

EVALUATION OF THE UNFPA SUPPORT TO FAMILY PLANNING 2008-2013

VOLUME I

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

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FOREWORD

"Family planning is about women's right and their capacity to take decisions about their health and well-being, contributing to the objectives of FP2020. It is a most significant investment to promote human capital development, combat poverty and harness a demographic dividend, thus contributing to equitable and sustainable economic development within the context of the Sustainable Development Goals."

Dr. Babatunde Osotimehin - International Conference on Family Planning in Nusa Dua, Indonesia (2016)

When UNFPA, the leading entity in the United Nations systems for sexual and reproductive health rights, first began its operations in 1969, family planning was at the heart of its mission. It is my pleasure to present to you the thematic evaluation of UNFPA support to family planning, 2008-2013.

This evaluation is one of three thematic evaluations conducted by the Evaluation Office under the 2014 - 2015 transitional budgeted evaluation plan since revision of the UNFPA Evaluation Policy in 2013. In line with the policy, UNFPA evaluations aim to meet both accountability and learning needs. They also seek to provide evidence of good practice.

This evaluation was conducted to meet accountability requirements as an independent assessment of the programming and implementation of UNFPA family planning interventions during the period 2008-2013. At the same time, it was in a forward-looking manner to focus on lesson learning to inform ongoing implementation of related programmes and strategies under the UNFPA Strategic Plan (2014-2017) and the Family Planning Strategy Choices, not Chance (2012-2020).

The evaluation process was highly participative and was marked by fruitful exchanges involving the UNFPA Programme Division, Technical Division, as well as representatives from Regional Offices and Country Offices. This approach generated valuable insights and identified a number of issues for attention throughout the evaluation process, thus optimizing the focus and utility of the evaluation. This facilitated a dynamic engagement with country offices and headquarter units and stimulated significant efforts to address areas of concern raised by the evaluators. I am pleased to note the responsiveness of UNFPA management in this respect, and believe that this illustrates the commitment of UNFPA to be a learning organization focused on continual improvement in performance. The progress made by UNFPA since 2013 and the significant efforts to address a number of challenges raised by the evaluation are highlighted in the management response.

The evaluation covers all countries where UNFPA works in family planning, with a particular focus on the 69 priority countries with low rates of contraception use and high unmet need for family planning identified by the London Summit on Family Planning in 2012. It includes family planning interventions covered by core and non-core resources, including those financed through the thematic fund GPRHCS, and those which are integrated into programmes and projects in maternal health, adolescent and young people's sexual and reproductive health, HIV and AIDS, gender, and humanitarian support. The main period of data collection and analysis took place in 2015, and whilst the main findings and conclusions assess performance up to 2013, they also reflect more recent developments.

Overall, the evaluation acknowledges notable progress and improvement since 2008. In particular, UNFPA, as a leading advocate of the International Conference on Population and Development (ICPD) agenda, is noted as highly effective in raising the profile and priority of family planning in

development at both the global and national level. UNFPA has been an active agent in the campaign for a human rights-based approach to family planning, in particular as a champion for the rights and needs of vulnerable and marginalised groups. UNFPA has provided effective leadership and guidance to the operational integration of family planning into other aspects of sexual and reproductive health and rights. At the country level, the evaluation found that UNFPA has consistently supported national ownership and government leadership in family planning, contributing to improved prospects for sustainability.

The evaluation is the result of an extensive collaboration with individuals across the organization as well as with representatives of other United Nations agencies, partner governments, national and development partners, and other key stakeholders and beneficiaries who provided critical insights in relation to the work of UNFPA in family planning. On behalf of the Evaluation Office, I would like to extend our sincerest thanks to all of them. Special thanks are offered to UNFPA country representatives and their staff in Bolivia, Burkina Faso, Cambodia, Ethiopia and Zimbabwe for strong engagement and support leading to the successful completion of the country case studies. I would also like to express our sincerest appreciation to the members of the evaluation reference group whose invaluable participation greatly enriched this exercise.

I hope this evaluation will inform the upcoming Strategic Plan and help UNFPA to overcome those challenges and obstacles that have not yet been fully addressed, harness new opportunities, and mobilize the international community to effectively advance the family planning agenda.

Andrea Cook

Director, UNFPA Evaluation Office

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Burkina Faso	
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Zimbabwe	

ABBREVIATIONS AND ACRONYMS

APRO	Asia and the Pacific Regional Office
ASRH	Adolescent Sexual and Reproductive Health
ASRO	Arab States Regional Office
BCC	Behaviour-Change Communication
BMGF	Bill and Melinda Gates Foundation
CA	Contribution Analysis
CIP	Costed Implementation Plan
CGD	Centre For Global Development
CO	Country Office
CP	Country Programme
CPAP	Country Programme Action Plan
CPE	Country Programme Evaluation
CSO	Civil Society Organisation
CSW	Commercial Sex Worker
CYP	Couple Years of Protection
EC	Emergency Contraception
EECARO	Eastern Europe and Central Asia Regional Office
EML	Essential Medicines List
EO	Evaluation Office
ESARO	East and Southern Africa Regional Office
FBO	Faith Based Organisation
FGD	Focus Group Discussions
FP	Family Planning
GBV	Gender Based Violence
GFF	Global Financing Facility
GPRHCS	Global Programme for Reproductive Health Commodity Security (Phase II now referred to as “UNFPA Supplies”)
GPS	Global Programming System
HDA	Health Development Army
HIP	High Impact Practices
HIV-UP	Preventing HIV and Unintended Pregnancies Strategic Framework
HQ	UNFPA Headquarters
HRBA	Human Rights-Based Approach
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
INGO	International Non-Government Organisation
IP	Implementing Partners
IPPF	International Planned Parenthood Federation
IUCD	Intra Uterine Contraceptive Device
KI	Key Informant

KII	Key Informant Interview
LACRO	Latin America and Caribbean Regional Office
LGBTI	Lesbian, Gay, Bisexual, Transgender, Intersexed people
LMIS	Logistics Management Information System
MCH	Mother and Child Health
MCHIP	Maternal and Child Health Integrated Programme
MCPR	Modern Contraceptive Prevalence Rate
MDG	Millennium Development Goal
MHTF	Maternal Health Thematic Fund
MISP	Minimum Initial Service Package
MNH	Maternal and Neonatal Health
MoH	Ministry of Health
MoU	Memorandum of Understanding
MSM	Men who have Sex with Men
NGO	Non-Government Organisation
OECD-DAC	Organisation for Economic Co-operation and Development's Development Assistance Committee
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission (of HIV)
RH	Reproductive Health
RHCS	Reproductive Health Commodity Security
RMNCH	Reproductive, Maternal, Newborn and Child Health
RO	Regional Office
SDG	Sustainable Development Goals
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health Rights
STI	Sexually Transmitted Infection
SWAp	Sector-Wide Approach
TMA	Total Market Approach
ToC	Theory of Change
ToR	Terms of Reference
ToT	Training of Trainer
UPR	Universal Periodic Review
USAID	United States Agency for International Development
VMG	Vulnerable and Marginalised Group

EXECUTIVE SUMMARY

Purpose and scope of the evaluation

The objectives of the evaluation are to assess how the framework of the *UNFPA Strategic Plan (2008-2013)* has guided the programming and implementation of UNFPA family planning (FP) interventions, and to facilitate learning and capture good practices from UNFPA experience in family planning.

The evaluation covers all countries where UNFPA works in family planning, focussing on the 69 priority countries with low rates of contraception use and high unmet need for family planning, as identified in the London Summit on Family Planning and FP2020, and also covering middle income countries where family planning needs are significant due to inequality of access. The evaluation includes family planning interventions covered by core and non-core resources, including those financed through the thematic fund, Global Programme for Reproductive Health Commodity Security (GPRHCS), and those which are integrated into programmes and projects in maternal health, adolescent and young people's sexual and reproductive health (SRH), HIV and AIDS, gender and humanitarian support.

Background of the evaluation

UNFPA was established in 1969 to provide leadership on population issues. Guided by the Programme of Action from the 1994 International Conference on Population and Development (ICPD) and the Millennium Development Goal (MDG) target 5.B¹, UNFPA works strategically to promote family planning within a sexual and reproductive health and human rights framework and with attention to vulnerable and marginalised groups. The current mandate of UNFPA support to family planning also builds on the results of the London Summit on Family Planning in 2012, which capped more than a decade of efforts to give family planning a higher profile and priority within the ICPD framework for sexual reproductive health and rights (SRHR). At the summit, FP2020 was established as a major global partnership to support and track progress towards meeting these commitments.

At the country level, UNFPA provides technical support to governments and supports civil society to pursue universal access to sexual and reproductive health (SRH) information and services, including family planning. At the global and regional levels, it develops technical guidelines, procures and distributes supplies, supports training for health and other development professionals, and advocates for improved policies and programmes.

Several UNFPA strategic frameworks guided the work in family planning during the period under evaluation (2008-2013):

- UNFPA Strategic Plan 2008-2011 and the related Development Results Frameworks (2008-2013)
- Reproductive Rights and Sexual and Reproductive Health Framework (2008-2012)
- Global Programme for Reproductive Health Commodity Security Phase I (2007-2012)
- Preventing HIV and Unintended Pregnancies: Strategic Framework (2011-2015)
- Choices not Chance – UNFPA Family Planning Strategy 2012-2020.

¹ Millenium Development Goal 5 was “Improve maternal health”. The goal had two targets: 5.A “Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio”; and 5.B “Achieve, by 2015, universal access to reproductive health.”

Although each framework has its own focus, family planning has been a component in all of them both as a specific area and as an integral part of other key strategies such as maternal health and HIV and AIDS. Nevertheless, differences between the frameworks reflect changing ways of addressing family planning over time.

Methodology

The overall approach to the evaluation was based on identifying the contribution of UNFPA to family planning and was responsive to gender, human-rights and cultural contexts. Contribution analysis served as the central analytical framework for the evaluation.

Based on a review of the UNFPA strategic frameworks, the evaluation team reconstructed a theory of change which in turn guided the development of a set of key assumptions and related overarching evaluation questions for each of the eight areas of investigation. This information was captured in an evaluation matrix along with sub-questions covering four OECD-DAC evaluation criteria: relevance, efficiency, effectiveness and sustainability as well as the criteria of coordination.

Methods of data collection included twelve country case studies, selected from the 69 UNFPA priority countries for family planning interventions. Field case studies were conducted in five countries (Bolivia, Burkina Faso, Cambodia, Ethiopia and Zimbabwe) and desk-case studies in seven countries (Nicaragua, Nigeria, Sudan, Tajikistan, Uganda, Rwanda, and Viet Nam). Five of these countries are “UNFPA Supplies” countries. Other sources of evidence included information from a comprehensive document review, key informant interviews with UNFPA staff at headquarters, regional and country offices, in addition to interviews with key stakeholders from governments and development partners. Two online surveys targeting UNFPA country offices and key in-country stakeholders were designed and implemented in 64 countries to gather perspectives (both qualitative and quantitative) on the diversity and scale of family planning-related interventions.

Analysis was based on the reconstructed theory of change and was guided by the evaluation matrix, which provided both qualitative and quantitative content based on all data sources. The matrix also served as the basis for testing the assumptions in the theory of change against evaluation evidence to provide credible answers to evaluation questions of programme effectiveness and contribution to results. Each area of investigation was used to inform and ensure the credibility of findings and conclusions.

Main Findings

UNFPA has been effectively engaged in global efforts to raise the profile of family planning as a development priority. These efforts have resulted in the explicit inclusion of family planning-related indicators in the Sustainable Development Goals. **UNFPA contributes to increased government ownership and sustainability by promoting national investment and the use of explicit budget lines for family planning commodities and programmes at national and sub-national level.** UNFPA also addresses institutional sustainability by supporting capacity development, mainly in the public sector and for commodity procurement and logistics as well as provider training. However, at country level, this often takes place in the absence of a coherent strategy, whereby high turnover and low staff retention undermines the sustainability of gains in family planning. UNFPA is a trusted partner of government, often acting on behalf of or supporting governments to lead and coordinate family planning activities. This close government relationship is seen as an

important UNFPA comparative advantage that can be used to advance issues and programmes. However, the influence of UNFPA, may be constrained particularly on sensitive or politically charged issues to sustain the partnership with the government.

There has been a visible shift in family planning positioning since the appointment of the current Executive Director and through the establishment of key partnership platforms, in particular FP2020. UNFPA leadership is appreciated by its global partners for its inspirational message about the importance of family planning, in particular as a means to safeguard the human rights and health of future generations and promote the demographic dividend. UNFPA engagement was leveraged by FP2020 partners in recognition of its comparative advantages, such as its global reach, a field staff network with deep experience, the GPRHCS platform, and the important role that UNFPA plays in garnering government engagement and commitment. UNFPA has brokered commitments to family planning by national governments, yet, particularly at the country level, it does not always use its strategic advantage to the fullest, such as to broker partnerships on sensitive issues or between government and civil society. Also, UNFPA is seen as missing a major opportunity to be a key broker in knowledge management of best or promising practices. Importantly, the priority focus on family planning that is called for in the various UNFPA strategies is limited as UNFPA is trying to do too much across too many countries with too few resources.

UNFPA staff and partners agree on the meaning and importance of integration as a key strategy to achieve the ICPD vision. However, tensions remain about whether and how family planning should be prioritised within the construct of integration. UNFPA has provided important global leadership and technical guidance on integration of family planning. In particular, UNFPA has stimulated and supported integration *upstream* at the policy and strategy level, ensuring that country frameworks address and include integration, with a predominant focus on sexual and reproductive health-HIV linkages, adolescent sexual and reproductive health and emergency responses. However, less attention has been paid to the integration of family planning within maternal health. Results from UNFPA support *downstream*, aimed at improving access to integrated family planning within other reproductive health services, are more difficult to discern. Technical support for family planning has been mainly provided through GPRHCS, which has had a predominantly supply side focus rather than a strong integration approach. At a programme and operations level, UNFPA staff often operate in silos, leading to a lack of alignment and missed opportunities for integration of family planning within other thematic areas.

UNFPA has identified key enabling factors and has contributed effectively to notable results in the areas of a strengthened and improved policy environment and strong national government commitment to family planning. At community level, cultural and social norms continue to pose limitations on policy implementation in family planning, despite appropriate efforts by UNFPA to engage with local organisations. UNFPA has also supported demand-creation activities implemented by state and non-state actors which has often contributed to sustained high levels, or increased levels of family planning uptake. However, there continues to be a knowledge and information gap and it has not been possible for the evaluation to address fully the effectiveness of UNFPA-supported demand-creation activities at community level.

UNFPA has made efforts to identify and address the needs of a limited range of vulnerable and marginalised groups (VMGs) at country, regional and global level, generally with a focus on adolescents and young people. UNFPA is recognised as an effective global advocate of the rights of vulnerable and marginalised groups, yet its leadership does not

always filter down to the country level. UNFPA at times avoids taking a stand on sensitive sexual and reproductive health rights issues of minority groups. While UNFPA promotes the participation of vulnerable and marginalised groups in programme activities, its focus on the empowerment of these groups to participate in programme development or advocacy is more limited. This has resulted in UNFPA supporting programmes to increase access to services for vulnerable and marginalised groups, yet important social and cultural barriers remain unaddressed on both the demand and supply side. Furthermore, the practice of carrying out situation analyses on the sexual and reproductive health and rights of vulnerable and marginalised groups is not systematic across country offices.

UNFPA is mandated to pursue a human rights-based approach (HRBA) to programming, and has identified the key characteristics of this approach in sexual and reproductive health. UNFPA has also articulated rights-based guidance for family planning (*“Choices not Chance”*). Further, UNFPA and WHO have jointly produced guidance on how to operationalise human rights within contraceptive services. **However, UNFPA staff and its partners do not always have a shared understanding regarding what constitutes a human rights-based approach for family planning. In practice, understanding is varied and most often focused on access to family planning services and an expanded range of contraceptive method options.** UNFPA has been vocal at the global level regarding the importance of a human rights-based approach, yet its record at the country level was found to be mixed where components supporting this approach are not consistently applied across programme countries. While a number of technical programmes (such as HIV prevention and gender based violence prevention programmes) pay greater attention to human rights-based components (such as participation, empowerment and accountability), it is often difficult to determine how human rights principles have been operationalised in family planning programmes. This indicates a missed opportunity for cross-learning among different technical areas on effective human rights based approaches.

UNFPA country offices emphasise an evolving mix of modes of engagement depending on the needs and opportunities in family planning over time. However, lack of a UNFPA-wide learning strategy weakens the availability of best practices and evidence-based data to help identify opportunities for different modes of engagement. Country office programming priorities in family planning are primarily driven by national needs, UNFPA organisational priorities, and funding availability. As a result, UNFPA country engagement was found not to take account of other donors’ activities and does not necessarily evolve from a comprehensive strategic assessment of how UNFPA can be catalytic in its support, intervene to unblock barriers, support accelerated progress in difficult areas or join up with other partners to build sustainable approaches.

UNFPA engages in knowledge management for family planning, including through GPRHCS and by providing field expertise and perspectives in the work of the High Impact Practices Initiative (in sexual and reproductive health rights). The lack of an explicit, fund-wide learning strategy for family planning backed up with rigorous standards for documentation and evidence weakens engagement in knowledge management. The lack of attention to defining and reporting higher level results in family planning, beyond the reporting of activities and outputs, also limits UNFPA capacity to serve as a credible knowledge broker about “what works”.

Through its flagship GPRHCS programme, UNFPA supply-side work has grown and contributes to expanding method mix, advocates for sustainable financing for family planning and includes support to training. UNFPA has supported a wide range of supply-

side training activities, including some activities aimed at improving cost-effectiveness and sustainability. Training support, however has generally been fragmented and unrelated to broader human resource development strategies. Little attention is paid to aspects of supervision, monitoring, or assessing the impact of training on user satisfaction. UNFPA has contributed to expanding method-mix, including support for introduction of more sensitive methods and has participated in interventions to reduce the costs of procurement at global and country levels. In addition, UNFPA has helped to expand the range of methods available in emergency and humanitarian situations through provision of emergency kits. That said, UNFPA has not fully explored the financial feasibility of maintaining a broad method-mix in low-income countries. Problems arise of equity in access to a range of methods, or the consequences on voluntary user choice when the method-mix is not systematically considered. UNFPA has supported moves towards greater sustainability through promotion of reproductive health commodity security (RHCS) with governments including advocacy for family planning budget allocations, technical support and supply-chain strengthening. UNFPA has promoted a total market approach involving the private and NGO sectors, participating with other stakeholders in strengthening the global procurement system and developing approaches to reduce the cost of contraceptive supplies.

UNFPA Headquarters provides technical guidance to country programmes in family planning through the development of global frameworks, strategies and guidance documents, while regional offices (ROs) have the mandate to broker and implement technical guidance. However, in practice, regional offices have variable capacities and their effectiveness differs across regions and technical areas. This contributes to a disconnect between the development of strategies and guidelines at the global level, and their implementation at country level. Technical guidance on family planning is more effectively disseminated when there is dedicated, thematic funding, as in the case of GPRHCS, to back a variety of supportive mechanisms (such as meetings, action planning workshops, and technical assistance). Headquarters and regional offices have limited input in assisting country offices to adapt technical guidance or identify changing needs in family planning in order to adequately align country programme design with the latest technical guidance and important principles. This gap presents a critical challenge in family planning for addressing areas such as operationalising a rights-based approach and improving quality of care in contraceptive service delivery.

Conclusions

1. UNFPA, in common with many national and international partners, has re-emphasised family planning and has contributed to the global consensus which returned family planning to its rightful place among the priorities of the ICPD Programme of Action. UNFPA responded to donor and partner advocacy to raise the profile of family planning internally and externally (globally and within partner countries). It has contributed directly through its own programming, and indirectly through advocacy, to securing increased financial resources for family planning. The advent of the GPRHCS contributed significantly to raising the profile of family planning within UNFPA and helped to alert partners to, and convince them of, the recommitment of UNFPA to family planning.

2. UNFPA has played an important role in the coordination of action in family planning at both the international and country levels while consistently supporting national ownership and government leadership of coordination structures and processes. In doing so, UNFPA has relied on its comparative advantages of close relationships with national governments and on its networks that include a wide range of stakeholders, as well as on

leveraging its country presence. UNFPA has also worked effectively to broker joint activities between government agencies, development partners and, to some extent, NGOs. However, UNFPA has found it difficult in some contexts to achieve a balance between being a privileged partner of government and meeting stakeholder expectations specifically in relation to advocacy for more space for civil society organisations and NGOs in family planning and in working to increase transparency and accountability for results.

3. UNFPA has had mixed success in promoting and supporting the integration of family planning with other sexual and reproductive health services, achieving more notable results at the level of national policies and plans. UNFPA has provided effective leadership and guidance to the operational integration of family planning services with HIV and AIDS prevention and treatment and in humanitarian responses. However, together with its partners, UNFPA has made more limited progress integrating family planning into other aspects of sexual and reproductive health at the level of service delivery.

4. UNFPA has engaged in efforts to improve the long-term prospects for family planning action across the key dimensions of national policy and of financial, institutional and cultural sustainability. It has been most successful in contributing to renewing national commitment to family planning and to strengthening financial sustainability. At country level, UNFPA has contributed to better financial sustainability for family planning by effectively advocating for stronger government commitments to resource allocation. However, there has been less progress in its efforts to sustainably strengthen health systems to deliver quality family planning services. Engaging with the development of reproductive, maternal, newborn and child health (RMNCH) investment cases and actively supporting their delivery presents a promising opportunity to redress this imbalance. Furthermore, despite engagement with community level organisations and efforts to support demand-creation, UNFPA and its partners face significant cultural barriers to family planning at local and community levels. Developing expertise on cultural engagement and working through the H6² may offer opportunities to deliver better outcomes, for example, by working more closely with, and through, partners that specialise in cultural engagement.

5. At global level, UNFPA has exercised an important leadership role as an advocate for a human rights-based approach (HRBA) to programming in family planning, and for the rights and needs of vulnerable and marginalised groups (VMGs). UNFPA has followed up on its global advocacy for a rights-based approach to family planning by collaborating on the development of operational guidelines for rights-based family planning programming which can be applied by national health services. It has also identified the rights and needs of vulnerable and marginalised groups and has developed programming frameworks for addressing those needs. However, there remains a gap between UNFPA supported policies and guidelines on rights-based approaches to family planning and efforts to put those guidelines into action in some countries. One reason for the gaps is limited resources, as the most vulnerable and marginalised populations are also the hardest to reach and consequently support is costly. However, part of this gap can be attributed to the lack of

² H6 (called "H4+" from 2008-2015) is a partnership of six organisations (UNAIDS, UNFPA, UNICEF, UN WOMEN, WHO and the World Bank) that aims to leverage their collective strengths and complementary advantages and capacities to support countries with high burdens of maternal, child and adolescent mortality and morbidity in their efforts to improve the survival, health and well-being of every woman, newborn, child and adolescent. H6 is the technical arm of the UN Secretary-General's Global Strategy for Women's, Children's and Adolescents' Health (2016-2030) and provides technical support to high-burden countries in their efforts to implement the Global Strategy and to tackle the root causes of maternal, newborn, child and adolescent mortality and morbidity, including gender inequality and socio-cultural and financial barriers.

internal collaboration and integration across technical silos, leading to an absence of a common understanding among UNFPA staff at regional and country office levels regarding how best to implement rights-based approaches to family planning. This, in turn, contributes to variations in the effectiveness of the UNFPA response at country level.

6. UNFPA lacks a body of systematically organised evidence on important aspects of effective programming in family planning, especially at national level. Most critically, UNFPA lacks evidence: (i) on the extent of integration of family planning into other segments of sexual and reproductive health; (ii) on the effect of different approaches and interventions on service quality, equity and access; and (iii) to validate and communicate good practices in family planning programming. All three gaps in the evidence base are detrimental to organisational learning and impede improved programme design, based on an understanding of “what works” and “what does not work” in family planning programming. In spite of this, UNFPA plays an important role in providing a practical field perspective when reviewing evidence on potential high impact practices generated by other development partners.

7. UNFPA country offices have a strong grasp of the country context and are attuned to the needs and priorities of their government partners. UNFPA has a comparative advantage undertaking policy and advocacy efforts, and is among the best-placed of multilateral organisations to work with national governments and other development partners on policy engagement for family planning. However, other development partners (in particular bilateral agencies and projects) may be better placed to undertake longer-term capacity development and scale-up of service delivery, notably due to their ability to plan and dedicate resources over a longer-term. The development of the integrated RMNCH investment case is an opportunity for UNFPA to advocate for family planning to be appropriately positioned at policy, planning, implementation and monitoring levels. This advocacy and positioning would promote funding from domestic sources or other sources for which the government has a measure of control (e.g. pooled funds or World Bank loans). UNFPA programming insufficiently explicitly addresses the landscape of what other development partners are doing in-country, leading to missed opportunities to leverage its comparative advantage for maximum synergy and results.

8. UNFPA has been effective in supporting national government to increase the emphasis and investment assigned to reproductive health commodity security and in helping to strengthen management of contraceptive supply chains. UNFPA has also made an effective global contribution to improved procurement and lower contraceptive prices. Further, it has contributed to improvements in the availability of different contraceptive methods. This improvement in the available mix of contraceptive methods is, in itself, an important element in a human rights-based approach to supporting family planning.

9. UNFPA country offices rely on effective and timely technical support and backstopping in family planning from headquarters divisions and from regional offices (ROs). There is a substantial body of written guidance, but the availability and quality of technical support varies widely across regions and from different divisions and branches. The implementation of the “regionalisation strategy” has been accompanied by a perceived disconnect between headquarters and country levels and confusion over regional office roles.

Recommendations

1. In order to address important challenges in advancing family planning, UNFPA should optimise its comparative advantages. Those advantages are its close technical and strategic relationship with governments and its central role in coordination and programming links to a wide array of stakeholders. The challenges include: holding governments accountable for maintaining or increasing their financial and other commitments to family planning; advocating for a human rights-based approach, including addressing the needs of marginalised groups; and engaging with a diverse set of actors to rationalise and scale up services.

2. In light of family planning being instrumental to the achievement of the UNFPA mandate and as an integral element in strategic and programme frameworks, UNFPA should examine previous efforts to strengthen integration and collaboration among technical “silos.” In this way, UNFPA can identify lessons and adjust its organisational approach to address continuing challenges. This is particularly important given the current trend to channel family planning interventions through major initiatives (FP2020, GPRHCS/“UNFPA Supplies”) which have a significant focus on the supply-side. It is essential to ensure that UNFPA places family planning firmly within a sexual and reproductive health and human rights context, in the framework of the Post-2015 Development Agenda. UNFPA needs to be able to communicate effectively to its staff and to stakeholders and partners that a focus on family planning does not imply a vertical programme, nor should an integrated approach imply that family planning is not a priority. Embedding family planning in long term investment cases and advocating for the allocation of domestic resources for implementation will boost sustainability.

3. UNFPA should strengthen the capacity of country offices to document and report on results of UNFPA support to family planning. To this end, UNFPA should intensify its efforts to ensure that the monitoring system measures results in family planning beyond activities and outputs. UNFPA should also elaborate a proactive learning agenda (at HQ level and within family planning focus countries) to contribute to the evidence base on family planning and enhance its role in synthesising, translating and disseminating evidence at regional and international level. In particular the learning agenda for family planning should identify strategic family planning programme issues to explore, and promising interventions undertaken by implementing partners to be validated and communicated to facilitate scale up and replication of successful initiatives. UNFPA should contribute actively to and consider or incorporate the findings of the *Independent Accountability Panel for Women’s Children’s and Adolescents’ Health Annual Report* which tracks commitments to and delivery of resources, results and rights.

4. UNFPA should continue to take a strong stance and ensure its leadership position in promotion of a human rights-based approach at global, regional and country levels. As a leading advocate of a human rights-based approach in development programming, UNFPA must align its programme activities so that its actions more fully reflect its aims. In particular, UNFPA should ensure that its current operational guidelines for implementing a human rights-based approach in family planning and reaching the most marginalised and vulnerable populations are backed up by a common understanding of the concrete actions required for implementation by country office staff and partners. At country level, UNFPA should intensify efforts to ensure that programmes prioritise quality of care, non-discrimination and voluntary choice of family planning and family planning methods, with a

special focus on the empowerment and participation of vulnerable and marginalised groups as rights-holders.

5. UNFPA should work at country level to focus on modes of engagement in family planning where it has a strong comparative advantage and where it has adequate resources to follow through. In practice, this means a greater focus than at present on the policy advocacy mode of engagement and specifically in relation to country reproductive, maternal, newborn and child health (RMNCH) investment case development processes. To this end, increased support is needed to strengthen systems and expertise for knowledge management (Recommendation 3) to inform and strengthen UNFPA critical roles in advocacy and brokering. Increased support and guidance should be provided to country programmes to enable constructive engagement in policy processes aimed at systems strengthening for integrated RMNCH delivery, including advocating for increased domestic fiscal space, promoting family planning in the Global Financing Facility and working to build sustainable commitment to family planning. UNFPA should also re-examine its commitment and approach to training as a key element of capacity development to ensure that training activities are embedded within national strategies for integrated human resource development and sequenced appropriately, rather than providing fragmented support to specific training activities. Further, UNFPA should explicitly analyse its programming in light of what other development partners are doing at country level. Specifically, in respect of broader health systems strengthening initiatives, UNFPA should ensure that landscape analysis is a key component of business planning.

6. UNFPA should clarify the roles and responsibilities of different branches in the Technical Division, other divisions and offices (especially regional offices) for technical and programme oversight of family planning. UNFPA should review how country offices are supported to implement effective, technically sound, rights-based and results-oriented family planning programme activities and revise roles, responsibilities, procedures and accountabilities accordingly.

1 INTRODUCTION

1.1 Purpose of the Evaluation

Family planning (FP) is a principal focus of the work of UNFPA worldwide. This evaluation of UNFPA support to family planning in the period 2008-2013 is both retrospective and forward-looking. Its purpose is to assess UNFPA performance in family planning during the period covered by the *UNFPA Strategic Plan 2008-2013*, and to provide learning to inform the implementation of the current UNFPA Family Planning Strategy and other relevant programmes, including the *Global Programme for Reproductive Health Commodity Security (GPRHCS) (2013-2020) (UNFPA 2014f)* and the *Preventing HIV and Unintended Pregnancies Strategic Framework (HIV-UP) (2011-2015) (UNFPA 2012g)*. The evaluation results will feed into the mid-term review of the current *UNFPA Strategic Plan 2014-2017*.

The objectives of the evaluation are to assess how the framework of the *UNFPA Strategic Plan (2008-2013)* has guided the programming and implementation of UNFPA family planning interventions, and to facilitate learning and capture good practices from UNFPA experience in family planning.

The evaluation covers all countries where UNFPA works in family planning, focussing on the 69 priority countries³ with low rates of contraception use and high unmet need for family planning as identified in the London Summit on Family Planning and FP2020, and also covering middle income countries where family planning needs are still high due to inequality of access. The evaluation includes family planning interventions covered by core and non-core resources, those financed through the thematic fund GPRHCS, and those which are integrated into programmes and projects in maternal health, adolescent and young people's sexual and reproductive health (SRH), HIV and AIDS, gender and humanitarian support.

1.2 Mandate and strategy of UNFPA in the field of family planning

Family planning emerged as a key public health and development intervention in the 1960s as a result of concerns regarding the impact of rapid population growth and high fertility. In the early years, a demographic rationale governed family planning advocacy and programmes focused mainly on supply, although there were also demand-generation efforts to increase awareness and acceptability of family planning. For many years, lack of availability was seen as the major challenge to increasing use of contraception. As the field of family planning gained experience and matured in the 1980s, programming increasingly focused on improving quality of care, acceptability and socio-cultural dimensions of access, including gender considerations (*Bruce 1990*). In the 1990s, there was a noted shift away from a demographic rationale toward embracing sexual and reproductive health and rights (SRHR) as human rights, made explicit in the International Conference on Population and Development (ICPD) Programme of Action in 1994. Putting individual rights, health and women's empowerment at the centre of family planning programmes, contributed to greater investment and programmatic interest in integrating family planning within a broader array of sexual and reproductive health services in order to better meet individual rights and needs as well as public health considerations.

Global contraceptive prevalence rose from 55 to 63 per cent between 1990 and 2010, although progress slowed significantly between 2000 and 2010 in comparison with the 1990s (*Alkema, Kantorova et al. 2013*). Prevalence rates stalled in many countries in the late 1990s and 2000s as global attention and resources increased to deal with the HIV and AIDS

³ Table 1, Volume II, Annex 6

pandemic with levels of funding for family planning remaining constant at best. Countries were unable to keep up with the increasing numbers of people entering their reproductive years.

During the 2000s, the global community focused on “repositioning family planning” by providing evidence on the various health, demographic and economic rationales for maintaining or increasing investments.⁴ Established in 2001 to address the challenge of ensuring adequate supplies of contraceptives including condoms for HIV prevention, the Reproductive Health Supplies Coalition (RHSC) was a major global initiative focused on family planning during this period. Family planning is also a component of “*Every Woman Every Child*”, a United Nations-led campaign started in 2010 to address the major health challenges facing women and children.

The London Summit on Family Planning in 2012 capped more than a decade of efforts to give family planning a higher profile and priority within the ICPD framework for sexual and reproductive health rights. It resulted in renewed commitments of resources and attention among donors, developing country governments and civil society organisations, to reduce unmet need and support contraceptive information and services for 120 million women and girls in the 69 priority countries.⁵ At the summit, FP2020 was established as a major global partnership to support and track progress towards meeting these commitments. At its halfway point in 2015, FP2020 reports that the partnership has generated a total of US\$1.4 billion in bilateral funding for family planning (32 per cent more than available in 2012) and has served 290.6 million users of modern contraception in the FP2020 focus countries (24.4 million more than in 2012) (*FP2020 2015*).

UNFPA was established in 1969 to provide leadership on population issues and generate resources for family planning. Guided by the Programme of Action from the 1994 ICPD and the addition of the Millennium Development Goal (MDG) target 5.B⁶ in 2007, UNFPA works strategically to promote family planning within a human rights framework and with attention to vulnerable and marginalised groups. Within its mandate of promoting sexual and reproductive health rights, the organisation is able to advance other development goals as well as support regional or national efforts to harness the demographic dividend⁷ through its investments in family planning.

UNFPA, as the agency within the United Nations system charged with addressing sexual and reproductive health including family planning, coordinates with the work of UNICEF, UNDP, UNAIDS and other United Nation funds and programmes. UNFPA does not provide sexual and reproductive health or family planning services directly; its primary role is to facilitate access to improved services within countries and carry out advocacy and policy work. At the country level, UNFPA provides technical support to governments and supports civil society to pursue universal access to sexual and reproductive health information and services, including family planning. At the global and regional levels, it develops frameworks and guidelines, procures and distributes supplies, trains health and other development professionals, and advocates for improved policies and programmes.

In 2007, UNFPA established the GPRHCS, a thematic fund created out of widespread concerns over supply problems for family planning and maternal health commodities. As a

4 Cleland, Bernstein et al. 2006, Barot 2008, Singh and Darroch 2012

5 See Table 1, Volume II, Annex 6

6 Millennium Development Goal 5 was “Improve maternal health.” The goal had two targets: 5.A “Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio;” and 5.B “Achieve, by 2015, universal access to reproductive health” (United Nations).

