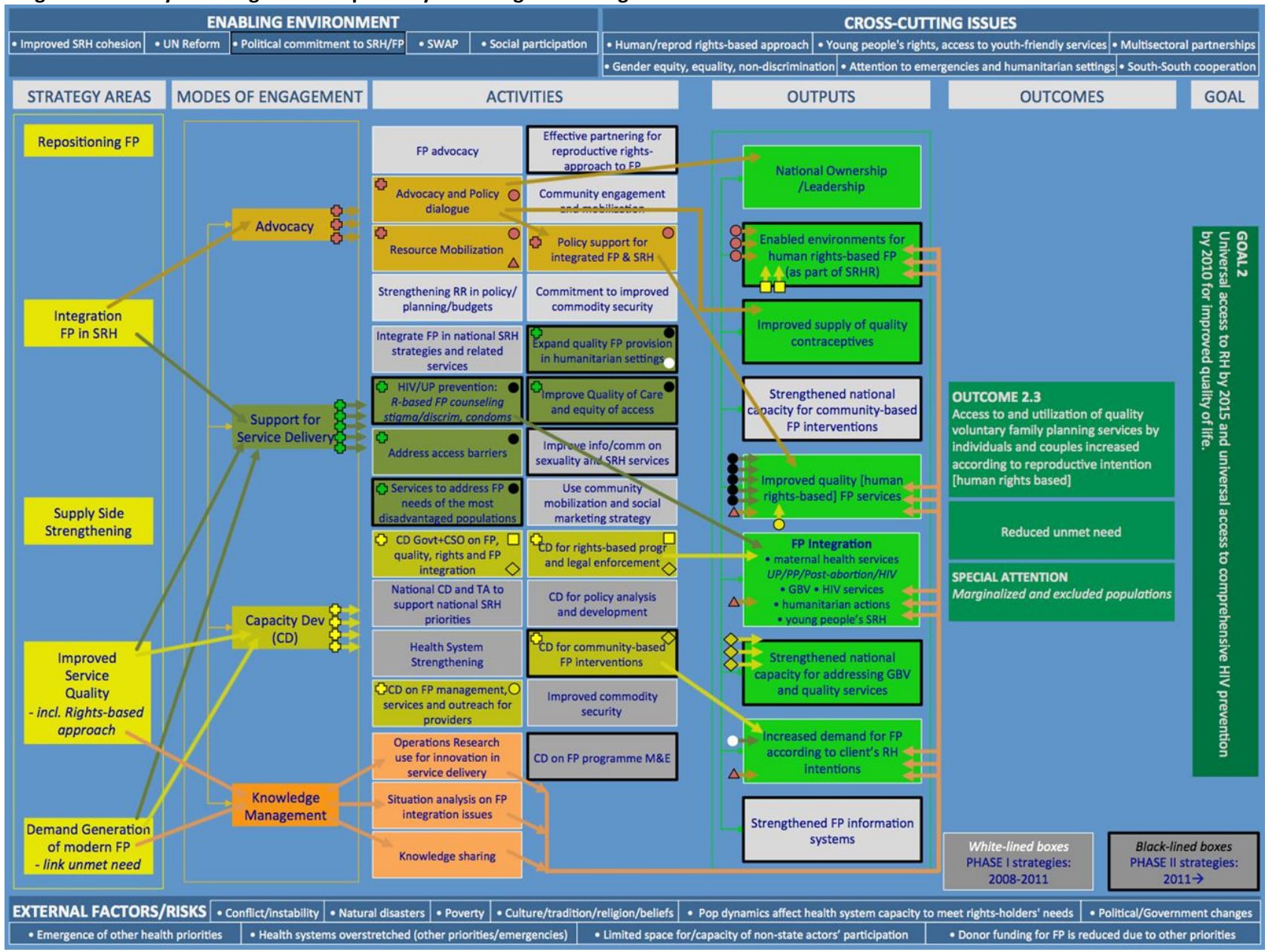


Diagram 6: Theory of Change to trace pathways of change – Investigation Area 6: RIGHTS-BASED APPROACH

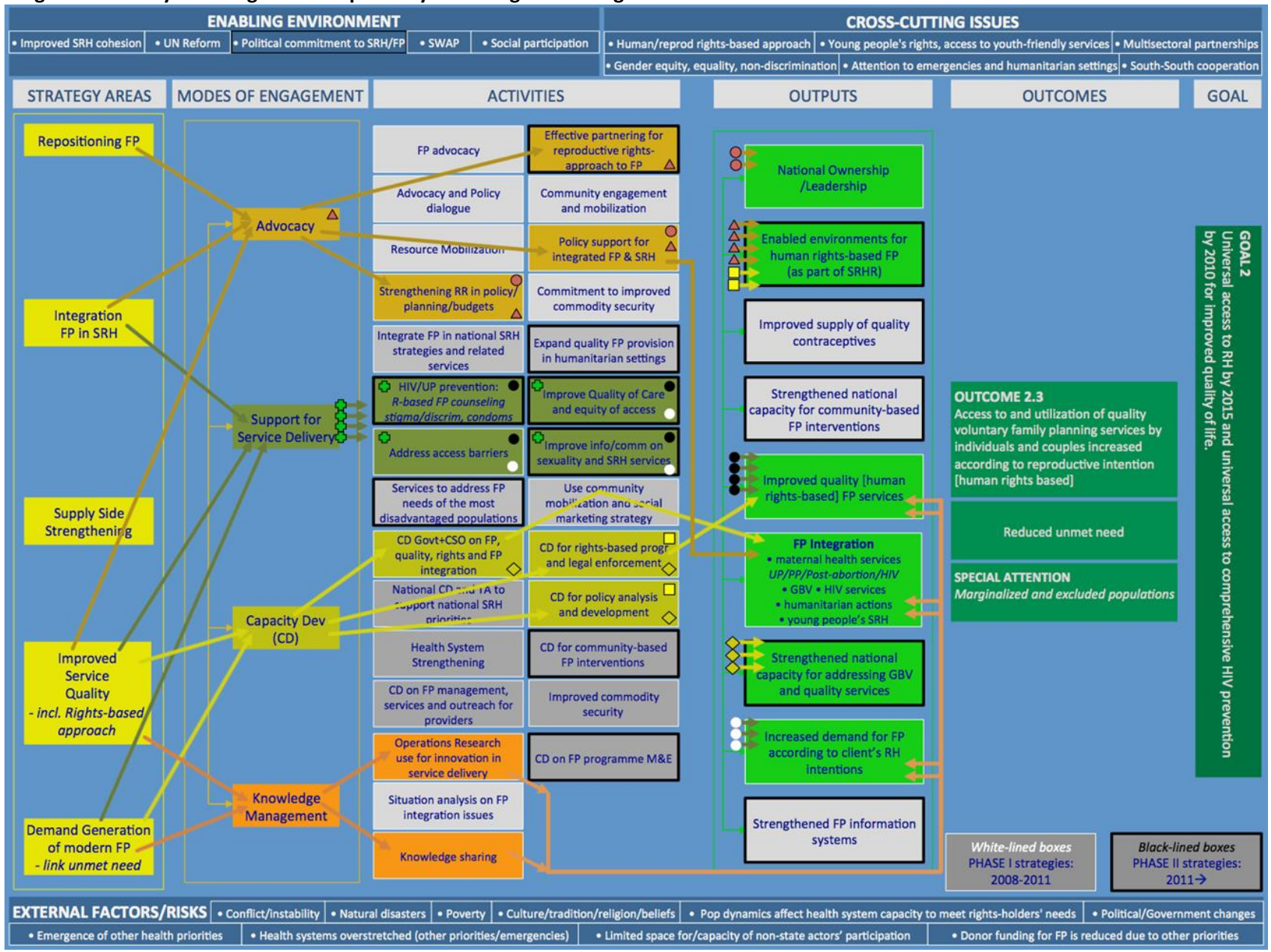


Diagram 7: Theory of Change to trace pathways of change – Investigation Area 7: MODES OF ENGAGEMENT

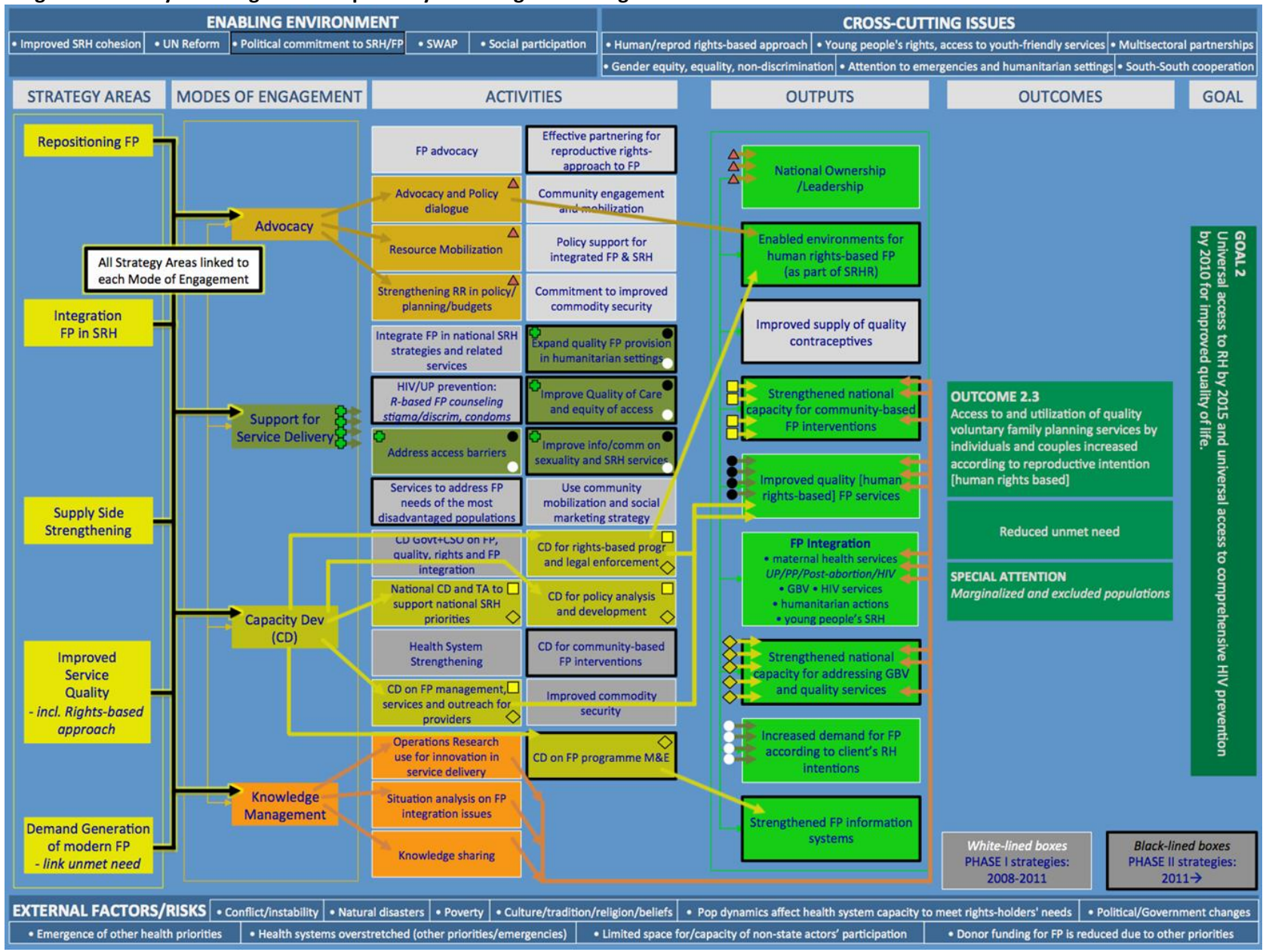
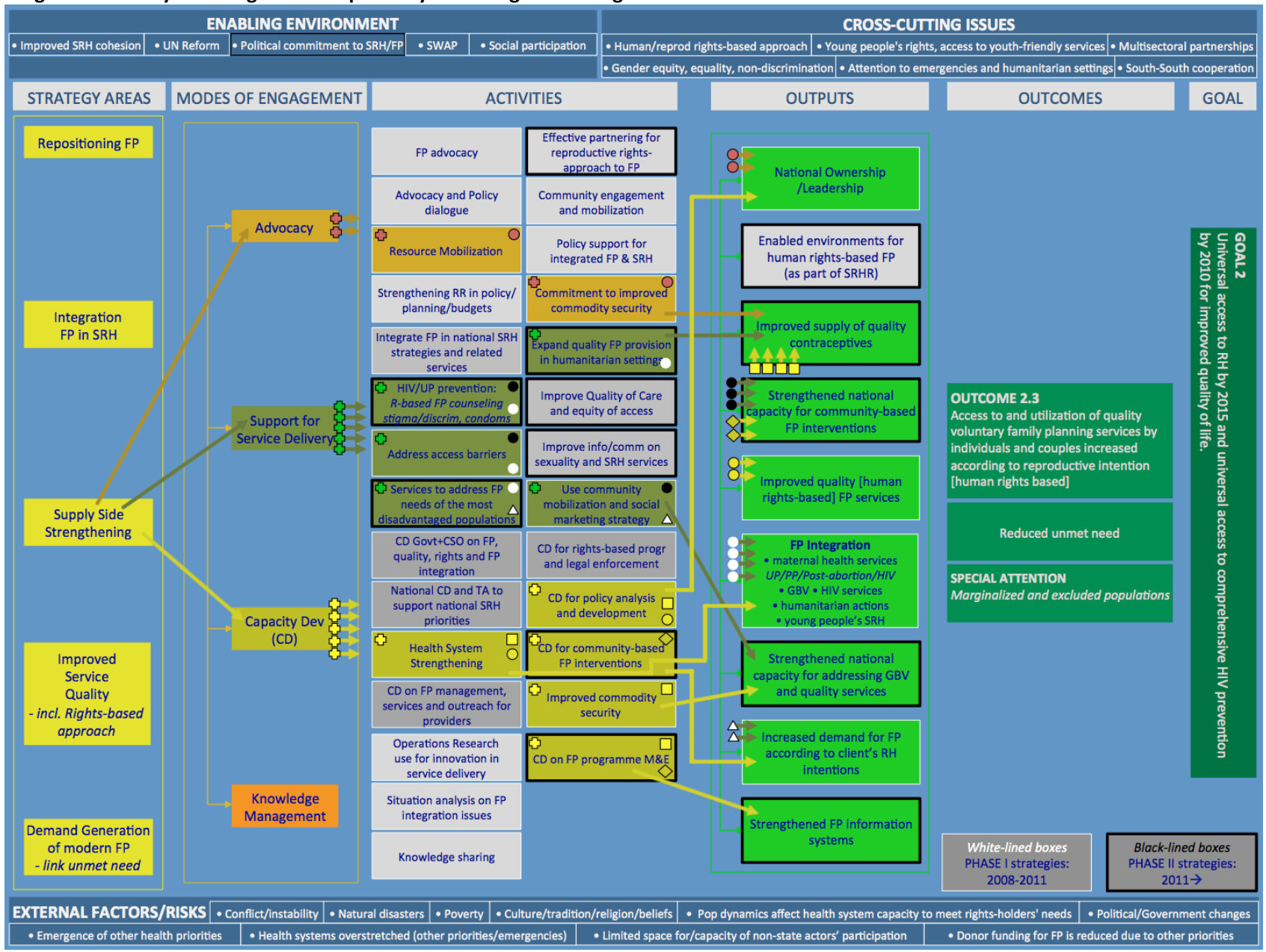


Diagram 8: Theory of Change to trace pathways of change – Investigation Area 8: SUPPLY-SIDE ACTIVITIES