7 The demographic dividend is the economic growth potential that can result from shifts in a population’s age structure, mainly when the share of the working-age population (15 to 64) is larger than the non-working-age share of the population (14 and younger, and 65 and older). (UNFPA)

thematic fund, it is an example of “non-core”⁸ funding from donors to shape UNFPA programming and to reprioritise family planning within its agenda. In 2011, to support the transition in executive leadership at UNFPA, the Centre for Global Development offered several recommendations to sharpen the focus of UNFPA work, specifically, to reaffirm positioning universal access to family planning at the core of its mission (CGD 2011). This was followed by UNFPA engagement in the London Summit on Family Planning and active participation in the FP2020 partnership, including serving as co-chair of the Reference Group.

Several UNFPA strategic frameworks guided the work in family planning during the period under evaluation (2008-2013):

- UNFPA Strategic Plan 2008-2011 and the related Development Results Frameworks (2008-2013)
- Reproductive Rights and Sexual and Reproductive Health Framework (2008-2012)
- Global Programme for Reproductive Health Commodity Security Phase I (2007-2012)
- Preventing HIV and Unintended Pregnancies: Strategic Framework (2011-2015)
- Choices not Chance – UNFPA Family Planning Strategy 2012-2020.

Although each framework has its own focus, family planning has maintained a prominent place in all of them both as a specific area, and as an integral part of other key strategies such as maternal health and HIV and AIDS. Nevertheless, differences between the frameworks reflect changing ways of addressing family planning over time. While the documents show an increased focus on family planning as a central priority for UNFPA within an integrated and rights-based approach, it is not clear which framework, if any, takes precedence in overall programming, or which is considered the most important in different contexts.

There is however a certain level of coherence, as illustrated by the principal family planning outcome of *“access to, and utilisation of, quality voluntary family planning services by individuals and couples increased according to their reproductive intentions”* which appears (in almost similar terms) in all frameworks. The exception is the *Preventing HIV and Unintended Pregnancies Strategic Framework (HIV-UP)*, which focuses more on family planning as a method of preventing unwanted pregnancies whilst maintaining the rights of people living with HIV (PLHIV) to have children when they want them. The new *UNFPA Strategic Plan (2014-2017)* integrates the family planning outcome within a more general outcome of increased availability and use of sexual and reproductive health services. *UNFPA Supplies (2013-2020)* focuses more explicitly on poor and marginalised groups, but it also uses the principal family planning outcome stated above.

In alignment with FP2020, UNFPA has targeted the 69 priority countries and made a commitment in 2012 to increase the allocation of its resources for family planning. UNFPA has significantly funded family planning activities and commodity security through GPRHCS during the period under evaluation (2008-2013); UNFPA was the second largest funder of family planning activities after the United States Agency for International Development (USAID). Total spending on family planning is hard to estimate, but UNFPA financial data show that the total was at least US\$705 million. If spending on family planning activities within other sexual and reproductive health programmes is included, the total may be as high as US\$959 million (see section 3 for detailed information on global and UNFPA spending on family planning).

⁸ “Non-core funding” is multi-bilateral funding which is not included in UNFPA “core” institutional budget, but is donated for specific programmes. “Core” and “non-core” funding is also known as “regular resources” and “other resources” (see for example the UNFPA annual *Statistical and Financial Reviews*).

UNFPA supported direct family planning interventions via core support, or the GPRHCS thematic fund, in 103 developing countries during this period including in East and Southern Africa (21), West and Central Africa (21), the Arab States (10), Eastern Europe and Central Asia (16), Latin America and the Caribbean (15), and Asia and the Pacific (20).⁹ Sub-Saharan Africa received the largest percentage of UNFPA core resources, followed by Asia and the Pacific Region. During 2012 and 2013 over 80 per cent of the UNFPA family planning spending was financed from non-core resources, the largest source being GPRHCS. Non-core spending was concentrated in the “global” category (GPRHCS) and in Sub-Saharan Africa. At country level, 69 per cent of all family planning spending during the period under evaluation was in Sub-Saharan Africa, with 12 per cent in Asia Pacific Region, 10 per cent in Latin America and the Caribbean, 6 per cent in the Arab States, and 2 per cent in Eastern Europe and Central Asia.¹⁰

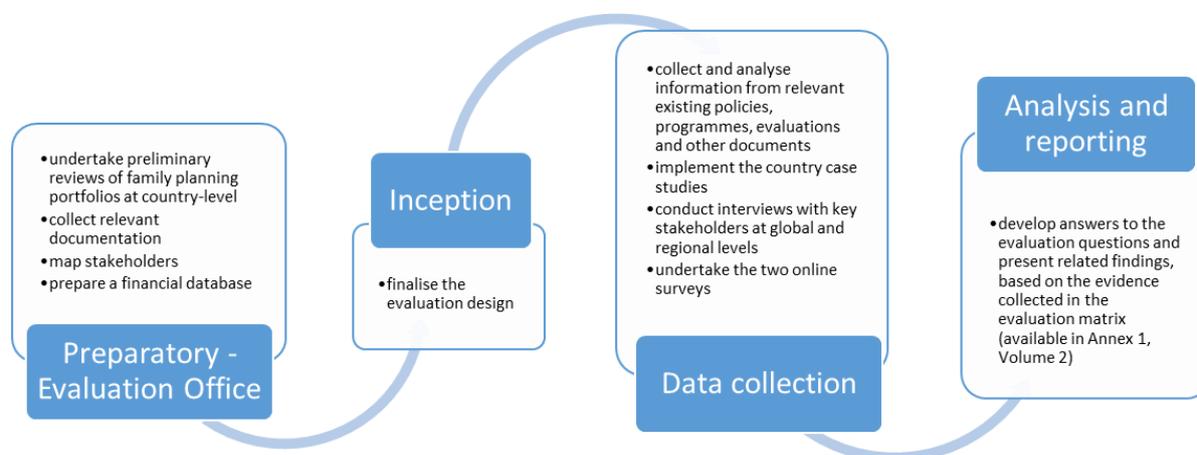
2 METHODOLOGY

This chapter describes the evaluation process and the methodology applied during the evaluation: the phased approach, the methods and tools for data collection, and the analysis methods. The overall approach to the evaluation was based on evaluating the contribution of UNFPA to family planning and was responsive to both gender and human rights and cultural sensitivity.

2.1 Overview of the evaluation process

This evaluation was carried out in four phases:

Figure 1: Evaluation phases



2.2 Methods and tools used in evaluation design

The following sections provide information on the different tools and methods used in the design and implementation of this evaluation.

⁹ See Table 2, Volume II, Annex 6

¹⁰ Figures derived from the ATLAS database and report in Annex 5 of the Inception Report. These percentages do not include spending at HQ or regional office levels. Family planning spending at regional office is relatively low (4.6 per cent of the total family planning spend), but HQ spending through GPRHCS is high (total 55 per cent of all family planning spending). See *Portfolio of UNFPA Family Planning Interventions 2008-2013, Volume II, Annex 4*

2.2.1 Analysis of UNFPA strategic framework

In order to establish the substantive scope of the evaluation, the evaluators reviewed the relevant key frameworks, which together provide the context for the UNFPA family planning (FP) work during the period under evaluation. The key outcomes and outputs derived from each of these policy frameworks were compared, showing both alignment and differences between the outcomes and outputs of the frameworks. While there is good alignment across all frameworks through time, there is variation at output level (*UNFPA 2014c: 8-9*).

Subsequently, a more detailed review of the policy frameworks was undertaken resulting in a logical reconstruction of the theory of change (ToC). The theory of change served as the basis for the formulation of concrete hypotheses about the contribution made by UNFPA programming to results in family planning. These hypotheses were, in turn, embedded in a set of specific assumptions for testing during the evaluation. An overall evaluation matrix was developed and maintained to ensure systematic collection and recording of all information.¹¹

2.2.2 Areas of investigation and assumptions to be assessed

Based on the review of UNFPA strategic frameworks and the logical reconstruction of the theory of change (*UNFPA 2014c: 16*), the evaluation team prioritised eight areas of investigation (AI). Collectively, these eight areas:

- i. Encompass the issues brought forward in the evaluation terms of reference (ToR)
- ii. Focus attention on key aspects of the reconstructed UNFPA theory of change, using UNFPA modes of engagement as a typology for family planning interventions
- iii. Assess the UNFPA family planning strategy applying the DAC evaluation criteria of relevance, effectiveness, efficiency and sustainability, as well as the criteria of coordination.

Associated with each area of investigation, a main evaluation question was developed based on input from the evaluation reference group (ERG). The table below shows the evaluation questions' themes, the corresponding criteria and the data sources.

Figure 2: Evaluation questions, criteria and data sources

Evaluation questions on:	Evaluation criteria	Triangulation of data sources						
		Document review	Country case studies - field	Country case studies - desk	Global KIs	Survey – external Stakeholders	Survey – UNFPA country offices	FP expenditure review
Integration	Relevance, effectiveness	♦♦	♦♦	♦♦	♦♦	♦	♦	♦♦
Coordination	Coordination, sustainability	♦♦	♦♦♦	♦♦♦	♦♦♦	♦♦	♦♦	♦
Brokerage and partnership	Effectiveness, sustainability	♦♦	♦♦♦	♦♦♦	♦♦♦	♦	♦	
Enabling environment	Relevance, effectiveness	♦♦♦	♦♦	♦♦♦	♦	♦♦	♦♦	♦
Vulnerable and marginalised groups	Relevance, effectiveness, efficiency	♦♦♦	♦♦♦	♦♦	♦	♦♦	♦♦	♦
Rights-based approach	Relevance, effectiveness	♦♦	♦♦♦	♦	♦♦	♦	♦	
Modes of Engagement	Relevance, efficiency, sustainability	♦♦♦	♦♦	♦♦	♦♦	♦♦♦	♦♦♦	♦

¹¹ See Theory of Change, Volume II, Annex 5

		Triangulation of data sources						
Evaluation questions on:	Evaluation criteria	Document review	Country case studies - field	Country case studies - desk	Global Klis	Survey – external Stakeholders	Survey – UNFPA country offices	FP expenditure review
Supply-side activities	Relevance, effectiveness, sustainability	◆◆◆	◆◆◆	◆◆◆	◆◆◆	◆◆◆	◆◆◆	◆◆
Support to country office from UNFPA HQ and regional offices			◆	◆◆	◆◆	◆	◆	

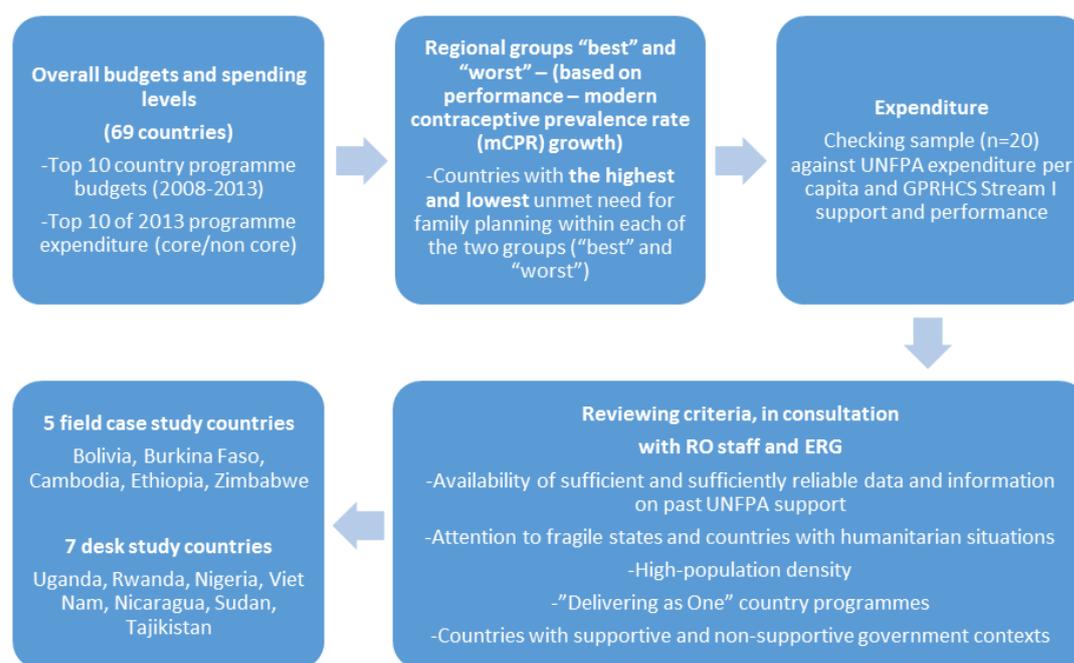
Legend: ◆◆◆ Provided extensive data for areas of investigation
 ◆◆ Provided some data for areas of investigation
 ◆ Provided relatively little data for areas of investigation

In connection with each area of investigation, the evaluators developed specific assumptions for verification and related indicators. The assumptions, along with sources of information, methods and tools for collection, were captured in the evaluation matrix.¹² The use of the evaluation matrix ensured that evaluators were collecting information in a systematic and structured way in order to assist in identifying gaps and organising data. This systemisation in turn facilitated analysis by clearly showing association between the evidence, findings and conclusions.

2.2.3 Geographical scope of the evaluation

The geographical scope of the evaluation consisted of the 69 UNFPA priority countries for family planning interventions with an in-depth assessment of interventions in 12 case study countries. During a multi-step process, the sample of case study countries was identified by applying successive screening criteria (see below).

Figure 3: Criteria for case study selection¹³



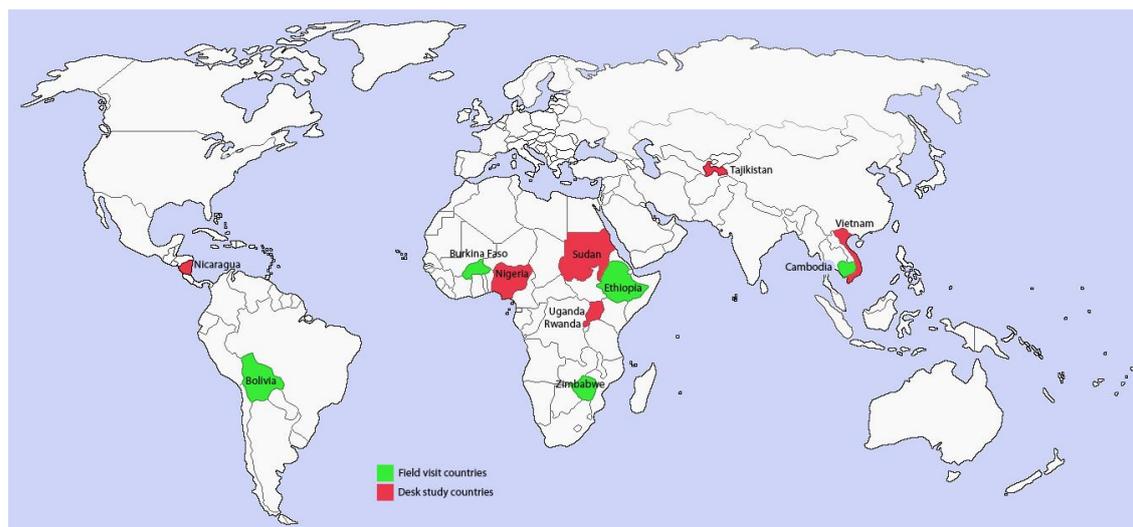
12 See Volume II Annex 1

13 GPRHCS Stream 1 funding is defined as multiyear funding (2008-2012) for a small number (12 countries) to help develop sustainable reproductive health supply systems

The final sample of case study countries is illustrative, rather than statistically representative, providing examples across a range of contexts. The selection provides a useful indicative sample for assessing the results of UNFPA support to family planning across a diverse set of high priority partner countries with a significant UNFPA programme presence and a reasonable assurance of readily-available evaluation information. For more details on the selection process refer to the inception report of this evaluation (*UNFPA 2014c: 25-38*).¹⁴

Figure 4 below illustrates the coverage.

Figure 4: Countries selected for country case studies (field and desk-based)



2.3 Methods and tools used for data collection

The evaluators used a combination of quantitative and qualitative methods for data collection and analysis, to strengthen credibility of information by triangulating across methods and sources of information.

The methods and tools used for data collection included:

- Desk-based document review of existing policies, programmes, evaluations and other documents
- Twelve country case studies: five field country studies and seven desk country studies¹⁵
- Two online surveys, among external stakeholders in UNFPA programme countries and UNFPA country offices (COs)
- Key informant interviews (KIIs): a series of face-to-face and telephone interviews with UNFPA staff at headquarters and regional offices and with external partners and stakeholders at international level, as well as working group sessions with UNFPA staff at headquarters
- Review and analysis of family planning expenditure data at UNFPA Headquarters and in a number of selected UNFPA country offices.

2.3.1 Document review

A document review was carried out from January to March of 2015. The evaluators developed a document database, which was then searched to identify UNFPA activities responding to each of the areas of investigation and evaluation questions. The document database was also used to fine-tune the online surveys, prepare for field country studies,

¹⁴ See also Annexes 6, 7 and 8 pp. 93-100

¹⁵ See table 8, Volume II, Annex 6

provide information for the desk country studies and to triangulate data. Key findings from the document review were collected in a specially-designed format covering all the evaluation assumptions, for use in the analysis stage of the evaluation.

2.3.2 Country case studies

The country case studies were not designed as individual country evaluations. Instead, the purpose was to provide insights into the eight areas of investigation, contribute to identifying more clearly “how” and “why” change occurs in order to identify the contributions of UNFPA, generate data for triangulation with other sources and identify lessons learned in different contexts.

The five country visits took place between December 2014 and June 2015. For each country, the evaluators performed the following tasks:

- A preparatory document review
- Family planning expenditure data collection and review
- Field visits
- Interviews with UNFPA country office staff and stakeholders (such as government representatives, ministry of health (MoH) staff, implementing and development partners, non-government organisations (NGOs) and international NGOs (INGOs), community leaders, networks and service delivery staff).

In addition, focus group discussions (FGDs) were conducted with family planning service users and a de-briefing session held with UNFPA country office staff. A country note was prepared for each of the field countries studies inclusive of an evaluation matrix detailing the evidence gathered to inform overall evaluation findings and conclusions.¹⁶

The seven desk country studies were carried out between February and June 2015. The studies were designed to contribute to the overall analysis of the eight areas of investigation and provide illustrative examples where appropriate. The desk study countries were selected to show main trends across countries in addition to significant deviations. Methods included document review and remote interviews with key UNFPA country office staff and external stakeholders.

2.3.3 Key informant interviews at global and regional level

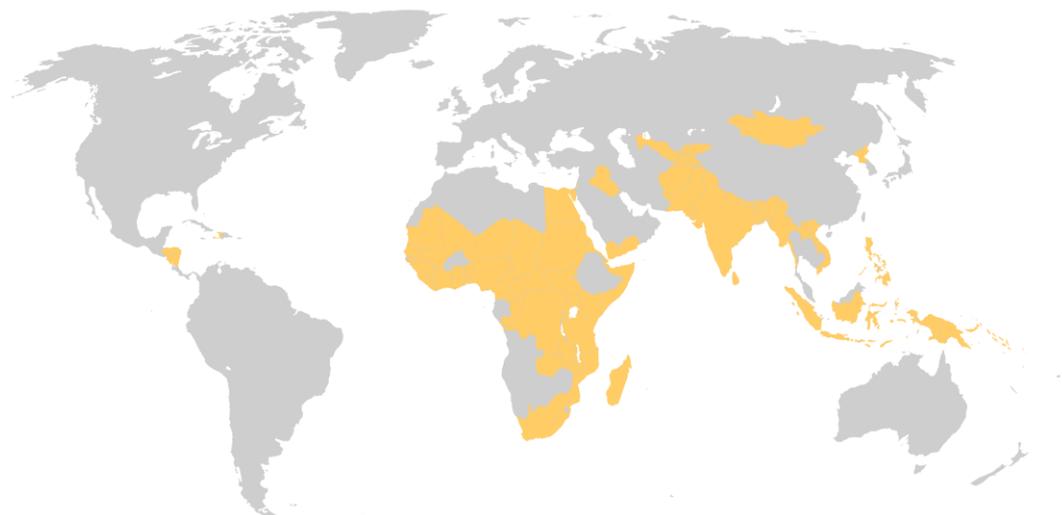
A first round of key informant interviews was carried out at UNFPA Headquarters (HQ) and regional office (RO) level for input into the inception report and to address the role and activities of UNFPA in family planning at these levels. Additional face-to-face and remote interviews were conducted to gather information from UNFPA staff and external stakeholders (multilateral and bilateral development partners, private foundations, INGOs) using tailored interview guides (see Annex 11). These interviews allowed the evaluators to explore in-depth the evaluation investigation areas and related questions. A complete overview of all interviewees is presented in Annex 8.

2.3.4 Online surveys of 64 countries

Two online surveys were carried out between March and May 2015. These surveys were designed to gather stakeholder perspectives (both qualitative and quantitative) from 64 countries (the five countries visited during the evaluation were excluded from the survey) (See Figure 5).

¹⁶ See country notes

Figure 5: Countries included in online surveys



The first survey targeted external stakeholders to gather information on particular interventions and alternative perspectives from those elicited in the case study countries. In total, 265 individuals from 62 countries responded to the survey. The external stakeholder survey questionnaire is presented in Annex 12.

The second survey targeted UNFPA country offices, focusing on obtaining additional information, notably on the diversity and scale of family planning-related interventions from the same 64 countries targeted in the stakeholder survey. In total, 55 country offices responded to the survey. The UNFPA country office survey questionnaire is presented in Annex 13.

The information collected through the surveys enabled triangulation of responses from different organisations and stakeholders. Results were entered into a format corresponding to each of the areas of investigation.

2.3.5 Financial analysis

Prior to 2012, UNFPA family planning expenditure was not captured as such by the UNFPA financial tracking system. Because of this, it was essential that the evaluators draw on data from different existing estimates and sources to obtain a “best estimate” of UNFPA family planning expenditure during the period of 2008-2013. As part of this exercise, the UNFPA Evaluation Office (EO) developed two additional methods to estimate family planning expenditure (see below). The methodology employed, challenges faced, and steps taken to mitigate difficulties are detailed within the methodological note presented in Annex 14.

Methods used included:

- Review of other estimates (produced by UNFPA and UNFPA with others) to identify UNFPA family planning expenditure. These included estimates from the UNFPA Finance Department, an estimate based on an internal survey of headquarters, regional offices and a sample of countries carried out by the Commodity Services Branch of the UNFPA Technical Division, estimates produced by an external management consultancy working with UNFPA senior management and actual spending in the GPRHCS.
- Analysis of Atlas financial system data, where the evaluation office developed a multi-stage process, which included a key word search, to identify both expenditures dedicated to family planning as well as expenditures of family planning activities embedded in other sexual and reproductive health projects using 2008-2013 data aggregated at country, regional and global levels. This accounts for the fact that family

planning activities continue to be mainstreamed, integrated and “hidden” within other sexual and reproductive health related projects. However, this estimation method faces limitations, and offers only a rough estimate of global UNFPA spending.

- Verification of family planning expenditure data at country level, through a survey among 12 UNFPA country offices.¹⁷ Under the guidance of the evaluation office, country offices identified projects which included family planning expenditure – those fully dedicated to family planning, as well as those in which family planning activities were mainstreamed into other sexual and reproductive health – and estimated the percentage spent on family planning annually under each project. Project expenditure was disaggregated into core and non-core funding. The percentages were used to develop an estimate of the total country office spending in support of family planning. It was hoped that the country level data would allow for identification of spending patterns which could be extrapolated to give an overall estimate. However the figures were too divergent to identify any patterns or trends. Although the results provided an accurate estimate of family planning expenditure by specific UNFPA country offices, it did not contribute to an estimate of the overall expenditure on family planning.

The estimates from the above processes were assessed for reliability through comparison with known family planning spending by GPRHCS, and triangulated (see global spending on family planning and UNFPA contribution in Section 3).

2.3.6 Limitations and mitigation strategies

The evaluators confronted a number of moderate limitations considered not to have affected the evaluation results (see Annex 7). However, there were some limitations worth mentioning that affected the analysis of almost all areas of investigation. Firstly, outcome data was not available. In addition, there was limited availability of robust evaluations in the area of family planning. This meant that the evaluators were unable to assess results at the outcome level and determine the UNFPA contribution at that level.

The mitigation strategy applied throughout the evaluation was to employ a mix-method approach to ensure triangulation of a wide range of information types, range of data collection methods and a variety of sources spanning across multiple geographical levels, and to focus at the outcome level using a more qualitative approach. This served to improve data reliability as well as the validity of findings and conclusions. The evaluators cross-referenced the different sources of information (both qualitative and quantitative) from the document review, interviews, focus groups, online surveys and remote interviews.

2.4 Methods and tools used for data analysis

The evaluation matrix served as the structure for information analysis across all areas of investigation and for the assumptions developed from the theory of change in relation to each evaluation question. Qualitative and quantitative analysis was conducted along with comparative analysis across the country case studies and descriptive analysis of the context in which UNFPA has developed its response to family planning at a global and country level.

¹⁷ Bolivia, Burkina Faso, the Democratic Republic of Congo, Cambodia, Ethiopia, Zimbabwe, Nicaragua, Nigeria, Rwanda, Tajikistan, Uganda and Viet Nam

Figure 6: Analysis of data and information obtained



For the country case studies, data collected was collated in a specific evaluation matrix structured along the eight areas of investigation and corresponding assumptions formed the basis for analysis. This approach allowed evaluators to ensure that the findings presented in the country notes, and later the synthesis report, were evidence-based.

For the online surveys, an overview of the responses by question was prepared and information included in the evaluation matrix for the synthesis report along with analysis of the responses. The information from the surveys was used to enrich other data collected through various sources and ensure credibility of findings.

During an initial evaluation team analysis workshop (June 2015), findings emerging from the literature review, country case studies, online surveys and the international key informant interviews were qualitatively analysed, seeking comparisons and contrasts. These preliminary findings were further developed by the evaluators and subsequently presented and discussed in a collaborative session with UNFPA staff and partners (November 2015). This process allowed the evaluation team to reflect on initial findings and conclusions and examine selected evaluation issues in greater depth through targeted working group meetings.

2.5 Assessing assumptions and challenging the theory of change

Focusing on key assumptions

In order to take advantage of contribution analysis (CA) as its central analytical framework, the evaluation needed to operationalise the challenge function element of contribution analysis. The challenge function serves to test and challenge the theory of change on which development interventions are founded and thereby to provide credible answers to evaluation questions about programme effectiveness and about the contribution of UNFPA support to results.

The evaluation achieved this by focusing on the key assumptions as detailed in the evaluation questions, which needed to be realised if UNFPA support to family planning was to make a credible contribution to results. The set of key assumptions developed during the inception phase for each of the eight major evaluation questions were then tested against evaluative evidence.

Building from evidence to findings and conclusions

In each evaluation area/question, the evaluators drew on the full set of data sources (document reviews, country desk studies, international key informant interviews, on-line surveys and field country studies) to develop the overall findings associated with the key assumptions. Findings were then reviewed and analysed in order to develop conclusions.

Implications for the theory of change

The evaluation conclusions presented in Chapter 4 have implications for the theory of change which underpins UNFPA support to family planning. During the analysis, the evaluators assessed progress against the theory of change, noting the pathways in which UNFPA support to higher level results in family planning¹⁸ have been effective channels from support to results at outcome levels. The evaluators also identified other pathways where challenges were encountered. Addressing these challenges would strengthen how UNFPA support contributes to a robust chain of effects and would lead to meaningful outcomes in family planning

3 MAIN FINDINGS AND ANALYSIS

Global spending on family planning and UNFPA contribution¹⁹

Summary

The overwhelming majority of financial resources spent on family planning are from sources within programme countries. However, international financial flows to family planning are significant and have grown steadily during the period under evaluation after a relative decline in previous years. UNFPA remains the single largest channel for international funds invested in family planning by bilateral and multilateral donor agencies. While determining accurate UNFPA expenditures on family planning remains difficult, especially before 2014, the broader trends in family planning funding are clear; UNFPA programming has responded to the re-prioritising of family planning with a significant increase in financial commitments through the GPRHCS, together with an increase in core funding.

Finance for family planning in developing countries comes from international and domestic sources. International sources include bilateral donors, agencies of the United Nations system, non-government organisations (NGOs), foundations and development banks. A large percentage of bilateral donor contributions to sexual and reproductive health (SRH) and family planning is channelled through the United Nation agencies, principally UNFPA.²⁰ Domestic sources in developing countries include national governments, NGOs and consumers.

Overall, global spending on family planning is challenging to identify, as family planning activities and funding are often integrated into other sexual and reproductive health and

¹⁸ See Volume II, Annex 5

¹⁹ This section was co-authored by Natalie Raaber, UNFPA Evaluation Research Consultant, together with the core evaluation team.

²⁰ Of the total amount spent for population assistance in 2012, 29 per cent was channelled through bilateral programmes, while 29 per cent was channelled through multilateral organisations and 42 per cent was spent by international NGOs (*UNFPA 2014d: 23*)

social development programmes. Whilst amounts spent on contraceptives can be identified,²¹ there are often family planning components in activities such as promotion, education, advocacy, capacity building and strengthening of logistics systems in other sexual, reproductive and health programmes which are not costed separately and therefore difficult to identify. Funding for family planning activities in education and integrated development programmes outside the health sector is also difficult to identify.²²

Estimates which can provide a point of departure for identifying the relative size of the UNFPA contribution during the period under evaluation include the Netherlands Interdisciplinary Demographic Institute (NIDI) annual estimates of overall resource flows for population activities (*UNFPA 2014d*).²³ The Kaiser Foundation has also developed estimates for spending on family planning and reproductive health (RH) in the period 2009-2011 (*Kates, Michaud et al. 2014*), along with WHO annual reproductive health and family planning spending estimates (see *WHO 2015a*), and figures compiled by FP2020. All these sources include UNFPA spending and donor funds channelled through UNFPA. NIDI is the only source which separates family planning spending from overall reproductive health spending.

The NIDI estimates are based on annual surveys by participating entities (country, international organisations, etc.) and provide a broad picture of resource flows from all sources. They show that overall spending by international donors on all population activities rose from US\$10.4 billion in 2008 to US\$12.4 billion in 2012. Much of this increase due to additional HIV and AIDS spending (see *UNFPA 2014d*). Despite the overall increase in donor spending, international resources are dwarfed by domestic spending, which is estimated at US\$55 billion in 2012, of which 34 per cent is government spending, 1 per cent NGO and the largest, 65 per cent, spending by consumers.²⁴

Within spending on population activities, estimated family planning spending by international donors increased from US\$0.6 billion in 2008 to US\$1.3 billion in 2013 (figures in current US\$). Although none of the United Nation agencies contribute significant funding themselves, they channel a large percentage of donor funds to recipient countries. During the period 2009-2011, UNFPA channelled 19 per cent of all donor funds²⁵ for family planning and reproductive health, making it the second largest source of international funds after United States Agency for International Development (USAID). This figure is considered to be a reasonable indication of the relative importance of UNFPA in family planning funding during the entire period under evaluation.

Analysis of UNFPA family planning spending

Similar to global spending on family planning, UNFPA spending in this area is also difficult to identify, given the current setup of internal financial systems. Family planning activities are often integrated with other sexual and reproductive health and rights (SRHR) programmes.

Similar to global spending on family planning, UNFPA spending in this area is also difficult to identify. Under the existing UNFPA financial tracking system, family planning activities are often integrated with other sexual and reproductive health and rights (SRHR) projects and cannot be readily ascertained. Moreover, prior to 2012, family planning spending in general

²¹ Procurement volumes can be identified through the information in the RH Interchange (e.g. *UNFPA 2014n*)

²² *UNFPA 2014d*, UNFPA Evaluation Office 2014, FP2020 2015

²³ The wealth of data generated by NIDI has been through project support from UNFPA. Currently, the CSB is supporting them to gather comprehensive family planning data at country level, and country offices in most countries are involved in the coordination and follow up processes

²⁴ We do not know how much of this is family planning spending.

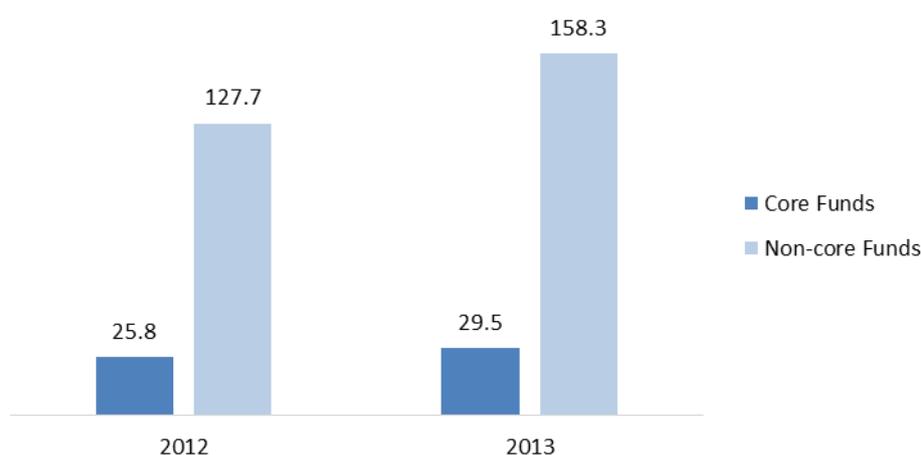
²⁵ This includes funds from bilateral donors, but does not include domestic funds, as discussed earlier.

(both dedicated and mainstreamed) was not explicitly tracked, but rather reported under the reproductive health, population and development and gender components of the results framework. However, spending under the GPRHCS, which accounts for the largest share of family planning spending, was tracked. In 2011, the Centre for Global Development Report (*CDG 2011:13*) and other external reports recommended that UNFPA improve its documentation of spending on family planning and the effectiveness of that spending. To this end, family planning was formally integrated in the *Development Results Framework of the 2012-2013 Strategic Plan* (outcome 3) as well as the *UNFPA Strategic Plan (2014-2017)* (outcome 1, output 2). This enabled UNFPA to make better estimates of direct spending.²⁶ However, mainstreamed expenditure (i.e. expenditure embedded in other reproductive health projects) remains difficult to capture.

On an annual basis, the UNFPA Finance Department reports UNFPA expenditure by development results within the *UNFPA Statistical and Financial Review*. UNFPA Finance Department figures for dedicated spending on family planning in 2012 and 2013 are shown in Table 2. On the basis of these estimates, family planning represented 23 per cent of total UNFPA spending in 2012 and 24 per cent in 2013, the largest proportion of spending (over 80 per cent) coming from non-core funds, essentially the GPRHCS. However, these figures do not capture family planning expenditure embedded in other reproductive health projects.

Information from the country case studies suggests that most core funding is spent on policy support and advocacy work, whilst non-core funding goes to commodity purchase and capacity building on the supply side. Non-core funds also support projects working on demand-generation and service provision to vulnerable and marginalised groups such as adolescents, indigenous people, and rural and urban poor.

Figure 7: UNFPA spending on family planning 2012 and 2013 US\$ million



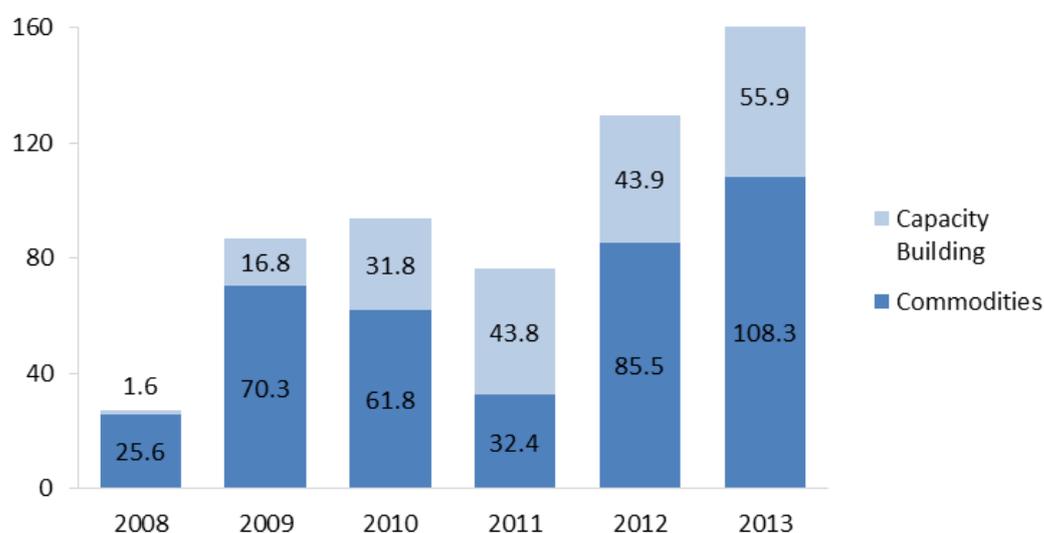
Sources: United Nations 2013, United Nations 2014b

Overall GPRHCS spending during the period under evaluation is shown in Table 3. Two-thirds of the GPRHCS spending was on commodities (mainly contraceptives) and one-third on a range of capacity building activities. Commodity Security Branch estimates that all the commodity spending, and between 90 and 95 per cent of the non-commodity spending, is directly attributable to family planning during the period under evaluation (2008-2013). Information from the country case studies suggests that the percentage may be lower, as

²⁶ Since late 2014 UNFPA has tagged family planning spending by intervention and activity areas. The new tagging of family planning will provide more reliable information in future, although family planning spending within other sexual and reproductive health programmes will still not be fully identified.

funds are used for a wide spectrum of activities, including capacity building and demand-generation in other areas of sexual and reproductive health and maternal health.

Figure 8: GPRHCS spending on commodities and capacity building 2008-2013 US\$ million



Sources: UNFPA 2013h, UNFPA 2014f

Of the sources reviewed, finance department estimates for 2012 and 2013 are the most robust. For earlier years, the GPRHCS spending gives a baseline figure, to which an estimate of up to US\$20 million annual spending from core funds can be added. Using this method, the total family planning spending during the period under evaluation is estimated at US\$705 million (14.5 per cent of UNFPA total expenditure from 2008-2013).²⁷ It is important to note that this figure (from the finance department) does not include family planning spending in other sexual and reproductive health projects, which may lead to some under counting.²⁸

The US\$705 million falls between Netherlands Interdisciplinary Demographic Institute (NIDI) figures for UNFPA family planning spending in the same period (US\$666m), and results from the evaluation office ATLAS database analysis of “pure” family planning projects, which gives a total of US\$790 million at country, regional office and headquarters levels for the period under evaluation. Table 7 of annex 14 shows the different estimates referred to in this section, including estimates of family planning spending embedded in other sexual and reproductive health projects for the period under evaluation.

Now it will be easier to identify family planning spending both internationally and within UNFPA. At international level, FP2020 has highlighted the need to track donor expenditure for family planning more specifically through adjustments to activity categories in donor financial systems, including the OECD credit reporting system (CRS). At country level, advances in tracking family planning spending are also more likely, with the development of the FP2020 indicators for domestic family planning spending by national governments.

²⁷ Total UNFPA expenditure from 2008-2013 is US \$4,850,265,866.

²⁸ This is in reference to finance department figures in the *Statistical and Financial Reviews*. Family planning spending figures for previous years developed by other UNFPA departments include estimates of family planning mainstreamed in other SRHR programmes, but the validity of these estimates cannot be fully assessed. As part of this evaluation, UNFPA Evaluation Office developed an estimate for family planning spending using the ATLAS database, and applying a multi-stage process to estimate family planning spending in other sexual and reproductive health programmes. The Evaluation Office estimates, including spending on family planning in other sexual and reproductive health projects, gives a much higher figure of US\$959m

Since 2014, the new UNFPA Global Programming System (GPS) within UNFPA has facilitated an improved tracking of family planning spending and will enable UNFPA to produce timely and more accurate reports as part of its drive for a results-oriented organisational culture. However, it is important to note that there will still be a certain level of value judgment at country office level where officers are responsible for estimating the proportion of spending on family planning in integrated projects.

3.1 Integration

EVALUATION QUESTION 1

To what extent has UNFPA supported integration of family planning with maternal health, HIV/sexually transmitted infection and gender based violence services in health plans and at primary health care level, in services for adolescents, and in emergency and humanitarian situations?

► **Assumptions**

- 1.1 UNFPA headquarters, regional office and country office staff and in-country partners are working towards a common understanding of the meaning and importance of service integration.
- 1.2 Country offices receive and put into practice technical guidance from headquarters and regional offices to support partners in delivering quality, integrated services.
- 1.3 UNFPA support has been effective in stimulating service integration by in-country partners (government, civil society organisations, private sector) in policies, plans and actual services.
- 1.4 Service integration leads to improved user access and quality of services.²⁹

► **Evaluation criteria covered:** relevance; effectiveness

Summary

UNFPA staff and partners agree on the meaning and importance of integration as a key strategy to achieve the ICPD vision. However, tensions remain about whether and how family planning should be prioritised within the construct of integration. UNFPA has provided important global leadership and technical guidance on integrating family planning, especially in the area of sexual and reproductive health and HIV linkages and in humanitarian settings. In particular, UNFPA has stimulated and supported integration *upstream* at the policy and strategy level, ensuring that country frameworks address and include integration, with a predominant focus on sexual and reproductive health-HIV linkages, adolescent sexual and reproductive health and emergency responses.

However, less attention is paid to integrating family planning within maternal health. Results from UNFPA support *downstream*, aimed at improving access to integrated family planning within other reproductive health services, are more difficult to discern. Technical support for family planning is provided mainly through the thematic GPRHCS, which has a predominantly supply-side focus rather than a strong integration approach. At a programme operations level, UNFPA staff operate in silos leading to a lack of alignment and missed opportunities for integration of family planning within other thematic areas.

3.1.1 A common understanding about the meaning and importance of integration

Integration has been a major feature and focus of UNFPA strategic plans, tied to achieving the vision from the 1994 Cairo International Conference on Population and Development

²⁹ See Theory of Change, Diagramme 1, Volume II, Annex 5

(ICPD) Programme of Action. In 2008, UNFPA issued a reproductive rights and sexual and reproductive health framework to provide overall guidance and a cohesive approach for UNFPA programmes. The framework defined four priority areas, including:

- Support for the provision of a basic package of sexual and reproductive health (SRH) services
- The integration of HIV prevention, management and care in sexual and reproductive health services
- Gender-sensitive life skills based sexual and reproductive health education for adolescents and youth
- Sexual and reproductive health services in emergencies and humanitarian crises. The basic package of sexual and reproductive health services was defined as including:
 - Family planning
 - Pregnancy-related services, including skilled attendance at delivery and emergency obstetric care
 - HIV prevention and diagnosis and treatment of sexually transmitted infections (STIs)
 - Prevention and early diagnosis of breast and cervical cancer
 - Adolescent sexual and reproductive health (ASRH)
 - Care for survivors of gender-based violence (GBV).³⁰

UNFPA is a recognised leader in defining sexual and reproductive health-HIV linkages at the global level in partnership with the International Planned Parenthood Federation (IPPF), WHO and UNAIDS. UNFPA and IPPF developed a rapid assessment tool, which by June 2014 was used by 46 countries, 32 of which are part of the 69 FP2020 group,³¹ contributing to the development of a body of evidence on sexual and reproductive health-HIV linkages (*IAWG 2014*). This body of evidence relates to needs and gaps, but there is considerably less information on how the results of these assessments were used to design interventions and improve linkages.

UNFPA has also contributed to advancing the integration of family planning and sexual and reproductive health within emergency and humanitarian situations. Key informants (KIs) note that UNFPA has been an important force in getting family planning and sexual and reproductive health included in the services provided by emergency relief organisations and to continually keeping it on the agenda in emergencies. UNFPA supported the development of a minimum initial service package (MISP) to guide emergency responses and the development and procurement of reproductive health (RH) kits that included contraceptives, post abortion care kits, post-rape kits, clean maternity kits and STI kits.³²

In practice, the way UNFPA defines and implements integration depends on the country context, leading to wide variation in the level and approach to integration supported by UNFPA programmes. In Zimbabwe, with a generalised HIV epidemic, the priorities for integration were focused on reproductive health-HIV linkages and gender based violence, whereas in Bolivia, Burkina Faso, Ethiopia and Uganda,³³ greater attention was focused on integration of family planning within primary health care and maternal care.³⁴ In Rwanda, family planning was implemented in a more vertical manner, given the strong political support and priority from the government for family planning services.³⁵ Global key informants noted that UNFPA missed an important opportunity to influence country-level

³⁰ See Assumption 1.1, Volume II, Annex 1

³¹ See Table 3, Volume II, Annex 6

³² Assumption 1.1

³³ See (Bolivia Country Note 2015, Burkina Faso Country Note 2015, Cambodia Country Note 2015, Ethiopia Country Note 2015, Zimbabwe Country Note 2015: Section 4.1)

³⁴ Assumption 1.2

³⁵ Assumption 1.2

strategies for integration, as the UNFPA Headquarters (HQ) staff do not participate directly in the development of country plans.³⁶

While there is considerable consensus between UNFPA and its partners on the importance of integration at a theoretical level, this consensus breaks down when it comes to how to ensure adequate attention for family planning within an integrated sexual and reproductive health framework. In 2010, UNFPA strategic documents and plans called for strengthening the focus on family planning which key informants felt was lost through the UNFPA approach to integration.

While several key informants applauded the “return” to a core focus on family planning by UNFPA since 2010, and within the *UNFPA Strategic Plan (2014-2017)*, they expressed concern that UNFPA resources and attention continue to be spread too thin, over too many technical areas, to effectively carry out a focus on family planning. In addition, the continued tendency for technical staff to work in “silos” affects UNFPA capacity to address integration at headquarters, regional and country levels.³⁷

Funding and programmatic efforts for family planning during the period under evaluation came largely from the GPRHCS, which focused mainly on contraceptive security and other “supply-side” issues (see Evaluation Question 8). GPRHCS is managed by the commodity security branch (CSB), which is separate from the sexual and reproductive health branch and gender, rights and culture branch. Interviews with key informants suggested that challenges in collaboration among branches led to a lack of consensus within headquarters regarding how best to support a holistic and integrated approach to family planning within sexual and reproductive health activities.³⁸ For example, the sexual and reproductive health and the commodity security branches notably do not have a harmonised approach towards family planning, with the sexual and reproductive health branch more focused on integration and rights and the commodity security branch focused on supply-side and commodity security.

3.1.2 Use of technical guidance to support integrated services

There is a wealth of technical guidance produced by UNFPA that supports the integration of family planning within sexual and reproductive health services.³⁹ As noted above, UNFPA has played a strong role in defining and advancing technical guidance on sexual and reproductive health (including family planning), HIV linkages and a minimum initial service package. This collaboration resulted in a set of internationally agreed-upon indicators to measure sexual and reproductive health and HIV integration and linkages at the policy, systems and service delivery levels, as well as in results at output, outcome and impact levels. UNFPA also produced guidance for integrating family planning and sexually transmitted infection/reproductive tract infections with other reproductive health and primary health services (with the Population Council) and a framework to address all four prongs of prevention of mother-to-child transmission of HIV (PMTCT), with prong two focused on the prevention of unintended pregnancies in women living with HIV.⁴⁰ With respect to the integration of family planning within maternal health, UNFPA partnered with USAID, WHO and the Maternal and Child Health Integrated Programme (MCHIP) to produce a call to action and strategies for postpartum family planning programming.⁴¹

³⁶ Assumption 1.1

³⁷ Assumption 1.2

³⁸ Assumption 1.1

³⁹ Assumption 1.1, Volume II, Annex 1

⁴⁰ Other prongs are: (1) primary prevention of HIV infection; (3) preventing vertical transmission or transmission of HIV from mothers to their infants and (4) providing care, treatment and support to mothers with HIV and their children. See Assumption 1.2

⁴¹ Assumption 1.1

Country offices determine how best to sort through and use available guidance and “pull” technical guidance as needed to incorporate into programme design and implementation. Although helpful, the plethora of technical documentation produced by UNFPA is considered by some to be an obstacle to its use. There are many examples of a “push” by headquarters or regional offices to provide technical guidance to country programmes as part of an initiative or rollout of new guidance or information. Examples include UNFPA technical assistance to support sexual and reproductive health/HIV integration in 13 East and Southern African countries in 2012 and the introduction of the minimum initial service package to support advocacy for the inclusion of family planning in the humanitarian response.⁴² As noted below (Section 3.1.3), there is more evidence regarding the use of guidance to support integration in national plans and strategies than in service delivery. The role of headquarters and regional offices to support country offices in the use and the application of guidance is discussed in section 3.9 of this report (HQ/RO/CO relations).

3.1.3 Effectively stimulating integration in policies, plans and services

UNFPA has supported a wide range of activities and programmes to stimulate and support increased access to integrated sexual and reproductive health services. External stakeholders report that UNFPA has contributed to the integration of family planning within other sexual and reproductive health services at policy, planning and service delivery levels although not to the same extent as suggested by UNFPA staff. Seventy per cent of external stakeholders surveyed across 64 countries say that UNFPA has shown leadership in realising good quality integrated sexual and reproductive health services in their country.⁴³ Global key informants spoke about UNFPA providing leadership at an international level to advance integrated sexual and reproductive health services through the advocacy and the development of operational guidance. However, they were less sure of how UNFPA contributed to improved results at the service-delivery level within different countries and related this to a lack of evidence-based documentation collected by UNFPA.⁴⁴

In field study countries, UNFPA stimulated and supported integration at the policy and strategy level, ensuring that country frameworks address and include attention to several, if not all, of the following areas: sexual and reproductive health-HIV linkages, family planning integration within maternal health, adolescent sexual and reproductive health, and services for gender based violence and reproductive health within humanitarian support. The bulk of examples identified by the evaluators relate to sexual and reproductive health-HIV linkages with less frequent reference to integration of family planning within maternal health services.⁴⁵ External stakeholders attribute this to the on-going effort of headquarters’ technical staff to promote sexual and reproductive health-HIV linkages, including a successful rollout of sexual and reproductive health-HIV linkages guidance in countries through a series of regional workshops, and support to include sexual and reproductive health-HIV linkages within proposals to the Global Fund to Fight AIDS, Tuberculosis and Malaria.⁴⁶

UNFPA integration strategies are dependent on country context and needs. In Burkina Faso, UNFPA integrated family planning into its youth strategy, which is focused on both HIV and pregnancy prevention. Given the importance of the maternal health rationale within the country plan to revitalise family planning, UNFPA is partnering on a pilot programme to expand postpartum contraceptive services.⁴⁷ In *Cambodia*, UNFPA also focused mainly on

⁴² Assumption 1.2

⁴³ Assumption 1.3

⁴⁴ Assumption 1.3

⁴⁵ Assumption 1.3, see (Bolivia Country Note 2015, Burkina Faso Country Note 2015, Cambodia Country Note 2015, Ethiopia Country Note 2015, Zimbabwe Country Note 2015: Section 4.1)

⁴⁶ Assumption 1.1

⁴⁷ See (Burkina Faso Country Note 2015: Section 4.1: 18)

integrating family planning within maternal health services. However, this strategy had the result of limiting programme focus to married women, and did not meet the needs of unmarried youth or other “non-traditional” groups.⁴⁸ In *Ethiopia*, UNFPA and other development partners support the development and implementation of guidelines for linking HIV and AIDS, family planning and maternal health.⁴⁹ UNFPA is currently supporting reproductive, maternal, newborn and child health (RMNCH) in 100 *woredas*,⁵⁰ including building capacity of health extension workers to deliver integrated services.⁵¹

In the field study countries, UNFPA conducted “upstream” work to support the inclusion of sexual and reproductive health rights within country development frameworks and plans. However, “downstream” work in capacity building for supporting service delivery is dependent on the availability of adequate funding. In countries which call for downstream work to support direct service delivery (see section 3.7.1), resource availability is a challenge, and UNFPA is spread too thinly in some countries. For example, in Zimbabwe, a multi-year project was funded specifically to address sexual and reproductive health-HIV linkages, which included major attention to the integration of family planning, providing UNFPA with the resources to support integration at service delivery levels.⁵² Without such support, it is unlikely that UNFPA country offices could work extensively to support service delivery, despite its direct impact on expanding access and use.

Many challenges persist regarding the effectiveness of activities aimed at increasing and strengthening the integration of family planning in sexual and reproductive health services at all levels. Several UNFPA country programme evaluations (CPEs) reported a gap between policy and implementation. UNFPA itself noted that “specific problems and obstacles in integration need to be addressed and understood better. UNFPA has gained experience in integration of family planning and HIV, but implementation remains a challenge” (*UNFPA 2014b: 3-4*).⁵³ A key obstacle appears to be the inadequacy of training strategies and a reliance on in-service or “one-off” training. These challenges are not unique to UNFPA; however, there is little evidence that UNFPA is working to address the need for more effective strategies regarding the implementation of training.⁵⁴ Further, country key informants noted that promoting some aspects of integration (often related to addressing needs of marginalised populations, such as youth or sex workers in countries like Cambodia and Zimbabwe) can put UNFPA in the role of advocating for government counterparts to adopt difficult or unpopular positions.⁵⁵

3.1.4 Integration leads to improved outcomes in user access and quality of services

In apparent contradiction with the role of UNFPA in advancing the ICPD vision, major knowledge gaps exist in the organisation on integration in relation to improved outcomes in access and service delivery. While there is extensive evidence in the public health literature to support the notion that integration is a cost-effective strategy, researchers have called for larger, well-designed studies to determine which strategies are most effective and to better understand the impact of linkages on a range of outcomes, such as contraceptive use, HIV incidence, and stigma and discrimination.⁵⁶

⁴⁸ See (Cambodia Country Note 2015: Section 4.1: 18)

⁴⁹ Assumption 1.1, see (Ethiopia Country Note 2015: Annex 3, Assumption 1: 45-46)

⁵⁰ *Woredas*, also known as districts, are the third-level administrative divisions of Ethiopia

⁵¹ Assumption 1.3

⁵² Assumption 1.3, see (Ethiopia Country Note 2015: Section 4.1: 13-15)

⁵³ Assumption 1.3

⁵⁴ Assumption 1.3

⁵⁵ Assumption 1.3, (Burkina Faso Country Note 2015: Annex 3: Assumption 3.1, Zimbabwe Country Note 2015: Section 4.1)

⁵⁶ Assumption 1.4, Volume II, Annex 1

UNFPA indicators on integration used between 2010 and 2013 included:

- The number of countries that have integrated sexual and reproductive health services (including family planning) into national health policies and plans
- The number of countries where UNFPA has supported the development of national health policies and plans with integrated sexual and reproductive health services (including family planning)
- The number of countries that have completed a sexual and reproductive health-HIV linkages assessment with support from UNFPA.

There are, on the other hand, no indicators that speak to the integration of family planning within other sexual and reproductive health issues (maternal health, gender based violence, HIV prevention) or vice versa. In 2012, UNFPA reported that 57 countries had national policies and plans that address integration, and 10 countries received support from UNFPA for the development of national policies and plans.⁵⁷

While these indicators provide an idea of the scope of work on integration, they do not answer important questions about impact, and contribution by UNFPA to that impact. As already mentioned, findings from this evaluation do not provide evidence about the extent to which integration has been operationalised within services, and therefore, whether activities supported by UNFPA resulted in improved outcomes in access and services. Given the role UNFPA plays to advance the ICPD agenda and sexual and reproductive health integration, this is an important gap in the understanding of institutional, structural, or other factors that impede integration.

3.2 Coordination and national ownership

EVALUATION QUESTION 2

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

- 2.1 UNFPA has developed and actively supported mechanisms to raise the profile of family planning in coordination with other family planning and sexual and reproductive health stakeholders at global, regional and national levels.
- 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.
- 2.3 Programmes are culturally, socially, institutionally and economically sustainable in different national contexts.⁵⁸

► Evaluation criteria covered: coordination; sustainability

Summary

UNFPA has been effectively engaged in global efforts to raise the profile of family planning as a development priority, resulting in a key outcome of the explicit inclusion of family planning-related indicators in the Sustainable Development Goals. UNFPA contributes to increased government ownership for family planning activities and sustainability by

⁵⁷ Assumption 1.4, see “Report of the Executive Director for 2012: Cumulative analysis of progress in implementation of the UNFPA Strategic Plan, 2008-2013 DP/FPA/2013/3 (Part I)” Annex 1: Indicator Update

⁵⁸ See Theory of Change, Diagramme 2, Volume II, Annex 5

promoting national investment and the use of explicit budget lines for family planning commodities and programmes at national and sub-national level. UNFPA also addresses institutional sustainability by supporting capacity development, mainly in the public sector and for commodity procurement and logistics and provider training. However, as with integrated service delivery, UNFPA support to capacity development often takes place in the absence of a coherent strategy for developing and sustaining human resources for family planning. The problems in retaining staff and resulting high turnover rates undermine the sustainability of gains in family planning.

UNFPA is a trusted partner of government, often acting on behalf of or supporting governments to lead and coordinate family planning activities. This close government relationship is seen as an important comparative advantage for UNFPA that can be used to advance issues and programmes. However, the influence of UNFPA may be constrained, particularly on sensitive or politically charged issues, to sustain the partnership with government.

3.2.1 Mechanisms to raise the profile of family planning

Following decades of progress, contraceptive prevalence rates slowed, plateaued or declined in the late 1990s and 2000s (*Alkema, Kantorova et al. 2013*) as attention and resources to expand family services did not keep pace with growing populations and demand. Funding specifically earmarked for family planning as part of overall allocations for international population assistance declined from US\$723 million in 1998 to US\$572 million in 2008 (*CGD 2011: 9*). This led to global and regional initiatives to “reposition family planning” as a priority for policymakers and health providers, especially in Sub-Saharan Africa and South Asia. At the start of the period under evaluation, it was widely recognised that there remained an “unfinished agenda” in family planning, given the inequities in access and the fact that there are over 200 million women with unmet need for contraception.

Key milestones in the global efforts to reposition family planning include the establishment of the Reproductive Health Supplies Coalition in 2001, the Maputo Plan of Action in 2006, the First International Conference on Family Planning in Kampala in 2009, and the Ouagadougou Partnership for accelerating family planning in West Africa in 2011. Family planning was also included within other important United Nations initiatives such as the United Nations Commission on Life-Saving Commodities (created in 2010), *Every Woman Every Child* (2010-present) and H4+⁵⁹ (2008-present). However, the watershed event in repositioning family planning was the London Summit on Family Planning in 2012 and the subsequent launch of FP2020, a global partnership. FP2020 supports the rights of women and girls to decide freely, and for themselves, whether, when and how many children they want to have and has the goal to reach 120 million more women and girls with contraceptive information, services and supplies by 2020.

Against this backdrop, there is a prevailing perception among stakeholders that in the years prior to the appointment of the current Executive Director in 2011, UNFPA had diluted its focus on family planning, in large part because of its sizeable and complex mandate to support sexual and reproductive health and rights programming more broadly, not just family planning. As a result, and although UNFPA participated in many of the efforts to reposition family planning in 2001-2011, leadership often came from other organisations. For example, USAID and the French Development Agency spearheaded the Ouagadougou Partnership, while DFID and the Bill and Melinda Gates Foundation (BMGF) co-hosted the London Summit on Family Planning.

⁵⁹ For more detail on H4, please see footnote 2

In 2011, a report to guide the new UNFPA Executive Director recommended that UNFPA refocus on family planning as the strategic core of its mission. It also recommended improving its documentation of spending and looking to the effectiveness of that spending as a critical indicator of impact for the agency (*CGD 2011: 13*). Other external reports cited a lack of transparency and difficulty in tracking family planning-specific spending and outcomes. This led UNFPA to develop a 15-point family planning reform agenda and implementation plan in 2012 to guide a revitalised family planning effort.⁶⁰ This evaluation did not find documentation that the 15-point reform agenda was being used as a strategic guidepost for tracking efforts in family planning within the organisation and for holding country managers accountable for results in family planning.⁶¹ However, interviews with key informants and UNFPA staff at global and regional levels, as well as during field visits, support the reality of an increased focus on family planning by UNFPA from 2012 onwards.

Stakeholders credit UNFPA with efforts to advocate globally for increased commitment and resources for family planning via the FP2020 platform, and for its on-going advocacy that resulted in ensuring that family planning is explicitly mentioned within the goals of the 2030 agenda for sustainable development. UNFPA is visibly engaged in the FP2020 initiative: it co-chairs both the Reference Group and the Country Engagement Working Group and has played an important role in generating country commitments to family planning. UNFPA country representatives serve as focal points (along with United States Agency for International Development (USAID) and ministry of health officials) for FP2020 and support the development of costed implementation plans (CIPs). Costed implementation plans are roadmaps or strategies that lay out family planning priority investments for a country, and are used as a resource mobilisation and advocacy tool for implementing the FP2020 commitment.⁶²

Increasing awareness of the relation between population dynamics and development has been an important stimulus to increased repositioning and commitments to family planning. UNFPA has a comparative advantage and has contributed in this area, given its strong technical expertise in population and development, including its emerging strategy for positioning family planning and its integration beyond sexual and reproductive health into the development and economic agenda by promoting the demographic dividend. At national level, UNFPA has made important contributions to shaping family planning policies in many countries, through advocacy and the provision of technical support to government. Stakeholders agree that UNFPA is a key player in family planning promotion, working with the ministry of health and other government ministries.⁶³ In three country case studies (Burkina Faso, Uganda and Zimbabwe), UNFPA contributed to the development of costed implementation plans intended to guide investment and achieve country commitments.⁶⁴ UNFPA is considered by stakeholders to be a key player that has the convening mandate to bring together the ministry and civil society organisations (CSOs). In Cambodia, according to a development partner, UNFPA receives credit for major changes in raising the profile of family planning: *“The current government commitment to reproductive health and family planning is the doing of UNFPA.”*⁶⁵

The advent of the Global Programme for Reproductive Health Commodity Security (GPRHCS) in 2007 enabled UNFPA to help raise the profile of family planning at the country level. It did this through thematic funding support to procurement, capacity building and demand-generation activities. Both development partners and UNFPA staff interviewees extolled the

⁶⁰ See Assumption 2.1, Volume II, Annex 1

⁶¹ Assumption 2.1

⁶² Assumption 2.1

⁶³ Assumption 2.1

⁶⁴ See (Burkina Faso Country Note 2015, Zimbabwe Country Note 2015: Section 4.2)

⁶⁵ See (Cambodia Country Note 2015: Section 4.2: 21)

importance of this thematic fund for maintaining some level of UNFPA attention to family planning during the initial part of the period under evaluation. UNFPA did not have a unifying strategy for family planning prior to 2012, apart from the activities supported under GPRHCS. In some countries (Burkina Faso, Zimbabwe), UNFPA used GPRHCS funds to support its entire family planning response, so that core funds could be allocated to other technical areas.⁶⁶ Some of the key results reported under the GPRHCS, such as couple years of protection (CYP) and method availability, however, do not adequately account for inputs from other donors and organisations.

In contrast to the external efforts to promote family planning, key informants said that it was less clear how internal efforts by UNFPA to revitalise its focus on family planning were faring. Some noted that UNFPA leadership is good at messaging the overarching rationale for investing in family planning, but is not as good at following through to ensure there is a common understanding of the family planning priorities within the organisation. UNFPA is a very decentralised organisation and programme countries set programme priorities. Several key informants spoke of the difficulty of “turning around” a large bureaucracy and of ensuring that country offices are held accountable for carrying out strategic priorities. The lack of an adequate internal focus, coupled with decentralisation, and the aforementioned lack of transparency regarding financial expenditures for family planning, hampered UNFPA effectiveness at prioritising family planning at country programme level.

3.2.2 National ownership in different national contexts

The degree of government ownership of family planning programmes varies widely from a high level of participation and control to a lower level of commitment in countries where family planning is politically sensitive. Government commitment to family planning at the national level is illustrated by the existence of family planning policies and programmes, budget allocations, and the inclusion of family planning commodities on essential medicines lists (EML).⁶⁷ Most of UNFPA focus countries⁶⁸ have family planning policies and GPRHCS data shows there are national budget commitments in 25 focus countries, of which 18 countries actually spent funds on procurement in 2013.⁶⁹ Moreover, commitment to family planning is also apparent from the fact that family planning is being taken up as an issue by other ministries working in related fields (education, women and youth affairs, planning and development) and by financial decision-makers, which leads to a broader base for national ownership.⁷⁰

To facilitate government ownership, UNFPA has worked strategically with other donors to identify and use entry points through family planning links to less sensitive sexual and reproductive health work. In Burkina Faso, the adoption of a maternal health rationale increased acceptability of family planning among policy makers and communities.⁷¹ In Cambodia, the concept of “birth-spacing” is preferred over family planning, as the former is framed within a maternal health rationale and context.⁷² Furthermore, UNFPA advocates within and outside health ministries to increase awareness of family planning and the economic, health and social rationales for increased investment and action, and in doing so, strengthens the capacity of the ministries of health (MoH) to carry out advocacy on behalf of contraceptive services, personnel and supplies. In Burkina Faso, UNFPA technical assistance was requested by the Ministry of Health to support its advocacy with the Ministry of Finance

⁶⁶ See (Burkina Faso Country Note 2015, Zimbabwe Country Note 2015: Section 4.2)

⁶⁷ Assumption 2.2, Volume II, Annex 1

⁶⁸ UNFPA (and FP2020) focus countries are the 69 priority countries with a per capita income of \$US 2,500 or less in 2010, See Table 1, Volume II, Annex 6

⁶⁹ See Country Tables 5 and 6, Volume II, Annex 6

⁷⁰ Assumption 2.2

⁷¹ Assumption 2.2

⁷² Assumption 2.2, see (Cambodia Country Note 2015: Section 4.2: 21)

to ensure budget allocations are maintained for contraceptive commodities.⁷³ In Bolivia, UNFPA has been a key actor in fostering joint promotion of family planning by the ministries of health, education, justice, autonomy, and planning and development through working with the ministries on the school sexuality curriculum, gender equality laws, and population and development planning.⁷⁴

Among development partners, UNFPA has comparative advantages in promoting national ownership of family planning, notably its political neutrality and close, on-going working relationship with the government. In Zimbabwe and Bolivia, UNFPA partners appreciated the continuity of its overall support, while other family planning bilateral donors either discontinued or restricted support because of political challenges. In Cambodia, UNFPA supported national ownership by successfully advocating for the inclusion of contraceptive services in the health equity fund scheme.⁷⁵ In Burkina Faso, UNFPA successfully advocated for inclusion of civil society organisations within coordination and funding mechanisms for family planning and for private sector service delivery, both of which contribute to enhanced sustainability and ownership.⁷⁶

Almost all UNFPA focus countries have coordination mechanisms aimed at strengthening government ownership and leadership of family planning.⁷⁷ These include:

- Donor committees which cover a broad range of sexual and reproductive health issues
- Family planning technical working groups
- Health sector basket funds and sector-wide approaches (SWAps)
- Commodity security committees which address planning, procurement and supply chain
- Budget support mechanisms.

In some countries, UNFPA has made important contributions to setting up the coordinating mechanism, such as the basket fund in Nigeria. More recently, the costed implementation plans serve as a tool for family planning coordination and investment in the 15 countries where these have been developed.⁷⁸ UNFPA has been involved in supporting costed implementation plans, as illustrated by countries such as Burkina Faso, Zimbabwe, and Uganda.

UNFPA participation and leadership in donor forums and coordination mechanisms for family planning is high, especially in government-led technical working groups in reproductive health. UNFPA aims to strike a balance between taking a leadership role itself within the development partner community and supporting government leadership and ownership. Coordination mechanisms are generally government-led and their effectiveness varies widely. In the country case studies, government and NGO partners appreciate UNFPA for its technical competence and its willingness to problem-solve and to “support the government to take the lead.” The onus is often placed on UNFPA to ensure the effectiveness of government-led coordination mechanisms. In Zimbabwe, when coordination meetings are not well executed, partners expect UNFPA to support the government in managing coordination in a strategic manner.⁷⁹

⁷³ See (Burkina Faso Country Note 2015: Section 4.2: 22)

⁷⁴ See (Bolivia Country Note 2015: Section 4.3: 21-22)

⁷⁵ Assumption 2.2, see (Cambodia Country Note 2015: Section 4.2: 20)

⁷⁶ Assumption 2.2, see (Burkina Faso Country Note 2015: Section 4.2: 22)

⁷⁷ Assumption 2.2

⁷⁸ Assumption 2.2

⁷⁹ Assumption 2.2

The UNFPA role to assist governments is considered a unique strategic asset that has the potential to address sensitive issues. However, it is not always used to its greatest advantage. Interviewees noted that the close relationship between UNFPA and the ministries of health could place UNFPA in a difficult position where sustaining the close partnership with the government often takes precedence over resiliently advocating for family planning in politically sensitive contexts. In Burkina Faso, stakeholders felt that UNFPA was not “doing enough” to hold the government accountable for financing contraceptives at the planned level. On the other hand, UNFPA was credited with pushing the agenda on the sensitive issue of sexual and reproductive health. In Ethiopia, development partner interviewees expressed the desire for UNFPA to do more to address government practices that could further promote informed choice, such as facility-level targets for contraceptive implants. In Cambodia, on the contrary, key informants indicated that UNFPA was an effective “critical partner” of the national government, balancing well its close technical role with advocacy efforts on behalf of marginalised groups.⁸⁰ Thus, the pattern of UNFPA engagement as a critical partner to government (complemented by its key technical role in support of family planning) varies across countries. UNFPA has choices to make in each country on how it will spend its political capital in advocating for family planning with governments. The present evaluation could not determine whether these choices are based on strategic assessment, or if they are dependent solely on the interest and capacities of the country staff. Partners often called for a more vocal and engaged UNFPA in relation to sensitive issues in sexual and reproductive health.

3.2.3 The cultural, institutional and economic sustainability of programmes in different national contexts

Programme sustainability requires policies, strategies and institutional capacity (human resources, systems and finances). UNFPA contributes to sustainability through its work to improve the policy environment, to mobilise resources and to increase demand-creation and capacity for family planning services.

Mobilising resources, especially for commodities, is a priority area of focus for UNFPA. UNFPA reports that GPRHCS-supported efforts to catalyse national and financial commitment to reproductive health commodity security (RHCS) resulted in mobilising more than \$565 million between 2007 and 2012 (*CGD 2011: 13*). In 2013, UNFPA reported that 25 of the 46 GPRHCS countries have a budget line for reproductive health commodities,⁸¹ and allocations increased in several countries, including Burkina Faso, Malawi, Nigeria and Uganda (*UNFPA 2014f: vii*).⁸²

UNFPA has also supported sustainability through capacity development in procurement, logistics management and service delivery. In 2013, Burkina Faso, Ethiopia and another eight countries⁸³ were supported to integrate logistics management training in training institutions. Furthermore, the majority of GPRHCS countries (67 per cent) conducted training for family planning service provision, including long-acting reversible methods (*UNFPA 2014f: vii*). The bulk of UNFPA training interventions are “in-service.”⁸⁴ Considering that staff turnover within the health sector is a common issue in many countries, it follows that capacity development, in and of itself, does not result in a sustainable capacity for services. In the country case studies for this evaluation, capacity development does not appear to be

⁸⁰ Assumption 2.2

⁸¹ See Country Table 5, Volume II, Annex 6

⁸² See section 3.7 for information on how UNFPA is advocating for inclusion of family planning within health insurance and other health financing schemes.