Annex 6: Country tables

Table 1: The 69 poorest countries in the FP2020 group

List of FP2020 countries (69)	
Afghanistan	Malawi
Bangladesh	Mali
Benin	Mauritania
Bhutan	Mongolia
Bolivia	Mozambique
Burkina Faso	Myanmar
Burundi	Nepal
Cambodia	Nicaragua
Cameroon	Niger
CAR	Nigeria
Chad	Pakistan
Comoros	Palestine
Congo	Philippines
Cote d'Ivoire	PNG
Djibouti	Rwanda
DRC	São Tomé
DRK	Senegal
Egypt	Sierra Leone
Eritrea	Solomon Islands
Ethiopia	Somalia
Gambia	South Africa
Ghana	South Sudan
Guinea	Sri Lanka
Guinea-Bissau	Sudan
Haiti	Tajikistan
Honduras	Tanzania
India	Timor-Leste
Indonesia	Togo
Iraq	Uganda
Kenya	Uzbekistan
Kyrgyzstan	Vietnam
Lao	Yemen
Lesotho	Zambia
Liberia	Zimbabwe
Madagascar	

Table 2: List of countries receiving direct FP interventions via core support or GPRHCS thematic fund (2008 – 2013) (103)

ESA	WCA	AP	LAC	AS	EEC
Angola	Benin	Afghanistan	Argentina		Albania
Botswana	Burkina Faso	Bangladesh	Bolivia	Djibouti	Armenia
Burundi	Cameroon	Bhutan	Brazil	Egypt	Azerbaijan
Comoros	Cape Verde	Cambodia	Chile	Iraq	Bosnia i Herzegovina
DRC	CAR	China	Cuba	Jordan	Georgia
Eritrea	Chad	DRK	Dominican Republic	Morocco	Kazakhstan
Ethiopia	Congo	India	Ecuador	Palestine	Kyrgyzstan
Kenya	Cote d'Ivoire	Indonesia	El Salvador	Somalia	Serbia
Lesotho	Equatorial Guinea	Iran	Haiti	Sudan	Tajikistan
Madagascar	Gabon	Lao	Honduras	Syria	Macedonia
Malawi	Gambia	Malaysia	Mexico	Yemen	Turkey
Mozambique	Ghana	Maldives	Nicaragua		Turkmenistan
Namibia	Guinea	Mongolia	Panama		Ukraine
Rwanda	Guinea-Bissau	Myanmar	Peru		Uzbekistan
Seychelles	Liberia	Nepal	Uruguay		
South Africa	Mali	Pakistan	Venezuela		
South Sudan	Mauritania	PNG			
Swaziland	Niger	Philippines			
Tanzania	Nigeria				
Uganda	São Tomé				
Zambia	Senegal				
Zimbabwe	Sierra Leone				
	Togo				

Table 3: Countries which have implemented the Rapid Assessment Tool by June 2014 – total 46, 32 of which are FP2020 countries

AFRICA	ARAB STATES	ASIA PACIFIC	EASTERN EUROPE AND CENTRAL ASIA	LATIN AMERICA AND THE CARIBBEAN
Benin	Lebanon	Afghanistan	Kyrgyzstan	Belize
Botswana	Morocco	Bangladesh	Russian Federation	Barbados
Burundi	Sudan	India		Dominican Republic
Burkina Faso	Tunisia	Indonesia		Guatemala
CAR		Maldives		Haiti
Cote d'Ivoire		Nepal		Jamaica
DRC		Pakistan		
Ghana		Sri Lanka		
Guinea Bissau		Vietnam		
Lesotho				
Malawi				
Mali				
Namibia				
Niger				
Nigeria				
Rwanda				
Senegal				
South Africa				
Swaziland				
Tanzania				
Togo				
Uganda				
Zambia				
Zanzibar				
Zimbabwe				

Source: *IPPF*: *RA_implementation_country_information_2014.pdf*
(FP2020 countries in red)

Table 4: List of GPRHCS countries (46)

Benin	Ethiopia	Malawi	Sierra Leone
Bolivia	Gambia	Mali	South Sudan
Burkina Faso	Ghana	Mauritania	Sudan
Burundi	Guinea	Mozambique	Tanzania
Cameroon	Guinea-Bissau	Myanmar	Timor-Leste
CAR	Haiti	Nepal	Togo
Chad	Honduras	Niger	Uganda
Congo (Brazzaville)	Kenya	Nigeria	Yemen
Côte d'Ivoire	Lao PDR	Papua New Guinea	Zambia
DRC	Lesotho	Rwanda	Zimbabwe
Djibouti	Liberia	Sao Tome and Principe	
Eritrea	Madagascar	Senegal	

Table 5: List of GPRHCS countries that had made commitments in national budget to RH commodities (25/46)

Benin	Ethiopia	Malawi	Sierra Leone
Bolivia	Gambia	Mali	South Sudan
Burkina Faso	Ghana	Mauritania	Sudan
Burundi	Guinea	Mozambique	Tanzania
Cameroon	Guinea-Bissau	Myanmar	Timor-Leste
CAR	Haiti	Nepal	Togo
Chad	Honduras	Niger	Uganda
Congo (Brazzaville)	Kenya	Nigeria	Yemen
Côte d'Ivoire	Lao PDR	Papua New Guinea	Zambia
DRC	Lesotho	Rwanda	Zimbabwe
Djibouti	Liberia	Sao Tome and Principe	
Eritrea	Madagascar	Senegal	

Source: *UNFPA GPRHCS Annual Report 2013, Annex 5*

Table 6: List of GPRHCS countries that actually spent money on RH commodities (18 of the 25/54)

Benin	Ethiopia	Malawi	Sierra Leone
Bolivia	Gambia	Mali	South Sudan
Burkina Faso	Ghana	Mauritania	Sudan
Burundi	Guinea	Mozambique	Tanzania
Cameroon	Guinea-Bissau	Myanmar	Timor-Leste
CAR	Haiti	Nepal	Togo
Chad	Honduras	Niger	Uganda
Congo (Brazzaville)	Kenya	Nigeria	Yemen
Côte d'Ivoire	Lao PDR	Papua New Guinea	Zambia
DRC	Lesotho	Rwanda	Zimbabwe
Djibouti	Liberia	Sao Tome and Principe	
Eritrea	Madagascar	Senegal	

Source: *UNFPA GPRHCS Annual Report 2013, Annex 5*

Table 7: List of FP 2020 countries in which government budgets have increased during the period under evaluation

List of FP2020 countries (69)	
Afghanistan	Malawi
Bangladesh	Mali
Benin	Mauritania
Bhutan	Mongolia
Bolivia	Mozambique
Burkina Faso	Myanmar
Burundi	Nepal
Cambodia	Nicaragua
Cameroon	Niger
CAR	Nigeria
Chad	Pakistan
Comoros	Palestine
Congo	Philippines
Cote d'Ivoire	PNG
Djibouti	Rwanda
DRC	São Tomé
DRK	Senegal
Egypt	Sierra Leone
Eritrea	Solomon Islands
Ethiopia	Somalia
Gambia	South Africa
Ghana	South Sudan
Guinea	Sri Lanka
Guinea-Bissau	Sudan
Haiti	Tajikistan
Honduras	Tanzania
India	Timor-Leste
Indonesia	Togo
Iraq	Uganda
Kenya	Uzbekistan
Kyrgyzstan	Vietnam
Lao	Yemen
Lesotho	Zambia
Liberia	Zimbabwe
Madagascar	

Source: Internet survey of UNFPA country offices.

- 66.7% of respondents reported increased government budgets (57 returned questionnaires = 90% response rate).

Table 8: List field and desk study countries

Field study countries	Desk study countries
Bolivia	Nicaragua
Burkina Faso	Nigeria
Cambodia	Rwanda
Ethiopia	Sudan
Zimbabwe	Tajikistan
	Uganda
	Viet Nam

Annex 7: Data collection limitations and related implications

Limitation regarding data collection	Evaluators response / Implication for the evaluation and/or validity of findings
Sampling of countries for case studies The final sample of case study countries is illustrative, rather than statistically representative, providing examples across a range of contexts	Conclusions across case study countries may not be generalizable for other countries, without prior reflection whether the evaluation findings are applicable in the country contexts.
Document review (global and for country case studies) • The available country programme evaluations, annual reports and other documents varied in quality and lacked specific information useful for analysis against the evaluation questions. • UNFPA CO annual reports often report on activities with little focus on results.	Efforts made to source additional documents on similar issues for similar geographic scope, in order to ensure triangulation between document sources and with other sources such as interviews. Acknowledge when evaluation results are inconclusive or contradictory. Desk studies focused on a limited number of areas of investigation where sufficient and quality information was available.
Interviews (global, country case studies) • Claims by UNFPA CO staff regarding UNFPA contributions to FP-related intervention results often could not be verified with documentation. • UNFPA EO staff was present, alongside external evaluators, during a number of face-to-face interviews; may have affected responses (positively or negatively) given by the respondents in form or contents. • Finding from remote interviews tended to provide less in-depth information (as compared with face-to-face interviews) due to limitations in establishing *rapport* online and time allocated.	The evaluators used information from complementary data sources in field study countries (e.g., key informant interviews (KIIs) with government staff, development partners, civil society) to assess and strengthen the credibility of claims of UNFPA contributions. Triangulation with document review.
Online survey – External stakeholders • Survey responses may be biased in favour of UNFPA, as (i) the sample itself was pre-selected by the UNFPA CO, and (ii) responses will be from those who are interested and perhaps are positively inclined towards UNFPA.	Survey outcomes are compared with other data sources for triangulation, such as interviews and documents.
Online survey – UNFPA COs areas of investigation • Survey responses may be biased in favour of UNFPA.	Survey outcomes are compared with other data sources for triangulation, such as the external stakeholder survey, interviews and documents.
Interviews and external stakeholders and CO online surveys • Respondents may not adequately recall information regarding UNFPA contributions up to seven years ago, nor actual trends over time (2008-2013) (recall bias).	Findings are triangulated with data from the document review.
Financial analysis, including the online financial survey among UNFPA COs as conducted by the EO • Multiple attempts have been made to capture family planning expenditure, including using the UNFPA financial management platform (Atlas), all showing varying degrees of reliability.	No general conclusions can be drawn regarding the relative size of the UNFPA contribution for FP interventions.

Annex 8: List of people interviewed

Persons met in New York

Organisation	Name	Position
UNFPA	Alphonso Barraques	
UNFPA	Louis Charpentier	Evaluation Advisor
UNFPA	Rita Columbia	
UNFPA	Tharanga Godallage	Data Specialist
UNFPA	Hugo Gonzales	Country Representative, Honduras
UNFPA	Laura Laski	Director, SRH Branch
UNFPA	Benedict Light	Senior Technical Advisor on RHCS
USAID	Kimberly Ogletree	
UNFPA	Bob Olarte	Knowledge management Advisor
USAID	Alexandra Todd-Lippock	Senior Technical Advisor
UNFPA	Farah Usmani	Chief, Programmes Division (?)

Persons attending the RG meeting

Organisation	Name	Position
UNFPA	Louis Charpentier	Evaluation Advisor
UNFPA	Rita Columbia	RH Technical Advisor, CSB
UNFPA	Laura Laski	Chief, SRH Branch
USAID	Shawn Malarcher	Senior Best Practices Utilisation Advisor
UNFPA	Sukanta Sarker	Technical Specialist
UNFPA	Farah Usmani	Chief, Programmes Division (?)
UNFPA	Selen Örs	Cluster Programme Coordinator, Ankara

Persons interviewed by phone

Organisation	Name	Position
Pop Council	Ian Askew	Director of RH Services and Research
UNFPA	Wame Baravilala	MH/RH Advisor, APRO
UNFPA	Lynn Collins	Technical Advisor, HIV
UNFPA	Rita Columbia	RH Technical Advisor, CSB
UNFPA	Henia Dakkak	Program Advisor, Humanitarian and Fragile Context Branch
DFID	Nel Druce	Senor Health Advisor, Development Partnerships Hub, DFID New Delhi
MSI	Megab Elliet	Vice President Strategy and Development
MSI	Lydia Emetta	Policy Advisor
Gates Institute (at Johns Hopkins Bloomberg School of Public Health	Duff Gillespie	Director, Advance Family Planning Project
MSI	Sam Guy	Associate Director Executive Office
UNFPA	Ezizgeldi Hellenov	RHCS Advisor, Sub-regional office for Central Asia
DFID	Jane Hobson	Senior Social Development Advisor, SRHR Team
MSI	Michaeil Holscher	Deputy CEO
IPPF	Jon Hopkins	Senior HIV Advisor
USAID	Beverly Johnston	Senior Policy Advisor
USAID	Sandra Jordan	Director for Communications and Outreach
UNFPA	Mona Kaidbey	Deputy Director, Technical Division

BMGF/FP2020	Monica Kerrigan	Former Deputy Director, FP now an advisor with FP2020
UNFPA	Laura Laski	Chief, SRH Branch
USAID	Shawn Malarcher	Senior Best Practices Utilisation Advisor
IPPF	Shreena Patel	Programme Office Service Delivery
Government of the Netherlands	Emmy Keemhuis de Regt	Senior Adviser SRHR, Ministry of Foreign Affairs,
WHO	Suzanne Reier	Technical Officer
UNFPA	Vinit Sharma	Regional Adviser, RH and RHCS, APRO
Reproductive Health Supplies Coalition	John Skibiak	Director
USAID	Ellen Starbird	Director, Office of Population and Reproductive Health
UNFPA	Siri Teller	Former UNFPA China country rep
Population Council	John Townsend	Vice President and Director of the Reproductive Health Program
UNFPA	Jagdish Upadhyay	Chief, Commodity Security Branch (CSB)

Persons interviewed by phone for desk studies

NAME	TITLE
Nicaragua	
Dr Edgard Narváez Delgado	SHR Programme Analyst / Family Planning and Commodities Officer, UNFPA
Dr Machú Largaespada Fredersdorff	Key informant (former Health Sector Development Expert, Embassy of the Kingdom of the Netherlands)
Nigeria	
Mr Sam Amade	Programme Manager UNFPA portfolio, Marie Stopes International
Dr Moriam Olaide Jagun	Senior Family Planning/Reproductive Health Program Manager, Health Population & Nutrition Office, USAID
Mr Koffi Kouame	Deputy Representative, UNFPA
Dr Effiom Effiom Nyong	Country Director, Marie Stopes International
Rwanda	
Ms Marie Claire Iryanyawera	Family Planning Analyst, UNFPA
Mr Juvenal Majoro	Family Planning Logistics Advisor, JSI/Deliver
Ms Daphrose Nyirasafali	Programme Specialist, Reproductive Health and Rights, UNFPA
Mr Théoneste Twahirwa	Chargé de programme Santé, Département fédéral des affaires étrangères DFAE, Direction du développement et de la coopération DDC, Bureau régional de la coopération suisse Grands Lacs
Sudan	
Dr Yousra Abdelgabbar	RH M&E, UNFPA
Dr Sufian Abdin	RHCS Officer, UNFPA
Dr Mohammed Ahmed M. Sidahmed	Assistant Representative/SRH team leader, UNFPA
Tajikistan	
Mr Khurshed Irgitov	FP/RHCS Programme Associate, UNFPA
Dr Ravshan Tohirov	Executive Director, Tajik Family Planning Alliance
Uganda	
Dr Angela Akol	Country Director, FHI360

Mr James Duworko	FP/RH Advisor, USAID
Anne G. Murphy	Deputy Director, Office of Health and HIV/AIDS, USAID
Dr Ismail Ndifuna	FP/RHCS Program Specialist, UNFPA
Viet Nam	
Dr Dat Van Duong	Team Leader, Sexual and Reproductive Health, UNFPA
Ms Kimberly Green	Chief of Party, PATH

Persons met during country visits

BOLIVIA	
NAME	**TITLE**
UNFPA	
Alejandra Alzerreca	Coordinator PIAV project
Ana Angarita	Representative
Gabriela Carrasco	Humanitarian Assistance Officer
Rene Alberto Castro	National Programme Officer SRH
William Michel Chavez	Coordinator GPRHCS
Juan Pablo Diaz	Official Sucre
Rolando Encinas	Officer-in-charge Chuquisaca sub-office
Tatiana Molina	Administration and Finance Associate
Celia Taborga	Assistant Representative
Rolando Pardo	Programme Analyst M&E
Claudia Resamano	Official Sucre
Diddie Schaff	National Adviser on Adolescence and Youth
Sara Vargas	Programme and Management Assistant
Walter Garrón Sara Vargas	Administrator GPRHCS
Daniela Villarpando	Communications Officer
MINISTRY OF HEALTH (LA PAZ, EL ALTO, CHUQUISACA)	
Gricel Alarcon	Director Epidemiology Unit
Henrry Flores Ayllon	Coordinator of “Continuo de Vida” programme, SEDES La Paz
Elizabeth Vacaflor Barrera	Regional Coordinator CEASS Sucre
Patricia Barrera	Chief of nursing, Coordinator SRH SEDES Chuquisaca
José Luis Bazán	Consultant CEASS
Carlos Bilbao	Consultant CEASS
Patricia Calvo	CEDES Sucre
Sandra Dávalos	Coordinator “Continuo de Vida” SEDES Chuquisaca
Roberto Escobar	Chief of Technical-Logistic Unit CEASS
Wilder Gallardo	Official SEDES Chuqisaca
Maria Huarachi	Coordinator of SRH Sucre Hospital
Grover Loayza	Director Epidemiology Unit

BOLIVIA	
NAME	**TITLE**
Amparo Morales	Executive Director CEASS
Elva Muñoz	Official SEDES Chuquisaca
Haydee Padilla	Advisor in Family and Community Health and SRH
Carla Parada	Vice-Minister of Health
Luis Ramírez	Official SEDES Chuqisaca
Jackeline Reyes	Director Planning Unit
Edwin Subirana	Official SEDES Chuqisaca
Patricia Tames	Manager of Supplies and Rational Use of Medicines UNIMED
Felix Tanqara	Director of Gynaecology-Obstetric Hospital Sucre
Dr. Maximo Ortuño	Official SEDES Chuqisaca
Carola Valencia	National Coordinator HIV Programme
Centro de salud periurbano "VILLA ROSARIO"	***Peri-urban health centre "VILLA ROSARIO"***
Gloria Alvis	FP Specialist
Edgar Estivenson	Doctor
Claudio Hernandez	Assistant doctor
Isabel Miranda	Psychologist
Victoria Sosa	District Health Chief
Puesto de salud rural*: *"LAS PALMAS"	***Rural health post "LAS PALMAS"***
Dora Miranda	SRH Coordinator
Roberto Peñarrieta	Director, Doctor-surgeon
Magaly Robledo	Family Health Coordinator
Justo Yampara	Dentist
DEVELOPMENT PARTNERS AND NGOS	
Haydee Cabrera	Manager of Social Marketing PROSALUD
Ramiro Claure	National Director Marie Stopes International Bolivia, Coordinator MSI Bolivia Sucre
Alexia Escóbar	Coordinator FCI Bolivia
Jhony López	Executive Director CIES
Nancy Manjon	UMRPSF (NGO Sucre)
Jaime Montero	Official, CIES
Jovanna Ordonez	Network T Sucre
Julieta Perez	Network Against gender violence
Bertha Pooley	Board Member of the National Working Group on Maternity and Safe Delivery
Rosario Quiroga	Health Official UNICEF
Patricia Saenz	Ex-Coordinator of Promotion and Logistics USAID
Wendy Torres	Member CAJPEA
Rayza Torriani	Executive Director National Working Group

BOLIVIA	
NAME	**TITLE**
SERVICE USERS (FGD PARTICIPANTS)	
Pamela Buduguez	Focus group participants – SRH service users
Anastasia Cataño	
Shiomara Mendoza	
Katerina Oblitas	
Martha Perez	
Odeman Reyes	
Maritza Vallejos	

BURKINA FASO	
Name	**Title**
UNFPA Burkina Faso	
Dr. Edwige ADEKAMBI DOMINGO	Country Representative
Dalomi BAHAN	Monitoring and Evaluation manager
Néné BARRY	National Programme Associate
Seydou BELEMVIRE	Programme Analyst RH
Dr Norbert COULIBALY	Programme Officer FP
Alain KABORE	Programme Manager Sayana Press
Ali KONE	National Programme Officer
Julien OUEDRAOGO	Programme Officer, Adolescents/Youth/HIV
Soumaila OUEDRAOGO	Monitoring and Evaluation
Olga SANKARA	Assistant Country Representative
Serge SARY	Programme Administrator, Sayana Press Programme
Siaka TRAORE	Programme Analyst, Advocacy/Communication
Aoua ZERBO	Programme Analyst, Midwifery
Lacina ZERBO	National Programme Associate
Ministry of Health	
Dr Issa BARA	Pharmacist (DSF)
Dr Isabelle BICABA	Director, Directrice de la Santé de la Famille
Dr Jean Chrisostome KADEBA	Acting Executive Director, Centrale d'Achat des Médicaments Essential et Génériques de des Consommables Médicaux (CAMEG)
Dr Cheick OUEDRAOGO	FP Manager (DSF)
Dr Djénéba SANON-OUEDRAOGO	Secretary General, Ministry Of Health
University of Ouagadougou	

BURKINA FASO	
Name	**Title**
Dr. George GUIELLA	Head of Population and Health Department, Institut Supérieur des Sciences de la Population and Director, PMA2020
Mr. Moussa ZAN	PMA Data manager
Development Partners and NGOs	
Roch AHOUNOU	Jhpiego, Finance Manager
Bali BAKO	JSI/DELIVER, Programme Officer
Dr. Brahima BASSANE	Family Care International, National Director
Mathieu BILGO	BURCASO, M&E Officer
Georges COULIBALY	Marie Stopes International, Programme Officer
Nicolette van DUURSEN	Marie Stopes International, Country Director
Oscar D. KOALGA	Agir-PF, Country manager
Firmin NACOULMA	Marie Stopes International, Monitoring and Evaluation
Dr. Dieudonné NARE	Plan Burkina, Interim Health Advisor
Jovith NDAHINYUKA	JSI/DELIVER, Regional Technical Advisor
Dr Stanislas Paul NEBIE	Jhpiego, Country Director
Dr Geneviève ONADJA	Initiative Privée et Communautaire (IPC), Director
Boureihima OUEDRAOGO	Association Burkinabé pour la Bien-Etre de la Famille (ABBEF), Executive Director
Habibou OUEDRAOGO	Agir-PF, Executive Director
Ousmane OUEDRAOGO	BURCASO, Coordinator
Yacouba OUEDRAOGO	Jhpiego, Programme Officer
Nana SANOGO	Initiative Privée et Communication (IPC), Programme Officer
Nomgma SAWADOGO	Family Care International, Programme Manager
Ladiama SERME	JSI/DELIVER, Programme Officer
Brigitte SYAN	Equilibre et Population, Advocacy Officer
Caroline TRAORE	Equilibre et Population, Organizational Support Officer
Dr. Guy Evariste André ZOUNGRANA	Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), Coordinator/Senior Technical Advisor for SayanaPress
Dédougou Regional Health Directorate (Field visit)	
Innocent GYENKANI	Dédougou Regional health Directorate, Pharmacist
Souleymane KABORE	Physician, Tougan district health
Robert KARAMA	Regional health Director, Dedougou Regional Health Directorate
Elisabeth KONDE	Midwilfe, RH focal point, Régional Heath directorate
Pierre Thomas MILLOGO	Pharmacist, Toma health district
Oumar OUATTARA	Physician, Solenzo health district
Jean François OUEDRAOGO	Pharmacist, Boromo health district
W. A. Aziz OUEDRAOGO	Physician, Nouna health district

BURKINA FASO	
Name	**Title**
Dapla PALENFO	Pharmacist, Solenzo health district
Sibila SAMBA	Pharmacist, Dédougou health district
Ibrahima SANOU	Pharmacist, Tougan health district
Aboubacar SIRIBIE	Physician, Boromo health district
Dr Oumarou THIOMBIANO	Family planning service manager, Dédougou Regional hospital
Johanny TRAORE	Epidemiology, Dédougou regional health directorate
Biessan YARO	Physician, Dédougou health district

CAMBODIA	
NAME	**TITLE**
UNFPA	
Dr Vandara Chong	National Programme Officer Youth, SRH, Life Skills and HIV Prevention
Dr Marc Derveeuw	Representative
Mr Saky Lim	Local Government and M&E Programme Officer
Mr Solim Ly	Operations Manager
Mr Tum May	Assistant Representative
Mr Pon Rieng	Finance/Programme Associate
Dr Sokun Sok	SRH Programme Specialist
Ms Kangabelle Thou	Maternal Health Programme Officer
Mr Soktha Yi	Population and Development Analyst
MINISTRY OF HEALTH (PHNOM PENH, KAMPOT, TAKEO)	
Dr Tann Chheng	Deputy Director, Provincial health department Kampot
Dr Ork Kunthy	MCH staff, Provincial health department Kampot
Dr Lam Phirun	Manager, National RH Programme
Prof Tung Rathavy	Director, National MCH Centre
Dr Nuth Sinath	Deputy Director, Provincial health department Takeo
Mr Va Sokea	Deputy Director, Central Medical Stores
Dr Prak Sonnarith	MCH Chief, Provincial health department Takeo
Ms Soul Sotheary	MCH staff, responsible for birth spacing, Provincial health department Kampot
Dr Seng Thavy	MCH Chief, Provincial health department Kampot
Kraing Ampil Health Centre, Kampot	
Ms Em Sara	Staff responsible for birth spacing

CAMBODIA	
NAME	**TITLE**
Ms Chap Somona	Head, Kraing Ampil health centre
Prey Lovea Health Centre, Takeo	
Ms Huy Chanthy	Midwife, responsible for birth spacing
Ms Hok Son Hang	Midwife, ante-natal care
Mr Ny Sam Oeun	MCH staff
Mr Khi Sitha	Head, Prey Lovea health centre
Ms Nau Sovanntha	Midwife
Puth Sor Health Centre, Takeo	
Ms Leng Chantha	MCH staff, OD Bati
Ms Mam Malin	Midwife
Mr Nhem Meng	Head, Puth Sor health centre
Ms Vong Sotheary	Midwife
MINISTRY OF EDUCATION, YOUTH AND SPORTS	
Dr Yung Kunthearith	Deputy Director, School Health Department
Mr. Kim Sanh	Deputy Director, School Health Department
DEVELOPMENT PARTNERS AND NGOS	
Ms Theary Chan	Executive Director, Reproductive and Child Health Alliance (RACHA)
Mr Thou Chum	Director, Public & Private Partnerships, Marie Stopes International (MSI) Cambodia
Dr Cheang Kannitha	National Professional Officer for Making Pregnancy Safer, World Health Organization (WHO)
Dr Suos Premprey	Senior Program Manager – Health, Development Cooperation, Australian Embassy
Dr Susanne Pritze-Aliassime	Project Manager, Rights-Based FP and Maternal Health Project, GIZ
Ms Laura L. Rose	Senior Health Economist, World Bank
Ms Chi Socheat	Executive Director, Population Services Khmer (PSK)
Cambodian Women for Peace and Development (CWPD)	
Mr Chhan An	Programme Manager
Mr Ban Chi	Project Coordinator
Ms Sos Finy	Field staff
Ms Meach Sotheary	Executive Director
Mr Heng Tola	M&E Manager

CAMBODIA	
NAME	**TITLE**
E-Cheng (footwear factory), Takeo	
Ms Ken Chantho	Factory nurse
Mr Thach Noun	OD Field staff, RHAC OD Bati
Ms Kreal Srey Poeu	Factory nurse
Reproductive Health Association of Cambodia (RHAC)	
Mr Po Daven	OD Field staff, RHAC OD Prey Kabas, Prey Lovea health centre, Takeo
Mr Ching Muth	Team Leader, RHAC Takeo
Mr Kol Pheng	Community-based distributor, Chum Rov
Ms Yung Sa-Em	Community-based distributor, Tnol Bot
Dr Veth Sreng	Community Health Specialist
Mr Mon Vantha	OD Field staff, RHAC OD Bati
Mr Seng Vichethr	Accountant
Dr Va Chi Vorn	Executive Director
USAID	
Mr Robin Mardeusz	Maternal & Child Health Team Leader
Dr Sam Sochea	Project Management Specialist, Office of Public Health and Education
USAID Quality Health Services – URC Cambodia	
Ms Katherine Krasovec	Chief of Party
Ms Sun Nara	Obstetric Care Technical Coordinator
Ms Chhoeur Socheat	FP Technical Coordinator
SERVICE USERS ((FOCUS) GROUP DISCUSSION PARTICIPANTS)	
(names known but kept confidential)	9 Female entertainment workers, focus group discussion; Cambodian Women for Peace and Development (CWPD) – SMARTgirl drop-in centre
(names not registered)	40+ Female community members, group discussion; Tnol Bot village, Prey Kabas district, Takeo province
(names not registered)	40+ Female community members, group discussion; Chum Rov village, Prey Kabas district, Takeo province
(names not registered)	6 Male community members; group discussion, Chum Rov village, Prey Kabas district, Takeo province

ETHIOPIA	
NAME	**TITLE**
UNFPA	
Muna Abdullah	Assistant Representative
Tesfu Alema	Programme Officer Tigray Region
Beyeberu Assefa	National Programme Office RH
Sabine Beckmann	RH/HIV/AIDS Coordinator
Gamachis Galalcha	Programme Officer RHCS
Behailu Gebremedhin	Programme Officer M&E
Tadese Hailemariam	Regional Coordinator SNNPR
Dorothy Lazaro	International Midwifery Adviser
Rediet Mesfin	Programme Associate
Victor Rakoto	Deputy Representative
Faustin Yao	Representative
MINISTRY OF HEALTH (Addis Ababa, Tigray, SNNPR), related government agencies and supply chain organisations	
Achameyeleh Alabachew	Director Planning and M&E, Directorate FHAPCO
Aster Aliso	HEW Nury Dulecha Health Post
Berhane Assefa	Technical Officer FPMCH Directorate
Ermis Ayale	FMHACA
Wondwossen Ayee	Deputy Director General PFSA
Amarech Bakalcha	HEW Nury Dulecha Health Post
Helen Berhane	FMHACA
Berizat	Head of Woreda Health Office, Hitalo Wakerat
Tesfaya Beyene	Head, Dulecha Health Centre
Dawit Dikasso	FMHACA
Mekdim Enkossa	Adviser MDG Fund
Getachew Genete	FMHACA
Yordanos Giday	Planning Officer Policy and Planning Directorate
Hagos Godefay	Head of RHB Tigray
Yohannes Letamo Hulawa	Deputy Head Curative and Rehabilitation Services SNNPR
Burriso Bu'lansho Shoashamo and 3 staff	Head Woreda Health Office Shabadino
Masresha Soresse	Integrated Family Health Programme