⁸³ The other eight countries were not identified in the report (*UNFPA 2014d: vii*)

⁸⁴ “In-service training” refers to training of persons already employed, e.g. health providers working in the public or private sector; “Pre-service” refers to activities which take place before a person takes up a job which requires specific training, i.e. before a person ‘enters service’.

embedded within a larger strategy to address human resources in family planning. Interviews with development and implementing partners (including ministry of health staff), indicate that sustainability is hampered when family planning is not included within pre-service curricula for health workers. In Burkina Faso, where UNFPA supported pre-service training, it focused on maternal health and did not include a focus on family planning. Moreover, sustainable service delivery capacity requires a system for follow-up and support of trainees in using their newly acquired skills, a programming gap evaluators noted in both Nigeria and Zimbabwe.

UNFPA has supported cultural sustainability of family planning at the community level through NGO and civil society implementing partners in several countries. Working through NGOs that are sensitive to cultural and traditional norms has enabled UNFPA to adapt its support to different contexts, and to increase acceptability and sustainability. Successful approaches have included:

- Rights-based programmes to empower adolescents, vulnerable and marginalised groups (VMGs) and indigenous groups
- Work with community and religious leaders
- Mobilisation of community gatekeepers.

In Bolivia, UNFPA pioneered work with many indigenous groups to empower women and increase their participation in a culturally sensitive way and to promote rights and access to services.⁸⁵ In Burkina Faso, UNFPA has purposefully embarked on a strategy to extend its scope and reach by strengthening community-based partnerships. In particular, it has worked through local level civil society organisations to generate demand and to address gender and cultural barriers in locally appropriate ways.⁸⁶ In Nigeria, UNFPA mobilised community “gatekeepers” as a strategy to overcome socio-cultural resistance to family planning and, in particular, sexual and reproductive health (*UNFPA Nigeria 2012: 55*).

This focus by UNFPA, on community level engagement for cultural sustainability, appears to be an appropriate complementary strategy to the promotion of family planning entry points (as a key intervention for women’s health and for national economic development) for promoting national ownership.

UNFPA has also promoted a total market approach (TMA), but only on a limited basis. Total market approach advocates for a rational segmentation of service provision and allocation of resources among the public, private and NGO sectors according to the capabilities of each and the characteristics of the groups they serve. For example, UNFPA took initial steps to introduce a total market approach in the Eastern Europe and Central Asia region, through the conduct in 2011 of a high-level consultation with participation of ministries of health and finance as well as NGOs (*UNFPA 2013f*). A total market approach is also included as a strategy in UNFPA Supplies since 2013. Given the resource constraints that UNFPA faces working across a large number of priority countries, engaging in a total market approach is a potential strategy for leveraging its limited resources, while expanding scope and potential sustainability of services. In addition, the UNFPA strategy in Burkina Faso provides a good example of how engagement with NGOs has resulted in extending UNFPA support to underserved populations and geographic regions.⁸⁷

⁸⁵ See (Bolivia Country Note 2015: Section 4.2: 20-21)

⁸⁶ See (Burkina Faso Country Note 2015: Section 4.5: 27)

⁸⁷ Assumption 2.3, see (Burkina Faso Country Note 2015: Section 4.2: 22-23)

3.3 Brokerage and partnerships

EVALUATION QUESTION 3

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**

- 3.1 At the global and regional level, UNFPA promotes family planning repositioning as an essential component of sexual and reproductive health and rights services through partnership with state and non-state actors.
- 3.2 At the country level, UNFPA country offices brokers partnerships between public agencies, civil society organisations, and private sector entities to promote family planning and its integration with other sexual and reproductive health programmes.
- 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.⁸⁸

► **Evaluation criteria covered:** effectiveness; sustainability

Summary

There has been a visible shift in family planning positioning since the appointment of the current Executive Director and through key partnership platforms, in particular FP2020. UNFPA leadership is appreciated by its global partners for its inspirational message about the importance of family planning utilising health, demographic, human rights and economic development rationales and using family planning as a means to safeguard the rights and health of future generations and promote the demographic dividend. UNFPA engagement was leveraged by FP2020 partners in recognition of its comparative advantages, such as its global reach, a field staff network with deep experience, the GPRHCS platform, and the important role that UNFPA plays in garnering government engagement and commitment.

UNFPA has brokered, at the country level, commitments to FP2020 thereby increasing commitment to family planning by national governments. However, UNFPA does not always use its strategic advantage in family planning to the fullest, such as to broker partnerships between government and civil society or on sensitive issues that UNFPA is best placed to address. Also, UNFPA is seen as missing a major opportunity to be a key broker in knowledge management of best or promising practices. Importantly, the priority focus on family planning that is called for in the various strategies is undermined as UNFPA is trying to do too much across too many countries with too few resources. This is also substantiated under EQ1 Integration, where it was noted that several key informants reported that UNFPA continues to be spread too thin, over too many technical areas, to effectively carry out a focus on family planning.

3.3.1 Global support for repositioning of family planning

Findings on UNFPA global efforts and mechanisms to reposition family planning (presented in detail in Section 3.2) indicate a profound shift in the perception of UNFPA as a champion of family planning both prior to and after the London Summit on Family Planning and the launch of FP2020.⁸⁹ Prior to 2012, UNFPA was seen as being primarily concerned with advancing its broader mandate of promoting sexual and reproductive health as envisioned in the ICPD Programme of Action at a time when family planning was not given its due priority because of other competing challenges, primarily (but not exclusively) around HIV and AIDS. As a result, in the period before 2011 and the arrival of the new Executive Director (ED), leadership on convening and brokering actions to reposition family planning seemed to be

⁸⁸ See Theory of Change, Diagramme 3, Volume II, Annex 5

⁸⁹ See Assumption 2.1, Volume II, Annex 1

taken up by other actors, mainly BMGF, DFID and USAID. UNFPA, while active in family planning forums, was not seen as a global broker of note.

After 2011, and around the time of the London Summit on Family Planning in 2012, UNFPA became much more active in working in partnership with other agencies to take up a greater role in brokering. As an example, UNFPA was very active in the push to have family planning explicitly included in the Sustainable Development Goals (SDG) framework. UNFPA partnership within FP2020 is seen as critical to ensuring that governments are engaged and committed to family planning.⁹⁰ Stakeholders also credit UNFPA with opening doors for FP2020 partners to assist at the country level, for example with the Futures Group⁹¹ to conduct a resource gap analysis for the Zimbabwe family planning costed implementation plan.⁹²

UNFPA has pursued other partnerships with important global actors specifically to advance family planning. These partnerships enable UNFPA to reinforce family planning as a priority through collaboration: for example, with USAID to increase cooperation among the agencies' field programmes, with the Bill and Melinda Gates Foundation in support of FP2020 strategies and activities and with WHO on the development of technical guidance.

USAID and UNFPA signed a memorandum of understanding (MoU) in 2014 to identify mechanisms for working together at the global and field levels. The memorandum of understanding builds on the already strong coordination between the two organisations on commodity security for family planning. Key informants from both organisations feel this arrangement has great potential for strengthening advocacy and commitment to family planning, particularly at the field level.⁹³ Both organisations co-lead the FP2020 Country Engagement Working Group, which has led to increased collaboration and regular information-sharing among their respective staff.⁹⁴ In addition, USAID and UNFPA work together on the high impact practices (HIP) activity, an initiative started by USAID in 2007 to provide evidence-based guidance on useful practices to scale up access to, and use of, quality family planning services. USAID leads this work; however, UNFPA was instrumental in moving the high impact practices from a USAID-specific activity to a platform that aims to respond to the needs of the broader family planning community. UNFPA has hosted the Technical Advisory Group for the high impact practices since 2012, and has played an important role by supporting field staff engagement, which helps to bring perspective to research findings and to define high impact practices that are practical and applicable to field settings.⁹⁵

UNFPA also had a long-standing strategic partnership with its sister United Nations agency, WHO, to support the updating of sexual and reproductive health guidelines in countries. This partnership brought together WHO expertise in guideline development and adaptation with UNFPA operational knowledge within country programmes and was intended to foster increased collaboration between the two United Nation agencies.⁹⁶

UNFPA signed a memorandum of understanding in 2014 with the Bill and Melinda Gates Foundation to guide collaboration over the course of the FP2020 partnership. The memorandum of understanding outlines several areas for collaboration, such as supply

⁹⁰ Assumption 3.1

⁹¹ The Futures Group, a Washington, D.C. based global development technical assistance firm, changed its name to Palladium in October 2015.

⁹² Assumption 3.2

⁹³ Assumption 3.1

⁹⁴ Assumption 3.1

⁹⁵ Assumption 3.1

⁹⁶ Assumption 3.1

chain management, expanding access to contraceptive technologies, development and implementation of national costed implementation plans, and promoting young women's access and use of family planning.⁹⁷

In addition, UNFPA, as a leader in commodity procurement is part of the "volume guarantee," an effort led by the Clinton Health Access Initiative (CHAI) at the request of BMGF to negotiate lower prices for contraceptive implants, Jadelle (with Merck) and Implanon (with Bayer). UNFPA, along with BMGF, USAID, DFID, Norad, SIDA and Children's Investment Fund Foundation (CIFF) are sharing the risk to guarantee a volume of commodity purchases over six years in return for a reduction in price by half (to US\$8.50 per unit).⁹⁸ UNFPA East Europe and Central Asia regional office also partnered with PATH to support road-mapping of a total market approach (TMA) to improve coordination of public and private sector financing of family planning commodities.⁹⁹

3.3.2 A broker of partnerships to promote family planning at country level

Since 2007, UNFPA has leveraged funding from the GPRHCS. This is a major mechanism through which country offices provide support for national family planning policies and strategies. It is also used to improve country level coordination, with particular attention to commodity security and logistics.¹⁰⁰ The GPRHCS thematic fund provided an important platform for UNFPA partnership with governments to revitalise family planning activities and, in particular, to successfully advocate for national budget allocations to cover the costs of contraceptive commodities (Burkina Faso and Cambodia),¹⁰¹ and for the development of costed implementation plans (Burkina Faso, Zimbabwe, Nigeria and Uganda).¹⁰² In Bolivia and Ethiopia, UNFPA has started to broker 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 across all the sectors.¹⁰³

UNFPA has a strong comparative advantage in the 69 focus countries, in part due to its long-standing on-going presence, with regard for its mandate to strengthen government capacity to lead and implement sexual and reproductive health programmes. Generally, key informants expressed the view that UNFPA made good use of its strategic positioning and closeness to ministries of health to advance cooperation across sectors for the promotion of family planning activities. In Bolivia, UNFPA brokered and fostered joint promotion of family planning by ministries of health, education, justice, autonomy, and planning and development, as well as through cooperation between other relevant United Nations agencies (PAHO and UNICEF).¹⁰⁴ In Burkina Faso, Cambodia and Zimbabwe, government partners described UNFPA as a steady and loyal partner who remains regardless of political crises, unlike bilateral partners, thereby building trust over the years.¹⁰⁵ Government stakeholders across the board described appreciation for UNFPA support and technical assistance. The following sentiment expressed regarding UNFPA support in Cambodia was heard from key informants elsewhere: *"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).

⁹⁷ Assumption 3.1

⁹⁸ Assumption 3.1

⁹⁹ Assumption 3.1

¹⁰⁰ Assumption 3.2

¹⁰¹ See (Burkina Faso Country Note 2015, Cambodia Country Note 2015: Section 4.3)

¹⁰² Assumption 3.2

¹⁰³ Assumption 3.2, see (Bolivia Country Note 2015, Ethiopia Country Note 2015: Section 4.3)

¹⁰⁴ Assumption 3.2, see (Bolivia Country Note 2015: Section 4.3: 21)

¹⁰⁵ See (Burkina Faso Country Note 2015, Cambodia Country Note 2015, Zimbabwe Country Note 2015)

UNFPA participates actively in the numerous government-led forums and committees coordinating country-level sexual and reproductive health and family planning activities, and has been instrumental in assisting several countries (Burkina Faso, Cambodia, Ethiopia, Uganda, and Nigeria) to convene family planning conferences and support increased government commitment to family planning under FP2020.¹⁰⁶ For example, in Zimbabwe, UNFPA is credited with increased resource mobilisation for implementing demographic and health surveys (DHSs) and censuses and was seen by other development partners as a critical broker on issues related to the capacity of the Zimbabwe National Family Planning Council (ZNFPC).¹⁰⁷

Civil society and NGO key informants expressed appreciation for the role UNFPA has played to broker partnerships between them and the government. In Burkina Faso, this was especially the case where the UNFPA strategy included efforts to strengthen its partnerships with NGOs and civil society organisations as a means to extend its geographic scope and access to contraceptive services. UNFPA successfully advocated for inclusion of civil society organisations on technical working committees. Many key informants felt that UNFPA had supported civil society organisation voices to be heard on important issues, such as advocating for government accountability to maintain or increase its resource commitments for contraceptive commodities.¹⁰⁸

In contrast, in Ethiopia, key informants noted there are opportunities for UNFPA to broker closer, horizontal partnerships between the government and the NGO and private sector. However, the current context of government restrictions on NGO activities makes this difficult.¹⁰⁹ Similar difficulties were noted by key informants in Nicaragua and Tajikistan. Key informants in Zimbabwe noted the difficulty that UNFPA had in serving as a broker or coordinator versus receiving funds to implement programme activities directly. Although UNFPA does not implement services, its provision of technical assistance in aspects of service delivery (such as quality assurance and training) is seen as an implementation role by some key informants, and as such puts UNFPA in direct competition with NGOs for funding from donors. This is felt by some to compromise its role in coordination.¹¹⁰

3.3.3 Visibility and strategic position of UNFPA at global, regional and country levels

Global key informants acknowledged that UNFPA has several comparative advantages as a global partner in family planning, including its global reach and network of offices, the GPRHCS platform, and strong and on-going relationships with ministries of health and other government stakeholders. Since 2012, UNFPA visibility at the global level for family planning repositioning has been closely linked to the FP2020 platform. Global key informants spoke about the inspirational role that UNFPA plays in “talking the talk” about the critical role of family planning in development programmes and for making the case to invest in contraceptive information and services, as well as in the sexual and reproductive health and rights of future generations, universal access for all, and a human rights-based approach.¹¹¹ However, because UNFPA has not improved its capacity to document and share results, some global key informants are less clear about its family planning strategy and whether, and how, UNFPA is making a unique contribution to the family planning movement. With many multilaterals, bilaterals and foundations offering visible leadership in family planning, key informants spoke of UNFPA not using its comparative advantage in a focused and

¹⁰⁶ Assumption 3.2, see (Bolivia Country Note 2015, Burkina Faso Country Note 2015, Cambodia Country Note 2015, Ethiopia Country Note 2015, Zimbabwe Country Note 2015: Section 4.3)

¹⁰⁷ Assumption 3.2, see (Zimbabwe Country Note 2015: Section 4.3: 19)

¹⁰⁸ Assumption 3.2, see (Burkina Faso Country Note 2015: S4.2: 21, S4.3: 23-24)

¹⁰⁹ Assumption 3.2, see (Ethiopia Country Note 2015: Section 4.3: 17-18)

¹¹⁰ Assumption 3.3, see (Zimbabwe Country Note 2015: Section 4.3: 19)

¹¹¹ Assumption 3.3

strategic manner to drive the agenda on issues they are in the best position to address. For example, with its global reach and networks of country programme implementers, UNFPA is seen as missing a major opportunity to be a key broker in knowledge management of best or promising practices.¹¹²

UNFPA visibility at the regional level is very much tied to its important convening authority and work to advance the ICPD Plan of Action and vision. With respect to family planning, there are some examples that show a mixed level of visibility across regions. UNFPA is a key player in Eastern Europe and Central Asia, as seen through its work to promote the total market approach,¹¹³ in part owing to its presence in a region with little bilateral support for family planning.¹¹⁴ In West Africa, UNFPA was not a visible leader in the initial efforts to reposition family planning through regional advocacy by the Ouagadougou Partnership. However, UNFPA is now engaged and plays an important role at the country level in supporting government engagement in the partnership (Section 3.2.1).¹¹⁵

The picture regarding UNFPA visibility was more positive overall at the country level. Key informants from all country case studies felt that UNFPA has sufficient visibility to broker relationships and coordinate amongst the government, NGO and private sectors partners. In Burkina Faso, Cambodia, Zimbabwe, Nigeria, Rwanda, Tajikistan and Uganda, UNFPA has been a major partner of the ministries of health and is seen as vital to family planning efforts. This is due to the comparative advantage of working with both government and civil society, having a position of trust with the government, and having strong technical staff in the field, especially related to commodity security.¹¹⁶

3.4 Enabling environment

EVALUATION QUESTION 4

To what extent has UNFPA supported the creation of an enabling environment at national and community levels to ensure family planning information thus allowing people to exercise their rights?

- ▶ **Assumptions**
 - 4.1 UNFPA has identified key enabling factors in different country contexts and developed effective interventions to strengthen these.
 - 4.2 UNFPA has successfully supported partners at country and community levels to improve demand-creation and access to services, thus enabling people to exercise their rights better.
 - 4.3 Headquarters and regional offices have supported country offices in identifying needs, creating an enabling environment and promoting demand and access in different contexts. (This assumption is presented in a separate final section (3.9) covering interactions between country offices and regional offices and headquarters in all relevant evaluation areas).¹¹⁷
- ▶ **Evaluation criteria covered:** relevance; effectiveness

¹¹² See Assumption 3.3, Volume II, Annex 1

¹¹³ Assumption 2.3

¹¹⁴ Assumption 2.3

¹¹⁵ See (Burkina Faso Country Note 2015: Section 4.3: 24)

¹¹⁶ Assumption 3.3

¹¹⁷ See Theory of Change, Diagramme 4, Volume II, Annex 5

Summary

UNFPA has identified key enabling factors and contributed effectively to notable results in the areas of a strengthened and improved policy environment and strong national government commitment to family planning. However, community cultural and social norms continue to pose limitations on policy implementation in family planning, despite appropriate efforts by UNFPA to engage at community level through local organisations.

UNFPA has also supported demand-creation activities implemented by state and non-state actors in many countries. This has often contributed to either increasing uptake, or sustained reasonably high levels of uptake of family planning. However, there is an information gap regarding the effectiveness of community-based demand-promotion interventions, and the effectiveness of UNFPA-supported demand-creation activities remains uncertain.

3.4.1 Identification and strengthening of key enabling factors

The types of factors UNFPA has tracked regarding the enabling environment for family planning and for which UNFPA has adequately responded, include the policy environment and community attitudes.

Key enabling environment factors to ensure family planning information and exercise of rights include:

- The policy framework political commitment
- Legal frameworks
- Space for involvement and capacity building of non-state actors
- Community attitudes and participation
- A coherent vision on sexual and reproductive health rights, including attention to gender issues (*UNFPA 2014c*).

Stakeholders and UNFPA country offices noted similar key enabling factors as most important for family planning in their countries. They both agreed that institutional capacity of providers is important, while the country offices more explicitly emphasised government policies and community attitudes.¹¹⁸

The re-emergence of family planning as a development priority and related donor support for the country FP2020 commitments has led to a policy environment, paired with strong government commitment, which is favourable to family planning, as in Zimbabwe.¹¹⁹ In Cambodia, the government has translated its commitment into a clear policy framework for family planning.¹²⁰ Meanwhile, in Bolivia, political support was not generalised and, instead, varied across decentralised government levels, with some (indigenous and other) groups promoting population growth.¹²¹ The Ethiopian Government, on the other hand, has shown strong commitment, but aspects of the legal framework discourage NGOs from engaging in rights-based approaches. At times, the legal or political environment appears less favourable for civil society.¹²² Bolivia is a clear example of this, while the implications of the recent approval of a law regulating NGO¹²³ activities in Cambodia remain to be seen.¹²⁴

¹¹⁸ Assumption 4.1, Volume II, Annex 1

¹¹⁹ See (Zimbabwe Country Note 2015: Sections 4.3 and 4.4: 19-21)

¹²⁰ See (Cambodia Country Note 2015: Section 4.4: 25)

¹²¹ See (Bolivia Country Note 2015: Section 4.4: 24)

¹²² See (Ethiopia Country Note 2015: S4.3: 18, S4.4: 21)

¹²³ Government's initiative to pass a law on associations and NGOs to regulate NGO operations in Cambodia has generated considerable criticism from civil society and development partners alike. Apart from a lack of consultation, there are concerns that the law, which was passed in August 2015, could be used to curtail NGO

Community attitudes, especially in traditional and rural areas, pose limitations on policy implementation. They are shown to harbour socio-cultural or religious disapproval of family planning in general (Bolivia, Burkina Faso) or for groups, such as unmarried young people (Cambodia, Ethiopia, Zimbabwe). In the latter countries, the public sector policies support family planning service provision to young, unmarried people, however community stigma (and sometimes providers' bias) with regard to unmarried adolescent sexual activity has implications for access.¹²⁵ In Ethiopia, community attitudes are increasingly positive due to promotional work of the Health Development Army (HDA).¹²⁶ This setup, however, is under scrutiny as women have sometimes expressed that excess pressure is placed on them to adopt a family planning method, paired with too little information.¹²⁷

UNFPA has adequately identified key factors that enable the family planning environment at country level,¹²⁸ and has developed effective interventions to strengthen enabling factors. UNFPA country offices and country stakeholders expressed that during the period under evaluation, UNFPA has strongly contributed to strengthening government policy, institutional capacity and community-based work, and helped to improve access to family planning. This was also confirmed in the 2007-2012 sexual and reproductive health rights policy evaluation commissioned by the Dutch Ministry of Foreign Affairs, which concluded that UNFPA *“has contributed to policy development, the setting up of logistical systems for commodity purchase and distribution at country level, and improved availability of family planning methods, thus facilitating the use of family planning”* (MoFA Netherlands 2013: 16).

On the other hand, both UNFPA country offices and external stakeholders noted that legal reforms received less attention as a potential enabling factor,¹²⁹ confirming findings from independent and UNFPA-authored evaluations and reports.¹³⁰ Examples of such legal reforms that UNFPA has advocated for, and could emphasise further, include:

- Eliminating discrimination and legal constraints on access to family planning services for special groups, including young people
- Dealing with violations of reproductive rights of women living with HIV
- Promoting a legal environment supportive of women's reproductive rights such as reforming laws requiring husbands' permission
- Setting a minimum age of marriage (*UNFPA 2013d: 20*).

The GPRHCS is also seen as contributing to strengthening country commitments to reproductive health commodity security, with 25 out of the 46 GPRHCS countries¹³¹ having established a budget line for reproductive health commodities.¹³² There are well-documented examples from several countries establishing or increasing the public budget-share of family planning commodities, including Cambodia, where the government committed to assuming the full cost for family planning commodities as of 2016, and Niger,

operations, including human rights-related activities (United Nations 2014a, HRW 2015, Lee, Flowers et al. 2015).

¹²⁴ Assumption 4.1

¹²⁵ Assumption 4.1

¹²⁶ “Health Development Army” refers to an organised movement of the community to promote participatory community engagement and adoption of healthy lifestyles with an emphasis on improving uptake of critical maternal and newborn health services. The Health Development Army provides a platform to engage the community in implementation of health interventions. The majority of the members are women.

¹²⁷ Assumption 4.1

¹²⁸ Assumption 4.1

¹²⁹ Assumption 4.1

¹³⁰ Assumption 4.1

¹³¹ See Table 5, Volume II, Annex 6

¹³² Assumption 4.1

where the dedicated budget line for essential drugs and reproductive health and family planning commodities quadrupled over the period 2007-2012.¹³³

Interventions contributing to overall positive results described above, typically included advocacy with decision-makers and opinion-leaders to improve understanding and to strengthen commitment at national and decentralised levels (Bolivia, Burkina Faso, Ethiopia, Uganda, Zimbabwe), and policy development support (all field study countries). Zimbabwe reported on a number of additional interventions, such as integration of family planning into other sexual and reproductive health areas, resource gap analysis and importantly the response of the country with regard to addressing gender based violence.¹³⁴ In Burkina Faso, the country office took action to align the UNFPA programme more effectively to government family planning strategies in order to close the gap between policy and implementation. This contributed to reported positive results in terms of long-acting family planning uptake.¹³⁵

In Cambodia, UNFPA took a critical stance alongside other development partners vis-à-vis the new law regulating NGO activities, leading to increased credibility and helping to maintain space for civil society.¹³⁶ However, in countries where the environment for civil society is hostile rather than weak (Ethiopia, Bolivia), UNFPA has opted for a low-profile approach to addressing regulations against NGOs. The evaluators did not find clear examples of UNFPA using its comparative advantage to strengthen the enabling environment for civil society and the rights-based approaches often brought to the table by NGOs. Again, more encouragingly, in Burkina Faso and Uganda, it was noted that UNFPA explicitly encouraged increased engagement of the private sector in family planning provision. This was also the case in Tajikistan and other Eastern Europe and Central Asia countries where UNFPA promoted the total market approach.

While the overall contribution to the enabling environment by UNFPA is positive, in several countries (Burkina Faso, Bolivia, Cambodia) the UNFPA contribution focused mostly at policy level, with only limited contribution at programmatic level. For example, in Bolivia, UNFPA has not supported initiatives to overcome the lack of reliable data at national level (i.e. through implementation of the demographic and health survey and census),¹³⁷ while in Cambodia, adolescents and unmarried women and men continue to face limited access to sexual and reproductive health and family planning services due to community and service provider attitudes.¹³⁸

UNFPA increasingly invests in knowledge generation, with some attention to gender issues in studies on young people in Ethiopia and Zimbabwe¹³⁹ and a variety of studies in Cambodia, including family planning client needs and satisfaction. Results of such studies are used to strengthen the enabling environment for family planning.¹⁴⁰

3.4.2 Improving demand for, and access to, family planning services at national and local levels

Several of the field study countries used similar strategies to improve family planning uptake at community-level, including community-based awareness-creation and distribution of contraceptives. In Cambodia, for example, village health support groups have been engaged

¹³³ Assumption 4.1

¹³⁴ See (Zimbabwe Country Note 2015: Section 4.4: 21)

¹³⁵ Assumption 4.1, see (Burkina Faso Country Note 2015: Section 4.4: 26)

¹³⁶ Assumption 4.1, see (Cambodia Country Note 2015: Section 4.4: 27)

¹³⁷ See (Bolivia Country Note 2015: Section 4.7: 31)

¹³⁸ Assumption 4.1, see (Cambodia Country Note 2015: Section 4.5: 29)

¹³⁹ See (Ethiopia Country Note 2015: Section 4.5: 23, Zimbabwe Country Note 2015: Section 4.7: 28)

¹⁴⁰ Section 3.6 of this report; Assumption 4.1, see (Cambodia Country Note 2015: Section 4.6: 35)

by the ministry of health and by various NGOs for this purpose, although they receive very little support from public health staff.¹⁴¹ Ethiopia has employed health extension workers¹⁴² and the Health Development Army (HDA) network as principal agents for family planning demand-creation.¹⁴³

Box 1: Improving access to contraceptives in Cambodian rural communities

People living in poverty are more likely to live in remote areas where they are underserved and disproportionately affected by costs associated with seeking health services. In Cambodia, unmet need in rural areas is higher than in urban settings (12.8 per cent versus 10.8 per cent). In 2013, UNFPA decided to financially and technically support RHAC, an NGO in Takeo province, to focus on community-based distribution of contraceptives (condoms, pills) and generate demand for long-term methods (intra uterine contraceptive devices (IUCDs) and implants). As part of the RHAC programme, information and educational community gatherings are held, targeting women so they can make informed choices about their reproductive health and contraceptive use. These events are reinforced through a mobile campaign using remork-motos (motorised rickshaws), a local mode of transport mostly used in urban centres in Cambodia. The remork-motos tour rural communities with messages announced through loudspeakers and information posters hanging from three sides of the vehicle. Programme monitoring data show a considerable increase in IUCD users. Along with measuring increased use, it is critical to take into consideration the potential tension between the rights-based approach towards family planning and offering incentives to providers and clients for some and not other contraceptive methods, particularly when the method is not client controlled as is the case with IUCD. Furthermore, the Reproductive Health Association of Cambodia (RHAC) programme generated evidence that financial barriers in rural settings limit access to long-term contraceptives. This evidence was subsequently used to successfully argue in favour of inclusion of long-term methods in the free-of-charge health equity fund benefit package that exempts those identified as living in poverty.

Source: Cambodia Country Note 2015: Section 4.6: 32-34

Family planning uptake either increased or remained high during the period under evaluation. UNFPA contributed to this by supporting demand-creation activities implemented by state and non-state actors and partners. At times, this involved mass media strategies (Burkina Faso, Sudan, Uganda) and community-based, targeted communication and contraceptive provision by NGOs and faith-based organisations (FBOs) (Burkina Faso, Cambodia, Ethiopia, Sudan). In Uganda, UNFPA supported multimedia combined with door-to-door campaigns.¹⁴⁴ Interventions in Burkina Faso focused on interpersonal communication and engagement with religious and community leaders to address socio-cultural barriers and to improve access to family planning.¹⁴⁵ However, the scope and scale of these interventions is not always clear; whether they are nation-wide programmes involving public services or smaller demonstration projects only involving a few facilities. The extent to which gender considerations shaped community-based intervention design is also unclear.

More broadly, a majority of the country offices indicated that they had supported demand-creation and access improvement activities during the period under evaluation.¹⁴⁶ Global, regional and country-level evaluations largely confirm this. The UNFPA Maternal Health Thematic Evaluation, for example, concluded that UNFPA supported a number of countries to generate demand in rural and remote areas by employing mobile clinics and voucher

¹⁴¹ See (Cambodia Country Note 2015: Section 4.4: 26)

¹⁴² Health extension works (HEWs) are employed to improve access to care in rural areas serving as the cornerstone of health extension programme

¹⁴³ Assumption 4.1, see (Ethiopia Country Note 2015: Section 4.4: 21)

¹⁴⁴ Assumption 4.2, Volume II, Annex 1

¹⁴⁵ See (Burkina Faso Country Note 2015: Section 4.4: 27)

¹⁴⁶ Assumption 4.2

schemes to promote access to family planning (*UNFPA 2011d*). Similarly, an Arab States Regional Programme evaluation found that the UNFPA partnerships with NGOs led to increased demand for sexual and reproductive health and family planning services in vulnerable and marginalised groups (*Thompson, Basil et al. 2013*).¹⁴⁷

There is an information gap regarding the effectiveness of community-based demand-promotion interventions. The evaluative information that is available regarding the effectiveness of UNFPA-supported demand-creation activities is contradictory. Independent evaluations and other sources generated evidence in favour of UNFPA having strengthened demand-creation,¹⁴⁸ but also found some evidence against this premise.¹⁴⁹ From among the former, the 2011 Maternal Health Thematic Evaluation concluded that UNFPA contributed to demand for family planning via communication, community mobilisation, research and partnerships with civil society organisations (*UNFPA 2011d*). From among the latter, an evaluation conducted in India found that “*in the urgency of attending to government’s needs for technical and other assistance, UNFPA programming has not paid adequate attention to the demand side of health issues – Improving health-seeking behaviour, demand-generation, and increasing utilisation of services, whether for family planning, or for other reproductive health services, particularly of the most vulnerable*” (*UNFPA India 2011: 111*). In Cambodia, the effect was thought to be questionable, while in Burkina Faso and Zimbabwe there was a lack of data in general or limited reporting by UNFPA, so effects could not be measured.¹⁵⁰

3.5 Vulnerable and marginalised groups

EVALUATION QUESTION 5

To what extent has UNFPA focused on the family planning needs of the most vulnerable and marginalised groups (VMGs), including identification of needs, allocation of resources, and promotion of rights, equity and access?

► **Assumptions**

- 5.1 UNFPA – globally and at country-level – performs situation analyses to identify needs, challenges and rights-violation and identifies good practices on how to address these.
- 5.2 UNFPA allocates resources to targeted programming for the most vulnerable and marginalised groups.
- 5.3 UNFPA promotes reproductive rights and supports capacity development to remove barriers and improve access, quality and integration of family planning services with other services for the most vulnerable and marginalised groups.
- 5.4 UNFPA actively encourages vulnerable and marginalised groups to participate in programme planning, implementation and monitoring, and the groups receive capacity building to this end.
- 5.5 Vulnerable and marginalised groups have improved access to sexual and reproductive services and their use of these services has increased.¹⁵¹

► **Evaluation criteria covered:** relevance; efficiency; effectiveness

¹⁴⁷ Assumption 4.2

¹⁴⁸ See, for example, (UNFPA 2011c, UNFPA 2011d, UNFPA 2012a, MoFA Netherlands 2013)

¹⁴⁹ See, for example, (UNFPA India 2011, UNFPA Nigeria 2012, University of Kinshasa and UNFPA 2012, MoFA Netherlands 2013); Assumption 4.1

¹⁵⁰ See Assumption 4.1, Volume II, Annex 1, see (Burkina Faso Country Note 2015, Cambodia Country Note 2015, Zimbabwe Country Note 2015: Section 4.4)

¹⁵¹ See Theory of Change, Diagramme 5, Volume II, Annex 5

Summary

UNFPA has made efforts to identify and address the needs of a limited range of vulnerable and marginalised groups at country, regional and global level, generally with a focus on adolescents and young people. While UNFPA is recognised as a leading global advocate of the rights of vulnerable and marginalised groups, its leadership does not always filter down to the country level. While UNFPA country offices have carried out situation analyses on the sexual and reproductive health and rights of vulnerable and marginalised groups, the practice is not systematic and not accounted for in the budget. Subsequently, country programme design does not include adequate research nor monitoring and evaluation components that would have provided essential information on the cultural and social barriers that exist on both the demand and supply side.

UNFPA does, however, allocate resources for programming for the most disadvantaged groups, actively promotes the rights and needs of vulnerable and marginalised groups with governments, promotes participation of these groups in programme activities, and supports initiatives that increase access to services for vulnerable and marginalised groups. An area of less attention is UNFPA efforts on the empowerment of vulnerable and marginalised groups. The effectiveness, impact and best practices of these streams of work with these groups, however, have not been systematically identified.

UNFPA strategic direction, during the period under evaluation, emphasises special attention to vulnerable and marginalised groups (VMGs), *“through data collection and analysis as well as qualitative studies (...) and by assessing their needs”* (UNFPA 2007: 12), giving them greater access to a range of modern contraceptives. These populations are described as including:

- The poorest of the poor and women living in poverty
- Adolescents and young people
- Women survivors of violence
- People living with HIV (PLHIV) and women living with HIV
- Female sex workers
- Minorities and indigenous people
- Women living with disabilities
- Refugees and internally displaced persons
- Women living under occupation
- Ageing populations and “populations of humanitarian concern.”¹⁵²

UNFPA is also committed to promoting the participation of vulnerable and marginalised groups in programme design, implementation, monitoring and evaluation.

The focus of UNFPA on vulnerable and marginalised groups is echoed by the *“Choices not Chance” Family Planning Strategy 2012-2020*, which sees the interventions of UNFPA as catalysts for change and able to reach vulnerable and marginalised groups (UNFPA 2013d). The importance of vulnerable and marginalised groups for UNFPA is furthermore emphasised in the *UNFPA Strategic Plan (2014-2017)* where women, adolescents and youth are the “key beneficiaries” of UNFPA work and explicitly represented in the ‘bull’s eye’ of the business plan.¹⁵³ The plan also states that UNFPA will *“prioritize the most vulnerable and marginalized, particularly adolescent girls and also indigenous people, ethnic minorities,*

¹⁵² The list of vulnerable and marginalised groups are not mutually exclusive

¹⁵³ The ‘bull’s eye’ represents the strategic goal of UNFPA, focusing on universal access to sexual and reproductive health, reproductive rights and reducing maternal mortality, to improve the lives of adolescents, youth and women, enabled by key factors (human rights, gender equality and population dynamics) (UNFPA 2013f).

migrants, sex workers, persons living with HIV and persons with disabilities” (UNFPA 2013m: 5).

3.5.1 Situation analysis on needs, challenges and good practices

In line with the above stated strategic priorities, UNFPA country offices have carried out situation analyses of the sexual and reproductive health and rights of vulnerable and marginalised groups. At both the global and country levels, needs-identification and situation analyses for vulnerable and marginalised groups have included studies on adolescents and people living with HIV and improving equality in access to family planning services, among others.¹⁵⁴ Similar studies were also conducted in different regions (EECARO, APRO).¹⁵⁵ At the country level, studies focused on unmet need (Rwanda), equity analysis of family planning needs (Ethiopia), access barriers (Nigeria) and knowledge, attitudes and practices (Sudan). In Kenya and Lebanon, UNFPA engaged in innovative studies and secondary data analysis related to addressing the unmet needs of vulnerable and marginalised groups and improving access to services.

Adolescents and young people received most attention in studies among the case study countries (Bolivia, Cambodia, Ethiopia, Nicaragua, Sudan, Tajikistan and Zimbabwe). Other vulnerable and marginalised groups identified include urban and rural poor, people in humanitarian settings, people in remote and rural areas, ethnic minorities and people living with disabilities, sex workers, migrants, people living with HIV, men who have sex with men and sexual minorities.¹⁵⁶ This shows that at the UNFPA programme country level, the operationalisation of targeting ‘vulnerable and marginalised groups’ results in identification of yet other groups as compared to those considered by the UNFPA global strategy.

Despite identification of a number of vulnerable and marginalised populations, only a few of these have been the subject of systematic situation analyses supported by UNFPA country offices as a first step in programme design to meet their needs. In Bolivia, evidence from studies carried out on indigenous groups was used for policy formulation to improve their access to sexual and reproductive health services and, in Nicaragua, a study was carried out on sexual and reproductive health practices among indigenous women. In Cambodia, research was carried out on migrant garment factory workers and the urban poor.¹⁵⁷

Reasons for the narrow range of vulnerable and marginalised group studies vary. Although vulnerable and marginalised groups are identified in UNFPA strategic plans and global documents as the highest priority, the country programme design process is not specifically based on prior identification of needs, and resources are not allocated to situation analysis or studies. Furthermore, the evaluators found no evidence of headquarter or regional office technical assistance visits to support design, implementation, monitoring (including results-oriented monitoring) and evaluation of assessments addressing the needs of vulnerable and marginalised groups.¹⁵⁸ Sometimes, reasons for limited situation analysis involving these groups are more targeted, such as in Ethiopia, where the government has stated that it aims to cover all women of reproductive age, “leaving no-one marginalised.”¹⁵⁹

¹⁵⁴ Assumption 5.1, Volume II, Annex 1

¹⁵⁵ Assumption 5.1

¹⁵⁶ Assumption 5.1

¹⁵⁷ See (Bolivia Country Note 2015: Section 4.7: 31, Cambodia Country Note 2015: Annex 3, Section 5.1: 76-77)

¹⁵⁸ Assumption 5.1, see (Bolivia Country Note 2015, Burkina Faso Country Note 2015, Cambodia Country Note 2015, Ethiopia Country Note 2015, Zimbabwe Country Note 2015: Section 4.5)

¹⁵⁹ Assumption 5.1, see (Ethiopia Country Note 2015: Annex 3, Assumption 5.1: 64)

The lack of development and dissemination of best practices by UNFPA was observed in several case study countries,¹⁶⁰ and the lack of systematic experience-sharing between country offices working in similar contexts is seen as a missed opportunity. Similarly, the lack of good practice documentation was noted in the independent evaluation of the *2008-2012 Arab States Regional Office (ASRO) Regional Programme on Advocacy Interventions*, stating that this “*compromises ASRO’s ability to maintain institutional memory in order to build on lessons learned*” (Thompson, Basil et al. 2013: 8-9). In the case of Bolivia, quality research developed by UNFPA has been disseminated countrywide and is used for policy making. However, there has been “*limited dissemination of the research results to other parts of UNFPA, although there is much that other country offices could learn from the experiences in Bolivia.*”¹⁶¹

3.5.2 Resources allocated for programmes for the most disadvantaged groups

UNFPA allocates resources for programming for the most disadvantaged groups. The large majority of focus countries are supporting work with adolescents, unmarried young people, the urban poor, rural communities, sex workers, and internally displaced people or refugees. Between one quarter and one-third of country offices also allocate resources to programmes for men who have sex with men, persons living with disabilities, and indigenous groups.¹⁶² The actual percentage of programme resources allocated and expended for interventions targeting vulnerable and marginalised groups cannot be determined from the UNFPA financial systems.

UNFPA has supported a range of interventions targeting vulnerable and marginalised groups. As with the situation analyses mentioned under 3.5.1, many UNFPA programmes prioritise targeting adolescents and youth and allocate resources accordingly. Adolescent and youth programmes supported by UNFPA in the country case studies focus on a range of sexual and reproductive health and family planning-related strategies and services, such as:

- Participation and empowerment (Bolivia, Ethiopia, Zimbabwe)
- Support to sexual and reproductive health and family planning services (Bolivia, Cambodia, Ethiopia, Zimbabwe)
- Advocacy for sexual and reproductive health needs and rights as well as information campaigns (Burkina Faso)
- Comprehensive sexuality education (Cambodia, Zimbabwe).

Other programmes address empowerment for indigenous women, HIV prevention and empowerment among transsexuals in Bolivia, migrant garment factory workers and sex workers in Cambodia (sexual and reproductive health, HIV, rights, family planning) and sex workers in Ethiopia (peer education and economic empowerment). In Zimbabwe, the national sex workers’ programme “Sisters with a Voice” provides HIV and sexual and reproductive health services through a network of clinics.¹⁶³ In Nicaragua, Nigeria, Rwanda, Sudan and Tajikistan, resources were allocated to young people, but also to programmes with sex workers, men who have sex with men, people living with HIV, indigenous people, humanitarian action and internally displaced people. UNFPA policy advocacy work in support of vulnerable and marginalised groups was considered highly relevant.¹⁶⁴ In Viet Nam, for example, access to services was generally considered inequitable for these groups and so the UNFPA policy advocacy work which supported them was considered very important.¹⁶⁵

¹⁶⁰ See (Bolivia Country Note 2015, Burkina Faso Country Note 2015, Cambodia Country Note 2015, Ethiopia Country Note 2015, Zimbabwe Country Note 2015: Section 4.5)

¹⁶¹ Assumption 5.1, see (Bolivia Country Note 2015: Section 4.5: 26)

¹⁶² Assumption 5.1 (results from internet surveys)

¹⁶³ See (Bolivia Country Note 2015, Burkina Faso Country Note 2015, Cambodia Country Note 2015, Ethiopia Country Note 2015, Zimbabwe Country Note 2015: Section 4.5)

¹⁶⁴ Assumption 5.1

¹⁶⁵ Assumption 5.1

Although UNFPA has allocated resources to work with vulnerable and marginalised groups, there has been little systematic identification of the effectiveness of these programmes. In effect, “UNFPA has demonstrated effort and activity but not impact for minorities or marginalized” (India, Afghanistan, Cambodia) (*UNFPA Cambodia 2011: 51*) and “a systematic programming focus on marginalized and excluded populations is missing in most programme plans” (*UNFPA 2011b: 26*). The Ministry of Foreign Affairs Netherlands evaluation (2013) covering its overall support to UNFPA found that “the organisation did not reach out sufficiently to vulnerable and hard to reach population groups” (*MoFA Netherlands 2013: 16*). In Cambodia, the impact of the programme to improve services for youth is limited due to the persisting social and cultural issues at both community and provider levels, especially in public facilities.¹⁶⁶ The lack of effectiveness is also highlighted in Burkina Faso, Ethiopia and Zimbabwe.¹⁶⁷

There are a number of reasons for the lack of evidence on effectiveness of interventions targeting vulnerable and marginalised groups. First, the provision of services through the public sector is not sufficiently responsive to context and needs of vulnerable and marginalised groups. Moreover, public service staff lack the client-friendly attitude that is needed for uptake of services, or insufficient priority is given to such services. There is ample documentation on discrimination against vulnerable and marginalised groups, particularly where capacity building efforts have not focused on rights-based awareness among service providers and have not created sensitivity to the specific needs and cultural contexts of disadvantaged and marginalised groups. In Bolivia, indigenous women and young people face limited access to public family planning services, among others, due to stigma, community censorship, and service provider bias.¹⁶⁸ Likewise, men who have sex with men and commercial sex workers face access difficulties due to provider bias in Ethiopia.¹⁶⁹ Stigma, discrimination and provider bias against vulnerable and marginalised groups were also reported in Burkina Faso, Cambodia and Zimbabwe.¹⁷⁰

Furthermore, the lack of attention towards measuring results and generating evidence for programme effectiveness is a recurrent weakness of UNFPA programming. This affects efforts towards vulnerable and marginalised groups. Recent evaluations point to weaknesses in results chains, lack of reporting on results at impact level (*MoFA Netherlands 2013: 64-65*), failure to measure effects of capacity building and to evaluate advocacy activities (*Thompson, Basil et al. 2013*), and lack of appropriate monitoring and evaluation mechanisms. All of this, taken together affects UNFPA capacity to assess programme results (*UNFPA 2012d: 50*) and the present evaluation concurs.¹⁷¹ This was also recognised by the *UNFPA Strategic Plan 2014-2017*, which points at the fact that UNFPA is perceived as weak on knowledge management and that it should invest in internal capacity building (*UNFPA 2013f:7*). Finally, the lack of evidence on effectiveness of interventions for vulnerable and marginalised groups is also due to the limited involvement of the target groups (especially groups other than adolescents and young people) in planning and programme implementation.¹⁷²

¹⁶⁶ See (Cambodia Country Note 2015: Section 3: 10, Section 4.5: 30)

¹⁶⁷ See (Burkina Faso Country Note 2015, Cambodia Country Note 2015, Ethiopia Country Note 2015, Zimbabwe Country Note 2015)

¹⁶⁸ See (Bolivia Country Note 2015: Section 4.5: 26)

¹⁶⁹ See (Ethiopia Country Note 2015: Section 4.5: 21)

¹⁷⁰ See (Burkina Faso Country Note 2015: Section 4.5: 28, Cambodia Country Note 2015: Section 4.5: 29, Zimbabwe Country Note 2015: Section 4.5: 22)

¹⁷¹ Sections 3.1, 3.6, 3.7 and Conclusions

¹⁷² Section 3.5.4

3.5.3 Rights promotion and capacity development to remove barriers and improve access to family planning services for the most disadvantaged groups

UNFPA is recognised as a global, visible advocate and leader in human rights and gender issues (see Section 3.6). Human and sexual and reproductive rights were incorporated in the *UNFPA 2008-2013 Strategic Plan*, are central to the current 2014-2017 strategic plan and are clearly linked to quality and effective implementation of policies and programmes. UNFPA strategies focus specifically on the rights of vulnerable and marginalised groups as priority groups and UNFPA is seen as a leader in advocating for the inclusion of reproductive rights on the agenda of programme countries: a role that UNFPA can assume more easily than other stakeholders in countries where a rights-focus attracts government scrutiny. UNFPA is also generally regarded as a leading agency on adolescents and youth policy and programming. In Bolivia, UNFPA raised awareness of the rights of vulnerable and marginalised groups among service providers, supported interventions that help vulnerable and marginalised groups exercise their rights and is recognised by other stakeholders as the lead actor to promote vulnerable and marginalised rights and keep these high on the public agenda.¹⁷³ In Cambodia and Ethiopia, UNFPA also made a substantial contribution to promoting the sexual and reproductive health rights of vulnerable and marginalised groups and removing service access barriers, such as programmes aiming to reduce service provider bias.¹⁷⁴

UNFPA has been a key advocate for the rights of sexual minorities in some countries, notably Bolivia, where it works with such groups to raise funds and support from other donors. Lesbian, gay, bisexual, transgender and intersex (LGBTI) people also received some degree of attention in Cambodia: their rights were addressed in the comprehensive sexual education work carried out with the Ministry of Education.¹⁷⁵ This has not happened in other countries where this is a sensitive issue, such as Ethiopia, and where UNFPA has not chosen to prioritise politically controversial groups such as men who have sex with men.¹⁷⁶ Therefore, the UNFPA leadership role at the global level regarding vulnerable and marginalised groups does not always filter down to the country level. Meanwhile, development partners sometimes encourage, and to a certain extent expect, UNFPA to take a stronger stand on rights with governments, especially for adolescents and youth, but also other vulnerable and marginalised groups, as was the case in Cambodia and Ethiopia.¹⁷⁷

UNFPA upstream activities and notably policy advocacy have paved the way for other stakeholders to influence policies targeting vulnerable and marginalised groups. This was found in Bolivia, Cambodia and Burkina Faso.¹⁷⁸ Implementation of actual programmes, downstream, is mostly carried out by NGOs, in all country desk studies. This is considered to be a good practice (Cambodia) since vulnerable and marginalised groups are most effectively reached by NGOs who have more credibility with the target groups. In Burkina Faso, working through NGOs also compensated for the limited capacity of public health services.¹⁷⁹ Downstream activities supported by UNFPA focus on the promotion of rights of vulnerable and marginalised groups and have included capacity building of service providers, notably training and orientation of teachers, health workers and other service providers as well as

¹⁷³ See (Bolivia Country Note 2015: Section 4.5: 27)

¹⁷⁴ See (Bolivia Country Note 2015, Cambodia Country Note 2015: Section 4.5: 30-31, Ethiopia Country Note 2015: Section 4.5)

¹⁷⁵ See (Bolivia Country Note 2015: Section 4.5: 27, Cambodia Country Note 2015, Ethiopia Country Note 2015, Zimbabwe Country Note 2015: Section 4.5)

¹⁷⁶ See (Ethiopia Country Note 2015: Section 4.5: 21)

¹⁷⁷ See (Cambodia Country Note 2015: Section 4.5: 31, Ethiopia Country Note 2015: Section 4.5: 20), Annex 3: 62

¹⁷⁸ See (Bolivia Country Note 2015: Section 4.5, Burkina Faso Country Note 2015: Section 4.5, Cambodia Country Note 2015: Section 4.5)

¹⁷⁹ See (Burkina Faso Country Note 2015: Section 4.5: 28, Cambodia Country Note 2015: Section 4.5: 29)

the media (geared towards encouraging constructive reporting about sex worker issues).¹⁸⁰ In Ethiopia, UNFPA and UNICEF have jointly developed a programme on young people that included capacity building for duty bearers in pastoral and urban communities.¹⁸¹ In Kenya, young people as a vulnerable group received skills and entrepreneurship training. In Cambodia, 840 health centre staff were trained to provide services to young people.¹⁸²

Partnerships with NGOs targeting vulnerable and marginalised groups have increased demand for sexual and reproductive health services. They have also facilitated experience sharing and support and raised awareness on the reproductive rights of vulnerable groups, among others in the Arab region (*Thompson, Basil et al. 2013*), Bolivia and Cambodia.¹⁸³ However, service provision remains limited overall, partially due to the low quality of public youth-friendly services, staff attitudes and confidentiality issues which inevitably result in young people not seeking services. Instead, young people prefer to resort to NGOs where they receive better information and services. Despite capacity building efforts aimed at increasing quality and access for all, service issues persist around quality of counselling and stigmatisation of unmarried clients, lesbian, gay, bisexual, transgender, intersexed people, commercial sex workers and other vulnerable and marginalised populations (Bolivia, Cambodia, Ethiopia).¹⁸⁴

These findings stress the necessity to link downstream activities with advocacy. This is clearly illustrated in Cambodia, where the *SMARTgirl* programme supported by UNFPA caters for 16,000 entertainment workers and addresses sexual and reproductive health, rights, HIV and family planning.¹⁸⁵ Despite this programme, and the programme on garment factory workers, stakeholders in Cambodia mention that *“stronger advocacy with government and development partners on the contraceptive needs of young people and other vulnerable and marginalised groups in the context of sexual and reproductive health could open the way for increased NGO involvement, and some forms of private sector involvement in addressing barriers and creating and responding to demand. Also, community engagement regarding the needs of adolescents and unmarried women, as well as other vulnerable and marginalised groups, may need more attention.”*¹⁸⁶

Building capacity for rights-based programming takes time and is particularly difficult in countries with a strong focus on family planning targets. Targets put pressure on service providers and users, for instance towards accepting the use of family planning (or of a certain family planning method), particularly in a context where advocacy and rights-based work by civil society is restricted (*Olson and Piller 2013*), as is the case in Ethiopia.¹⁸⁷ The country case studies for this evaluation highlight specific challenges: vulnerable and marginalised groups are often subject to discrimination and lack of sensitivity to their specific needs. The promotion of a human rights based approach requires that prospective users of family planning are adequately informed including on alternative methods of family planning.¹⁸⁸

¹⁸⁰ See (Burkina Faso Country Note 2015, Cambodia Country Note 2015, Ethiopia Country Note 2015: Section 4.5, Zimbabwe Country Note 2015: Section 4.5: 23)

¹⁸¹ See (Ethiopia Country Note 2015: Annex 3, Assumption 5.3: 65-66)

¹⁸² (UNFPA Cambodia 2013: 22, 23, UNFPA Cambodia 2014: 34, Noij, Kasumi et al. 2015)

¹⁸³ See (Bolivia Country Note 2015: Section 4.5: 27, Cambodia Country Note 2015: Section 4.5: 30-31)

¹⁸⁴ See (Bolivia Country Note 2015: Annex 3, Assumption 5.1: 61, Cambodia Country Note 2015: Section 4.5: 28-29, Annex 3, Assumption 5.3: 77, Ethiopia Country Note 2015: Annex 3, Assumption 5.5: 67)

¹⁸⁵ See (Cambodia Country Note 2015: Section 4.5: 30)

¹⁸⁶ See (Cambodia Country Note 2015: Section 4.5: 31)

¹⁸⁷ Section 3.4.1

¹⁸⁸ Section 3.5.2

3.5.4 Encouraging programme participation and related capacity building in vulnerable and marginalised groups

UNFPA generally promotes participation of vulnerable and marginalised groups in programme activities and, to some extent, supports capacity development. Again, adolescents and youth are the most visible among targeted vulnerable and marginalised groups for both programme participation and capacity building efforts. Initiatives to build empowerment and capacity of vulnerable and marginalised groups to advocate for their rights were evident in Cambodia and Bolivia.¹⁸⁹ In Zimbabwe, UNFPA has provided support to young people's networks focusing on capacity building for advocacy, communication and creating a voice.¹⁹⁰ Capacity building of youth networks is also found in Rwanda, Sudan, and Nicaragua and often includes leadership training and capacity building for programme planning and negotiation skills aimed at advocating for youth-related issues with local government. Capacity building of young people's networks has been successful at provincial level in Bolivia and is now being rolled out at national level by the networks themselves.¹⁹¹

More limited efforts are found elsewhere: for example, in Burkina Faso and Ethiopia, UNFPA does not have a systematic approach to proactively encourage participation of vulnerable and marginalised groups (and other beneficiaries).¹⁹² As already mentioned, in the absence of programme support from UNFPA to increase participation and empowerment, NGOs fill the gap (Burkina Faso, Viet Nam), and appear as a sustainable and often culturally appropriate means of implementation. Also, a results-oriented monitoring of such interventions is critical, yet there is little evidence that this is systematically carried out by UNFPA.

Other than programmes for youth, a focus on participation and capacity building for other vulnerable and marginalised groups is less visible, with some exceptions. In Bolivia, UNFPA has supported raising awareness for family planning rights with service providers, government and diverse vulnerable and marginalised groups. The support has included identifying better ways to exercise sexual and reproductive health and family planning rights, and supporting programmes which, aside from adolescents, also empower indigenous women and transgender women to participate in programme development.¹⁹³ In Zimbabwe, UNFPA is supporting the establishment of sex worker drop-in centres, where peer educators are trained, and a new initiative is underway to train female sex worker (FSW) peer educators as paralegals who will build a female sex worker network to provide outreach and support services focusing on human rights and gender-based violence (GBV).¹⁹⁴ Sex worker empowerment activities, including capacity building for effective participation in national and other forums have also taken place in Cambodia, Rwanda and Nicaragua.¹⁹⁵ Globally, UNFPA has supported the strengthening of capacities of sex workers to participate in the development of policies and programmes through the Global Network of Sex Work projects (*UNFPA 2013g*).

3.5.5 Improved access to, and utilisation of family planning services by vulnerable and marginalised groups

UNFPA has supported capacity building and implementation of specific programmes to raise awareness of, increase access to, and then promote the use of, services for vulnerable and marginalised groups. The *2013 UNFPA Strategic Plan* progress report affirmed that, globally,

¹⁸⁹ See (Bolivia Country Note 2015: Section 4.5: 27, Cambodia Country Note 2015: Section 4.5: 32)

¹⁹⁰ See (Zimbabwe Country Note 2015: Annex 3, Assumption 5.4: 69)

¹⁹¹ See (Bolivia Country Note 2015: Section 4.5: 27)

¹⁹² See (Burkina Faso Country Note 2015: Section 4.5: 29, Ethiopia Country Note 2015: Section 4.5: 22)

¹⁹³ See (Bolivia Country Note 2015: Section 4.5: 26)

¹⁹⁴ See (Zimbabwe Country Note 2015: Section 4.5: 24)

¹⁹⁵ Assumption 5.4

improved country capacity to expand the number of youth-friendly services had led to improving young people's access to such services (*UNFPA 2013i*). Examples at country level include attention to improving services for sex workers and poor people (Cambodia, Zimbabwe), indigenous women (Bolivia), rural populations (Burkina Faso) and young people (Bolivia, Burkina Faso and Zimbabwe),¹⁹⁶ as well as services for sex workers, young people and people in humanitarian situations (Sudan, Vietnam, Rwanda, Nigeria). This included support for demand-generation to increase the use of family planning services.

At the same time, important access and utilisation barriers remain, including social attitudes and cultural factors on the demand side, and service quality and provider attitude issues on the supply side (Bolivia, Cambodia).¹⁹⁷

Box 2: Social and cultural barriers to the uptake of family planning

Barriers were identified by focus group participants in the Bolivia country case study; their comments included:

- “Our parents still consider it taboo to talk to their children about sexuality” (young people)
- “The men still think family planning means loose living, so I do not tell my husband I am using a method” (indigenous women)
- “The nurses advised me to start using family planning after my last baby was born, and I feel much more secure” (FP service users)
- “In some rural areas people are two-faced: on one hand they say family planning is good for women, and on the other they do not accept it because it goes against the Church and traditional beliefs” (indigenous women)

Source: *Bolivia Country Note 2015: Section 4.5: 27*

There is limited quantitative data from specific vulnerable and marginalised groups on use of, or satisfaction with, the services provided, and little documentation of which types of activities are most effective to overcome barriers for different vulnerable and marginalised groups. Monitoring and evaluation of interventions to develop an evidence base requires time and technical skills, which are not always available or included in programme budgets. Although UNFPA has supported projects to improve access, reliable data on user satisfaction of different vulnerable and marginalised groups was not found by the evaluators. Also, while the downstream demand-side activities have largely been implemented by NGOs,¹⁹⁸ findings from Bolivia, Burkina Faso and Zimbabwe showed that UNFPA has not paid sufficient attention to the monitoring of the effectiveness of these activities in increasing access for vulnerable and marginalised groups.¹⁹⁹

3.6 Human rights-based approach

EVALUATION QUESTION 6

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 headquarters and regional offices for a rights-based approach in country?

► Assumptions

6.1 UNFPA staff and key partners have a shared understanding of the meaning and importance of a rights-based approach to family planning.

¹⁹⁶ (Bolivia Country Note 2015, Burkina Faso Country Note 2015, Cambodia Country Note 2015, Zimbabwe Country Note 2015: Section 4.5)

¹⁹⁷ See (Bolivia Country Note 2015, Cambodia Country Note 2015: Section 4.5)

¹⁹⁸ Section 3.5.3

¹⁹⁹ See (Bolivia Country Note 2015, Burkina Faso Country Note 2015, Zimbabwe Country Note 2015: Section 4.5),

- 6.2 UNFPA programming incorporates human rights principles in the assessment, design, implementation and evaluation of family planning programme interventions.
 - 6.3 UNFPA is developing a body of evidence and lessons learned regarding human rights-based approaches for family planning.
 - 6.4 Country offices receive and put into practice technical guidance from headquarters and regional offices to support rights-based family planning. (This assumption is presented in a separate final section (3.9) covering interactions between country offices and regional offices and headquarters in all relevant evaluation areas.)
 - 6.5 Rights-holders consider that duty bearers understand their rights to family planning and sexual and reproductive health.²⁰⁰
- **Evaluation criteria covered:** relevance; effectiveness

Summary

UNFPA is mandated, as a result of the ICPD and United Nations direction, to pursue a human rights-based approach (HRBA) to programming, and has identified the key characteristics of this approach in sexual and reproductive health. UNFPA has also articulated rights-based guidance for family planning (*Choices not Chance*). Further, UNFPA and WHO have jointly produced guidance on how to operationalise human rights within contraceptive services. However, UNFPA staff and its partners do not have a shared understanding regarding what constitutes a human rights-based approach for family planning. In practice, understanding is varied and most often focused on access to family planning services and an expanded range of contraceptive method options.

UNFPA has been vocal at the global level regarding the importance of a human rights-based approach. UNFPA has shown persistence and leadership in some countries, while needs still have to be addressed in other countries. Examples of components supporting human rights-based approach are not consistently applied throughout programme countries and there is little evidence that the variation results from an explicit assessment of needs and opportunities. Client satisfaction was more likely to be evident in NGO than in government facilities, indicating a major gap in the rights-based quality of care in the public sector of programme countries.

While a number of technical programmes (such as HIV prevention and gender based violence prevention programmes) pay greater attention to human rights-based approach components (such as participation, empowerment and accountability), it is more difficult to determine how human rights principles have been operationalised in family planning programmes. This difference indicates opportunities for cross-learning among different technical areas on effective human rights-based approaches.

3.6.1 A shared understanding about the meaning and importance of a human rights-based approach to family planning

The 1994 ICPD in Cairo reaffirmed the basic human 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, and the rights to attain the highest standards of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents*” (United Nations 1994: 40). As the United Nations agency tasked with achieving the ICPD vision, UNFPA is mandated to incorporate a human rights-based approach within all of its development efforts. UNFPA is a visible advocate for human rights and provides important global and country level leadership in its publications and guidance regarding the importance of human rights-based approaches. The United Nations produced key reference

²⁰⁰ See Theory of Change, Diagramme 6, Volume II, Annex 5

documents, including the “*Common Understanding*” (2003), on how the United Nations system could mainstream a human rights-based approach within its policies and practices. UNFPA mentioned the importance of human and reproductive rights within its 2008-2011 Strategic Plan, and produced a handbook in 2011 on how to incorporate rights programming (Box 3).²⁰¹ Human and reproductive rights remain important in the 2014-2017 strategy, which puts forward the tenet that the quality and effective implementation of policies and programmes for gender equality and rights contributes to the success of programmes.²⁰²

Box 3: Elements of human rights-based programming (UNFPA, 2011-2025)

- Emphasises the process as well as the outcome of programming
- Draws attention to the most marginalised populations
- Works towards equitable service delivery
- Extends and deepens participation
- Ensures local ownership of development processes
- Strengthens accountability of all actors

The *Choices not Chance* strategy, articulated by UNFPA in 2012, defined human rights in operational terms for family planning programmes, notably by calling for the elimination of incentives and targets or fees that incentivise health care providers to advocate for adoption of contraception or of any specific method.²⁰³ Also in 2012, rights advocates expressed concerns regarding the quantitative goal established by FP2020 to reach 120 million women and girls with contraceptive information and services. Some felt that this harkened back to pre-ICPD days when the prevailing rationale for family planning was rooted in demographic or health arguments rather than as an inherent right. As a result, since the launch of FP2020 at the London Summit on Family Planning in 2012, different frameworks and documents were developed that define human rights principles for family planning.²⁰⁴ One such resource is guidance produced by UNFPA and WHO on how to operationalise human rights within contraceptive services (Box 4).

Box 4: Action points and corresponding human rights principles (WHO and UNFPA, 2015)

- Ensuring access for all (non-discrimination)
- Commodities, logistics and procurement (availability)
- Organisation of health facilities (accessibility)
- Quality of care (acceptability, quality, informed decision-making, privacy and confidentiality)
- Comprehensive sexuality education (accessibility)
- Humanitarian context (right to accessible services)
- Participation by potential and actual users (participation)

Source: UNFPA and WHO 2015

There is near universal mention of human rights in UNFPA global and country planning and programme documents, and, among UNFPA staff, there is a strong consensus about the importance of a human rights-based approach as a guiding element within its programmes. However, this does not carry forward to a shared understanding by UNFPA staff and its partners regarding what constitutes a human rights-based approach to family planning: there is great variation in how staff describe what human rights-based approach means in operational terms, especially for family planning programmes.²⁰⁵ Since most UNFPA family planning activities are supported through thematic GPRHCS funds, a human rights-based

²⁰¹ See Assumption 6.1, Volume II, Annex 1

²⁰² Assumption 6.1

²⁰³ Assumption 6.1

²⁰⁴ Assumption 6.1

²⁰⁵ Assumption 6.1

approach for family planning was often cast by country offices in terms of improving access to the supply of quality family planning services and an expanded range of contraceptive methods. This was the case in several countries, including Ethiopia, Uganda, and Rwanda, where staff rooted a human rights-based approach within a services context (accessibility, acceptability, availability and quality). By contrast, staff from UNFPA Zimbabwe (where there is a strong focus on HIV and gender based violence prevention) and staff from UNFPA Bolivia (where meeting the needs of indigenous groups is the main focus) defined the human rights-based approach in broader terms, citing principles of non-discrimination, equity and participation as key components of their work.²⁰⁶

In general, UNFPA civil society partners shared a commitment to a human rights-based approach in family planning, and many wanted UNFPA to advocate more strongly with governments to operationalise human rights commitments within sexual and reproductive health and family planning programmes and to bridge the gap between rhetoric and reality.²⁰⁷ However, UNFPA has not formed a shared understanding, across the organisation, of what it means to operationalise a human rights-based approach within its family planning activities, despite articulating guidelines on a human rights approach.

3.6.2 Incorporation of human rights principles in assessment, design, implementation and evaluation of programme intervention

As noted, human rights language and principles infuse nearly all UNFPA programme documents. However, it is much more difficult to find specifics on what is done to operationalise human rights in programmatic terms. For example, the terms of reference for several country programme evaluations included a question regarding UNFPA attention to human rights, yet the reports offered scant mention of whether, and how, the country office applied a human rights-based approach.²⁰⁸ In the few evaluations that do offer findings on a human rights-based approach, these were associated with gender activities such as the prevention of female genital cutting (FGC), child marriage and other harmful practices.²⁰⁹ The findings from a UNFPA Nigeria country programme evaluation (Box 5) illustrate the some of challenges in how human rights is operationalised as well as monitored within programmes.²¹⁰

Box 5: Gap between rhetoric and operationalisation of human rights-based approach

Operational definitions of human rights-based approaches to programming were missing from annual work plans (AWPs), annual reports and similar documents and iconic elements of the human rights-based approach (evidence of training, use or accent on the principles, norms and standards as well as support for the roles and responsibilities of duty bearers and claims holders, etc.) were not found in programme documents beyond the copious declarations found in the country programme action plan (CPAP).

Source: UNFPA Nigeria 2012: 17

One possible reason for the dearth of information in evaluations about how UNFPA has worked to advance human rights could be the lack of overall consensus, including outside UNFPA, on exactly how best to operationalise human rights within sexual and reproductive health and, in particular, family planning programmes. A human rights-based approach for family planning is just emerging as an important programme issue and research question

²⁰⁶ Assumption 6.1, see (Bolivia Country Note 2015, Zimbabwe Country Note 2015: Section 4.6)

²⁰⁷ Assumption 6.1

²⁰⁸ Assumption 6.2, Volume II, Annex 1

²⁰⁹ Assumption 6.2

²¹⁰ Assumption 6.2

within the global community as evidenced by the recent spate of publications and discourse noted above.²¹¹

UNFPA attention to human rights was most explicit in contexts that are addressing gender-based violence (Bolivia, Zimbabwe) and the needs of vulnerable and marginalised groups, such as indigenous populations (Bolivia), sex workers (Cambodia, Zimbabwe), migrant factory workers (Cambodia) and handicapped youth (Burkina Faso).²¹² Country programmes supported different components of a human rights-based approach, but it was not clear whether this was deliberate, based on a systematic situational analysis, or whether the differences were due to variations in understanding or capacity on how to operationalise a human rights-based approach in programme design. In Bolivia, UNFPA addressed rights in family planning through a holistic strategy that empowered users to demand their rights and strengthened the capacity of service providers to respond accordingly. UNFPA supported government and civil society partners to address empowerment, non-discrimination, equity and access to family planning as key elements and advocated to keep human rights high on the public agenda through promotion and advocacy.²¹³

In Burkina Faso, the focus of UNFPA support for family planning was on expanding access to underserved populations and expanding service modalities and the method-mix. Similarly, in Zimbabwe the main thrust regarding family planning was to expand access to contraceptive information and services for youth and improve method choice by adding long-acting reversible contraception to the method-mix. However, in both countries, there was little systematic attention to other important components of a rights-based family planning programme, such as support for quality assurance, accountability mechanisms and participation. Further, in both Burkina Faso and Zimbabwe, the government is implementing results-based financing for family planning, which includes facility and provider incentives for contraception uptake, but no explicit attention for client rights, presenting a missed opportunity for leadership by UNFPA on implications and safeguards needed to ensure a human rights-based approach.²¹⁴

In Ethiopia, ambitious national goals for family planning prevalence have resulted in targets for family planning uptake at all service delivery levels. UNFPA has made important contributions to tangible results on access and method-mix and important aspects of a rights-based approach on the supply side. However, on the *demand side*, UNFPA has not fully taken a stand on support to the right to choose family planning services, in partnership with development partners and civil society organisations about the potential pressures on voluntary, informed choice and the human rights and programme implications.²¹⁵ Key informants at the country and global level believe UNFPA, as a multilateral organisation, is in a unique position to advance rights within family planning and to advocate against practices that could potentially result in adverse impact on the rights of clients and potential clients.