ETHIOPIA	
NAME	**TITLE**
Marta Minwyelet Terefe	Assistant Director MCH Directorate FMoH
Tesfaya	Clinical Officer SNNPR
Director, FP nurse and MCH staff	Hiwane Health Centre Mekele
2 HEWs	Maynebrit Health Post
OTHER GOVERNMENT MINISTRIES	
Fikre Gesso	Acting Director of Population and Development Directorate National Planning Commission
DEVELOPMENT PARTNERS	
Yirga Ambaw	USAID
Beth Haytmanek	USAID
Joshua Karnes	USAID
Kassa Mohammed	Health Adviser DFID
Zelalem Demeke Roberto Peñarrieta	Programme Manager MNCH, CHAI
Rita Santos	Head of Development Cooperation AECID
Bouwe-Jan Smeding	First Secretary Health, Embassy of the Kingdom of the Netherlands
UN AGENCIES	
Sarah de Nasi	UNH4+ WHO
Amsalu Shiferaw	Health Specialist UNICEF
Neghist Tesfaye	Strategic Intervention Adviser UNAIDS
Luwan Teshome	Programme Officer WHO
NGOs and CSOs	
Gedamu Abera	Head of Department Mekele University Midwifery Department
Adem	Team leader, Research and Planning FGAE
Ambachew	MSH Tigray
Atsede	FGAE Tigray
Esayas Alemayehu	Executive Director YNSD
Begashaw Dabena	CORHA
Ketsela Desalegn	FHIP
Gashaw Dubale	JSI
Mekonnen Feleke	Head FGAE Regional Office SNNPR
Holie Folie	Executive Director CORHA

ETHIOPIA	
NAME	**TITLE**
Dejena Getahun	Research and M&E Officer CORHA
Dagmawit Girmay	Deputy Director DKT
Mengistu Kasa	Head Model Clinic FGAE
Melaku Legesse	USAID/DELIVER
Misiker Lemma	MSI
Jelatu Lepesse	USAID/DELIVER
Mengistu	Professor Mekele University Midwifery Department
Genet Mengistu	Executive Director FGAE
Tesfaye Seifu	Deputy Director Technical Operations SCMS
Abebe Shibru	Deputy Country Director MSI Ethiopia
Tadese	DKT Tigray
Liyu Wogayehu	Project Coordinator NNPWE
Nahom Wolde	M&E Officer NNPWE
Yirga	OSSA Tigray
Yeshiharig Yosgon	FGAE
SERVICE USERS AND FGD PARTICIPANTS	
Addis Ababa	
Selamawit Zedalem, Yabsra Tefera, Berhanu Mellese, Mulugeta Zemichael, Kidane Tesfaye, Heok Meseret, Yeshewooyk Tefra (YNSD)	
SNNPR (Addis Ketam subcity Hawassa)	
Community leaders: Hira Hirboro, Eyob Gababo, Saba Araya, Almetsehay Worku, Almaz Minyam Boltana	
SNNPR (Nury Dulecha Health Post)	
13 health centre clients	
9 FP users (all HDA leaders/members)	
Tigray (Maynebrit)	
25 female FP users and non-users	
Kebele Chief and 2 Village elders	
Tsinat, Social and Development NGO	

ZIMBABWE	
Name	**Title**
UNFPA Zimbabwe	
Cheikh T. Cisse	Country Representative
Tamisayi Chinhengo	Programme Specialist, ASRH
Choice Damiso	Programme Specialist, Gender
Dagmar Hanisch	Technical Specialist, HIV Prevention & SRH
Agnes Makoni	Programme Analyst, Maternal Health
Sunday Manyenya	Programme Analyst, Planning, Monitoring and Evaluation
Rudo Mhonde	Programme Analyst, Monitoring, Evaluation and Research
Piason Mlambo	Programme Specialist, Population and Development
Edwin Mpeta	Programme Specialist, Reproductive Health
Yu Yu	Deputy Country Representative
Ministry of Health and Child Care	
Sister Machini	Registered General Nurse and Senior In-Charge, Midwife, Rosa Rural Hospital, Mazowe
Dr. Bernard Madzima	Director, Family Health Division
Ms. Muchaneta Mandara	Reproductive Health Officer
J Mhlanga	Registered General Nurse, Rosa Rural Hospital, Mazowe
Mutanaurwa	Registered General Nurse, Rosa Rural Hospital, Mazowe
Sr. Mutswiri	Registered General Nurse, Rosa Rural Hospital, Mazowe
Ms. Margaret Nyandoro	Deputy Director, Reproductive Health
Zimbabwe National Family Planning Council	
Dr. M. Murwira	Executive Director
Development Partners and NGOs	
Geoffrey Acaye	UNICEF, Health Manager
Goodshow Bote	PADARE, M&E Officer
Acton Chimera	PSZ, Deputy Director
Anthony Daly	DFID, Health Nutrition and HIV Advisor
Dr. Karin Hatzold	PSI, Deputy Director - Programmes
Kelvin Hazangwi	PADARE, National Director
Dr. Jo Keatinge	USAID, Development Health Specialist
Mavis Mabedhla	PSZ, Clinical Services Manager
Edinah Masiyiwa	WAG, Executive Director
Alson T. Mhazo	John Snow International/DELIVER PROJECT
Raguel Mthombeni	Crown Agents, Supply Chain Specialist
Vivian Murisa	Crown Agents, DTTU Project Executive
Netty Musanhu	MUSASA, Director

ZIMBABWE	
Nakai Nengomasha	PADARE, Programme Officer
Dadirayi Nguwo	PSZ
Chenjerai Sisimayi	World Bank, Health Specialist
Dr. Lucia Takundwa	USAID
Walter Vengesayi	PADARE, Programme Officer
Kathleen Webb	USAID, Health Officer

Annex 9: In-country key informant interview topic guide

IN-COUNTRY INTERVIEWS

Objectives
The purpose of the key informant interviews in-country is to contribute to the overall evaluation in order to:

- Provide input for answering the evaluation questions
- Triangulate documentary evidence and other data
- Identify lessons learned.

In-country interviews will focus on questions within the investigation areas of integration of family planning with other SRH services, national ownership of family planning programmes, partnerships, development of an enabling environment, vulnerable and marginalised groups, the rights-based approach, modes of engagement and the supply side. The interviews will explore practical experiences and perceptions of a wide range of stakeholders, to triangulate with input from other sources and to provide material for in-depth analysis. The interviews will include additional questions where necessary to identify the contribution of UNFPA. An interview guide is shown below.

Participants
An International Consultant will conduct the majority of the interviews on behalf of the Evaluation Team, assisted by a national consultant. The list of interviewees will be finalized with the CO prior to the country visit. It will include, but not be limited to:

- CO: Country Representative and key staff
- MoH
- Other government ministries
- Other development partners (donors, NGOs and INGOs)
- Networks (women's network, HIV and AIDS networks, others)
- Service delivery staff
- Community leaders and other KI's
- Users

The CO will review the list in advance and provide the necessary contact information to the consultants.

Process
The consultants will set up appointments and will provide in advance a brief outline of the purpose of the visit and major points of inquiry that will be covered.

Product
The result of each interview will be captured in a matrix that summarizes the key findings from the interview with no attributions to individual informants. Confidentiality of key informants will be maintained throughout.
The matrix shows the points to be covered in the first column. The remaining columns and cells of the matrix show which points will be addressed for each category of interviewee. The numbers refer to the corresponding sections of the evaluation matrix.
The actual wording of the questions for each individual (or group) will be developed during the interviews themselves.

INTERVIEW GUIDE – IN-COUNTRY INTERVIEWS

Area 1 – Integration

Explain main Evaluation Question –*To what extent has UNFPA supported integration of family planning with maternal health, HIV/STI and GBV services in health plans and at primary health care level, in services for adolescents, and in emergency and humanitarian situations?*

a) What does it mean, Integration of services?
b) Is Integration important – why/why not?
c) How is Integration implemented in [country] by MoH/others?
    a. Think of Areas: Maternal Health, HIV, GBV, humanitarian setting, Adolescent SRHR
    b. What strategies/activities
    c. Reflection in Government policies and programmes?
d) What role did UNFPA play in this, in motivating partners to strengthen Integration?
    a. Capacity building? Pre-service/in-service/ad-hoc
    b. Reflection in CO plans and programmes
    c. Evidence of user consultations?
    d. (Potential: any contradiction felt between Integration and renewed focus on FP?)
e) <u>UNFPA CO only</u>:
    a. Did you receive TA from HQ and/or RO on how to strengthen Integration?
        i. If yes- what, when, how, how often?
        ii. Was the TA useful; were you able to follow the TA advice?
f) Checking user satisfaction:
    a. <u>FP service users only</u> (F/M, VMG, PLHIV): Have access and quality of FP services improved due to Integration? Why/why not?
    b. <u>Non-users only</u>: Do you think access and quality of FP services have improved due to Integration? Why/why not?

Area 2 – National ownership (ex-Coordination)

Explain main Evaluation Question –*To what extent has UNFPA successfully contributed on its own and in coordination with others to strengthening national leadership of family planning and improving sustainability?*

This is about raising the profile of FP and repositioning FP as a key SRHR component in national Government and other key stakeholders' agenda.

1. What initiatives by UNFPA to achieve this in [country]?
2. Via what mechanisms, partners?
    a. CSO Participation in FP policy, planning, accountability at national level?
3. With what results?
    a. National FP policies/programmes?
    b. Increased national budget allocations for FP?
    c. Other donors supporting national ownership of FP? (by themselves of due to UNFPA advocacy)
4. In [country] context: are FP programmes socially/culturally/institutionally/economically sustainable?

Area 3 – Brokerage and Partnerships

Explain main Evaluation Question – *To what extent has UNFPA acted as a broker at country level to promote family planning, acting in partnership with the public, private and non-state sector service providers?*

1. How do you see the importance of UNFPA in [country] playing such role as broker/advocate for FP towards other organizations – Government, NGOs, private?
2. How well has UNFPA in [country] played that role? How?
    a. Does UNFPA have sufficient visibility to play that role well?
3. Do key stakeholders acknowledge this special role of UNFPA in [country] and its 'comparative advantage'?
4. What partnerships has UNFPA established, and between which organizations, to advance the FP agenda and the integration of FP with other SRH programmes?
5. In addition, in which other partnership is UNFPA participating for this purpose?

Area 4 – Enabling environment

Explain main Evaluation Question – *To what extent has UNFPA supported the creation of an enabling environment at national and community levels to ensure family planning information and exercise of rights?*

1. An enabling environment is about creating the conditions that allow progress – legal, institutional, political support etc. What has UNFPA done in [country] to create/improve the enabling environment for FP:
    a. At national level – examples of enabling factors? How did these improve FP info/services?
    b. At community level – examples? How did these improve FP info/services?
2. Have people who previously has limited or no access (people with unmet need, VMG), been enabled to better exercise their rights to access quality FP services? What did UNFPA do to create demand and improve access?
3. UNFPA CO only:
    a. Did you receive TA from HQ and/or RO on how to strengthen the enabling environment?
        i. If yes- what, when, how, how often?
        ii. Was the TA useful; were you able to follow the TA advice?

Area 5 – Vulnerable and marginalized groups

Explain main Evaluation Question – *To what extent has UNFPA focused on the family planning needs of the most vulnerable and marginalised groups, including identification of needs, allocation of resources, and promotion of rights, equity and access?*

1. According to you, how does UNFPA in this country define these VMG?

    For interviewer: VMG (ToR Ch7) = e.g. adolescents, unmarried people, the urban poor, rural communities, sex workers, people living with HIV, persons living with disabilities, indigenous people

2. To address FP needs of VMG, has UNFPA in [country]:
    a. Done needs assessment, identifying good practices? [with attention for gender issues?] Examples?
    b. Allocated resources? Which projects? How much funds/% of programme budget?
    c. Done advocacy, promoted the rights and needs of VMG [with attention for gender issues?] -- to remove barriers to FP access, address discrimination, improve quality, integrate services? Examples?

d. Done Capacity Development of VMG? [with attention for gender issues?] Examples?
e. UNFPA CO only: Received TA from HQ/RO on this? Useful?

3. Are VMG representatives involved in UNFPA programme design, implementation, monitoring?
    a. Did they receive Cap building for this? [with attention for gender issues?]
4. Checking evidence: is there evidence for improved access/utilization of FP services by VMG?
5. Checking user satisfaction:
    a. VMG - FP service users only (F/M): Are you happy with the availability and quality of FP services? Why/why not?
    b. Non-users only: Do you think VMG users are happy with the availability and quality of FP services? Why/why not?

Area 6 – Rights-based approach[15]

Explain main Evaluation Question – *To what extent has UNFPA implemented a human rights-based approach to family planning, in particular regarding access to and quality of care?*

2. How important is it that a RBA is used for FP?
3. What does it mean: RBA; how do you understand RBA to FP?
4. Is this also how UNFPA in [country] as an organization understands it?
    a. If not, what is different?
5. How is the RBA put into practice by UNFPA in [country]?
    a. First open, then prompt several of the following:
        i. Advocacy with key stakeholders, Cap Dev
        ii. Programme design: needs assessment, implementation, M&E
        iii. Focus on improving access/reducing barriers to FP for specific groups – issue of non-discrimination/equality, meeting unmet need
        iv. Focus on need to avoid coercion/pressure to use FP
        v. Focus on improving quality of FP (for certain groups) e.g. improve range of methods
        vi. Involving/participation of special groups/VMG, end-users, stakeholders
6. UNFPA CO only:
    a. Did you receive TA from HQ and/or RO on how to put RBA into practice?
        i. If yes- what, when, how, how often
        ii. Was the TA useful; were you able to follow the TA advice?
7. Checking user satisfaction:

[15] RBA as in Inception draft report: To ensure adequate attention to the gender equality and rights element in UNFPA's Strategy, we will apply five principles:

1. Normative Content: The extent that programming incorporates and reflects internationally accepted norms and standards on rights;
2. Non-discrimination: The equality of rights holders is incorporated into program design and programs prioritize access for the most marginalized and vulnerable group members;
3. Participation: Mechanisms for participation by rights holders in policy and program development and in accountability mechanisms are in place;
4. Transparency: Information on rights and access to associated services is readily available to rights holders;
5. Accountability: The extent that interventions include attention to mechanisms whereby rights holders have access to information on the performance of duty bearers.

IPPF's SRHR Charter refers to: The right to sexual and reproductive health implies that people are able to enjoy a mutually satisfying and safe relationship, free from coercion or violence and without fear of infection or pregnancy, and that they are able to regulate their fertility without adverse or dangerous consequences. And then states 12 Rights (eg to Life, Equality and freedom of discrimination, Family planning, Information, Health care, Participation…)

a. FP service users only (F/M, VMG): Are you happy with the availability and quality of FP services? Why/why not?
b. Non-users only: Do you think users are happy with the availability and quality of FP services? Why/why not?

Area 7 – Modes of engagement

Explain main Evaluation Question –*To what extent has UNFPA adapted its mode of engagement[16] to evolving country needs in different settings, using evidence and best practice?*

1. Are you aware of the different 'modes of engagement' available to UNFPA? [if needed explain, see footnote]
2. Has country context changed over time in a way that would make change in mode of engaged necessary?
3. Has UNFPA done monitoring and collection of evidence/best practices to assess need to change modes of engagement?
    a. M&E systems in place to generate evidence?
4. Have changes in modes of engagement helped to make FP Programmes in [country] more sustainable?
5. UNFPA CO only:
    a) Did you receive TA from HQ and/or RO on how to strengthen Integration?
        i. If yes- what, when, how, how often?
        ii. Was the TA useful, were you able to follow the TA advice?

Area 8 – Supply-side activities

Explain main Evaluation Question –*To what extent has UNFPA support for supply-side activities promoted rights-based and sustainable approaches and contributed to improved access to quality voluntary family planning?*

1. What share of UNFPA's activities/budget is dedicated to supply-side aspects? What kind of interventions/activities? Role of GPRHCS?
2. Has the method mix improved? Due to UNFPA support? (nationally, at service delivery points?)
3. Have stockouts of FP methods reduced?
4. Supply-side = commodities/methods, logistics… and service quality (apart from method mix and non-stockouts). Who looks after quality of FP services eg BCC, counselling, attention for gender issues and needs of VMG? [>attention for rights-based approaches, access]
    a. Has UNFPA supported capacity building in this area?
5. Sustainability: has Government budget share for FP methods/commodities increased?
6. (Potential issue: if focus is on supply-side strengthening, is there risk of 'pushing' the demand side beyond what can be seen as unmet need and client RH intentions? Contradictions between renewed focus on FP/focus on supply-side AND rights-based approach?)
7. UNFPA CO only:
    c. Did you receive TA from HQ and/or RO on supply-side procurement and capacity building?
        i. If yes- what, when, how, how often
        ii. Was the TA useful; were you able to follow the TA advice?

[16] "Modes of engagement" refers to the four modes of engagement in the current UNFPA strategic plan (support for service delivery, capacity building, advocacy, knowledge management). These modes of engagement have been included in the ToC diagram and discussion in section 3.2.1

Annex 10: Focus group discussion guide for in-country case studies

Objective of the Focus Group Discussion
Focus group discussions will be held during the country case study visits. The aim is to get more in-depth information and understanding into perceptions and opinions by stakeholders and end-users, in order to contextualize and illustrate quantitative findings (such as the online survey and in-country programme data) and triangulate across methods and respondents.

Setup and participants
During each country visit, the aim is to have up to four FGDs, each with around 8 participants, with a duration of around 1.5 hours each in 2-3 locations, both urban and rural/semi-urban.

1. One FGD with NGO representatives working directly (or indirectly) with UNFPA; probably in an urban area;
2. One FGD with representatives/members of one or more vulnerable or marginalized groups (VMG); probably in an urban area;
3. Two FGDs with users and non-users of family planning services, one with females 18-45, one with males 18-45; probably in semi-urban or rural setting. ('Using' and 'non-using' refers to what happens between two partners during sexual intercourse.)

Sampling and recruitment
FGD with NGO representatives: From a list of NGOs working with or for UNFPA, randomly eight representatives will be invited for the FGD. Recruitment will be done by the national consultant through the secretariat of each NGO. Inclusion criteria should be: 18 years or over.
FGD with FP users/non-users: In a semi-urban or rural setting, community health workers (CHWs) or extension workers will be asked beforehand to identify and invite 8 females and 8 males, with in each group if possible both users and non-users of contraceptives. Inclusion criteria should be: 18-45 years of age, having children, no family of or close relationship to the CHW.
FGD with VMG: After assessing DHS and relevant other reports about VMG, together with the national researcher (an) organization(s) will be identified representing the most vulnerable and/or marginalized group(s) in the country. They will be approached and the national researcher will try to recruit 8 participants e.g. through snowball sampling.
For any of the above groups: if needed interpreters will be used.

Analysis
Points raised and discussed in the focus groups will be triangulated with other evaluation data for the corresponding research area. FGD's will be recorded for reference, but not transcribed.

1. Topic Guide FGD with NGO representatives

Understanding family planning

1. Do you provide SRHR services; if yes which services
2. Is FP part of the services, if yes in what way (information, counselling, give/sell contraceptives)
3. Role/purpose of FP? Views on link between FP and SRH generally? Understanding?
4. For whom is FP – prompt: women, men? Younger, older? In union/married or not in union/unmarried? Special groups?

Choice and access to services

5. Availability of modern contraception? Which ones – and short/long-acting/permanent? Where - public, NGO, private? Out of stock problems?
6. Accessibility of modern contraception? Distance, time
7. Affordability? Cost, free of charge?
8. Acceptability? Local practices of spacing/limiting children? Cultural beliefs, religion? Understanding in community; support, opposition?
9. Acceptability – staff attitude, respect for client needs/views? Do some services 'push' clients to use (certain types of) FP methods? Or limit access to certain groups?
10. Accountability? How do services report on results, what goes well/not well? To local Government, health sector/facility, UNFPA, other?
11. Technical quality
12. Client satisfaction? Why?
13. FP access/choice/quality: Enablers? Barriers/what had been done to reduce these?

Context

14. Unmet need – is it high/low, and why? What can be done about this? Are there specific groups that have bigger need than others? Or that have less access than others?
15. Role of Government – in favour of improving FP services or not? Explain. Are there aspects of the Government FP policy and programme that limit/hinder clients to access FP services? What can be improved at policy level?
16. Collaboration between Government and other stakeholders?
17. Integration of FP with other services – what is current status of integration e.g. .Mat Health, HIV/STI, GBV, adolescent health etc.? Do you see this as good or bad?

Role UNFPA (country office, programme)

18. Financial/technical/other support received by whom in field of FP? Partnering with other organization(s)?
19. Support received from UNFPA, direct/indirect?
    a. If yes: How, type (fin, tech)? Incidentally or over longer period?
    b. Experiences with UNFPA support? Positive, not so positive? What was good, what could be improved
20. More generally how do you see UNFPA's role in-country? What do they do, what should they do? Is this how UNFPA sees it own role; explain?
21. Is the UNFPA programme specific for the country, well-adapted to the country needs/ context/ policies?
22. Are you aware that UNFPA has tried to involve end-users/clients/specific groups/stakeholders in discussions on what is needed in-country regarding FP; on improving access; on improving quality?
23. Is there any evidence for participation of CSO and private sector in family planning policy, planning and accountability mechanisms at national level?
24. Did UNFPA's support in-country, in general, help to improve access to FP services and reduce barriers? And to improve quality?
25. Did UNFPA help to make FP more important on the Government agenda (incl. budget, steady larger share of total FP spending)? And with donors (e.g. attention, budget)? NGOs?
26. If yes –how did UNFPA do that, and what was success? If no – didn't they try or did they try but not succeed? Why not?
27. Does UNFPA talk about FP by itself or mostly/always in context of linking it to one or more SRHR services>
28. Did UNFPA pay special attention to/how:

a. Integration of FP with other services?
b. VMG? -Needs assessment? Advocacy? Programmes (budget)? VMG participation in programme planning, monitoring, capacity building?
c. Capacity building in general – of service providers, Government staff, NGOs, VMG?
d. Rights issues? Rights-based approach?
e. Gender issues? Role of women, men, young people M/F?
f. Sharing knowledge, lessons learned about what works well and what less?

29. Overall, what contribution do you consider UNFPA has had in initiating and supporting processes of change in family planning in this country?

2. Topic Guide FGD with users/non-users / VMG

Understanding FP

30. Have you heard about RH services? What are they?
31. Do you use SRH services? If yes which ones? If not, why not?
32. And have you heard about FP services? What are they for? Who needs them? Do you use them – why/why not?
33. Your preferences and intention of limiting or spacing children? Why? How?
34. For whom is FP – prompt: women, men? Younger, older? In union/married or not in union/unmarried? Special groups?
35. Sources of information on FP?

Choice and access

1. Availability of modern contraception? Which ones – and short/long-acting/permanent? Where - public, NGO, private? Out of stock problems?
2. Accessibility of modern contraception? Distance, time
3. (Affordability) Cost/who pays? Free of charge?
4. (Acceptability) Local practices of spacing/limiting children? Cultural beliefs, religion? Who decides? Can wife decide without husband's knowledge?
5. Understanding in community; support, opposition?
6. Experiences -Good ones, bad ones? What should be changed/improved?
7. Quality – client satisfaction? How to improve?
8. What are barriers to FP service use? How to address?
9. (Unmet need) - Are there many people who want to use FP but currently can't? Why?
10. (Acceptability)– staff attitude, respect for client needs/views? Do some services 'push' clients to use (certain types of) FP methods? Or limit access to certain people/groups?
11. (Integration) – where do you find FP services – in FP clinic or also other places (ANC, STI, …)

Annex 11: Interview guide for UNFPA headquarters, regional offices, country offices and international stakeholders

Objectives:
The purpose of the key informant interviews of internal UNFPA and external stakeholders is to contribute to the overall evaluation in order to:

- Provide input for answering the evaluation questions
- Triangulate documentary evidence and other data
- Identify lessons learned.

HQ interviews will focus on the role (including relevance, effectiveness) of UNFPA HQs in providing strategic technical and programmatic direction, guidance and support to Country Programmes in the assessment, design, implementation and monitoring/evaluation of family planning activities, especially with respect to the integration of family planning within SRH services, programming to reach vulnerable and marginalized populations, addressing contraceptive security and incorporating rights-based approaches for family planning. In addition, the interviews will explore how effectively UNFPA collaborates with other internal and external stakeholders to support an enabling environment, to broker and coordinate FP activities, and to support learning and best practices for programming to advance FP as a right and an essential component of SRH services. Finally, with external stakeholders, the focus will be on how effectively UNFPA works to advance family planning globally and to lead on relevant topics and important challenges related to marginalized populations, equity, human rights and quality of care. Additional questions will be introduced to identify the contribution of UNFPA to processes of change. Interviews at country level will be focussed on specific areas of investigation which are particularly relevant in that country, to be identified from the document review and other sources.

Participants:
An International Consultant (KE1) will conduct the majority of the interviews on behalf of the Evaluation Team, preferably in person at UNFPA HQs. The list of interviewees will be finalized during the Inception Period interviews of Reference Group members. It will include, but not be limited to:

- Executive Director of UNFPA
- Previous Executive Directors (in post during evaluation period)
- Reference Group members
- Director of the Technical Division, and selected staff members from each of the following branches:
    - Sexual and Reproductive Health Branch (including those involved in the former Adolescent and Youth Program)
    - Commodity Security Branch
    - HIV and AIDS Branch
    - Gender, Human Rights and Culture Branch
    - Population and Development Branch
    - Humanitarian Response Branch
    - Resource Mobilisation Branch
- Key UNFPA external partners and donors
- Other implementing partners
- Country Office staff

The UNFPA Evaluation Office (EO) will vet the list in advance and provide the necessary contact information to the consultants.

Process:
The consultants will set up appointments and will provide in advance a brief outline of the purpose of the visit and major points of inquiry that will be covered.

Product:
The result of each interview will be captured in a matrix that summarizes the key findings from the interview with no attributions to individual informants. Confidentiality of key informants will be maintained throughout.

Points to be covered	HQ CSB	HQ SRHB	HQ HAB	HQ Other	UN Agencies	INT'L Partners	IMPL Partners	DONORS
INTEGRATION OF FAMILY PLANNING WITH OTHER SRH								
1.1 UNFPA HQ, RO and CO staff and in-country partners share a common understanding of the meaning and importance of integration	X	X	X	X			X	
1.2 Country offices receive and put into practice technical guidance from HQs and ROs to support quality, integrated service delivery	X	X	X	X				
NATIONAL OWNERSHIP								
2.1 UNFPA has developed and/or participated in mechanisms to raise the profile of family planning in coordination with other FP stakeholders at National level	X	X	X	X	X	X	X	X
PARTNERSHIPS								
3.1 At the global level, UNFPA promotes FP repositioning as an essential component of SRHR services through partnership with others	X	X	X	X	X	X	X	X
ENABLING ENVIRONMENT								
4.3 HQ and ROs have supported CO in identifying needs and promoting demand and access in different contexts	X	X	X	X		X	X	X
VULNERABLE AND MARGINALISED GROUPS								
5.1 UNFPA takes into account the needs of vulnerable and marginalised groups, during the programming process	X	X	X	X		X	X	X
5.2 UNFPA allocates resources to programming for the most disadvantaged groups	X	X	X	X				
5.5 RO and HQ provide support to identify VMG and their needs, and good practice on how to address them	X	X	X	X				
RIGHTS BASED APPROACH								
6.1 UNFPA staff have a shared definition and understand the meaning of a rights-based approach for FP	X	X	X	X		X		X
6.2 UNFPA programming incorporates human rights principles in the assessment, design, implementation and evaluation of FP program interventions.	X	X	X	X		X		X
6.3 UNFPA is developing a body of evidence and lessons learned regarding human rights-based approaches for FP	X	X	X	X	X	X		X
6.4 Country offices receive and put into practice technical guidance from HQs and ROs to support rights-based FP	X	X	X	X				
MODE OF ENGAGEMENT								
7.1 UNFPA adapts its mode of engagement and programme development to take into account the characteristics and needs of country context and change over time	X	X	X	X		X		X
7.3 HQ and ROs provide support and TA to CO to identify and adapt to changing needs over time	X	X	X	X				
7.4 UNFPA identifies and applies good practice at country, regional and global levels	X	X	X	X		X	X	X
SUPPLY SIDE								
8.1 Training supported by UNFPA is client-cantered promoting freedom of choice in FP	X	X	X	X			X	
8.3 Strengthened procurement and logistics systems will be financially sustainable by national governments	X	X	X	X		X	X	X

Key

HQ = UNFPA Headquarters	SRHB = Sexual and Reproductive Health Branch	HAB = HIV and AIDS Branch	UN Agencies = WHO, UNICEF, World Bank
HQ Other = Program Management; Operational Support and Quality Assurance; Gender Human Rights and Culture; Humanitarian Response Branches			
INT'L Partners = USAID, Gates Foundation, IPPF	Implementing Partners = MSI, PSI, Pop Council, MHV		Key Donors = DFID, EU, SIDA, Netherlands

Annex 12: Online survey – Stakeholders

UNFPA No. 11 - EXTERNAL STAKEHOLDERS SURVEY

Online country stakeholder survey - Introduction

UNFPA is undertaking an evaluation of UNFPA support to family planning in the period 2008-2013.

Euro Health Group (EHG), Denmark, in collaboration with the Royal Tropical Institute (KIT), the Netherlands, have been engaged to implement the evaluation. Data collection includes country case studies, document review, key informant interviews and desk studies.

To ensure coverage of activities in all countries where family planning is a priority in UNFPA work, the evaluation also includes an online survey among UNFPA country offices. The survey will be carried out in all 69 FP2020 priority countries (except Ethiopia, Burkina Faso, Cambodia, Zimbabwe and Bolivia where in-country case studies will be carried out). An on-line survey of other stakeholders will also be carried out in the same countries.

We would very much appreciate the participation of your organisation in the survey.

The survey has been designed to provide the maximum level of information for evaluation while limiting demands on you and your staff's valuable time. We hope the staff who have knowledge of your family planning activities during the period 2008-2013 will be able to work as a team to provide joint answers to the survey questions which reflect the thinking and experience of your organisation.

Please be assured that this is an independent evaluation and your responses will remain entirely confidential and will not be attributed specifically to your organisation. In our analysis, responses will be aggregated across different categories and therefore not identifiable as responses of specific offices. The study is designed to answer questions about UNFPA family planning work in general and is not aimed at assessing the performance of your particular office in any way.

Please note that you cannot save and exit the questionnaire and return to it later. Therefore, you may wish to use the option of printing the PDF version of the questionnaire (attached to the email) prior to completing it, if you wish to prepare your answers in advance.

If you have any questions or any difficulties in completing the questionnaire please contact Mrs. Vera Nedic at vnedic@ehg.dk

We thank you in advance for your participation.