Several global key informants noted that UNFPA provides an important platform for leadership on adopting a human rights-based approach for family planning and that it has been strong in international leadership forums. However, the experience at country level is mixed and is dependent on country office capacity and willingness to push on rights issues that might risk relationships with governments. For example, UNFPA showed excellent

²¹¹ Assumption 6.1

²¹² Assumption 6.2, see (Bolivia Country Note 2015, Burkina Faso Country Note 2015, Cambodia Country Note 2015, Zimbabwe Country Note 2015: Section 4.6)

²¹³ Assumption 6.2, see (Bolivia Country Note 2015: Section 4.6: 29-30)

²¹⁴ Assumption 6.2, see (Burkina Faso Country Note 2015: Section 4.6 30, Zimbabwe Country Note 2015: Section 4.6: 25)

²¹⁵ See (Ethiopia Country Note 2015: Section 4.6: 25)

leadership and persistence in pursuing rights in China,²¹⁶ but has not yet been as successful in contexts where government programmes employ targets and incentives, and where concerns are raised about voluntarism.²¹⁷ UNFPA has yet to find, and adequately communicate, a way to navigate the potential tensions between the push for results in family planning (whether demographically or otherwise driven) and respect for individual rights.

3.6.3 Development of a body of evidence and lessons learned regarding human rights-based approaches for family planning

In line with its stated commitment to supporting a human rights-based approach in development activities, UNFPA established the *Universal Periodic Review* (UPR) in 2006 to systematically review the fulfilment by each United Nation member state of its human rights obligations. This review generates recommendations to which each state under review is obligated to respond. The *Universal Periodic Review* is conducted every five years. The first review assessed the 2008-2011 cycle and serves as an important evidence base on the status of human rights trends going forward. However, within the sexual and reproductive health rights recommendations, the first *Universal Periodic Review* focused heavily on gender equality, gender based violence (GBV) and women's and girls' rights, but much less so on family planning and contraception.²¹⁸ At the global level, efforts underway by FP2020 and other international groups to study rights-based approaches for family planning will be critical to expanding the evidence base.

There was little evidence of a systematic effort by UNFPA to identify and synthesise lessons on the application of a human rights-based approach or on other important programme topics. For example, key informants spoke of UNFPA successful advocacy efforts to support quality of care and choice in China; however, little has been done to share this information internally or externally. Moreover, country offices have undertaken efforts to generate evidence that can inform the design or impact of rights-based programming. In Bolivia, UNFPA supported studies on young people, indigenous groups, sexual minorities and survivors of gender based violence for use in programme design and advocacy.²¹⁹ In Cambodia, UNFPA is increasingly generating evidence on family planning client needs and satisfaction, which has been used to advocate on rights issues with the government and other stakeholders (Box 6).²²⁰ However, beyond specific initiatives at country level, there does not appear to be an organisation-wide research agenda to promote learning on priority issues across the organisation.

Box 6: Studies co-commissioned by UNFPA Cambodia

UNFPA Cambodia is committed to generating evidence on family planning client needs and satisfaction, to improve client-oriented programmes and service delivery, important aspects of quality of care and human rights-based approach. Three key research topics include a literature review on sexual and reproductive health and rights of migrant workers (Cockcroft, M 2014); a study on teenage fertility and its socio-economic characteristics and risk factors (Meng, K et al 2013); and a study on reproductive preferences in Cambodia (Westoff et al, 2013). The country office has used this information to advocate for rights issues with the government and other stakeholders and the results provide insights as to the role of a rights-based approach.

Source: (Cambodia Country Note 2015: Section 4.6: 35).²²¹

²¹⁶ Assumption 6.2

²¹⁷ Assumption 6.2

²¹⁸ Assumption 6.3, Volume II, Annex 1

²¹⁹ Assumption 6.3

²²⁰ Assumption 6.3, see (Bolivia Country Note 2015: Section 4.5: 26, Cambodia Country Note 2015: Section 4.6: 35)

²²¹ Assumption 6.3

3.6.4 Rights holders' and duty bearers' understanding of sexual and reproductive health and family planning rights

In general, clients attending programmes that focused explicitly on quality of care, awareness of rights to access, or quality service delivery (Bolivia, Burkina Faso) expressed satisfaction with services and the providers that support them. In Bolivia, the focus on quality led to better access to family planning by indigenous women.²²² In Burkina Faso, focus group discussion participants (young, unmarried women attending an NGO service supported by UNFPA) understood their right to quality family planning, they felt they were treated with dignity and respect, their confidentiality was assured and they received information about methods and side effects. In contrast, focus group discussion participants from public sector facilities complained they received no information about side effects and suggested that health care providers were not concerned about privacy and confidentiality. This was of special concern to adolescent clients.²²³ In Cambodia, opinions were mixed, with some women expressing satisfaction with the friendliness of health providers and the level of information provided and others stating dissatisfaction.²²⁴ In Ethiopia, participants noted that if they were dissatisfied with the quality of services by the health centre they would not complain but rather go to an NGO provider instead.²²⁵ Overall, client satisfaction was more likely to be evident in NGO than in government facilities, indicating a gap in rights-based quality of care in the public sector settings: an issue that UNFPA is in a position to address, given its global leadership in human rights-based approaches and its role as technical advisor to governments.

3.7 Different modes of engagement

EVALUATION QUESTION 7

To what extent has UNFPA adapted its modes of engagement to evolving country needs in different settings, using evidence and best practice?

► Assumptions

- 7.1 Headquarters and regional offices provide support and technical assistance to country offices to identify and adapt to changing needs over time. *(This assumption is presented in a separate final section (3.9) covering interactions between country offices and regional offices and headquarters in all relevant evaluation areas).*
- 7.2 UNFPA country offices monitor changes in country context and needs over time and adapt their mode of engagement and programme development accordingly.
- 7.3 UNFPA interventions and engagement modes support country moves towards increased sustainability of family planning and sexual and reproductive health interventions.
- 7.4 UNFPA identifies and applies good practice at country, regional and global levels.²²⁶

► Evaluation criteria covered: relevance; efficiency; sustainability

Summary

Country office programming priorities in family planning are driven by national needs, UNFPA organisational priorities and actual funding availability. UNFPA country offices programme an evolving mix of modes of engagement (policy, advocacy, capacity

²²² Assumption 6.5, see (Bolivia Country Note 2015: Section 4.6: 25-27)

²²³ Assumption 6.5, see (Burkina Faso Country Note 2015: Annex 3, Assumption 6.5: 73)

²²⁴ Assumption 6.5, see (Cambodia Country Note 2015: Annex 3, Assumption 6.5: 87)

²²⁵ Assumption 6.5, see (Ethiopia Country Note 2015: Annex 3, Assumption 6.5: 71)

²²⁶ See Theory of Change, Diagramme 7, Volume II, Annex 5

development, service delivery and knowledge management) depending on the needs and opportunities in family planning over time, with a tendency to focus on supply-side where funds are available. UNFPA country offices have a good grasp of the country context and tend to monitor changing needs, adapting programmes accordingly, although consideration of the landscape of other development partners when designing and delivering country programmes is less explicit. This affects UNFPA ability to optimise the use of its own resources and capacity to deliver through others and to strengthen coalitions in country for delivering results beyond those that UNFPA can provide alone.

UNFPA engages in knowledge management for family planning, including through GPRHCS and by serving as a technical expert in the work of the high impact practices initiative (in sexual and reproductive health rights). However, the lack of an explicit, fund-wide learning strategy for family planning supported by clear standards for documentation and knowledge management undermines the UNFPA approach. There is a need to build capacity to generate robust evidence and to strengthen and define results and reporting in family planning. Furthermore the current limitation of reporting to supply-side activities and outputs, instead of higher level outcomes, also constrains engagement. UNFPA thereby restricts its ability to effectively influence the quality of its programming and realise its potential as a knowledge broker and thought leader on key issues in sexual and reproductive health rights.

3.7.1 Shifting modes of engagement to adapt to changing country priorities and needs

The business model articulated in the current *UNFPA Strategic Plan 2014-2017* identifies four modes of engagement for UNFPA to undertake in different settings, namely: service delivery, capacity development, knowledge management and advocacy and policy dialogue/advice.²²⁷ The business model was developed in response to several challenges, such as the lack of a clear strategic focus, fragmentation of resources due to working in too many countries, and limited clarity on the role UNFPA should play in differing contexts (*UNFPA 2013g*). The model proposed two key shifts:

- The allocation of resources to those countries with the highest level of need and the lowest capacity to finance development activities
- A move by UNFPA away from support to service delivery to more upstream work in knowledge management and advocacy and policy dialogue/advice.²²⁸

The business model was not in place during the period 2008-2013, and at the time of this evaluation, there has not been enough time to generate evidence about whether there is already an effect on shifting assistance upstream, or on addressing the challenges of resource allocation. At this time, there is limited evidence to indicate that the business model has been a driving force for programming in the countries under review. Many of these countries are high need, low income settings and even under the new business model would most likely receive funding across all four modes of engagement. However, even within these considerations, it does not appear that UNFPA country policy, planning and programming is shifting upstream in line with the new business model. Instead, UNFPA programming continues to be influenced primarily by national priorities, and by UNFPA organisational priorities and available resources.²²⁹ UNFPA country offices have a good grasp of country context and they monitor changing needs and adapt programme interventions accordingly. In designing programmes of support to family planning, UNFPA country offices work within identified resource limitations and align activities closely with the priorities and needs of the public sector. Thus, the primary drivers for the modes of

²²⁷ See Assumption 7.2, Volume II, Annex 1

²²⁸ Assumption 7.2

²²⁹ Assumption 7.2

engagement used by UNFPA to support family planning are the country offices' financial and human resource capacities and the needs and capacities of host governments.

For example, in Ethiopia, the country programme was shaped by government priorities to scale up service access as well as by resource availability through GPRHCS, leading to a focus on supply-side interventions and support for service delivery, procurement and capacity building in the supply chain.²³⁰ While it is appropriate that UNFPA has aligned its support to the strong supply-oriented policy and programme environment in Ethiopia, there remains an important gap in advocacy for safeguarding client choice in the context of a major government drive to increase contraceptive uptake.²³¹ Changes in the country context in Ethiopia were monitored informally, rather than systematically, for example, against explicit criteria or in relation to triggers that would signal the right moment to shift to a more upstream mode of engagement. In addition, the modes of engagement were not tailored to differences among decentralised regions, which are at different stages of development and have different needs for support.²³² Some regions were ready for a shift upstream away from supply-side investments to knowledge management and advocacy, while others with persistent low coverage and financing gaps were still in need of a more comprehensive approach. Supply-side investments continued nonetheless when GPRHCS funding became available as there was insufficient capacity at sub-national level to identify and adjust modes of engagement.

As in Ethiopia, during the period 2008-2013, strategic shifts in UNFPA modes of engagement occurred based on changes in the programmatic landscape in the other countries studied.

In Cambodia, the major change in the landscape was the increased political commitment for family planning, which enabled UNFPA to slowly shift from an emphasis on commodity provision and direct service delivery to more upstream modes, involving policy, advocacy, capacity development and knowledge management.²³³ In both Zimbabwe and Burkina Faso, modes of engagement remained predominantly downstream and focused on service delivery and capacity development.²³⁴ In Zimbabwe, this occurred despite a history of one of the first successful and long-standing family planning programmes in the region and in the world. The Zimbabwean economic and political crisis in 2008 resulted in a breakdown of health services and the inability to finance basic services. It was necessary for UNFPA and other development partners to focus on service access, capacity building and demand-creation rather than shift to upstream modes more characteristic of a national programme farther along in its development.²³⁵

In Burkina Faso (Box 7), in response to an improved national commitment to family planning, UNFPA expanded its support for service provision and capacity development through a major shift in strategy that extended geographic focus from three regions to nationally, aided by an expanded number of civil society partnerships.²³⁶

²³⁰ Assumption 7.2, see (Ethiopia Country Note 2015: Section 4.7: 27)

²³¹ Assumption 7.2, See (Ethiopia Country Note 2015: Section 4.6: 25)

²³² See (Ethiopia Country Note 2015: Section 4.7: 26)

²³³ Assumption 7.2, see (Cambodia Country Note 2015: Section 4.7: 36-37)

²³⁴ See (Burkina Faso Country Note 2015, Zimbabwe Country Note 2015: Section 4.7)

²³⁵ Assumption 7.2, see (Zimbabwe Country Note 2015: Section 4.7: 26)

²³⁶ Assumption 7.2, see (Burkina Faso Country Note 2015: Section 4.7: 32)

Box 7: Programming for family planning sustainability with UNFPA support in Burkina Faso

The current strategy for UNFPA under the seventh country programme includes strengthening partnerships with NGOs and civil society organisations as a means to extend its geographic and technical reach. UNFPA is supporting 20 capacity building NGOs, which in turn support 160 CBOs in family planning service delivery at the village level. Under the previous programme, UNFPA partnered with just one organisation, but has since increased its partnership portfolio to include groups with a wide range of diverse and complementary skills. This facilitates testing various approaches across a wide geographical area and in different contexts and building cultural sustainability for family planning.

Source: (UNFPA Burkina Faso 2012).

The UNFPA business model does not adequately acknowledge the specificities required to invest in and deliver the full range of technical programme areas including new and emerging technical areas, which may require different modes of engagement. Newer technical areas, for example, (such as gender, human rights, integration) may have very different programming requirements than more established areas, such as family planning. The differences may arise in relation to whether and how the new area is recognised by other partners, donors, government and civil society. Policy and advocacy efforts are often critical to securing interest by development partners to address a new programme issue or technical area. The inclusion of the demographic dividend into the national vision, for example, requires a different kind of policy and advocacy engagement. Prior to incorporating the demographic dividend in public policy planning, it is important to build understanding of, and consensus around the concept itself. In contrast, from a policy perspective, the family planning service is a relatively mature field; many countries have adequate policies, but there may be a gap between policies and their implementation. As a result, service delivery may continue to be relevant, even in a mature programme. There may, for example still be a need to introduce new contraceptive methods or service delivery approaches to address plateaus in prevalence or to reach underserved populations, as noted in the aforementioned Zimbabwe example.

Finally, UNFPA programme documents do not adequately take into account the landscape of other development partners and what this means for UNFPA investment and modes of engagement. There are many highly capable and technically proficient organisations working in the field of family planning. Many are working in fields adjacent to family planning (such as maternal health) and could be in a strong position to strengthen their family planning delivery and supply side support. Expanding service delivery and building capacity generally require large and longer-term planned investments of human and financial resources, which may be better suited to other partners. For example, the World Bank's Global Financing Facility, large donor programmes and pooled funds that link to domestic resources, generally have greater potential for building sustainable national commitment within the broader framework of health systems strengthening. This raises the question as to whether UNFPA is best positioned in a particular country to support service delivery, and how it should achieve this, given it has limited resources that are stretched among many countries.

In Burkina Faso, UNFPA took advantage of the crowded family planning landscape and brokered partnerships with many strong technical international and national NGOs to leverage a relatively small budget and extend service delivery activities.²³⁷ In Bolivia, however, UNFPA remained the key development partner in reproductive health for the

²³⁷ Assumption 7.2, see (Burkina Faso Country Note 2015: Section 4.3: 24-25)

government, following the withdrawal of USAID assistance, and was in position to play an important role in support for family planning.²³⁸

What is important for sustainable delivery, considering the constraints that UNFPA faces, is that it should be able to assess the evolving context in each country and build partnerships that increase domestic financing and policy commitments, integrating family planning into the wider range of systems and funding mechanisms, using its position to foster a shared responsibility for family planning delivery and results. In the future, these results will be monitored through the recently established Independent Accountability Panel, a global mechanism set up by the UN Secretary General to monitor and hold to account national and global commitments to RMNCAH resources, results and rights.²³⁹

3.7.2 Programming for increased sustainability of family planning and sexual and reproductive health interventions

There are numerous examples of how country offices are contributing to programme sustainability (see Section 3.2.3) across the various modes of engagement, but especially through advocacy to improve the policy environment for family planning and reproductive health commodity security. The GPRHCS is a cornerstone of UNFPA efforts to foster the sustainability of family planning access, availability and quality. However, there is stronger evidence and documentation of outcomes related to advocacy and policy than there is for capacity development modes of engagement.²⁴⁰

Advocacy by UNFPA with national governments to increase budget allocations for commodity purchases has resulted in increases in budget allocations for reproductive health commodities in 27 countries in 2013 (*UNFPA 2014f*). For example, in Bolivia UNFPA supported the inclusion of family planning in the basic health insurance package, including provisions for the government to cover the cost of family planning commodities and supplies.²⁴¹ In Burkina Faso, UNFPA advocacy resulted in an increased national budget support for family planning commodities. Unfortunately, the government fell short of its commitment in the past two years, and civil society organisations called for increased UNFPA advocacy to address future accountability.²⁴² In Cambodia, UNFPA successfully worked towards the inclusion of contraceptives in the pro-poor health equity fund schemes which enabled the poor to access family planning services free of charge and contributed to sustainability, because the government indicated it would continue to sustain the health equity funds even if development partners no longer support them.²⁴³ In Ethiopia, as the national family planning programme grew stronger, UNFPA support evolved from an initial focus on procurement towards strengthening the capacity of the government to manage its own procurement and management of the supply chain, including at decentralised regional levels.²⁴⁴

Since its inception in 2007 until its replacement in 2013, GPRHCS has supported capacity development through training in family planning counselling and communication and supply of long-acting reversible methods. While GPRHCS reports provide data on the number of countries where training has been supported (i.e., facilitation of training, provision of master training, provision of training materials, technical guidance for training and financial support for training), there is little evidence related to the effect of training activities on sustained

²³⁸ Assumption 7.2, see (Bolivia Country Note 2015: Section 4.8: 35)

²³⁹ See <http://www.everywomaneverychild.org/news-events/news/1298-announcement-of-every-woman-every-child-s-independent-accountability-panel>

²⁴⁰ Assumption 7.3, Volume II, Annex 1

²⁴¹ Assumption 7.3, see (Bolivia Country Note 2015: Section 4.7: 32)

²⁴² Assumption 7.3, see (Burkina Faso Country Note 2015: Section 4.7: 33)

²⁴³ Assumption 7.3, see (Cambodia Country Note 2015: Section 4.7: 37)

²⁴⁴ Assumption 7.3, see (Ethiopia Country Note 2015)

changes in provider behaviours related to access or quality of care (*UNFPA 2014e: 36*). In Uganda, stakeholders noted that UNFPA supported capacity development for many years within the same districts and perhaps the same people, with unclear results.²⁴⁵ Challenges related to the sustainability of UNFPA supply-side interventions are discussed more fully in Section 3.8.3.

3.7.3 Knowledge management to develop, apply and disseminate good practices

Since 2001, UNFPA has had in place a fund-wide knowledge management strategy to guide and promote the generation and use of strategic information in programming and management.²⁴⁶ Knowledge management is a clearly stated priority within the current *UNFPA Strategic Plan 2014-2017*, given that the imperative for UNFPA is to shift from “*delivering things to delivering thinking*” (*UNFPA 2013m: 13*). During the period under evaluation (2008-2013), UNFPA has been working to strengthen its capacity to document and share good practices internally.

At the organisational level, this has included annual good practice contests, starting in 2012. These contests support learning across the organisation on topics of interest, such as adolescent and youth programming, effective partnering and results-based financing.²⁴⁷ To date, the contests have resulted in the identification of over 250 good practices in sexual and reproductive health and programme management, which have been vetted through a peer (internal) review process and are disseminated and available to all staff through the UNFPA intranet.²⁴⁸ As the main knowledge management intervention within UNFPA, the identification of good practices, whether via competition or annual reporting, has limitations. The established criteria to guide the peer review of good practices (relevance, innovation, sustainability, results-oriented and replicable) lack clear, rigorous parameters to guide the documentation process. Further, there is no standard to define the type or quality of documentation needed to objectively support the criteria, nor is there a requirement to link the UNFPA good practice to what is already known in the existing literature.

While the descriptions of UNFPA good practices highlight important work being implemented, the documentation tends to be on the level of activity and outputs. However, it rarely communicates information that might help others to generalise what makes the experience a good practice.²⁴⁹ Attention is not explicitly paid to how these should, or could, be replicable in similar or other contexts, and what are the cost and scale-up considerations. An example is the husband school in Niger (*UNFPA 2011c*). While a widely disseminated good practice by UNFPA, the information disseminated lacks critical information about how the practice should be promoted or applied in other contexts, especially given that the practice is not aligned with UNFPA values on gender equality because of its implicit acceptance of the primacy of male decision-making.²⁵⁰ In other contexts, this approach could lead to greater authoritarian control over women. It is thus important for UNFPA to identify carefully what works in what contexts but also why it works and the risks or assumptions that would be encountered in moving it to a different setting.

UNFPA does not systematically document the process and results for identified good practices in a manner that would stand up to scrutiny and qualify externally as a best practice.²⁵¹ Moreover, evidence generated by UNFPA on family planning results, lessons or good practices is generally used for donor reporting and communications; but is rarely

²⁴⁵ Assumption 7.2

²⁴⁶ Assumption 7.4, Volume II, Annex 1

²⁴⁷ Assumption 7.4

²⁴⁸ Assumption 7.4

²⁴⁹ Assumption 7.4

²⁵⁰ Assumption 7.4

²⁵¹ Assumption 7.4

published in peer review journals. There are some notable exceptions such as a recent article on what does not work in adolescent programming (*Chandra-Mouli, Lane et al. 2015*). This lack of dissemination through published literature limits the influence of UNFPA and the perceived reliability of the evidence it generates with external stakeholders.

Key informants consistently raised the issue that UNFPA results-orientation is weak, which hampers its effectiveness as a knowledge broker and arbiter of sound programming related to family planning (*Section 3.3.3*) and priority issues for family planning such as integration, a human right-based approach and gender. In Zimbabwe, implementing partners 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) to document outcomes.²⁵² The country office is hampered by a lack of capacity to undertake operations or implementation research, which affects the availability of data for analysis of results and evidence-based documentation of lessons learned to contribute to best practice discussions (*Jackson, Njovana et al. 2014*).

The lack of an explicit organisation-wide learning agenda to proactively organise efforts to identify lessons learned or generate evidence on key topics. This makes it difficult for UNFPA to identify what is working and what is not, across country programmes. Nor does it enable UNFPA to be strategic about investing scarce resources for studies or dissemination efforts. For example, in Burkina Faso, the country office routinely identified lessons learned on an annual basis, as part of its routine reporting requirements for its annual progress report. However, descriptions tend to be general, retrospective in nature, and lack data review and analysis. The country office also provides technical assistance to the Ministry of Health for an annual good practices meeting, but along the same lines. Staff would welcome technical assistance to strengthen documentation and dissemination efforts: however, the country office receives little feedback on the information they share from either the regional office or headquarters.

In spite of this, GPRCHS has demonstrated the important role a thematic fund can play in transferring knowledge and supporting innovation in country programmes. For example, in Burkina Faso, GPRHCS financial and technical assistance was a catalyst for the pilot introduction of Sayana Press®, an important innovation for injectable contraceptive service delivery that supports task-shifting to lower level cadres of health workers.²⁵³

Country offices support knowledge management in a variety of ways, and value the sharing of knowledge, although not systematically. In Bolivia, best practices for work with indigenous groups were identified, documented and implemented successfully by the country office in different departments. The country office has also taken advantage of its access to best practices from other countries, with support from the Latin American and Caribbean Regional Office (LACRO). The most effective learning method has been through visiting staff from LACRO who have shared experiences from elsewhere and discussed with country office staff how they can be adapted and applied in the Bolivian environment.²⁵⁴ As noted earlier (*Section 3.6.3*), in Cambodia, UNFPA has invested in generating evidence on family planning client needs and satisfaction by co-commissioning studies to use in strengthening programmes targeting young people and entertainment workers.²⁵⁵

²⁵² Assumption 7.4, see (Zimbabwe Country Note 2015: Section 4.7: 28)

²⁵³ See Assumption 7.4, Volume II, Annex 1, see (Burkina Faso Country Note 2015: Section 4.7: 33)

²⁵⁴ Assumption 7.4, see (Bolivia Country Note 2015: Section 4.7: 32)

²⁵⁵ Assumption 7.4, see (Cambodia Country Note 2015: Section 4.6: 35)

UNFPA is part of the high impact practices²⁵⁶ initiative, a partnership led by USAID, WHO, IPPF and UNFPA which engages over 20 international organisations working in family planning. UNFPA partnership in this effort is highly valued by key informants, as UNFPA supports field staff to attend meetings where evidence is presented and reviewed regarding potential high impact practices. UNFPA brings important and practical perspectives regarding programme implementation and field realities to the process of reviewing evidence briefs and how the practices might be relevant to programme practitioners and managers in the field.²⁵⁷ Therefore, even though UNFPA is not seen within this group as a significant contributor of primary source evidence, its understanding of country and programme contexts is critical to the evaluation of evidence that others generate.²⁵⁸

Given the strategic position of UNFPA as a key development partner for government ministries as well as its geographic reach, there is a great need and opportunity for UNFPA to strengthen the knowledge management mode of engagement so that it can effectively influence the quality of its programming and realise its potential as a “thought-leader” on important issues in sexual and reproductive health rights.

3.8 Family planning supply-side activities

EVALUATION QUESTION 8

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

- 8.1 Provider training supported by UNFPA is client-centred, quality-focused and promotes rights and freedom of choice in family planning.
- 8.2 UNFPA support to procurement promotes availability of a wider method-mix.
- 8.3 Strengthened procurement and logistics systems and related health system improvements are designed to be financially sustained by national governments.
- 8.4 At global level, UNFPA has developed an improved and efficient procurement system to deliver quality contraceptives to countries.
- 8.5 Headquarters provides appropriate support to country office level in capacity building.²⁵⁹

► Evaluation criteria covered: relevance; effectiveness; sustainability

Summary

Supply-side work in family planning led by GPRHCS, the flagship UNFPA family planning programme, has grown in importance. UNFPA has supported a wide range of supply-side training activities, including some activities aimed at improving cost-effectiveness and sustainability. However, training support has been fragmented and unrelated to human resource development strategies, with little attention to aspects of supervision, monitoring, or assessing the impact of training on user satisfaction.

²⁵⁶ A high impact practice (HIP) is defined as an effective service delivery or systems intervention that when scaled up and institutionalised, will maximise investments in a comprehensive family planning strategy. HIPs help focus resources for the greatest impact (HIP 2015).

²⁵⁷ Assumption 7.4

²⁵⁸ Assumption 7.4

²⁵⁹ See Theory of Change, Diagramme 8, Volume II, Annex 5

UNFPA has contributed to expanding the method-mix, including support for the introduction of more sensitive methods and has participated in interventions to reduce the costs of procurement at global and country levels. In addition, UNFPA has helped to expand the range of methods available in emergency and humanitarian situations through provision of emergency kits. That said, UNFPA has not fully explored the financial feasibility of maintaining a broad method-mix in low-income countries, problems of equity in access to a range of methods, or the impact on voluntary user choice when the method-mix is biased in favour of specific methods.

UNFPA has supported moves towards greater sustainability through promotion of reproductive health commodity security (RHCS), with governments, including advocacy for family planning budget allocations, technical support, supply-chain strengthening, and promotion of a total market approach involving the private and NGO sectors. To that extent, UNFPA has participated with other stakeholders in strengthening the global procurement system and developing methods to reduce the cost of contraceptive supplies, although its effectiveness has been limited by structural and organisational constraints.

3.8.1 Training for family planning service providers

UNFPA support for training in quality rights-focused service provision and in logistics systems for contraceptives complements its support to commodity provision.²⁶⁰ UNFPA has supported a wide range of training in all focus countries.²⁶¹ UNFPA has provided technical input and financial support for training, and has contracted specialist trainers and training agencies where appropriate. Training has covered technical aspects of family planning, counselling, gender related issues, service quality, community-based provision, procurement, supply chain management, logistics management information system (LMIS) and quality control of supplies.²⁶² Typically, trainings target the public sector while at the same time including NGOs (both as trainees and as specialist trainers) providing services for the public sector under contract to UNFPA.²⁶³ For example, in Bolivia, UNFPA contracted two large NGOs specialising in sexual and reproductive health to provide family planning training to the Ministry of Health,²⁶⁴ and in Tajikistan, the Family Planning Association provided basic reproductive health commodity security and supplies management training for primary health care managers. Where the political context is favourable, training supported by UNFPA promotes sexual and reproductive health rights and choice. Stakeholders agree that UNFPA has made an important contribution to all aspects of service provider training, as well as to strengthening the supply chain, yet they recognise that UNFPA capacity for training in contraceptive logistics and in clinical and counselling skills is limited.²⁶⁵

To increase sustainability, UNFPA has successfully promoted the inclusion of family planning and reproductive health commodity security in training for health professionals and university curricula in several countries. For example, family planning has been integrated in midwifery training in Cambodia and Bolivia.²⁶⁶ This firmly establishes family planning as an integral part of the work of health professionals. UNFPA has also promoted task-shifting of family planning to lower-level professionals in Ethiopia and Bolivia.²⁶⁷ Task-shifting is an important method to increase cost-efficiency and access, enabling a wide range of family planning services to be offered at primary health care level in urban and in remote rural

²⁶⁰ See Assumption 8.1, Volume II, Annex 1

²⁶¹ Assumption 8.1

²⁶² Assumption 8.1

²⁶³ Assumption 8.1, see (Bolivia Country Note 2015, Burkina Faso Country Note 2015, Zimbabwe Country Note 2015: Section 4.8)

²⁶⁴ Assumption 8.1

²⁶⁵ Assumption 8.1

²⁶⁶ See (Bolivia Country Note 2015, Cambodia Country Note 2015: Section 4.8)

²⁶⁷ See (Bolivia Country Note 2015, Ethiopia Country Note 2015: Section 4.8)

areas. In addition, task-shifting can make an important contribution to sustainability as it reduces the cost of service delivery, dramatically in some cases. UNFPA has supported training for staff who take on new family planning work as a result of task-shifting.²⁶⁸

Box 8: Task shifting and service provider training in Ethiopia

UNFPA has supported task-shifting in several countries, helping ministries of health to devolve family planning service provision tasks to staff with lower levels of qualification. This improves access for users and rationalises the use of scarce human resources. In Ethiopia, UNFPA has supported training for health extension workers (HEWs) in inserting implants. UNFPA has supported the government programme to make implants available in health posts, which are the lowest level primary health care facilities staffed by health extension workers. This gives women access to the method in their own community. Task-shifting is still a work-in-progress, as health extension workers have not yet been trained in the removal of implants: those who wish to have their implants removed must travel to the nearest health centre.

Source: Assumption 8.1; Ethiopia Country Note 2015: Section 4.8: 29-30

Training has also been closely linked to efforts to expand method-mix. In particular, UNFPA has taken the initiative to support training when new or underutilised family planning methods are introduced, to ensure that staff are able to administer new methods and provide counselling to users. In Cambodia and Bolivia, UNFPA support for introduction of the female condom has been accompanied by training of service providers in primary health care facilities to ensure they have the knowledge to promote the method. When methods have been introduced without sufficient service provider training, staff do not promote the methods to potential users. This results in caseloads falling and service providers missing out on practice which causes them to lose their skills, and subsequently methods fall into disuse. This has been the case with IUCDs in several countries including Burkina Faso and Zimbabwe.²⁶⁹

UNFPA has also supported sustainability of training through “training of trainers” (ToT) programmes in the public sector, and through capacity building of institutions and large NGOs focused on providing training to the public sector.²⁷⁰ UNFPA has been instrumental in brokering training arrangements between governments and the NGO sector. In particular, availability of funds for training through GPRHCS has enabled UNFPA to provide additional support.²⁷¹ However, while GPRHCS aims to include service quality and promotion of choice in training, there are political and cultural obstacles for training in family planning provision to specific groups in some countries. For example, in Ethiopia provision of family planning to unmarried people is included in Ministry of Health protocols, but there is opposition to provision at community level due to cultural norms. This, in turn, affects the ability of service providers to put training into practice.²⁷²

Although large numbers of service providers have been trained with support from UNFPA, there is no information available on how effective that training is in improving quality or user satisfaction, or on promoting a rights-based approach.²⁷³ Questions on user satisfaction are included in the new GPRHCS annual facility surveys, but no data is available for the period

²⁶⁸ Assumption 8.1

²⁶⁹ Assumption 8.1, see (Burkina Faso Country Note 2015, Zimbabwe Country Note 2015: Section 4.8)

²⁷⁰ Assumption 8.1

²⁷¹ Assumption 8.1

²⁷² See (Ethiopia Country Note 2015: Section 4.4: 21: 21)

²⁷³ Assumption 8.1

under evaluation.²⁷⁴ Training has been measured in terms of the number of people trained rather than its overall impact on service quality. In Burkina Faso, for example, UNFPA has supported the training of hundreds of health workers in a range of topics, including clinical family planning, community based distribution, logistics and procurement, behaviour-change communication and information, education and communication (BCC/IEC) and logistics management information system (LMIS), but there has been no assessment of its impact in improving service quality. Training often has to be repeated due to high staff turnover and poor incentives for staff to change or adapt following training. Also, training has been focused on service providers with little attention to supervision, monitoring of the use of skills acquired through training in the work environment, or assessing the impact of training.²⁷⁵

Service provider training is necessary but not sufficient to ensure quality services and promotion of choice. Post-training follow-up and supervision, together with quality monitoring are also needed, with provision for refresher training when necessary. Although training in supervision has been provided (i.e. in Ethiopia and Burkina Faso) there has been no assessment on the effectiveness or quality of supervision provided and whether or how it improved service outcomes.²⁷⁶ In fact, it appears that UNFPA has taken a fragmented approach to training rather than integrating its support into overall strategic plans for human resource development by country governments. Although training needs are country-specific, the lack of a robust, articulated UNFPA strategy for training and retaining field staff can undermine the effectiveness of training.²⁷⁷

3.8.2 Support for a wider method-mix

UNFPA has supported procurement, together with a range of related capacity building activities on the supply-side, aimed at expanding access to a choice of methods. Capacity building has included all aspects of supply chain strengthening (forecasting and planning, procurement, distribution, supplies management, information systems) as well as service provider training (discussed above). During the period under evaluation, countries in GPRHCS Stream 1 received the most support²⁷⁸ and showed improvement in the percentage of facilities with three or more family planning methods in the period 2008-2012.²⁷⁹ Availability of method-mix also broadened during the period under evaluation in all the case study countries included in this evaluation.²⁸⁰

UNFPA has played a leading role in the introduction of new and underutilised methods globally and at country level. At country level, it has procured a steadily increasing range of methods in the focus countries.²⁸¹ At global level, it has been a key player in the introduction and acceptance of Sayana Press®, emergency contraceptives, the female condom, and lower-priced implants.²⁸² UNFPA has also contributed to international efforts to reduce the cost of implants, which has, in turn, reduced costs at country level and facilitated inclusion of implants in the method-mix.

²⁷⁴ As the facility surveys cover the whole of each country where they are carried out, whilst it can be asserted that UNFPA contributes to any observed changes, it cannot be claimed that they are attributable to the UNFPA interventions.