Michele Gross
Chief Executive Officer
Euro Health Group

UNFPA No. 11 - EXTERNAL STAKEHOLDERS SURVEY

*** 1. In which country are you working? Please specify in the box below.**

Afghanistan	Guinea Bissau	Papua New Guinea
Bangladesh	Haiti	Philippines
Benin	Honduras	Rwanda
Bhutan	India	Sao Tome and Principe
Bolivia	Indonesia	Senegal
Burkina Faso	Iraq	Sierra Leone
Burundi	Kenya	Solomon Islands
Cambodia	Kyrgyzstan	Somalia
Cameroon	Lao PDR	South Africa
Central African Republic	Lesotho	South Sudan
Chad	Liberia	Sri Lanka
Comoros	Madagascar	State of Palestine
Congo	Malawi	Sudan
Cote d'Ivoire	Mali	Tajikistan
Djibouti	Mauritania	Timor Leste
DPRK	Mongolia	Togo
DRC	Mozambique	Uganda
Egypt	Myanmar	Tanzania
Ethiopia	Nepal	Uzbekistan
Eritrea	Nicaragua	Viet Nam
Gambia	Niger	Yemen
Ghana	Nigeria	Zambia
Guinea	Pakistan	Zimbabwe

*** 2. What describes the type of organisation or agency your work for?**

- [ ] National or local government
- [ ] National non-government organisation
- [ ] International non-government organisation
- [ ] National network/platform/coalition of organisations
- [ ] Multi-lateral, bilateral or other donor
- [ ] Other

*** 3. Has your organisation been a partner of UNFPA in any of the following family planning activities in the period 2008-2013 (tick all that apply)?**

- [ ] Advocacy to raise the profile of family planning, promote supportive policies and/or mobilise resources
- [ ] Family planning demand creation
- [ ] Integration of family planning with other SRH services
- [ ] Family planning for vulnerable and marginalised groups (adolescents, poor, remote rural groups, indigenous people, minority groups, sex workers, refugees, others)
- [ ] Improving quality and access to family planning services
- [ ] Procurement of family planning commodities
- [ ] Capacity building in the supply chain
- [ ] Family planning service provider training
- [ ] Knowledge management (research, use of evidence, best practice)
- [ ] Not sure
- [ ] Other

*** 4. Does UNFPA participate in government and development partner forums which aim to coordinate and strengthen work in family planning (tick all that apply)?**

- [ ] Sector-Wide Committees
- [ ] Basket funds
- [ ] Government led working groups
- [ ] NGOs and donor organizations networks
- [ ] No
- [ ] Not sure

Other (please specify)

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*** 5. Has UNFPA taken a leading role in these forums?**

- ( ) Yes
- ( ) No
- ( ) Not sure

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6. Have these forums contributed to improving family planning through (tick all that apply):

- [ ] Advocacy
- [ ] Policy input
- [ ] Provision of funds or material resources
- [ ] Technical assistance
- [ ] Donor coordination
- [ ] No significant contribution
- [ ] Not sure

Other (please specify)

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*** 7. What has been the principal focus of work by UNFPA in family planning in your country during the period 2008-2013?**

- ○ Support to service delivery
- ○ Support to demand creation
- ○ Capacity building
- ○ Advocacy
- ○ Integration of family planning and sexual and reproductive health services
- ○ Knowledge management (e.g. research, use of evidence and best practice)
- ○ Facilitating donor coordination
- ○ Procurement of family planning methods and Reproductive Health Commodity Security
- ○ Not sure

Other (please specify)

*** 8. In the period 2008-2013, have family planning needs changed in any of the following ways in your country (tick all that apply)?**

- ☐ Overall demand for family planning has grown
- ☐ Overall demand for family planning has stagnated or reduced
- ☐ Demand for different family planning methods has changed
- ☐ There are new demands from different groups (eg. rural women, unmarried youth, others)
- ☐ Reduced ability to pay for family planning services

*** 9. Has the type of support provided by UNFPA for family planning changed in any of the following ways in this period (tick all that apply)?**

	More	Less	Same
Service delivery	○	○	○
Capacity building	○	○	○
Advocacy	○	○	○
Knowledge management	○	○	○
Donation of family planning methods	○	○	○
Not sure	○	○	○

Other (please specify)

*** 10. Are family planning services integrated with other sexual and reproductive health services (maternal health, HIV/STI, GBV) or other development programmes in your country? Please tick all that apply.**

- ☐ In health plans
- ☐ In government services at PHC level
- ☐ In NGO or private sector clinics
- ☐ In services for adolescents
- ☐ In humanitarian and emergency situations
- ☐ In other development programmes (community outreach, education etc.)
- ☐ No integration
- ☐ Not sure

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11. During the period 2008-2013, do you know if UNFPA has contributed to integration of family planning with SRH and other services at one or more of the following levels?Please tick all that apply.

- ☐ Policy level
- ☐ In planning
- ☐ In service delivery (government, NGO, private sector)
- ☐ Not sure

UNFPA No. 11 - EXTERNAL STAKEHOLDERS SURVEY

*** 12. An enabling environment is about creating the conditions that allow progress – policy and legal framework, institutional capacity and support, community attitudes etc.**
What are the key enabling factors for family planning in your country (tick all that apply)?

- [ ] Political commitment
- [ ] Policy and legal framework
- [ ] Institutional capacity of family planning providers (MoH, NGOs, private sector)
- [ ] Community attitudes
- [ ] Don't know

Other (please specify)

*** 13. In your view, does the current legal and policy environment (laws and policies on the promotion of access to modern methods of contraception, on gender equality, on provision of SRHR and family planning related information and services) contribute to accessible and good quality family planning services for all?**

- ( ) Yes
- ( ) No
- ( ) Not sure

*** 14. Has UNFPA worked to strengthen enabling factors during the period 2008-2013 through (tick all that apply)?**

- [ ] Support to Government policy development
- [ ] Support to Legal reform
- [ ] Institutional capacity building
- [ ] Community-based work on attitude change
- [ ] Other
- [ ] None
- [ ] Not sure

UNFPA No. 11 - EXTERNAL STAKEHOLDERS SURVEY

15. Have these interventions helped to improve access to quality family planning information and services for people with unmet needs and for vulnerable and marginalised groups?

- ◯ Yes
- ◯ No
- ◯ Not sure

UNFPA No. 11 - EXTERNAL STAKEHOLDERS SURVEY

*** 16. In the period 2008-2013, has UNFPA supported family planning and SRH programmes for any of these vulnerable or marginalised groups (VMG)?(tick all answers that apply).**

- [ ] Adolescents
- [ ] Unmarried people
- [ ] The urban poor
- [ ] Rural communities
- [ ] Sex workers
- [ ] People living with HIV
- [ ] Men who have sex with men
- [ ] Persons living with disabilities
- [ ] Indigenous people
- [ ] Internally displaced people or refugees
- [ ] Minority groups
- [ ] Not sure
- [ ] No

Other (please specify)

*** 17. Has UNFPA promoted the rights and needs of vulnerable and marginalised groups in the following ways (please tick all that apply):**

- [ ] Removing barriers to family planning access
- [ ] Addressing discrimination and stigma,
- [ ] Improving quality,
- [ ] Integrating family planning with other services
- [ ] Social mobilization and empowerment
- [ ] Not sure

Other (please specify)

* 18. Has UNFPA disseminated examples of good practice in family planning from within your country or from elsewhere?

- ◯ Yes
- ◯ No
- ◯ Not sure

* 19. Has UNFPA supported capacity building for family planning service providers?

- ◯ Yes
- ◯ No
- ◯ Not sure

UNFPA No. 11 - EXTERNAL STAKEHOLDERS SURVEY

20. Has capacity building included training or material support for (tick all that apply):

- ☐ Counselling on different family planning methods
- ☐ Provision of different family planning methods
- ☐ Improving quality of care and exercise of rights
- ☐ Gender perspectives
- ☐ Not sure

Other (please specify)

UNFPA No. 11 - EXTERNAL STAKEHOLDERS SURVEY

* 21. Has UNFPA procured family planning methods for your country in the period 2008-2013?

- ◯ Yes
- ◯ No
- ◯ Not sure

* 22. Has UNFPA worked to strengthen the national family planning commodity procurement and logistics systems?

- ◯ Yes
- ◯ No
- ◯ Not sure

* 23. Has the government budget for family planning procurement and logistics increased in the period 2008-2013?

- ◯ Yes
- ◯ No
- ◯ Not sure

UNFPA No. 11 - EXTERNAL STAKEHOLDERS SURVEY

Your perceptions of UNFPA support to family planning

*** 24. We are interested in your perceptions on UNFPA support to family planning in your country:**

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree
UNFPA support responds well to national priorities	○	○	○	○	○
UNFPA allocates resources to the most vulnerable groups	○	○	○	○	○
UNFPA identifies and applies good practice at country and regional levels	○	○	○	○	○
Training supported by UNFPA is client-centered promoting freedom of choice in family planning	○	○	○	○	○
Strengthened procurement and logistics systems with UNFPA support will be financially sustained by the government	○	○	○	○	○

*** 25. UNFPA has shown leadership in realizing good quality integrated SRHR services in this country**

- ○ Yes
- ○ No
- ○ Not sure

If "yes", please say in what areas

26. Please add any comments related to UNFPA that would be helpful

UNFPA No. 11 - EXTERNAL STAKEHOLDERS SURVEY

THANK YOU VERY MUCH FOR PARTICIPATING IN THE SURVEY!

Annex 13: Internet Survey – Country offices

UNFPA - No. 11 - Country Office Survey

Online Country Office survey - introductory letter

UNFPA is undertaking an evaluation of UNFPA support to family planning in the period 2008-2013.

Euro Health Group (EHG), Denmark, in collaboration with the Royal Tropical Institute (KIT), the Netherlands, have been engaged to implement the evaluation. Data collection includes country case studies, document review, key informant interviews and desk studies.

To ensure coverage of activities in all countries where family planning is a priority in UNFPA work, the evaluation also includes an online survey among UNFPA country offices. The survey will be carried out in all 69 FP2020 priority countries (except Ethiopia, Burkina Faso, Cambodia, Zimbabwe and Bolivia where in-country case studies will be carried out). An on-line survey of other stakeholders will also be carried out in the same countries.

We would very much appreciate the participation of your Country Office in the survey.

The survey has been designed to provide the maximum level of information for evaluation while limiting demands on you and your staff's valuable time. We hope the staff who have knowledge of your family planning activities during the period 2008-2013 will be able to work as a team within the Country Office to provide joint answers to the survey questions which reflect CO thinking and experience.

Please be assured that this is an independent evaluation and your responses will remain entirely confidential and will not be attributed specifically to your Country Office. In our analysis, responses will be aggregated across different categories and therefore not identifiable as responses of specific Country Offices. The study is designed to answer questions about UNFPA family planning work in general and is not aimed at assessing the performance of your particular office in any way.

Please note that you cannot save and exit the questionnaire and return to it later. Therefore, you may wish to use the option of printing the PDF version of the questionnaire (attached to the email) prior to completing it, if you wish to prepare your answers in advance.

If you have any questions or any difficulties in completing the questionnaire please contact Mrs. Vera Nedic at vnedic@ehg.dk

We thank you in advance for your participation.

Michele Gross
Chief Executive Officer
Euro Health Group

UNFPA - No. 11 - Country Office Survey

*** 1. Name of Country Office**

Afghanistan	Guinea Bissau	Papua New Guinea
Bangladesh	Haiti	Philippines
Benin	Honduras	Rwanda
Bhutan	India	Sao Tome and Principe
Bolivia	Indonesia	Senegal
Burkina Faso	Iraq	Sierra Leone
Burundi	Kenya	Solomon Islands
Cambodia	Kyrgyzstan	Somalia
Cameroon	Lao PDR	South Africa
Central African Republic	Lesotho	South Sudan
Chad	Liberia	Sri Lanka
Comoros	Madagascar	State of Palestine
Congo	Malawi	Sudan
Cote d'Ivoire	Mali	Tajikistan
Djibouti	Mauritania	Timor Leste
DPRK	Mongolia	Togo
DRC	Mozambique	Uganda
Egypt	Myanmar	Tanzania
Ethiopia	Nepal	Uzbekistan
Eritrea	Nicaragua	Viet Nam
Gambia	Niger	Yemen
Ghana	Nigeria	Zambia
Guinea	Pakistan	Zimbabwe

*** 2. Is there a national family planning policy and programme in your country?**

- Yes
- No
- Not sure

*** 3. To what degree does the government support and promote FP in your country?**

- ◯ Strong
- ◯ Moderate
- ◯ Weak
- ◯ Not sure

*** 4. From 2008-2013, what were the principal family planning interventions supported by your CO each year (tick all that apply)?**

	2008	2009	2010	2011	2012	2013
Family planning advocacy to support a favorable policy and program environment (see question 12 for more details)	☐	☐	☐	☐	☐	☐
Family planning demand creation through social and behavioural communication	☐	☐	☐	☐	☐	☐
Integration of family planning with other sexual and reproductive health (SRH), primary health, nutrition or other services	☐	☐	☐	☐	☐	☐
Improve access to family planning services for vulnerable and marginalized groups (adolescents, poor, remote rural groups, indigenous people, minority groups, sex workers, refugees, etc.)	☐	☐	☐	☐	☐	☐
Community-based and mobile outreach programmes	☐	☐	☐	☐	☐	☐
Family planning in the private sector (including social marketing, social franchising)	☐	☐	☐	☐	☐	☐
Procurement of family planning methods	☐	☐	☐	☐	☐	☐
Capacity building in the supply chain	☐	☐	☐	☐	☐	☐
Capacity building in quality of care	☐	☐	☐	☐	☐	☐
Family planning service provider training	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐

*** 5. In the period 2008-2013, who have been your most important family planning implementing partners each year (tick all that apply)?**

	2008	2009	2010	2011	2012	2013
National government	☐	☐	☐	☐	☐	☐
Sub-national government (regional, provincial, local)	☐	☐	☐	☐	☐	☐
NGO	☐	☐	☐	☐	☐	☐
National networks (e.g. women's networks, youth networks, people living with HIV)	☐	☐	☐	☐	☐	☐
Universities and research institutes	☐	☐	☐	☐	☐	☐
Professional associations	☐	☐	☐	☐	☐	☐
Private sector	☐	☐	☐	☐	☐	☐
Not sure	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐

*** 6. Are family planning services and methods available outside the public sector (tick all that apply)?**

- [ ] NGO clinics and outlets
- [ ] Private, for-profit providers
- [ ] Pharmacies
- [ ] Local stores/kiosks/vending machines
- [ ] Through other development and outreach programmes
- [ ] Not sure
- [ ] Other

Other (please specify)

*** 7. During the period 2008-2013, has UNFPA contributed to integration of family planning with other SRH services (maternal health, HIV, youth and adolescent SRH) (tick all that apply):**

- [ ] Policy level
- [ ] In planning
- [ ] In service delivery (government, NGO, private sector)
- [ ] No contribution
- [ ] Not sure

*** 8. Does UNFPA participate in government and development partner forums which aim to coordinate work in family planning (tick all that apply)?**

- [ ] Sector-wide committees
- [ ] Basket funds
- [ ] Government-led working groups
- [ ] NGOs and donor organizations networks
- [ ] Other
- [ ] No

Other (please specify)

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9. How have these forums contributed to improving family planning (tick all that apply)?

- [ ] Advocacy
- [ ] Policy input
- [ ] Provision of funds or material resources
- [ ] Technical assistance
- [ ] Donor coordination
- [ ] No significant contribution
- [ ] Not sure
- [ ] Other

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*** 10. Has UNFPA worked with partners to develop or support mechanisms to promote or increase the priority of family planning?**

- ◯ Yes
- ◯ No
- ◯ Not sure

*** 11. An enabling environment is about creating the conditions that allow progress – legal, institutional, political support, community support etc.**
What are the key enabling factors for family planning in your country (tick all that apply)?