²⁷⁵ See (Burkina Faso Country Note 2015: Section 4.8: 34)

²⁷⁶ Assumption 8.1, see (Burkina Faso Country Note 2015, Ethiopia Country Note 2015: Section 4.8)

²⁷⁷ Assumption 8.1

²⁷⁸ Assumption 8.2

²⁷⁹ As indicated in the GPRHCS-financed annual facility surveys

²⁸⁰ Assumption 8.2, see (Bolivia Country Note 2015, Burkina Faso Country Note 2015, Cambodia Country Note 2015, Ethiopia Country Note 2015, Zimbabwe Country Note 2015: Section 4.8)

²⁸¹ Assumption 8.2

²⁸² Assumption 8.2

At country level, UNFPA has encouraged governments to widen the method-mix using a number of related strategies. Work has included advocacy and policy support to governments to encourage introduction of new methods, some of which are controversial in specific country contexts. For example, emergency contraception (EC) is often rejected for political, cultural or religious reasons, and there may be opposition to making it available to young people. Promotion of female condoms also causes controversy in countries with low levels of women's empowerment.²⁸³ UNFPA has also taken the initiative in procurement of new methods to instigate proceedings. For example, in Bolivia, UNFPA donated emergency contraceptives, female condoms and implants to the government for inclusion in the national supply system.²⁸⁴

UNFPA has advocated for inclusion of family planning methods in essential medicine lists; an important step for ensuring they are integrated into national budgets. International stakeholders have also recognised the discreet leadership that UNFPA has played in getting Misoprostol on the essential medicines list in many countries, which has revolutionised access to safe abortion.²⁸⁵ In all the case study countries, stakeholders recognised the contribution of UNFPA to the expansion of the method-mix.²⁸⁶

Box 9: Expanding method-mix in a sustainable way in Bolivia

In Bolivia, UNFPA has made an important contribution to expanded method-mix through procurement of three methods previously unavailable in the country: female condoms, emergency contraceptives and implants. To enhance sustainability, the donated contraceptives have been used as seed capital to set up a ring-fenced, revolving fund within the national procurement and supply agency (CEASS). Municipal governments purchase the methods from CEASS to meet demand in health facilities, thus replenishing UNFPA. Although UNFPA has supported service provider training, more promotion is needed, as take-up of the new methods is still slow.

Source: (Bolivia Country Note 2015: Section 3: 11-12, Section 4.7: 32)

Although there is no internationally accepted definition for an acceptable method-mix, it is important to address this issue if the mix is skewed (such as in Zimbabwe where there is overwhelming use of pills, and in India where surgical sterilisation dominates the mix). The impact of a skewed method-mix on user voluntary choice has not been documented or debated. Some stakeholders consider that the method-mix is still poor, and that UNFPA has not paid sufficient attention to the financial feasibility of a broad method-mix. In poorer countries where the government has resource limitations, provision of a broad mix in some geographical areas may mean that insufficient funds are left to cover even a basic mix in other areas. UNFPA has explored this issue in some countries through cost-effectiveness studies, which provide an evidence base for dialogue with government (for example, in Ethiopia).²⁸⁷

Even in countries where there is a wide range of methods available, they are not always accessible to everyone, and take-up may be slow. Reasons include lack of promotion and service provider training, government protocols which limit provision of methods by lower level health workers, lack of facilities and infrastructure for long-acting and permanent methods (IUCD, tubal ligation), service provider bias, and political or cultural barriers (i.e. Bolivia where take-up has been low due to lack of promotion).²⁸⁸ Service provider bias limits

²⁸³ Assumption 8.2

²⁸⁴ Assumption 8.2, see (Bolivia Country Note 2015: Section 3: 12)

²⁸⁵ Assumption 8.2

²⁸⁶ Assumption 8.2, see (Bolivia Country Note 2015, Burkina Faso Country Note 2015, Cambodia Country Note 2015, Ethiopia Country Note 2015, Zimbabwe Country Note 2015: Section 4.8)

²⁸⁷ Assumption 8.2, see (Ethiopia Country Note 2015: Section 4.8: 29)

²⁸⁸ See (Bolivia Country Note 2015: Section 4.8: 45)

promotion of certain methods or provision to specific groups; it can also reduce take-up of specific methods and inhibit client-empowered choice. For example, availability and acceptance of vasectomy is still low in the large majority of countries due to cultural obstacles, lack of service provider skills and inadequate promotion to potential users.

UNFPA has worked to reduce barriers to new methods. It has done this through advocacy (e.g. emergency contraception promotion in Bolivia), strengthening distribution systems, service provider training, support for education and promotion and demonstration projects through NGOs. An example of this is the Marie Stopes International (MSI) and the national International Planned Parenthood Federation (IPPF) affiliate, which ran outreach campaigns with mobile clinical services which successfully increased the take-up of IUCDs in Burkina Faso.²⁸⁹ Service provider training in technical aspects and counselling is a key element, as service providers are responsible for “point of sale” promotion to users. At the global level, the UNFPA role in meeting the implant volume guarantee, and the Sayana Press initiative shows commitment to improving method-mix. This combination of strategies has led to a broader method-mix in many countries.

UNFPA has also supported work addressing the social and cultural determinants of choice, to reduce political and cultural barriers (e.g. family planning for young unmarried people and in cultures with high respect for fertility, where UNFPA has supported promotion of family planning for birth spacing). It supports work to empower women to make their own choices in family planning and sexual and reproductive health, working with government and non-government sectors (Bolivia). In respect for those who choose natural methods, UNFPA also procures the Cyclebeads used in the “standard days method.”

Finally, UNFPA has also helped to expand the range of methods available in emergency and humanitarian situations through provision of emergency kits. In the early kits, methods offered were male and female condoms and emergency contraceptives. These methods are appropriate for post-conflict support where sexual violence is frequent. Decisions on the contents of emergency kits are now taken by country offices, but in non-conflict humanitarian situations more injectables and hormonal methods are now included, to cater to women who were using these methods prior to the emergency.²⁹⁰

3.8.3 Financial sustainability of logistics and procurement systems strengthening

Sustainability is a key objective of GPRHCS, which aimed to move UNFPA away from its former role of *ad hoc* procurement to fill family planning supply gaps towards planned and sustainable country-driven approaches. UNFPA has employed a set of complementary strategies to ensure sustainability. One strategy focuses on advocacy and providing technical support for development of national reproductive health commodity security policies. UNFPA has worked with other large donors (DFID, USAID, the Netherlands, the Nordic countries) to support governments in policy development (Burkina Faso).²⁹¹ This is a first step towards government commitment and sustainability.

UNFPA has also carried out advocacy with governments to institutionalise budgeting for family planning commodities and to ensure the money is actually spent on contraceptives. This has included advocacy with ministries of health, often in coordination with other large donors, and support for the ministries of health in budget negotiations with national finance ministries responsible for resource allocation decisions (Cambodia, Bolivia, Ethiopia). Advocacy messages have focused on the future benefits and cost savings which countries

²⁸⁹ Assumption 8.2, see (Bolivia Country Note 2015: Section 4.8, Burkina Faso Country Note 2015: Section 4.8)

²⁹⁰ Assumption 8.2

²⁹¹ Assumption 8.3, see (Burkina Faso Country Note 2015: Section 4.3: 21)

will enjoy due to better overall sexual and reproductive health, which will more than offset any additional short-term costs from increased spending on family planning.²⁹²

Another strategy of UNFPA has been to increase domestic financing for family planning commodities. A rational method-mix is needed to ensure that commodity supply is within countries' capacity to pay, and that government can continue to finance the mix in the medium to long term.²⁹³ UNFPA advocacy with ministries of planning, population and development has added more support to negotiations with ministries of finance (Ethiopia, Bolivia).²⁹⁴ Multi-year guaranteed donor support, such as that provided by GPRHCS, enables governments to develop national systems and institutionalise national budgetary support. Inclusion of reproductive health commodity security in joint funding mechanisms, such as sector wide approaches and basket funds, helps stimulate national commitment and budget allocations.²⁹⁵ According to respondents to the country office internet survey, government budgets for family planning have increased in two-thirds of the 69 focus countries, and UNFPA has contributed to this change.²⁹⁶

UNFPA has supported governments in developing different types of national budgetary support. In Nicaragua and Cambodia, the central ministries of health have included a specific line in the national budget for family planning. In Bolivia, the government has included family planning in the national health insurance scheme, which supplies free contraceptives to users.²⁹⁷

A cornerstone of the UNFPA strategy to encourage governments to fulfil their commitments includes regional advocacy and peer pressure from other regional governments (*DFID 2013a*). This pressure is applied as low-income countries often have difficulties in reserving the funds for family planning when more immediate and acute needs arise (e.g. response to natural disasters, epidemics). UNFPA has also developed some effective methods of ring-fencing funds, such as a revolving contraceptives fund in Bolivia, which used a UNFPA donation as seed capital.²⁹⁸ To ensure that supply is within the capacity of countries to pay and sustain,²⁹⁹ UNFPA has worked to reduce the cost of supplies at the global level and hence reduce procurement costs for governments. UNFPA has also worked with the Guttmacher Institute (U.S.A.), and other research organisations, to identify the cost-effectiveness of different methods, and has disseminated the information to country governments as part of advocacy efforts.³⁰⁰

Yet another UNFPA strategy focuses on capacity building in the supply chain (planning and forecasting, procurement, information systems, distribution, monitoring and stock control) and this has led to higher efficiency and cost savings (*DFID 2013a*). UNFPA has worked to strengthen national family planning commodity procurement and logistics systems in almost all focus countries; a contribution recognised by country stakeholders.³⁰¹ Mechanisms for support have included secondment of staff to key positions in the national supply chain, promotion and technical support for forecasting and planning systems involving public, NGO and private sectors, training in procurement, and introduction of information systems for

²⁹² Assumption 8.3, see (Bolivia Country Note 2015, Cambodia Country Note 2015, Ethiopia Country Note 2015: Section 4.8)

²⁹³ Assumption 8.3

²⁹⁴ See (Bolivia Country Note 2015, Ethiopia Country Note 2015: Section 4.8)

²⁹⁵ Assumption 8.3

²⁹⁶ Assumption 8.3, see Table 7 (results from country office internet survey)Annex 6

²⁹⁷ See (Bolivia Country Note 2015: Section 4.7: 32)

²⁹⁸ Assumption 8.3, see (Bolivia Country Note 2015: Section 3: 11-12)

²⁹⁹ Assumption 8.3

³⁰⁰ Assumption 8.3

³⁰¹ Assumption 8.3

supplies management and stock control. Many countries now carry out their own procurement and some can generate sufficient margins to ensure sustainability of the procurement agency.³⁰² Overall, approximately one-third of GPRHCS funding has been spent on capacity building to increase sustainability.³⁰³ In extraordinary situations, UNFPA has stepped in to assist with procurement.³⁰⁴

Finally, UNFPA has carried out advocacy and training for a total market approach (TMA) involving the public, private and NGO sectors. A total market approach increases efficiency and reduces overlaps (*Solo 2011*). Coordination of supply and unified procurement both lower costs. UNFPA has supported work on a total market approach in Tajikistan and the Eastern Europe and Central Asia Region (EECAR), and has carried out capacity building for future total market approach work.³⁰⁵

Overall, key informants consider that UNFPA has been a lead player in FP2020 in achieving country commitments to family planning. It has done this by using its comparative advantages of its network of country offices in all focus countries, its closeness to government, and its links with other in-country stakeholders. It has also been instrumental in promoting the inclusion of family planning in national health insurance schemes (Bolivia).³⁰⁶ Positive results in reduction of stock-outs identified in GPRHCS annual facility surveys are, in part, attributable to the impact of UNFPA strategies and efforts towards sustainability at country level,³⁰⁷ while impact on country budget allocations will be more visible in future when FP2020 financial systems identify national spending on family planning.

3.8.4 Improved procurement systems at global level

UNFPA has worked in partnership with other leading stakeholders in family planning to establish and develop major initiatives, aimed at increasing the efficiency of procurement and reducing procurement costs through collaboration and bulk procurement. The principal initiatives have been the Reproductive Health Supplies Coalition (RHSC), AccessRH,³⁰⁸ the RHInterchange³⁰⁹ and the Pledge Guarantee for Health partnership³¹⁰

Since 2011, UNFPA has procured contraceptives at prices below median international benchmarks (*DFID 2013b*).³¹¹ Through AccessRH, lead times for supply have been substantially reduced. For example, in 2011, the lead time for male condom delivery was reduced by three months, and the large majority (93 per cent) of clients were satisfied with the price. On the other hand, the UNFPA average procurement cost per couple years of protection (CYP) rose between 2011 and 2012 (from US\$2.70 to US\$3.04); however the rise was attributed to inclusion of a larger proportion of expensive implants in the method-mix. UNFPA has been an active participant (together with other stakeholders) in negotiations with manufacturers to lower implant prices. Working in coordination with other

³⁰² Assumption 8.3

³⁰³ Assumption 8.3

³⁰⁴ Assumption 8.3. Also see UNFPA Office of Audit and Investigation Services (2016). Audit of the Governance and Strategic Management of UNFPA Supplies. The report notes that a “UNFPA Supplies Sustainability Strategy” was under development at the time of field audit work. See: <http://www.unfpa.org/internal-audit-reports-listing-page>

³⁰⁵ Assumption 8.3

³⁰⁶ See (Bolivia Country Note 2015: Section 4.7: 32)

³⁰⁷ Assumption 8.3

³⁰⁸ AccessRH is a procurement and information system that was developed by the RHSC and is now managed by UNFPA.

³⁰⁹ The RHInterchange (RHI) is an online tool for sharing information on contraceptive orders and shipments.

³¹⁰ The Pledge Guarantee for Health partnership 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.

³¹¹ UNFPA and USAID price listing 2010 and 2011 (MSH 2015)

stakeholders, UNFPA contributed to a reduction of the implant price by 50 per cent in 2012. The average cost per couple years of protection (CYP) of UNFPA procurement is expected to drop to US\$2.37 by 2020.³¹²

There have been some structural and organisational limitations to UNFPA participation in the above initiatives. UNFPA is unable to participate in pledging guarantees because it is not permitted to take out credit. While, at the same time, UNFPA has not been willing to support an alternative mechanism to facilitate procurement by large NGOs, by enabling them to access credit on the basis of donor support pledged to UNFPA.³¹³ Key informants consider that UNFPA is slow-moving and bureaucratic, and has failed to respond quickly to changing needs in its administration and development of the web-based AccessRH and RHInterchange sites. Users assert that the RHInterchange site requires updating in both structure and content. Although UNFPA procurement branch is aware of these needs, UNFPA has not provided the support needed to carry out the improvements.

UNFPA has been active in development of the new Coordinated Supply Planning Group of Reproductive Health Supplies Coalition (RHSC), which is the counterpart of the Coordinated Assistance for Reproductive Health Supplies (CARhs) group, the fire-fighting fund available to cover contraceptive shortfalls in countries. Working with the Coordinated Supply Planning Group, UNFPA has played an important role in increasing efficiency of forecasting and avoiding duplication. UNFPA work has focused on injectables and implants to date but will expand to other methods in the future.

3.9 Support to country offices from UNFPA headquarters and regional offices

Summary

UNFPA Headquarters provides technical guidance to country programmes in family planning through the development of global frameworks, strategies and guidance documents, and regional offices have the mandate to broker and implement technical guidance. However, in practice they have different capacities and their effectiveness varies across regions and technical areas. This contributes to a disconnect between the development of strategies and guidelines at the global level, and their implementation at the country level.

Technical guidance on family planning is more effectively disseminated when there is dedicated, thematic funding as in the case of GPRHCS, to back a variety of supportive mechanisms, such as meetings, action planning workshops and technical assistance. Headquarters and regional offices have limited input in assisting country offices to adapt technical guidance, identify changing needs in family planning and contribute substantively so that country programme design is adequately aligned with the latest technical guidance and important principles. This disconnect presents a critical challenge in family planning for addressing areas such as operationalising a rights-based approach and improving quality of care in contraceptive service delivery.

The support provided by headquarters and regional offices to country offices has been analysed as a cross-cutting issue for all eight areas of investigation, with the analysis broken into two principal areas:

- I. Technical guidance for family planning from headquarters and regional offices and its implementation at country level:
 - Different support roles of headquarters and regional offices

³¹² (DFID 2013b, UNFPA 2013b, UNFPA 2014d)

³¹³ Assumption 8.4

- Capacity building in family planning for country offices and implementing partners
- II. Support from headquarters and regional offices in identification of needs for different approaches to family planning at country level and changes over time.

3.9.1 Technical guidance and support for family planning including capacity building

UNFPA headquarters provides support for family planning at a strategic level. It does this through the development of global frameworks, strategies and technical guidance documents, and through advocacy at international and regional levels. In general, the number of headquarters staff in Technical Division is too small to provide technical assistance and guidance for family planning directly with country offices and there are limited financial resources from core funding for technical support. The exception is the thematic funds (GPRHCS, Maternal Health Thematic Fund, etc.), which provide headquarters with resources to interact directly with country offices.³¹⁴

Support from regional offices (ROs), on the other hand, is more focused on the programmatic aspects of implementation (*Section 3.9.2*). However, regional offices also assist country offices in adaption of global strategies to different country contexts and provide technical assistance and capacity building. The regional offices provide family planning support to country offices through focal points in GPRHCS and in other areas relevant for family planning, including sexual and reproductive health, gender and humanitarian assistance.³¹⁵ However, the tendency for headquarters, regional offices and country office staff to work in technical silos limits the extent to which guidance on family planning is integrated with other technical areas (*Section 3.1.1*).

At the regional level, the decentralisation process at UNFPA that occurred during the period under evaluation (2008-2013), resulted in a redefinition of roles and responsibilities for the provision of technical support to country office programmes. Prior to 2011, technical support was the responsibility of country support teams (CST) with direct connections to headquarters technical staff. The country support teams were merged into regional offices so that the latter could provide integrated programmatic, operational and technical support to country offices.³¹⁶

Technical support needs are planned annually by country offices and their regional offices, and needs are met through a combination of input from regional office technical staff and consultants. Larger country offices generally require less support from the regional office, as they have greater technical capacity of their own. The result of the reorganisation of technical support was found to be mixed. The Bolivia country office considers that it has constant and high quality technical support from the Latin American and Caribbean regional office.³¹⁷ In Cambodia, technical support needs are met by the Asia and the Pacific regional office (APRO), even although support is not necessarily frequent.³¹⁸ However, on specific topics, country key informants indicated their technical needs are not sufficiently met through the current structure. Some preferred the previous structure of country support teams in headquarters, which allowed for greater access to broader perspectives and international-level expertise.³¹⁹

³¹⁴ Section 3 of this report (financial section) compares family planning spending from core and non-core funds.

³¹⁵ The presence of focal points for different FP-related areas of work depends on the size of the regional office and its priority work areas. Regional offices have focal points in some or all of the areas listed above.

³¹⁶ See Assumption 1.2, 6.4, Volume II, Annex 1

³¹⁷ Assumption 7.1, see (Bolivia Country Note 2015: Section 4.9: 32-36)

³¹⁸ Assumption 7.1, see (Cambodia Country Note 2015: Section 4.9: 41)

³¹⁹ Assumptions 1.2 and 6.4

Documents and tools alone are not enough to provide the support needed for implementation of family planning interventions at country level.³²⁰ Regional office support for family planning includes technical assistance visits to country offices, training workshops at country and regional levels, regional meetings for planning, monitoring and evaluation, experience sharing, dissemination of best practices and introduction of new techniques and methods such as the total market approach.³²¹ Additional on-the-ground support to country offices from the regional office is essential, and more resources are needed for technical assistance and input both from regional office and directly from headquarters. Country offices consider that personal visits by regional office experts are one of the best ways to adapt methods and tools to specific country contexts.³²²

Regional office interventions with decision-makers at country and at regional level (through the regional political organisations and high-level meetings) have also generated important political support and high level regional meetings facilitate peer pressure from leaders across national boundaries to advance family planning.³²³ GPRHCS activities have had the highest profile at regional level, and have provided practical input to country programmes as well as sharing of best practices within the regions. However, while headquarters and regional office support is appreciated, headquarter contact with country offices is not systematic and regional offices have varying levels of capacity, with some unable to cover all the country office technical needs.

Experience-sharing and dissemination of best practices can provide important technical guidance to country programmes (as well as to other partners and stakeholders), but has not been fully exploited within UNFPA (*Section 3.7.3*). GPRHCS has emphasised experience-sharing in its annual regional planning meetings, where participating country offices look for ways to apply best practices in their country programmes. The Asia Pacific regional office has started an eBulletin for sharing experiences on a monthly basis; the eBulletin is well received by country offices in the region.³²⁴ Some key experiences have been disseminated through UNFPA websites, but country offices do not frequently pick up and apply information from the web.³²⁵ Moreover, the information provided does not give the guidance needed for users to adapt or replicate the practice (*Section 3.7.3*). Key informants at the global and country level indicated that country representatives, and other UNFPA team members, share experiences with their counterparts in other country offices on an informal, rather than a systematic, basis.

Technical guidance varies across technical areas, with its dissemination and use depending largely on the existence of a champion, or thematic fund, as a focal point to catalyse action. During the period under evaluation, country offices have requested, received and put into practice technical support from headquarters and regional offices in a wide range of family planning areas.³²⁶ These include service delivery, needs identification, promotion of demand and access to services, and commodity security.³²⁷ Yet, the level of support from headquarters and regional offices to family planning programmes at country level has been limited, with the main source of support being GPRHCS.

With regard to integration of sexual and reproductive health with HIV and AIDS programmes, headquarter staff were key in developing a wealth of technical guidance

³²⁰ Assumptions 1.2, 6.4

³²¹ Assumptions 1.2, 6.4

³²² Assumptions 1.2, 6.4

³²³ Assumptions 1.2, 6.4

³²⁴ Assumptions 1.2, 6.4

³²⁵ Assumptions 1.2, 6.4

³²⁶ Assumption 7.1

³²⁷ Assumptions 1.2, 6.4. Online survey results, Volume II, Annex 11

documents and in catalysing action. UNFPA collaborated with several partners, including the IPPF, WHO, and Young Positives to develop the *Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages: A Generic Guide*. 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. The tool was rolled out extensively to UNFPA country offices, especially in the Africa region,³²⁸ and the assessment tool was implemented in 23 countries. However, there is little evidence to support the notion that country offices were provided with follow-up technical guidance on how to use the results (*Section 3.1.1*). In Zimbabwe, the results served as the basis to advocate for the *Integrated Support Programme* (*Section 3.1.2*), while in Burkina Faso there appeared to be no direct programme follow-up and use of the information gleaned from the linkages assessment.³²⁹

As already noted, UNFPA has provided global leadership in defining a human rights-based approach (HRBA). There are several documents that provide guidance, including a manual on the human rights-based approach programming and the new implementation guide for ensuring human rights within contraceptive service delivery (*Section 3.6.1*). Because of the aforementioned supply-side orientation of family planning assistance from GPRHCS, UNFPA has not progressed as far on human rights-based approaches as it has for sexual and reproductive health-HIV Linkages. However, there are recent moves to remedy this situation, through collaboration between the Commodity Security and Gender, Human Rights and Culture Branches to rollout the new WHO guidance on ensuring rights within contraceptive service delivery to several programmes in Africa.³³⁰

Commodity security is the most frequent area of technical support from both headquarters and regional offices. This support has been planned, funded and managed by GPRHCS and has included a strong emphasis on capacity building. The support has incorporated workshops and training on procurement, planning and forecasting for reproductive health commodity security and facility surveys to monitor progress. It has also included many aspects of supply-chain strengthening, as well as the set-up and strengthening of logistics management information systems (LMISs) and their use. Country offices indicated that they received more support than specifically requested in most areas (this may include technical guidelines and policies which are passed down to all country offices) and that the support was put into practice.³³¹ The evaluators did not identify specific technical support on contraceptive methods from headquarters during the period under evaluation except in the case of the introduction of the new injectable technology, Sayana Press®, in Burkina Faso.³³²

The level of regional office activity in capacity building for family planning is variable, with stronger input from the regional offices of Eastern Europe, Asia and the Pacific, Latin America and the Caribbean to introduce new strategies and models for working in family planning. EECARO for example, has carried out research, preparatory work, development of tools and capacity building in a total market approach to family planning, which has been successfully implemented in all countries in the region.³³³ APRO identified quality of care as an important issue in many countries of the region, often constituting a more challenging obstacle than physical access to services. In response, APRO organised regional training sessions on service quality and counselling in the period 2010-2012. Seven countries in the

³²⁸ Assumption 1.2

³²⁹ See (Burkina Faso Country Note 2015: Section 4.1: 19-20, Zimbabwe Country Note 2015: Section 4.1: 14)

³³⁰ Assumptions 6.4

³³¹ Assumptions 1.2, 6.4

³³² See (Burkina Faso Country Note 2015: Section 4.8: 34)

³³³ Assumptions 1.2, 6.4

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.³³⁴

Technical guidance documents and tools developed at the global level are not always applicable in specific country contexts and often have to be adapted. While GPRHCS regional meetings organised by the headquarter team have served as an important means for sharing family planning experiences, there has been some, but not sufficient, support in adapting that guidance to country contexts.³³⁵ In Ethiopia for example, human rights remain at the level of rhetoric and general principles, but not as an operational programmatic approach. With the challenges that arise from a strong quantitative orientation in the family planning programme, there is an important missed opportunity for headquarters or regional offices to bring in a broader perspective and lessons learned from other country experiences to support a human rights-based approach in similar or comparable contexts.³³⁶ As noted, the lack of an explicit organisation-wide learning or knowledge management agenda does not allow UNFPA to “connect dots” between countries with needs and issues of importance (*Section 3.7.3*).

3.9.2 Identification of needs for different approaches to family planning and programming changes over time

UNFPA Headquarters carries out extensive advocacy at the international level to promote policy and programme change in response to changing needs. Much of this work is done at international events and conferences such as the London Summit on Family Planning, FP2020 meetings and the ICPD Beyond 2014 regional conferences. Headquarters has also been an active participant in FP2020 working groups, liaising with country offices to obtain country commitments to the FP2020 programme. Key informants indicated that UNFPA has been the most effective FP2020 partner for obtaining country commitments, due to the links between its international work at headquarter level and its network of country offices at country level in all the FP2020 focus countries (*Section 3.3.1*). Regional offices have also provided support at country and regional levels to advocate for government response to changing needs. For example, the Latin America and Caribbean regional office has a system for environmental scanning to identify and advise country offices and development partners about changes in country contexts.³³⁷ However, it is the country offices that are most aware and best placed to identify where they need to adapt their approach (*Section 3.7.1*).

An important opportunity for headquarters and regional offices to provide strategic direction in family planning arises during the development of new country programmes (CPs). These determine the overall framework of UNFPA support to each country for a period of five years. Country programmes are developed in consultation between UNFPA and national governments and are agreed by both parties. Regional offices and headquarters have little input to country programme development; their main role (through the programme review committee) is to review and ensure the quality of the country programme. However, their input is limited and the opportunity for overview and guidance is not fully exploited.³³⁸ Interviews with key informants indicated that involvement earlier in the process would enable headquarters to have a more substantive input on content in family planning and related areas.³³⁹

³³⁴ Assumption 8.5

³³⁵ Assumptions 1.2, 6.4

³³⁶ See (Ethiopia Country Note 2015: Section 4.6: 25-26)

³³⁷ Assumption 7.1

³³⁸ see Assumption 7.1, Volume II, Annex 1

³³⁹ Assumptions 1.2, 6.4

UNFPA is fully aware of the need to strengthen support to the country offices,³⁴⁰ and in 2012, initiated a field support initiative to facilitate and improve communications and flow of support between headquarters, regional offices and country offices, and to integrate elements of technical and programmatic support to the country offices.³⁴¹ An inter-divisional working group, led by Programme Division, was set up to strengthen field support to the country offices. The initiative includes support for all aspects of UNFPA work in the field, including family planning. The initiative aims to provide an integrated service desk, established in 2013, to country offices and facilitate the coordination of inputs from relevant divisions at headquarter level. The impact of the new initiative was not observed during the evaluation; there was no substantive mention of results or actions taken by the working group and key informants noted continued difficulties with coordination related to country programmes.

4 CONCLUSIONS

Family planning is one of several components within an integrated sexual and reproductive health and rights (SRHR) framework. Programming to advance sexual and reproductive health and rights, or any one component or service such as family planning (FP), requires a holistic strategy or approach that addresses the multifaceted determinants of access and use at the policy, service system and community levels. Programming of this nature is a complex undertaking; no one organisation can achieve progress on its own, particularly if managing limited resources across a large number of countries. To advance family planning services requires a more shared vision of how the organisation can contribute strategically, based on a specific comparative advantage. Moreover, there must be a shared understanding among staff of the rationale for ensuring that family planning is given adequate attention within an integrated sexual and reproductive health rights framework.

UNFPA has experienced some difficulty navigating across these complex issues related to its support for family planning. However, this evaluation concluded that UNFPA has made significant progress to reinvigorate its own commitment and strengthen its attention to advance family planning, resulting in important gains in certain areas.

UNFPA has effectively leveraged its country presence and close relationships with national governments to successfully raise the profile of family planning globally and at country level, while consistently supporting national ownership and government leadership in coordination (Conclusions 1 and 2). In particular, UNFPA advocacy has resulted in renewed national commitment to family planning, leading to stronger government commitments to resource allocation and a strengthened and improved policy environment for family planning (Conclusion 4). In addition, UNFPA has supported national governments to increase the emphasis on investment assigned to reproductive health commodity security and helped to strengthen the management of contraceptive supply chains (Conclusion 8).

UNFPA is a well-known advocate for the ICPD agenda, calling for universal access to sexual and reproductive health and rights. At the global level, UNFPA has exercised an important leadership role as an advocate for integrating family planning into broader sexual and reproductive health services, adopting a human rights-based approach and committing to reaching vulnerable and marginalised groups. As yet there is a critical gap between UNFPA commitments and the extent to which it has been effective at operationalising and documenting within its programmes of support (Conclusions 3, 5 and 6). In particular, integration is hampered by inadequate staff collaboration across technical silos and by unresolved tensions about how to promote family planning as a priority within an integrated sexual and reproductive health rights framework.

³⁴⁰ Assumptions 1.2 and 6.4

³⁴¹ Assumptions 1.2 and 6.4

UNFPA country offices have a solid understanding of the political, cultural and programmatic contexts within which they work. Despite this, they have had mixed success in leveraging their comparative advantage as the main provider of technical advice for sexual and reproductive health rights and as a standard bearer for ICPD. Reasons for this include challenges relating to the varying capacities of country and regional offices to:

- Broker politically sensitive issues (for example on human rights vulnerabilities)
- Support appropriate modes of engagement, especially related to capacity building of health systems
- Support scale up of demand and service delivery.

In addition, UNFPA is hampered by the absence of an organisational learning agenda and gaps in capacity to effectively document results (Conclusion 6).

Although the 2008-2013 evaluation covers a period that ended more than two years ago, the findings are relevant. Many of the issues identified were not unique to the family planning evaluation, nor were they considered “new,” as they had been raised in prior country or thematic evaluations. Such issues include:

- Managing across silos
- Vertical vs. integrated approaches for family planning
- Capacity to advocate on politically sensitive issues related to rights and vulnerable and marginalised groups
- knowledge management.

There is a need for UNFPA to go beyond the technical or programmatic realm of guidelines and provide clear expectations and pathways for operationalising guidelines while ensuring that staff have the capacity to implement them and are held accountable for doing so. Looking ahead, there are important opportunities for addressing the evaluation conclusions and recommendations as strategic planning gets underway for the next period.

The evaluation conclusions presented in this section have implications for the theory of change which underpins UNFPA support to family planning. Some of the pathways from UNFPA support to higher level results as identified in the theory of change³⁴² have been shown to be effective channels from support to results at outcome levels. Others have encountered challenges which need to be addressed in order to strengthen the underlying theory of how UNFPA support contributes to a robust chain of effects leading to meaningful outcomes in family planning. For example, the pathway from UNFPA advocacy and policy engagement to integration of family planning services with other services in sexual and reproductive health has been shown to be robust, with assumptions validated and linkages verified from UNFPA support to changes in national policies and health service guidelines on integrated service delivery. It has further been validated at service delivery level for some sub-sets of sexual and reproductive health rights services, including HIV and AIDS programming and provision of sexual and reproductive health services in humanitarian settings.

However, the link from UNFPA policy engagement to integration of family planning and sexual and reproductive health at service delivery level remains weak (Conclusions 1 and 3) and requires reinforcement by other pathways to integration in the theory of change. In particular, the pathway from UNFPA support to capacity development and training to improvements in the quality and accessibility of family planning services (including integration) faces challenges (Conclusions 4 and 7). The limitations in human resource planning and management would need to be addressed for UNFPA support to training in family planning to contribute effectively to service improvement.

³⁴² See Volume II, Annex 5: Theory of change.

CONCLUSION 1: RAISING THE PROFILE OF FAMILY PLANNING

UNFPA, in common with many national and international partners, has re-emphasised family planning and has contributed to the global consensus which returned family planning to its rightful place among the priorities of the ICPD Programme of Action. UNFPA responded to donor and partner advocacy to raise the profile of family planning internally and externally (globally and within partner countries). It has contributed directly through its own programming, and indirectly through advocacy, to securing increased financial resources for family planning. The advent of GPRHCS contributed significantly to raising the profile of family planning within UNFPA and helped to alert and convince partners of the recommitment of UNFPA to family planning.

► Origin: EQ 2, EQ 3, EQ 4

The effective engagement of UNFPA at the international level to reposition efforts for family planning has been strongly supported by development partners and key stakeholders. This support, and the advocacy efforts of UNFPA, have combined to make a tangible contribution to increasing financial resources allocated to family planning. The growing strength of GPRHCS as a UNFPA flagship programme and continued engagement with FP2020 have combined to strengthen UNFPA credibility in advocating for re-prioritising family planning at international and national levels. It also provides evidence of the internal repositioning of family planning.

However, while UNFPA has made family planning a priority during the period under evaluation and developed a new strategy (“*Choices not Chance*”), it has had limited success in integrating and aligning family planning activities across the organisation to achieve results at scale. In part, this is related to the incomplete integration of family planning within other sexual and reproductive health activities (Conclusion 3). UNFPA also lacked a mechanism to guide the relative inputs of different divisions such as the Commodity Security Branch (which manages GPRHCS/Supplies) and the Sexual and Reproductive Health Branch (both branches are part of the Technical Division). As a result, country offices lacked consistent guidance on the importance of addressing family planning in their programmes.

CONCLUSION 2: COORDINATION AND BROKERING

UNFPA has played an important role in coordinating action in family planning at both the international and country levels while consistently supporting national ownership and government leadership of coordination structures and processes. In doing so, UNFPA has relied on its comparative advantages of a close relationship with national governments and network to a wide range of stakeholders. By leveraging its country presence, UNFPA has also worked effectively to broker joint activities between government agencies, development partners and, to some extent, NGOs. However, UNFPA has found it difficult in some contexts to achieve a balance between being a privileged partner of government and meeting stakeholder expectations specifically in relation to advocacy for more space for civil society organisations and NGOs in family planning and in working to increase transparency and accountability for results.

► Origin: EQ 2, EQ 3, EQ 4

At international level, UNFPA engagement in the FP2020 process provides an important example of support to coordinate action on family planning at a global level. More recently, UNFPA has contributed to the long and ultimately successful process of brokering agreements for inclusion of family planning in the Sustainable Development Goals (SDGs). At country level, UNFPA has used its comparative advantage and close relationships with

national governments to advocate for ownership and leadership of family planning, in coordination with other stakeholders, and to broker joint activities between different government agencies, development partners and NGOs. It has also been successful in linking global and national initiatives in family planning by working to obtain country commitments to FP2020, a key indicator of national ownership.

At country level, there is an inevitable tension between the close technical, policy and programmatic relationship between UNFPA and national governments and the ability of UNFPA to act as a vocal advocate. In this capacity, UNFPA works with development partners and civil society to ensure that governments are held to account for results in family planning. This tension also applies to the UNFPA role in helping to ensure that national and sub-national government authorities do not maintain or introduce elements of coercion into family planning programming.

UNFPA is agile and effective in managing this tension in some countries (Cambodia) but less so in others. For example, while it has worked to engage civil society in family planning initiatives, it has sometimes been cautious in promoting and brokering partnerships between NGOs and governments on sensitive issues. Finally, UNFPA has not yet fully exploited important opportunities to involve civil society and the private sector in the development of a total market approach for family planning and would benefit from donor backing in-country on these types of issues.

CONCLUSION 3: INTEGRATION OF FAMILY PLANNING AND SEXUAL AND REPRODUCTIVE HEALTH

UNFPA has had mixed success in promoting and supporting the integration of family planning with other sexual and reproductive health services, with more notable achievement of results at the level of national policies and plans. UNFPA has provided effective leadership and guidance to the operational integration of family planning services with HIV and AIDS prevention and treatment and in humanitarian responses. However, together with its partners, UNFPA has had more limited progress integrating family planning into other aspects of sexual and reproductive health at the level of service delivery.

► Origin: EQ 1

UNFPA support to integration “upstream” at the level of national health plans and strategies has been effective and it is evident that UNFPA and the vast majority of its national partners are committed to a policy of integration. The effect of this policy commitment is, however, not as evident at the level of service delivery. There remain significant gaps in the integration of family planning within sexual and reproductive health services such as maternal health services and attention to sexual and reproductive health. Family planning is also often overlooked when services are provided to address other sexual and reproductive health issues, such as gender based violence (GBV).

In part, the gap between national commitment to integration and the results at an operational level can be attributed to problems generally encountered when national strategies and operating guidelines confront the realities of service provision in the field (problems in staffing, training, supply, materials etc.). However, with a general shift of UNFPA support upstream, there is a concomitant decrease in service delivery and demand-side activities. In particular, UNFPA has prioritised its global leadership role in defining the integration of family planning with HIV and AIDS services, and in integration of family planning in emergency and humanitarian aid. There has been in comparison less focus on family planning integration with maternal health and with adolescent sexual and reproductive health services.

Paradoxically, the renewed emphasis on family planning evident at UNFPA has, to some extent, made it more challenging to maintain a strong focus on integration of family planning into other sexual and reproductive health services. Internally, the UNFPA priority focus on family planning programming has been highlighted by the growing importance of the Global Programme for Reproductive Health Commodity Security (GPRHCS),³⁴³ with a strong supply-side orientation. UNFPA has not adequately communicated the need to effectively support sexual and reproductive health and family planning integration without diminishing the renewed focus on family planning exemplified by GPRHCS.

Furthermore, the way in which integration itself is measured within UNFPA monitoring frameworks may diminish its importance. For example, integration is not an explicit measure within GPRHCS monitoring of family planning activities. Other frameworks often include indicators reflecting on the extent to which integration is incorporated into national health policies and plans, yet lack indicators to inform on the implementation of those plans at the level of institutions and services. As a result, UNFPA and its partners lack credible evidence of the extent to which effective integration takes place and of the effect of integration on user access and service quality. This in turn makes it difficult for UNFPA and its partners to identify and address those barriers which may impede effective integration. It also reduces the availability of evidence to support advocacy for integration if it cannot be linked to more effective and accessible services.

CONCLUSION 4: SUSTAINABILITY

UNFPA has engaged in efforts to improve the sustainability of family planning action across the key dimensions of national policy and of financial, institutional and cultural sustainability. It has been most successful in contributing to renewing national commitment to family planning and to improved financial sustainability. At country level, UNFPA has contributed to improved financial sustainability for family planning by effectively advocating for improved government commitments to resource-allocation. However, there has been less progress in supporting efforts to sustainably strengthen health systems to deliver quality family planning services. Furthermore, despite engagement with community level organisations and efforts to support demand-creation, UNFPA and its partners face significant cultural challenges to family planning at local and community level. Developing expertise on cultural engagement and working through the H6³⁴⁴ may offer opportunities to deliver better outcomes, for example, by working more closely with, and through, partners that specialise in cultural engagement.

► Origin: EQ 2, EQ 4, EQ 8

UNFPA has contributed effectively to notable results in the areas of a strengthened and improved policy environment at country level. It has built on the platform of a growing national commitment to family planning to promote, and often lead, initiatives to ensure reproductive health commodity security (RHCS) through national government budget allocations for the purchase of family planning commodities. However, there has been less progress in supporting overall efforts to sustainably strengthen national health systems to deliver quality family planning services.

³⁴³ Note that as of end of 2015, GPRHCS is referred to as “UNFPA Supplies”

³⁴⁴ H6 (called “H4+” from 2008-2015) is a partnership of six organisations (UNAIDS, UNFPA, UNICEF, UN WOMEN, WHO and the World Bank) that aims to leverage their collective strengths and complementary advantages and capacities to support countries with high burdens of maternal, child and adolescent mortality and morbidity in their efforts to improve the survival, health and well-being of every woman, newborn, child and adolescent. H6 is the technical arm of the UN Secretary-General's Global Strategy for Women's, Children's and Adolescents' Health (2016-2030) and provides technical support to high-burden countries in their efforts to implement the Global Strategy and to tackle the root causes of maternal, newborn, child and adolescent mortality and morbidity, including gender inequality and socio-cultural and financial barriers.

A key challenge for UNFPA has been finding mechanisms to help translate renewed national government commitments to family planning into sustained improvements in capacity to deliver quality services and ensure equitable access. UNFPA has most often addressed this challenge by providing support for training and related interventions, but training and capacity building support by UNFPA is often fragmented and rarely embedded in a comprehensive national strategy for fielding and sustaining human resources. Importantly, UNFPA has not supported the development of necessary human resource strategies where they do not exist. Rather, UNFPA has focused mainly on in-service training, with less emphasis on professional, pre-service training and little attention to supervision and follow-up of trainees. In addition, given the structural problem of a monitoring system focused almost entirely on activities, there has been no real measurement of training outcomes and their effects on service quality, or the effective engagement of newly trained staff over time.

Renewed national commitments to family planning often face real and significant challenges at local level where they confront opposing community cultural and social norms, especially in traditional and rural settings. One important way that UNFPA responds to these local challenges is by engaging with the community through local organisations, especially by involving them in demonstration projects. UNFPA also supports demand-creation activities by state and non-state actors which attempt to address cultural objections to family planning, although the results of many projects have not been fully documented or disseminated. At the time of this evaluation, the information about the effectiveness of community-based demand-promotion interventions supported by UNFPA is limited and the information that does exist is contradictory.

CONCLUSION 5: HUMAN RIGHTS AND VULNERABLE AND MARGINALISED GROUP MEMBERS

At the global level, UNFPA has exercised an important leadership role as an advocate for a human rights-based approach (HRBA) to programming in family planning, and for the rights and needs of vulnerable and marginalised groups. UNFPA has followed up on its global advocacy for a rights-based approach to family planning by collaborating on the development of operational guidelines for a rights-based family planning programming which can be applied by national health services. It has also identified the rights and needs of vulnerable and marginalised groups and has developed programming frameworks for addressing those needs. However, there remains a gap between UNFPA supported policies and guidelines on rights-based approaches to family planning and efforts to put those guidelines into action, especially at the country level. One reason for gaps is limited resources, as the most vulnerable and marginalised populations are also the hardest and the most expensive to reach. In part, this can be attributed to the lack of internal collaboration and integration across technical silos, leading to an absence of a common understanding among UNFPA staff at regional and country office levels regarding how best to implement rights-based approaches to family planning. This contributes to variations in the effectiveness of the UNFPA response at country level.

► Origin: EQ 5, EQ 6

UNFPA has been a vocal global advocate of human rights in family planning and has identified human rights as a guiding principle in global and country programming documents. In support of a human rights-based approach, UNFPA has identified the rights and needs of vulnerable and marginalised groups who are the key targets of its support. It has also developed frameworks to focus on defining and helping to meet the needs of vulnerable and marginalised group members for access to quality family planning services. At country level, UNFPA has supported programmes targeting a wide range of vulnerable and marginalised groups, with a strong focus on adolescents in many countries. UNFPA has also made important contributions to the development of participatory models where

vulnerable and marginalised groups feel a sense of ownership of programmes, but these have not been widely disseminated or scaled up.

However, because UNFPA staff and partners do not have a shared and clear understanding of how to operationalise and implement a human rights-based approach to family planning (despite the development of operational guidelines), there remains a gap between policy support for a rights-based approach to family planning and the nature and content of programmes and services. UNFPA country programmes have often focused on the right of access to services and an expanded range of contraceptives, paying some attention to gender equity but with insufficient attention to other key aspects of a human rights-based approach such as the elimination of incentives and targets that influence voluntary choice of methods and can lead to service provider bias. In addition, programming for adolescents still faces challenges in many cultural environments which do not respect and protect young people's rights and which restrict their access to services.

CONCLUSION 6: EVIDENCE AND LEARNING

UNFPA lacks a body of systematically organised evidence on important aspects of effective programming in family planning, especially at national level. Most critically, UNFPA lacks evidence: (i) on the extent of family planning integration into other segments of sexual and reproductive health; (ii) on the effect of different approaches and interventions on service quality, equity and access and (iii) to validate and communicate good practice in family planning programming. All three important gaps in the evidence base are detrimental to organisational learning and impede improved programme design, based on an understanding of what works and what does not work in family planning programming. Despite these gaps, UNFPA plays an important role in providing a practical field perspective when reviewing evidence on potential high-impact practices generated by other development partners.

► Origin: EQ 3, EQ 4, EQ 5, EQ 6, EQ 7, EQ 8

UNFPA programming and monitoring systems generate a large body of information on activities supporting family planning, but very little on the contribution made to results. UNFPA also has limited capacity to generate a set of evidence-based lessons learned. Without this evidence, it is difficult for UNFPA to assess and strengthen its own family planning programme, and to share experiences and disseminate lessons learned to country governments and other stakeholders. In addition, UNFPA lacks an organisation-wide learning agenda to guide the generation of lessons and evidence about its activities and to support its role as a knowledge broker.

Organisational learning in support of family planning is most critically weakened by an inadequate body of evidence on:

- The extent to which family planning is integrated into all aspects of sexual and reproductive health programming
- The effect of integration (when it is achieved) on service quality and access
- How stakeholders and partners can document, share and adopt recognised good practices in family planning, especially for improved capacity development.

Evidence is also needed for effective brokerage of partnerships and to communicate the effectiveness of UNFPA activities to rights-holders as well as other stakeholders and development partners.

Besides the integration issue, there are important operational areas where UNFPA has invested considerable effort in supporting family planning but has not developed a credible body of evidence on results and effectiveness. For example, UNFPA has supported

community-based demand-promotion interventions in many countries, working through government and NGO sectors. However, there has been little analysis of the lessons learned from these interventions, their effectiveness in increasing demand, or their sustainability: all critical inputs for organisational learning.

UNFPA has a key leadership role in countries as an advocate for human rights and gender equity and is well-positioned to address these issues, beyond improving the supply of quality family planning services and methods. Yet, efforts to effectively operationalise a human rights-based approach to sexual and reproductive health programming and family planning have not sufficiently benefited from a body of evidence of what works or lessons learned. This has made it more difficult for UNFPA to respond robustly to resistance and successfully advocate with governments and other partners to ensure that rights are respected, protected and fulfilled.

CONCLUSION 7: MODES OF ENGAGEMENT

UNFPA country offices have a strong grasp of the country context and are well attuned to the needs and priorities of their government partners. UNFPA has also a comparative advantage undertaking policy and advocacy efforts, and is the best-placed multilateral organisation to work with national governments and other development partners on policy engagement for family planning. However, other development partners (in particular bilateral agencies and projects) may be better placed to undertake longer-term capacity development and scale-up of service delivery. This is due in part to their ability to plan and dedicate resources over a longer-term period and to provide sustained support to strengthening health systems. The development of the integrated RMNCH investment case is an opportunity for UNFPA to advocate for family planning to be appropriately positioned at policy, planning, implementation and monitoring levels. This positioning would promote funding from domestic or other sources for which the government has a measure of control (e.g. pooled funds or World Bank loans). UNFPA programming rarely explicitly addresses the landscape of what development partners are doing in-country, reducing opportunities to leverage its comparative advantage for maximum synergy and sustainable results.

► Origin: EQ 7

UNFPA programming and modes of engagement in family planning have been adjusted to country needs, taking into account the national priorities, the local context and a varying range of needs across different regions and population groups within each country. At the same time, strategies are also driven by country office technical capacities, including a willingness and ability to manage risk and controversy.

Through its close working relations with country governments, UNFPA has demonstrated it is well placed to work upstream on policy advocacy in family planning on behalf of and with other development partners. It has achieved an acknowledged position of leadership in advocacy and policy engagement for family planning. However, the global architecture has changed to enable better implementation of the Sustainable Development Goals and the Secretary General's Global Strategy for Women's, Children's and Adolescents' Health. UNFPA could consolidate its leadership position in policy and advocacy to support implementation of the strategy. It could focus particularly on equity, reaching marginalised groups, human rights in family planning, and the full attainment of sexual and reproductive health and rights. UNFPA could also promote dialogue around a number of diverse challenges, including the humanitarian-development continuum or strategic planning in ministries of finance to take advantage of the demographic dividend.

At the time of this evaluation, the UNFPA business model (adopted in 2014) does not appear as yet to drive strategic focus or to determine the specific combination of modes of

engagement in country programming to the extent foreseen. Nor does it seem to be fully addressing the problems of the fragmentation of resources across a large number of countries and the need to shift support upstream. This is partly because, on the whole, country offices are still focused on supply-side funding and delivery models rather than prioritising how UNFPA can forge partnerships to build longer term, sustainable domestic commitment to family planning delivery in the context of an integrated approach.

UNFPA has continued to work in the area of service delivery through both direct procurement and support for government and other partners in service provision, although limited financial and human resources have affected its capacity to engage fully. These roles changed somewhat with the advent of GPRHCS Phase I, resulting in greater focus on capacity building, especially to strengthen national systems and processes for managing the supply chain for contraceptives. The increased focus on commodity supply, in comparison to capacity building is evident in UNFPA Supplies, and this appears to be driven at least partly by donor requirements rather than a strategic decision. Countries are now developing their RMNCH investment cases, prompted by an interest in engaging in the World Bank Global Financing Facility. This presents opportunities to use performance-based results to match grant funds with more conventional loans. This, in turn, supports faster progress on maternal and child health (including family planning) through expanding domestic fiscal space and increasing sustainability.

Capacity building has been a challenging mode of engagement for support to family planning partly because of systemic weaknesses in human resources for health services in many programme countries. This is due in part to the fact that UNFPA lacks sufficient resources, thus limiting technical capacity and availability of technical support. In view of the significant need for broad-based strengthening within health systems, UNFPA is not well placed to meet such needs in practice. Other development partners are often better placed to address the long-term service delivery and capacity building modes of engagement than UNFPA. The challenge for UNFPA is how to define its role appropriately within these complex landscapes, and moreover, to define appropriately its expected contribution and results in the context of significant challenges presented in strengthening health systems in many countries.

The post 2015 global architecture envisages a role for United Nations health agencies (the H6) to provide technical assistance to countries implementing the Secretary General's Global Strategy for Women's, Children's and Adolescents' Health. This role anticipates close cooperation and coordination among the health agencies as well as with national governments, other development partners and civil society, and focuses on capacity building, technical interventions, advocacy and policy support rather than programme financing and delivery. The Addis Ababa Action Agenda, among other global financing aims, sets out a path for countries to increase domestic financing in order to finance their own priorities more sustainably through public-private partnerships, innovative financing schemes, and increased domestic resources derived through – among other mechanisms – improved taxation collection. UNFPA is potentially well placed to ensure that, as countries build their own financing and implementation capacity, family planning programmes are an early and high priority choice for inclusion.

Finally, support to knowledge management remains one of the weakest modes of engagement for UNFPA because of a continuing lack of investment in generating knowledge on effectiveness and results. GPRHCS stands out as an exception as it has generated information for management decision-making at country level and shared experiences and lessons learned within UNFPA. Under-investment in knowledge-generation for effective programming in family planning limits the ability of UNFPA to influence programme implementation internally and among its partners. The global Independent Accountability Panel started work earlier in 2016 (under a commission appointed by the Secretary

General³⁴⁵). UNFPA could use this process as an opportunity to: (i) structure its own knowledge management to help countries identify best options, lessons from others, and critical pathways and (ii) channel its own experience and knowledge towards the Accountability Panel to inform its thinking, support its findings, and strengthen the role of integrated family planning in the RMNCAH continuum of care.

CONCLUSION 8: CONTRIBUTING TO COMMODITY SECURITY

UNFPA has been effective in supporting national government to increase the emphasis and investment assigned to reproductive health commodity security and in helping to strengthen management of contraceptive supply chains. UNFPA has also made an effective global contribution to improved procurement, lower contraceptive prices and to the availability of quality reproductive health medicines that meet global standards. Further, it has contributed to improvements in the availability of different contraceptive methods. This improvement in the available mix of contraceptive methods is, in itself, an important element in a human rights-based approach to supporting family planning.

► Origin: EQ 8

UNFPA has carried out effective work with partners to promote reproductive health commodity security with country governments, and has supported implementation of strategies for reproductive health commodity security through strengthening of all links in the supply chain and advocacy for government family planning budgets. Countries benefitting from GPRHCS have been those where UNFPA has made its most significant contributions to reproductive health commodity security because of focused attention and resources sustained over a number of years. UNFPA has also been a leading participant in global initiatives, which have improved procurement and lowered prices.

Most importantly, UNFPA has provided effective support to improve the contraceptive method-mix through procurement of supplies and through advocacy for the introduction of new methods. Improving the method-mix is related to the supply-side aspects of a human rights-based approach to family planning, and has taken into account the needs of special groups, despite some of these methods being politically sensitive. More controversial methods include promotion of emergency contraception for young people and female condoms; both of which support women's right to regulate fertility and take control of their contraceptive method. It should be noted that UNFPA support to improved access to Misoprostol helps to reduce the need for women to seek recourse to unsafe abortion.

At the same time, there are concerns about the extent to which users' voluntary choice may be constrained in situations where the method-mix or method-promotion is biased in favour of specific methods, such as implants or surgical sterilisation. This issue has not been debated or fully researched and is not yet sufficiently monitored by UNFPA, especially in country contexts where this is most relevant. This may be related to UNFPA staff capacity to address sensitive issues in ways that do not jeopardise on-going relationships with national authorities (Conclusion 2).

CONCLUSION 9: TECHNICAL SUPPORT AND OVERSIGHT

UNFPA country offices rely on effective and timely technical support and backstopping in family planning from headquarter divisions and from regional offices (ROs). There is a substantial body of written guidance but the availability and quality of technical support varies widely across regions and between different divisions or branches. The implementation of the recent "regionalisation strategy" has been accompanied by a

³⁴⁵ See, for example, panel information here: <http://www.everywomaneverychild.org/accountability/independent-accountability-panel>

perceived disconnect between headquarters and country levels and confusion over the role of regional offices.

► Origin: All EQs

There is a substantial, and perhaps overwhelming, body of written technical guidance on family planning developed and disseminated to country offices, as evidenced by the number of UNFPA strategic frameworks that include family planning. However, the application of guidance is varied and dependent on the interest and capacity of country offices to prioritise and operationalise technical guidance within programmes. There are important differences in the quality and quantity of headquarter and regional office support for different aspects related to family planning. For example, integration of family planning into other sexual and reproductive health services has been relatively well addressed through guidelines and support for implementation of the sexual and reproductive health-HIV linkages assessment methodology. However, despite the existence of operational guidelines and the rollout of training in a human rights-based approach, there has been little practical technical support to country offices on how to implement a human rights-based approach for family planning, particularly in countries where there may be important challenges to address.

The strongest technical assistance has been provided by the thematic funds. These have significant resources available for regional activities and for direct input from headquarters to country offices. As a dedicated programme, GPRHCS has been the principal resource for regional offices and headquarters to provide capacity building support to country offices in family planning, at least in the countries where the programme has been implemented.

Given the current limitations on technical support and backstopping from headquarters and regional offices, the overall quality of family planning programming at the country level is highly dependent on the technical capacity of country office personnel. However, regional offices have the potential to play a strategic role in country office capacity building. They can introduce to their regions new models and techniques for supporting family planning, such as the total market approach. The process for developing new country programmes provides an important opportunity for constructive technical support from headquarters and regional offices to assist country offices in identifying changing needs and opportunities in family planning.

There is evidence that the 2009 “regionalisation strategy” has been met with some resistance, as it has minimised direct interaction between headquarters and country offices, which is considered valuable by country office staff. Limitations in regional office capacity to meet all needs has added to this resistance.

5 RECOMMENDATIONS

RECOMMENDATION 1 – COORDINATION AND BROKERAGE

UNFPA should build on its close technical and strategic relationship with governments and its central role in coordinating and programming links to a wide array of stakeholders to address more effectively important challenges in advancing family. These challenges include holding governments accountable for maintaining or increasing their financial and other commitments to family planning; advocating for a human rights-based approach, including addressing the needs of marginalised groups; and engaging with a diverse set of actors to rationalise and scale up services.

► Priority: Very High

► Addressees: TD, PD, DHR, country offices

- ▶ Based on conclusions: C2, C3, C4, C6

OPERATIONAL IMPLICATIONS

- ▶ At the country level where the national context allows, UNFPA representatives and staff should pursue strategies to promote better cooperation between governments and NGOs and private sector actors, and advocate for a total market approach (TMA) to family planning. This could involve promoting civil society engagement in advocacy, coordination and implementation of programmes with governments, striving to address sensitive issues and brokerage through regional events, action plans and promoting different platforms for action.
- ▶ When agreeing on new country programmes and action plans, UNFPA should provide support to build capacity for the development and implementation of transparent systems of reporting by governments to enhance their accountability for results in family planning; include results-reporting and accountability requirements in agreements with implementing partners, and monitor them accordingly.
- ▶ UNFPA should ensure that competencies of UNFPA country representatives and senior country and regional programme/technical leaders emphasise skills related to high-level advocacy (especially regarding politically sensitive areas) and managing partnerships.
- ▶ At the global level, UNFPA should continue to promote inclusion of a human rights-based approach to family planning in all major development initiatives (Sustainable Development Goals, etc.), and participate in monitoring implementation of agreements to ensure governments and donors fulfil their commitments to family planning goals. UNFPA should also track efforts and results at country level to support a human rights-based approach in programming.

RECOMMENDATION 2 - INTEGRATION

In light of family planning being instrumental to the achievement of the UNFPA mandate and being an integral element in strategic and programme frameworks, UNFPA should examine previous efforts to strengthen integration and collaboration among technical “silos” in order to identify lessons and adjust its organisational approach to address continuing challenges. This is particularly important given the current trend to channel family planning interventions through major initiatives (FP2020, GPRHCS/“UNFPA Supplies”) which have a focus on the supply-side. It is essential to ensure that UNFPA places family planning firmly within a sexual and reproductive health and human rights context, in the framework of the Post-2015 Development Agenda. UNFPA needs to be able to communicate effectively to its staff and to stakeholders and partners that a focus on family planning does not imply a vertical programme, nor should an integrated approach imply that family planning is not a priority. In countries developing RMNCH investment cases, UNFPA has an excellent opportunity to pursue family planning integration with the right emphasis on sexual and reproductive health and rights. Embedding family planning in long term investment cases and advocating for the allocation of domestic resources for implementation will boost sustainability.

- ▶ Priority: Very high
- ▶ Addressees: Technical and Programme Divisions, regional offices and country offices
- ▶ Based on conclusions: C1, C8, C9

OPERATIONAL IMPLICATIONS

- ▶ UNFPA should undertake an internal review to assess root causes of the long-standing challenges to mainstream family planning within other UNFPA focus areas at headquarters, regional office and country office levels. This should be aimed at reducing tensions between integrating family planning within sexual and reproductive health and rights and repositioning family planning as a priority focus. The result of this review should reaffirm management expectations and accountabilities to eliminate the current tendency of staff from different programme areas within headquarters and country offices to work in a non-integrated way. By aligning the family planning work of all programme areas, UNFPA can better contribute to realising the goals of the ICPD Programme of Action, which placed family planning firmly within an overall adolescent sexual and reproductive health and rights framework.
- ▶ UNFPA should provide operational guidance to ensure that a family planning perspective are incorporated at all stages of programme cycle: identification and formulation of family planning-related objectives at initial stage, including entry points for integration, if the context allows; and in implementation, monitoring and evaluation stages, including identifying what specific changes are intended to occur. This does not preclude the need for specific family planning programmes aimed at redressing structural, systemic and deeply ingrained family planning gaps and challenges in programme countries.
- ▶ UNFPA should require country offices to present the rationale for taking or not taking action to address integration of family planning within HIV, maternal health (ante-natal and post-partum and post-abortion care), adolescent sexual and reproductive health, and gender (including gender based violence) programmes within country programme documents (CPDs) and country programme action plans (CPAPs), to ensure family planning is integrated at the programmatic design stage. In addition, UNFPA should require country offices to state what processes and resources (financial and staff) will be needed and mobilised to support integrated programming.
- ▶ As strategies are developed for new thematic funds and the continuation of the GPRHCS thematic fund (now called *UNFPA Supplies*), UNFPA should review opportunities to link support for family planning with other sexual and reproductive health rights programming.
- ▶ UNFPA should ensure that monitoring frameworks include indicators for the extent of family planning integration and measure the effect of integration on improving service access and quality.

RECOMMENDATION 3 – LEARNING AGENDA

UNFPA should strengthen the capacity of country offices to document and report on results of UNFPA support to family planning. To this end, UNFPA should intensify its efforts to ensure that the monitoring system measures results in family planning beyond activities and outputs. UNFPA should also elaborate a pro-active learning agenda (at headquarters level and within family planning focus countries) to contribute to the evidence base on family planning and enhance its role in synthesising, translating and disseminating evidence at regional and international level. In particular, the learning agenda for family planning should identify strategic family planning programme issues requiring further examination. It should also single out promising interventions undertaken by implementing partners, then validate and disseminate them with a view to scaling up and replicating successful initiatives. UNFPA should contribute actively to, and consider or incorporate the findings of, the Independent Accountability Panel for Women’s Children’s and Adolescents’ Health, which will publish an annual report tracking commitments to and delivery of resources, results and rights.

- ▶ Priority: Very high
- ▶ Addressees: TD, PD, SIKM, regional offices, country offices, implementing partners

- ▶ Based on conclusions: C1, C5, C6, C7

OPERATIONAL IMPLICATIONS

- ▶ The Programme Division should continue efforts to strengthen the results-oriented monitoring capacity of country offices. Regional offices, with the support of the Evaluation Office, should also build the capacity of country offices to undertake evaluations of selected, potentially innovative family planning projects and to document lessons learned from the most effective interventions. Since resources are limited UNFPA should consider setting a minimum allocation of core funds in annual workplans and budgets to support this action.
- ▶ Managers should jointly communicate and reinforce expectations with staff about the importance of, and their accountability for, effectively documenting programme practices and contributing to knowledge sharing and use.
- ▶ The Technical Division should develop a learning agenda to support and foster exchange related to emergent “promising” practices. This agenda should focus on priority issues in family planning where UNFPA is well-placed to identify and support generation of lessons learned (such as a human rights-based approach for family planning and mainstreaming gender in family planning). UNFPA should consider how partnerships can support this strategy, including internally with the Evaluation Office, to strengthen UNFPA contributions to the evidence base on family planning.
- ▶ UNFPA should put in place a consultative mechanism for ensuring regular contacts and discussion among the staff of the Technical Division, Programme Division and the Strategic Information and Knowledge Management Branch to ensure cross-divisional agreement on the content, process and progress of the family planning learning agenda at UNFPA.
- ▶ UNFPA should engage with the Independent Accountability Panel (IAP) to promote family planning monitoring, lesson learning and knowledge promotion across all development partners and national programmes.
- ▶ UNFPA should ensure that the operational implications (developed above) are addressed by the update of the UNFPA knowledge sharing strategy, which is currently under revision.

RECOMMENDATION 4 – A HUMAN RIGHTS-BASED APPROACH AND VULNERABLE AND MARGINALISED GROUPS

UNFPA should continue to take a strong stance and ensure its leadership position in promoting a human rights-based approach at global, regional and country level. Moreover, in line with the commitments of universal inclusiveness of the 2030 Agenda for Sustainable Development, UNFPA should focus programming initiatives to ensure that no one is left behind. In particular, UNFPA should ensure that its current operational guidelines for implementing a human rights-based approach in family planning and reaching the most marginalised and vulnerable populations are backed up by a common understanding by country office staff and partners of the concrete actions required for implementation. UNFPA should intensify efforts to ensure that, at country level, the programmes it supports prioritise quality of care, non-discrimination and voluntary choice of family planning and family planning methods, with a special focus on the empowerment and participation of vulnerable and marginalised groups as rights-holders.

- ▶ Priority: High
- ▶ Addressees: TD, PD, regional offices, country offices

- ▶ Based on conclusions: C4, C5, C6

OPERATIONAL IMPLICATIONS

- ▶ UNFPA should further clarify organisational expectations and accountabilities for ensuring that supported family planning initiatives at country level embody human rights-based approach principles.
- ▶ UNFPA should provide country office staff with skills-building and technical assistance to support taking strong, organisationally consistent stands on human rights in family planning programmes.
- ▶ UNFPA should define the operational implications of the objective to “target the needs of the most vulnerable,” including how to manage trade-offs between allocating resources to reach vulnerable and marginalised groups and contributing to FP2020 targets to reach 120 million women and girls. In light of Agenda 2030, UNFPA should require country offices to outline the rationale and prepare detailed needs-assessments for targeting specific marginalised and vulnerable groups, including resource requirements.
- ▶ UNFPA should ensure that the human rights elements of support to family planning are monitored and reported (through the UNFPA strategic information system) by incorporating appropriate indicators into country programme monitoring frameworks.
- ▶ UNFPA should ensure that the process for reviewing country programme documents and country programme action plans include components related to advancing a human rights-based approach and addressing the needs of vulnerable and marginalised groups.
- ▶ In light of Agenda 2030, UNFPA should develop a family planning-specific communication tool to ensure that advocacy efforts include messages delivered by UNFPA staff on the importance and content of supporting family planning at global, regional and country levels which consistently emphasise human rights in family planning programmes and services.
- ▶ At the country level, UNFPA should advocate with government and stakeholders, including development partners, civil society organisations and NGOs to strengthen participation of rights-holders, including key vulnerable and marginalised groups and their representatives, in programme design and in the development of mechanisms for ensuring transparency and accountability by service providers.
- ▶ As part of the learning agenda (Recommendation 3), UNFPA should develop an evidence base to support advocacy and demands for government accountability on human rights in family planning. The initiative to roll out new guidance on a human rights-based approach in family planning should be accompanied by efforts to document and evaluate the outcomes in selected countries. Evidence should be gathered on the rights-issues identified, what was prioritised and addressed, and how actions taken resulted in changes in access, participation and the rights of service users.

RECOMMENDATION 5 – MODES OF ENGAGEMENT

UNFPA should work at country level to spread itself less thinly and focus on modes of engagement in family planning where it has a strong comparative advantage and where it has the adequate resources to follow through. In practice, this means a greater focus than at present on the policy advocacy mode of engagement and specifically in relation to country reproductive, maternal, newborn and child health investment case development processes. To this end, increased support is needed to strengthen systems and expertise for knowledge

management (Recommendation 3) to inform and strengthen UNFPA critical roles in advocacy and brokering. Increased support and guidance should be provided to country programmes to enable constructive engagement in policy processes aimed at strengthening systems for delivery of integrated reproductive, maternal, newborn and child health. This should include advocating for increased domestic fiscal space, promoting family planning in the Global Financing Facility and working to build a sustainable commitment to family planning. UNFPA should also re-examine its commitment and approach to training as a key element of capacity development to ensure that training activities are embedded within national strategies for integrated human resource development and sequenced appropriately, rather than providing fragmented support to specific training activities. Further, UNFPA should explicitly analyse its programming in light of what other development partners are doing at country level. Specifically, in respect of broader health systems strengthening initiatives, UNFPA should ensure that landscape analysis is a key component of business planning.

- ▶ Priority: Medium-High
- ▶ Addressees: TD, PD, regional offices, country offices
- ▶ Based on conclusions: C6, C7, C8

OPERATIONAL IMPLICATIONS

- ▶ UNFPA should require country offices to specify in country programme action plans where their country is situated in relation to the development of an integrated reproductive, maternal, newborn and child health investment case, whether and how it is drawing down on the Global Financing Facility and how UNFPA activities relate to what is being done by other development partners around an integrated approach. In addition, UNFPA should ensure that country programme action plans include consideration of the financial resources and technical capacity required to undertake selected modes of engagement, detail other available resources, explain why UNFPA should provide funding, and whether sufficient funds are available. Country offices should also be required to identify the exit strategy and discuss how they will work to strengthen sustainability in the delivery of family planning services and ensure a transition away from UNFPA funding to domestic financing wherever possible (even domestic financing accessed through international development agency credits or other fiscal support).
- ▶ UNFPA should require country offices to justify their intention to support service delivery and other downstream activities together with concrete exit or transition strategies. To the extent possible, UNFPA should move upstream in all types of interventions in support of family planning and transition downstream activities to bilateral development partners. Country offices should work through pooled funding mechanisms (or other implementing partners with the resources and technical capacity to effectively implement programmes) or national resources that may be boosted through access to the World Bank Global Financing Facility or international development agency credits. In cases where it makes strategic sense for UNFPA to support capacity building, it should ensure that training plans are incorporated into a comprehensive strategy, include evaluation of the outcomes, and assess the effects of training over a protracted period.
- ▶ As noted in the recommendation on the learning agenda, UNFPA should strengthen capacity to support government and other partners in results-oriented monitoring, and in evaluation as required to support the knowledge management mode of engagement (which cuts across all country categories of prioritisation), engaging with the International Accountability Panel where appropriate.

- ▶ UNFPA should develop indicators to track UNFPA policy and advocacy results in terms of how they have influenced others to take action at global and country levels. UNFPA indicators should be closely aligned to national and global indicators wherever possible.

RECOMMENDATION 6 – TECHNICAL SUPPORT AND OVERSIGHT

UNFPA should clarify the roles and responsibilities of different branches at Technical Division, other divisions and offices (especially regional offices) for technical and programme oversight of family planning. UNFPA should review how country offices are supported to implement effective, technically sound, rights-based and results-oriented family planning programme activities and revise roles, responsibilities, procedures and accountabilities accordingly.

- ▶ Priority: Medium
- ▶ Addressees: TD, PD, regional offices, country offices
- ▶ Based on conclusions: C1, C3, C5, C6, C9

OPERATIONAL IMPLICATIONS

- ▶ UNFPA should review prior efforts by UNFPA Headquarters to improve coordination and technical assistance across branches and divisions, with a view to identifying the root causes for the persistent misalignment. UNFPA should also develop clear responsibilities and accountabilities to address the lack of cohesiveness within the Technical Division (between sexual and reproductive health and GPRHCS teams, in particular) and among the Technical Division, the Programme Division and the regional offices so that technical advice and backstopping for support to family planning is consistent in quality, content, timeliness and availability for all country offices.
- ▶ UNFPA should ensure that headquarters and regional office technical input on support to family planning is available to country office staff early in the programme design process. They should build on this initial point of support to provide ongoing technical assistance and backstopping during programme implementation, especially through support to monitoring and to evidence gathering on effectiveness of support to family planning. UNFPA should ensure consistent messaging on all aspects of family planning, especially on integration and on a human rights-based approach.
- ▶ Related to the learning agenda (Recommendation 3), UNFPA should ensure that there are clear accountabilities for advancing knowledge management in family planning. It should further ensure that knowledge management is a priority component of technical support to country offices and that expert staff at headquarters and regional offices collaborate and communicate promising practices and evidence-based approaches (generated by UNFPA and by other organisations and experts) across country offices through sharing of experiences, mentoring and providing consistent technical support.