- ☐ Government policy
- ☐ Legal framework
- ☐ Institutional capacity
- ☐ Community attitudes
- ☐ Not sure
- ☐ Other

*** 12. What has UNFPA done to strengthen these enabling factors related to family planning during the period 2008-2013 (tick all that apply)?**

- ☐ Support to government policy development
- ☐ Promote or raise the profile of family planning eg through advocacy within the health sector
- ☐ Promote or raise the profile of family planning with other sectors beyond health (e.g. education, environment, etc.)
- ☐ Support to legal reform
- ☐ Institutional capacity building
- ☐ Community-based work on attitude change
- ☐ Knowledge management (e.g. research, use of evidence, best practice)
- ☐ Nothing
- ☐ Other

*** 13. In the period 2008-2013, has UNFPA allocated resources to support family planning programmes for any of the following vulnerable and marginalised groups (VMG) (tick all that apply)?**

- ☐ Adolescents
- ☐ Unmarried young people
- ☐ The urban poor
- ☐ Rural communities
- ☐ Men who have sex with men
- ☐ Sex workers
- ☐ Injecting drug users
- ☐ LGBTI
- ☐ Persons living with disabilities
- ☐ Indigenous people
- ☐ Internally displaced people or refugees
- ☐ Not sure
- ☐ Others
- ☐ None of the above

*** 14. Has UNFPA promoted the rights and needs of VMG in the following ways (tick all that apply):**

- ☐ Removing cultural, legal, geographical or economic barriers to family planning access
- ☐ Addressing discrimination and stigma
- ☐ Improving quality
- ☐ Integrating family planning with other services
- ☐ Social mobilization and empowerment
- ☐ Other
- ☐ None of the above

*** 15. In the period 2008-2013, has UNFPA implemented a rights-based approach to family planning for these and other groups?**

- ◯ Yes
- ◯ No
- ◯ Not sure

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16. What has been the focus of this rights-based work (tick all that apply)?

- [ ] Improving access
- [ ] Improving quality of care
- [ ] Providing information and expanding contraceptive options
- [ ] Strengthening participation
- [ ] Strengthening accountability mechanisms
- [ ] Addressing stigma and discrimination
- [ ] Other

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*** 17. What have been the principal modes of engagement for family planning work in your country during the period 2008-2013 (tick all that apply each year):**

	2008	2009	2010	2011	2012	2013
Support to service delivery	☐	☐	☐	☐	☐	☐
Capacity building	☐	☐	☐	☐	☐	☐
Advocacy	☐	☐	☐	☐	☐	☐
Knowledge management	☐	☐	☐	☐	☐	☐
Commodity procurement and RHCS	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐
Not sure	☐	☐	☐	☐	☐	☐

*** 18. In the period 2008-2013, has the CO identified changing needs for support in family planning?**

- ◯ Yes
- ◯ No
- ◯ Not sure

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19. Did these changes lead to different modes of engagement?

- ◯ Yes
- ◯ No
- ◯ Not sure

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*** 20. Did any of these other factors lead to changes in the mode of engagement (tick all that apply)?**

- [ ] UNFPA policies and priorities
- [ ] Availability of funds for specific programmes
- [ ] Government priorities
- [ ] Emergency or humanitarian situations
- [ ] Availability of skilled staff in CO
- [ ] Technical support and promotion by RO or HQ
- [ ] Activities of other development partners
- [ ] Evidence from evaluation of CO activities
- [ ] Other

*** 21. Which knowledge management practices have been the most useful to improve your family planning programme? (tick all that apply each year)**

	Most important	Very important	Important	Neutral	Not important	Not very important	Unimportant
Monitoring and evaluation in-country	◯	◯	◯	◯	◯	◯	◯
Research studies in-country	◯	◯	◯	◯	◯	◯	◯
Conferences	◯	◯	◯	◯	◯	◯	◯
Use of literature and documentation from other countries	◯	◯	◯	◯	◯	◯	◯
Exchange through UNFPA HQ and Regional Office	◯	◯	◯	◯	◯	◯	◯
Exchange through personal contacts and communications	◯	◯	◯	◯	◯	◯	◯

*** 22. How has the CO helped apply best practice in family planning? (tick all that apply)**

- [ ] Advocacy with government and other partners
- [ ] Technical support to implementing partners
- [ ] Dissemination through conferences, publications, web sites
- [ ] Other
- [ ] No support for application of good practice
- [ ] Not sure

*** 23. Has the CO supported capacity building for family planning service providers?**

- ◯ Yes
- ◯ No
- ◯ Not sure

*** 24. If yes, has capacity building included training or material support for (tick all that apply):**

- [ ] Counselling on different family planning methods
- [ ] Provision of different family planning methods
- [ ] Gender perspectives
- [ ] Quality of family planning services
- [ ] Community-based family planning interventions
- [ ] Other

25. If UNFPA has procured family planning commodities for your country in the period 2008-2013, which were they (tick all that apply)? If UNFPA has not procured any, leave this question unanswered.

	2008	2009	2010	2011	2012	2013
Pills	☐	☐	☐	☐	☐	☐
Injectables	☐	☐	☐	☐	☐	☐
Condoms	☐	☐	☐	☐	☐	☐
Female condoms	☐	☐	☐	☐	☐	☐
Implants	☐	☐	☐	☐	☐	☐
IUD	☐	☐	☐	☐	☐	☐
Emergency contraceptives	☐	☐	☐	☐	☐	☐
Materials for tubal ligation or vasectomy	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐

* **26. Has UNFPA worked to strengthen the national family planning commodity procurement and logistics systems?**

- ◯ Yes
- ◯ No
- ◯ Not sure

* **27. Has the government budget for family planning procurement and logistics increased in the period 2008-2013?**

- ◯ Yes
- ◯ No
- ◯ Not sure

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28. If yes, did UNFPA contribute to this change?

- ◯ Yes
- ◯ No
- ◯ Not sure

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* **29. Has your Country Office requested, received and put into practice technical guidance from Headquarters in any of the following areas (tick all that apply)?**

	Requested	Received	Put into practice
Support for partners in delivery of quality integrated family planning services	☐	☐	☐
Identification of family planning needs	☐	☐	☐
Creating an enabling environment	☐	☐	☐
Promoting family planning demand	☐	☐	☐
Promoting family planning access	☐	☐	☐
Rights-based family planning	☐	☐	☐
Adapting your mode of engagement to changing needs over time	☐	☐	☐
Capacity building in RH commodity security	☐	☐	☐
Knowledge management (e.g. operations research, situation analysis and/or knowledge sharing)	☐	☐	☐
Other areas	☐	☐	☐
No support or guidance	☐	☐	☐
Not sure	☐	☐	☐

*** 30. Has your Country Office requested, received and put into practice technical guidance from Regional Office in any of the following areas (tick all that apply)?**

	Requested	Received	Put into practice
Support for partners in delivery of quality integrated family planning services	☐	☐	☐
Identification of family planning needs	☐	☐	☐
Creating an enabling environment	☐	☐	☐
Promoting family planning demand	☐	☐	☐
Promoting family planning access	☐	☐	☐
Rights-based family planning	☐	☐	☐
Adapting your mode of engagement to changing needs over time	☐	☐	☐
Capacity building in RH commodity security	☐	☐	☐
Knowledge management (e.g. operations research, situation analysis and/or knowledge sharing)	☐	☐	☐
Other areas	☐	☐	☐
No support or guidance	☐	☐	☐
Not sure	☐	☐	☐

UNFPA - No. 11 - Country Office Survey

Your perceptions of UNFPA support to family planning

*** 31. We are interested in your perceptions on UNFPA support to family planning in your country. Please select a response to the following statements:**

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree
UNFPA family planning support responds well to national priorities and changes in need over time	○	○	○	○	○
UNFPA takes a leadership role in advocacy with government on family planning issues	○	○	○	○	○
UNFPA allocates resources to the most vulnerable groups	○	○	○	○	○
UNFPA supports improvements in quality of services and access to a range of family planning methods	○	○	○	○	○
UNFPA identifies good practice at country and international level and applies it at country level	○	○	○	○	○
Training and services supported by UNFPA are client-centred, promoting freedom of choice in family planning	○	○	○	○	○
Strengthened procurement and logistics systems with UNFPA support will be financially sustained by the government	○	○	○	○	○

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree
UNFPA has contributed to integration of family planning with other SRH services in this country	○	○	○	○	○

*** 32. Does the CO think there are areas in which UNFPA should place more emphasis in their policies and programmes?**

- ○ Yes
- ○ No
- ○ Not sure

If the answer is "yes", please say in what areas

33. Please add any comments related to UNFPA family planning support that would be helpful

UNFPA - No. 11 - Country Office Survey

THANK YOU VERY MUCH FOR PARTICIPATING IN THE SURVEY!

Annex 14: Methodological note on financial analysis

I. Introduction

A critical aspect of the Global Thematic Evaluation of UNFPA Support to Family Planning, expenditure in support of family planning was sought for the time frame of the evaluation (2008-2013). Though difficult to calculate with certainty (due to limitations discussed below), the UNFPA evaluation office and evaluation team developed a methodology to generate an estimate of family planning expenditure. The methodology employed, challenges faced, and steps taken to mitigate these are detailed within this methodological note. The methodological note also provides information on other attempts (by UNFPA and UNFPA with others) to capture UNFPA family planning expenditure.

II. Background: Capturing Expenditure in Support of Family Planning at UNFPA

Over the past years, multiple attempts have been made to capture family planning expenditure. Though not exhaustive, a few examples are detailed below.

McKinsey Exercise

In 2010/2011, McKinsey & Company was brought on by UNFPA to develop proposals for a family planning reform agenda and, subsequently, an implementation plan. Building on UNFPA's longstanding commitment to family planning, the reform plan offered suggestions on areas of work that could be deepened and potential priorities on which to focus, including strategy, procurement processes and metrics for monitoring. The report, too, provided an estimate of UNFPA family planning expenditure for 2011, placing support at 20-25% of total UNFPA spending. However, through interviews with UNFPA colleagues and McKinsey & Company staff, the evaluation team learned that the percentage generated was based on anecdotal information and personal experience of UNFPA colleagues at headquarters and within country offices. Colleagues underscored that the methodology used to calculate expenditure lacked scientific rigour and, though indicative, should not be considered reliable.

Netherlands Interdisciplinary Demographic Institute (NIDI) and UNFPA Programme Division

Through the Resource Flows Project (RF), the Netherlands Interdisciplinary Demographic Institute (NIDI) and UNFPA Programme Division worked to monitor progress in the implementation of Programme of Action (PoA) adopted at the International Conference on Population and Development (ICPD) in 1994. The RF Project tracked expenditure for population activities. More specifically, expenditure on the "costed population package" (described in paragraph 13.14 of the ICPD Programme of Actions) was captured: 1) Family planning services; 2) Basic reproductive health services; 3) Sexually transmitted diseases and HIV/AIDS prevention; 4) Basic research, data and population and development policy analysis.[17]

Governments, intermediary organizations, donors and others reported annually on the amount spent under each category. As an intermediary organization, UNFPA reported annually on family planning expenditure (as one of the population activities categories). However, the methodology used to calculate family planning expenditure for 2008-2011 - the years prior to the introduction of the dedicated family planning code (U3) - remains unclear, despite efforts by the evaluation office to clarify.

[17] See "Accompanying Manual for UNFPA/NIDI Survey on Financial Flows for 2013 Intermediate Organisations."

Technical Division Exercise

In 2013, the UNFPA Technical Division (the commodity securities branch) undertook an exercise to track 2012 family planning expenditure. At country level, a survey was sent to 16 country offices, requesting information on family planning expenditure, both mainstreamed (i.e. FP expenditure embedded within other sexual and reproductive health projects) and dedicated (U3 code)). The percentage of family planning expenses identified based on the 16 country offices was extrapolated and applied to all country-level expenses. All regional/sub-regional offices were requested to participate in the survey and, at HQ level, the analysis was conducted on the two organizational units (Technical Division and Procurement Services Branch) which account for 80% of global programme funds. An analysis of the data indicated that, in 2012, 40.6% of UNFPA programme expenditure was in support of family planning. Though not without limitations - the percentages applied by country offices to arrive at expenditure levels were subjective and extrapolation, though a relatively accurate projection technique, added an additional layer of uncertainty - this exercise produced an useful estimate of 2012 FP expenditure.

Finance Department and Technical Division Exercise

Following this, the UNFPA Finance Department – together with Technical Division – developed a methodology to capture family planning expenditure for 2013. The Finance Department reports annual expenditure under the outcomes of a given strategic plan's development results framework (which are, themselves, reflected in Atlas). From 2008-2011, the Finance Department reported expenditure under the four focus areas of the strategic plan: population and development, gender equality, reproductive health and rights, and programme coordination and assistance.

Following the mid-term review of the 2008-2013 strategic plan, the new strategic plan (2012-2013) re-defined the outcomes and, accordingly, the Finance Department calculated expenditure under the seven new outcomes (captured as U codes). Here, a dedicated family planning project outcome code was developed (U3) - "Increased access to and utilization of quality family planning services for individuals and couples according to reproductive intentions." According to the Statistical and Financial Review (produced by the Finance Department), family planning accounted for around 22-25% of total programmable expenses from 2012-2013.

Table 1: UNFPA TOTAL RESOURCES ASSISTANCE BY PROGRAMME AREA

UNFPA Assistance by Development Result Framework Outcomes	($m)		%	
	2012	2013	2012	2013
Population Dynamics (U1)	54.5	50.6	8.1%	6.6%
Maternal and Newborn Health (U2)	169	199.7	25.2%	26.2%
Family Planning (U3)	**153.5**	**187.8**	**22.9%**	**24.6%**
HIV and Sexually Transmitted Infection (STI) Prevention Services (U4)	33.2	31.7	5.0%	4.2%
Gender Equality and Reproductive Rights (U5)	76.1	73.2	11.4%	9.6%
Young People's SRH and Sexuality Education (U6)	43.8	51.4	6.5%	6.7%
Data Availability and Analysis (U7)	72.9	75.5	10.9%	9.9%
Programme Coordination and Assistance	66.6	79.6	9.9%	10.4%
Other	0	13.4	0.0%	1.8%
Total	**669.6**	**762.9**	**100%**	**100%**
Source: Statistical And Financial Review Data. From Report of the Executive Director				

However, this approach only captures expenditure under U3; expenditure mainstreamed under other outcomes is not reflected. In order to capture both dedicated and mainstreamed expenditure, the Finance Department retroactively applied a percentage to 2013 data to arrive at an estimated figure – roughly 37% of total expenditure in 2013 was in support of family planning. This, too, has its limitations – the process of retroactively applying a percentage based on 2014 data to 2013 data raises concerns of validity. Nonetheless, as with the TD exercises on 2012 expenditure, this provides a suggestive/ indicative figure.

III. Evaluation of UNFPA Support to Family Planning

UNFPA Evaluation Office Exercise

In 2014, in preparation for the evaluation of UNFPA support to family planning, the evaluation office conducted an analysis of Atlas data in order to arrive at a figure for family planning expenditure from 2008-2013.

As shared above, tracking the totality of expenditure in support of family planning poses significant challenges, with the reliability and validity often the figure inadequate. In addition to the unique U3 code – introduced in 2012-2013 to capture family planning expenditure – family planning activities continue to be mainstreamed, integrated and "hidden" within other project outcome codes during this period (as well as periods prior, where family planning activities were wholly mainstreamed).

Thus, the evaluation office undertook a multi-stage process to identify family planning activities, with expenditure data analysed separately at global, regional, and country level. In addition to considering all U3 expenditure as expenditure in support of family planning, all activities under the following "original outcome codes" were also coded as family planning activities.

Table 2: Original outcome codes

Original Outcome Code	Description of Outcome Code	Classified as Family Planning activities
R204	Availability of RH Commodities	U3
R3	Access and Utilization of FP Services	U3
R302	Capacity to Express Concerns	U3
R304	Male involvement in RH/RR/Gender	U3

In order to capture activities in support of FP mainstreamed at the activity level (and missed/overlooked by the above project outcome process), a keyword search was conducted for particular fields of the Atlas dataset: "fund code," "fund code description," "project title" "implementing partner description." Based on literature and some basic analysis of the data, the following keywords were used to identify youth and adolescent projects.

Table 3: Key words used to search the Atlas dataset

Around Family Planning Word:	Around Birth Control:	Around Counseling :	Around GPRHCS :
"Family Planning"	"contraception"	"Family guidance"	"RHCS"
"FP"	"contraceptive"	"Family Life"	"GPRHCS"
"PF"	"condom"	"Male involvement"	
"RH/FP"	"cond" (selected only)	"MALE INVOLVMT"	
"RH/PF"	"preservatifs"	"MALE IN"	
"NPFPC"	"condon"	"MALEINVOVMENT"	
"familiale" (selected)	"Steril"	"Male participation"	
"Planning Fam"	"fertility"	"participación de los hombres"	
"planificación familiar"	"abortion"	"participation des hommes"	
"FRHS"	"emergency pills"		
"DGFP"			
"NCPFP"			

This approach will capture activities and/or projects that are not necessarily in support of family planning and will, conversely, exclude/leave out expenditure in support of family planning. Without verification from country offices and other UNFPA departments, it is not possible to know from Atlas data alone the full extent of activities in support of family planning.

EO Survey of Country Case Study Offices (Desk and Field)

To complement the above exercise (completed at HQ on an Atlas dataset), a survey of desk and field case study country offices was conducted. Twelve offices were contacted and asked to provide a thorough breakdown of country office expenditure on family planning from 2008-2013. The evaluation office was able to use data from 12 countries in total: 11 of the case study countries plus

one additional country office (the DRC). Though DRC CO was not a case study, the country office undertook the exercise and the data provided will be used.

Table 4: Countries included in the EO survey on expenditure

Country Offices Survey and Follow-up Completed Data Able to be Utilized		
Field	**Desk**	**Other**
Bolivia	Nicaragua	DRC
Burkina Faso	Nigeria	
Cambodia	Rwanda	
Ethiopia	Tajikistan	
Zimbabwe	Uganda	
	Viet Nam	

During the period under evaluation, activities in support of family planning were either mainstreamed (captured under other SRH projects/ a non family planning project outcome code) or constituted a project wholly dedicated to family planning. As expenditure in Atlas was captured at project level, activities (and their related expenditure) in support of family planning embedded within non-family projects were unable to be tracked. Indeed, mainstreaming poses particular challenges to accurately identifying the entirety of projects and activities in support of family planning in Atlas, and subsequently, in determining the amount spent in support of family planning.

To address this, desk and field case study country offices – deeply familiar with the specifics of a project – were requested to report on family planning expenditure. Though a degree of subjectivity exists in, inter alia, estimating/assigning the percentage of a project dedicated to family planning (in cases where the activities have been embedded), Evaluation Office believed the country office to be best positioned to address this, offering an estimate based on intimate knowledge of a project and its implementation.

The EO piloted the survey with several country offices and sought feedback/input from colleagues across the organization (at HQ, regional and country level). Feedback was incorporated and the survey (and accompanying guidance notes) were refined.

Similar to the exercise conducted on 2012 data by Technical Division (detailed above) on which this survey was closely modelled, country offices were provided with two guidance notes: one focusing on which activities should be considered family planning activities and the other on estimating percentages. On the former, guidance listed the expenses that should be considered expenditure in support of family planning, including projects with a U3 code, projects funded through the Thematic Fund for Reproductive Health Commodity Security, expenses incurred to strengthen information systems pertaining to family planning or expenses incurred to create enabled environments for human rights family planning.

A typology/percentage guidance note was also provided. This note listed activities - under different Strategic Plan (2014-2017) outputs - that can be considered to have a family planning component, with the corresponding suggested percentage included. While this was offered as a tool to support

the country office, the country office was encouraged to offer the percentages that best reflected the actual expenses related to family planning in the particular country.

Under the guidance of the UNFPA Evaluation Office, the country office identified projects in support of family planning – those fully dedicated to family planning as well as those in which family planning activities were mainstreamed – and reported the amount spent (annually) under each project. Project expenditure was disaggregated into core and non-core funding. The country office was then asked to estimate the percentage (%) of the project in support of family planning – 100% in cases where projects were fully dedicated to family planning and an estimated percentage for projects in which family planning activities were an aspect of the project (mainstreamed). The type of implementing partner (NGO, government and/or UNFPA) – information also provided by the country office - is captured in the tables, as well.

The above approach was chosen due, primarily, to challenges in obtaining family planning expenditure through the use of the UNFPA financial management platform (Atlas), as outlined above.

IV. Arriving at an family planning expenditure estimate – 2008-2013

The above processes generated a wealth of data, though via multiple methodologies, complicating comparison. However, in order to arrive at a rough and credible – though with limitations outlined above - estimation of UNFPA expenditure in support of family planning from 2008-2013, the evaluation team will collate the results from several exercises.

- We will use the best estimate of expenditure in support of FP (which includes both full and mainstreamed) generated by the Finance Department for 2013 will be utilized.
- The best estimate of expenditure in support of FP (which includes both full and mainstreamed) generated through the Technical Division's exercise on 2012 data will be utilized.
- The evaluation team will then compare these amounts to total annual UNFPA spending for 2013 and 2012 to determine the average percentage spent on family planning. That percentage will then be applied (with all the limitations this entails) to previous years to determine expenditure in support of FP for 2008-2011.

The evaluation team will use the evaluation office exercise on Atlas data and the expenditure tables generated by the 12 country case studies as triangulation points, lending further credibility to the exercise. The country case study expenditure tables will also offer a closer/in-depth look at expenditure trends (in specific countries), the type of expenditure (core or non-core), implementing partners, as well as the typology of family planning activities implemented by UNFPA over time and within different regions.

An overall estimate of family planning spending from 2008-2013 will therefore be made, with all the discussed caveats on their reliability.

Table 5: HQ, National and Regional Overview 2008-2013 – GPRHCS AND FP BY YEAR

FAMILY PLANNING, INCLUDING GPRHCS							
EXPENDITURE	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**TOTAL**
HQ	13,272,957	86,665,167	75,789,094	48,452,566	99,059,126	112,552,928	**435,791,838**
National	14,819,081	34,237,524	50,294,394	60,014,237	71,788,565	86,320,919	**317,474,720**
Regional	2,936,115	4,875,892	5,795,528	6,075,871	3,525,059	14,183,412	**37,391,877**
TOTAL	**31,028,153**	**125,778,583**	**131,879,016**	**114,542,674**	**174,372,750**	**213,057,259**	**790,658,435**

Table 6: HQ overview 2008-2013 – GPRHCS AND FP BY YEAR

HQ TOTALS								
EXPENDITURE	**Codes**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**TOTAL**
FP only	U3	7,601,146	13,142,690	9,144,854	8,650,383	2,900,181	3,333,720	**44,772,974**
GPRHCS only	*	5,671,811	73,522,477	66,644,240	39,802,183	96,158,945	109,219,208	**391,018,864**
FP+GPRHCS		**13,272,957**	**86,665,167**	**75,789,094**	**48,452,566**	**99,059,126**	**112,552,928**	**435,791,838**

Note:
GPRHCS: All GPRHCS expenditures are coded with **Outcome Code** U3 and the **Fund Code** ZZT05. In other words, at the HQ level, there are no ZZT05 Fund Code entries with a different Outcome Code. The GPRHCS expenditure is separated in the left column.

FP: The second column includes all FP expenditure coded as U3, but with other Fund Codes than ZZT05.

The third column therefore needs to be the sum of the first two columns: GPRHCS (coded U3 and ZZT05) + FP (coded U3, but with a different Fund Code).

Table 7: National overview 2008-2013 – TOTAL GPRHCS AND FP BY YEAR – ALL COUNTRIES

TOTALS FOR ALL COUNTRIES								
EXPENDITURE	**Codes**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**TOTAL**
FP only	U3	13,917,399	28,243,481	34,017,546	43,067,333	58,197,206	69,333,545	**246,776,509**
GPRHCS only	*	1,611,462	11,128,639	22,967,737	26,459,816	28,677,323	41,328,821	**132,173,798**
GPRHCS as FP	ZZT05/U3	-709,780	-5,134,596	-6,690,889	-9,512,912	-15,085,964	-24,341,447	**-61,475,588**
(FP+GPRHCS) – GPRHCS as FP		**14,819,081**	**34,237,524**	**50,294,394**	**60,014,237**	**71,788,565**	**86,320,919**	**317,474,720**

* GPRHCS **Fund Codes** with **Outcome Codes** A1, G1, P1, R1, R2, R202, R207, R3, R4, U1, U2, U3, U4, U5, U6, U7

Explanation of GPRHCS Project Outcome Codes

Code	Description
A1	Programme Coordination and Assistance
G1	Gender Equality & HR in Policies
P1	Population Dynamics Linkages
R1	Policy Environment Promotes RR&SRH
R2	Access to Maternal Health Services
R202	Quality RH
R207	Capacity to Manage Integration of RH
R3	Access to Voluntary FP Services
R4	Demand for HIV & STI Services
U1	Population dynamics and its interlinkages with the needs of young people (including adolescents), sexual and reproductive health (including family planning), gender equality and poverty reduction addressed in national and sectoral development plans and strategies.
U2	Increased access to and utilization of quality maternal and newborn health services
U3	Increased access to and utilization of quality family planning services for individuals and couples according to reproductive intentions
U4	Increased access to and utilization of quality HIV- and STI-prevention services especially for young people (including adolescents) and other key populations at risk
U5	Gender equality and reproductive rights advanced particularly through advocacy and implementation of laws and policy
U6	Improved access to SRH services and sexuality education for young people (including adolescents)
U7	Improved data availability and analysis around population dynamics, SRH (including family planning) and gender equality

Note: GPRHCS included in 'FP only' figure and US included in 'GPRHCS only' figures: Therefore, the GPRHCS figures coded as U3 must be deducted to avoid double counting.

Regional overview 2008-2013 – GPRHCS AND FP BY REGION BY YEAR

TOTALS FOR ALL REGIONS								
EXPENDITURE	**Codes**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**TOTAL**
FP only	U3	1,821,135	4,133,836	4,269,401	4,288,391	2,695,649	13,770,990	**30,979,402**
GPRHCS only	*	1,682,412	2,558,170	3,737,183	4,048,648	2,717,628	3,395,883	**18,139,924**
GPRHCS as FP	ZZT05/U3	-567,432	-1,816,114	-2,211,056	-2,261,168	-1,888,218	-2,983,461	**-11,727,449**
(FP+GPRHCS) – GPRHCS as FP		**2,936,115**	**4,875,892**	**5,795,528**	**6,075,871**	**3,525,059**	**14,183,412**	**37,391,877**
ASRO: Arab States								
EXPENDITURE	**Codes**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	
FP only	U3	0	0	0	0	294,148	242,427	**536,575**
GPRHCS only	*	0	99,565	105,638	153,748	91,095	27,711	**477,757**
GPRHCS as FP	ZZT05, U3	0	0	0	0	-91,983	-27,711	**-119,694**
(FP+GPRHCS) – GPRHCS as FP		**0**	**99,565**	**105,638**	**153,748**	**293,260**	**242,427**	**894,638**
APRO: Asia and the Pacific								
EXPENDITURE	**Codes**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	
FP only	U3	551,842	966,936	1,158,098	1,254,349	365,424	217,637	**4,514,286**
GPRHCS only	*	554,125	758,606	817,087	1,126,588	-11,519	0	**3,244,887**
GPRHCS as FP	ZZT05, U3	-554,125	-752,332	-702,354	-854,166	0	0	**-2,862,977**
(FP+GPRHCS) – GPRHCS as FP		**551,842**	**973,210**	**1,272,831**	**1,526,771**	**353,905**	**217,637**	**4,896,196**
EECARO: Eastern Europe and Central Asia								
EXPENDITURE	**Codes**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	
FP only	U3	13,307	210,488	240,329	117,502	341,680	297,118	**1,220,424**
GPRHCS only	*	13,307	180,513	227,446	294,370	341,700	527,835	**1,585,171**
GPRHCS as FP	ZZT05, U3	-13,307	-180,513	-227,446	3,790	-341,700	-297,118	**-1,056,294**
(FP+GPRHCS) – GPRHCS as FP		**13,307**	**210,488**	**240,329**	**415,662**	**341,680**	**527,835**	**1,749,301**
ESARO: Eastern and Southern Africa								
EXPENDITURE	**Codes**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	
FP only	U3	0	417,147	542,823	0	237,459	11,219,414	**12,416,843**
GPRHCS only	*	657,779	412,595	545,358	268,944	0	1,184,499	**3,069,175**
GPRHCS as FP	ZZT05, U3	0	-417,147	-542,823	0	0	-1,184,499	**-2,144,469**
(FP+GPRHCS) – GPRHCS as FP		**657,779**	**412,595**	**545,358**	**268,944**	**237,459**	**11,219,414**	**13,341,549**
LACRO: Latin America and the Caribbean								
EXPENDITURE	**Codes**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	
FP only	U3	1,255,986	2,063,183	2,071,077	1,968,393	930,670	1,075,622	**9,364,931**
GPRHCS only	*	457,201	640,768	1,776,972	1,528,484	1,770,084	1,258,215	**7,431,724**

GPRHCS as FP	ZZT05, U3	0	0	-474,859	-462,645	-928,267	-1,076,510	**-2,942,281**
(FP+GPRHCS) – GPRHCS as FP		**1,713,187**	**2,703,951**	**3,373,190**	**3,034,232**	**1,772,487**	**1,257,327**	**13,854,374**
WCARO: West and Central Africa								
EXPENDITURE	**Codes**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	
FP only	U3	0	476,082	257,075	676,514	526,267	718,772	**2,654,710**
GPRHCS only	*	0	466,122	264,682	676,514	526,267	397,624	**2,331,209**
GPRHCS as FP	ZZT05, U3	0	-466,122	-263,575	-676,514	-526,267	-397,624	**-2,330,102**
(FP+GPRHCS) – GPRHCS as FP		**0**	**476,082**	**258,182**	**676,514**	**526,267**	**718,772**	**2,655,817**

* GPRHCS **Fund Codes** with **Outcome Codes** A1, R1, R3, U1, U2, U3, U4, U6, U7

Explanation of GPRHCS Project Outcome Codes

Code	Description
A1	Programme Coordination and Assistance
R1	Policy Environment Promotes RR&SRH
R3	Access to Voluntary FP Services
U1	Population dynamics and its interlinkages with the needs of young people (including adolescents), sexual and reproductive health (including family planning), gender equality and poverty reduction addressed in national and sectoral development plans and strategies.
U2	Increased access to and utilization of quality maternal and newborn health services
U3	Increased access to and utilization of quality family planning services for individuals and couples according to reproductive intentions
U4	Increased access to and utilization of quality HIV- and STI-prevention services especially for young people (including adolescents) and other key populations at risk
U6	Improved access to SRH services and sexuality education for young people (including adolescents)
U7	Improved data availability and analysis around population dynamics, SRH (including family planning) and gender equality

Note: GPRHCS included in 'FP only' figure and US included in 'GPRHCS only' figures: Therefore, the GPRHCS figures coded as U3 must be deducted to avoid double counting.