



FINAL EVALUATION OF THE 7th COOPERATION PROGRAM BETWEEN MADAGASCAR AND UNFPA 2015-2019

Final Report

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Final evaluation of the 7th Cooperation Program between Madagascar and UNFPA 2015 – 2019:
Madagascar

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LIST OF ACRONYMS AND ABBREVIATIONS

ARSSAM	Support for Security Sector Reform in Madagascar
ASOS	Action Socio-sanitaire Organisation Secours
AfDB	African Development Bank
ILO	International Labour Organization
WB	World Bank
BCC	Behavior Change Communication
CECJ	Listening and Legal Advice Center
IYC	Interministerial Youth Committee
ICPD	International Conference on Population and Development
CNSS	National Health Solidarity Fund
CPAP	Country Program Action Plan
CPD	Country Program Document
UHC	Universal Health Coverage
MD	Maternal death
DRJS	Regional Directorate of Youth and Sports
DRSP	Regional Directorate of Public Health
BBMS	Behavioral and Biological Monitoring Survey
DHS	Demographic and Health Survey
ENSOMD	National MDG Indicator Monitoring Survey. Madagascar.
FACE	Financial Authorization and Certificate of Expenditure
FISA	Fianakaviana Sambatra
OF	Obstetric fistula
WVOF	Women Victims of Obstetric Fistulas
FSSMN	Maternal and Newborn Health Surveillance Sheet
HACT	Harmonized Approach for Cash Transfer
ICM	International Confederation of Midwives
HDI	Human Development Index
IFIRP	Inter-Regional Paramedical Training Institute
INSTAT	Statistics Institute
STI	Sexually Transmitted Infection
YPE	Young Peer Educator
MID	Ministry of Interior and Decentralization
MEN	Ministry of National Education
MJS	Ministry of Youth and Sports
MPPSPF	Ministry of Population, Social Protection, and the Promotion of Women
MSM	Marie Stopes Madagascar
MSANP	Ministry of Public Health
SDG	Sustainable Development Goals
MDG	Millennium Development Goals
WHO	World Health Organization
NGO	Non-governmental organization
UNAIDS	United Nations Organization on HIV/AIDS
ORSEC	Relief organization
PBF	Peace Building Fund
PE	Implementing partner

FP	Family planning
NDP	National Development Plan
NYP	National Youth Policy
UNDP	United Nations Development Program
PRD	Regional development plan
AWP	Annual work plan
RGPH	General Population and Housing Census
RSSS	Reform of the security sector
SALFA	Sampan'asa Loterana Momba ny Fahasalamana
SDMR	Maternal death surveillance and response
SE/CNLS	Executive Secretariat of the National AIDS Committee
AIDS	Acquired Immune Deficiency Syndrome
SMN	Maternal and newborn health
SNISE	Integrated National Monitoring and Evaluation System
NSDS	National Statistics Development Strategy
M&E	Monitoring and Evaluation
UNS	United Nations System
EMONCB	Basic Emergency Obstetric and Neonatal Care
EMONCC	Comprehensive Emergency Obstetric and Neonatal Care
SPSR	Securing Reproductive Health Products
RH	Reproductive Health
SRA	Adolescent Reproductive Health
AYRH	Reproductive Health of Adolescents and Youth
SSR	Sexual & Reproductive Health
UNDAF	United Nations Development Assistance Framework
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
GBV	Gender-based violence
HIV	Human Immunodeficiency Virus
ZI	Area of intervention

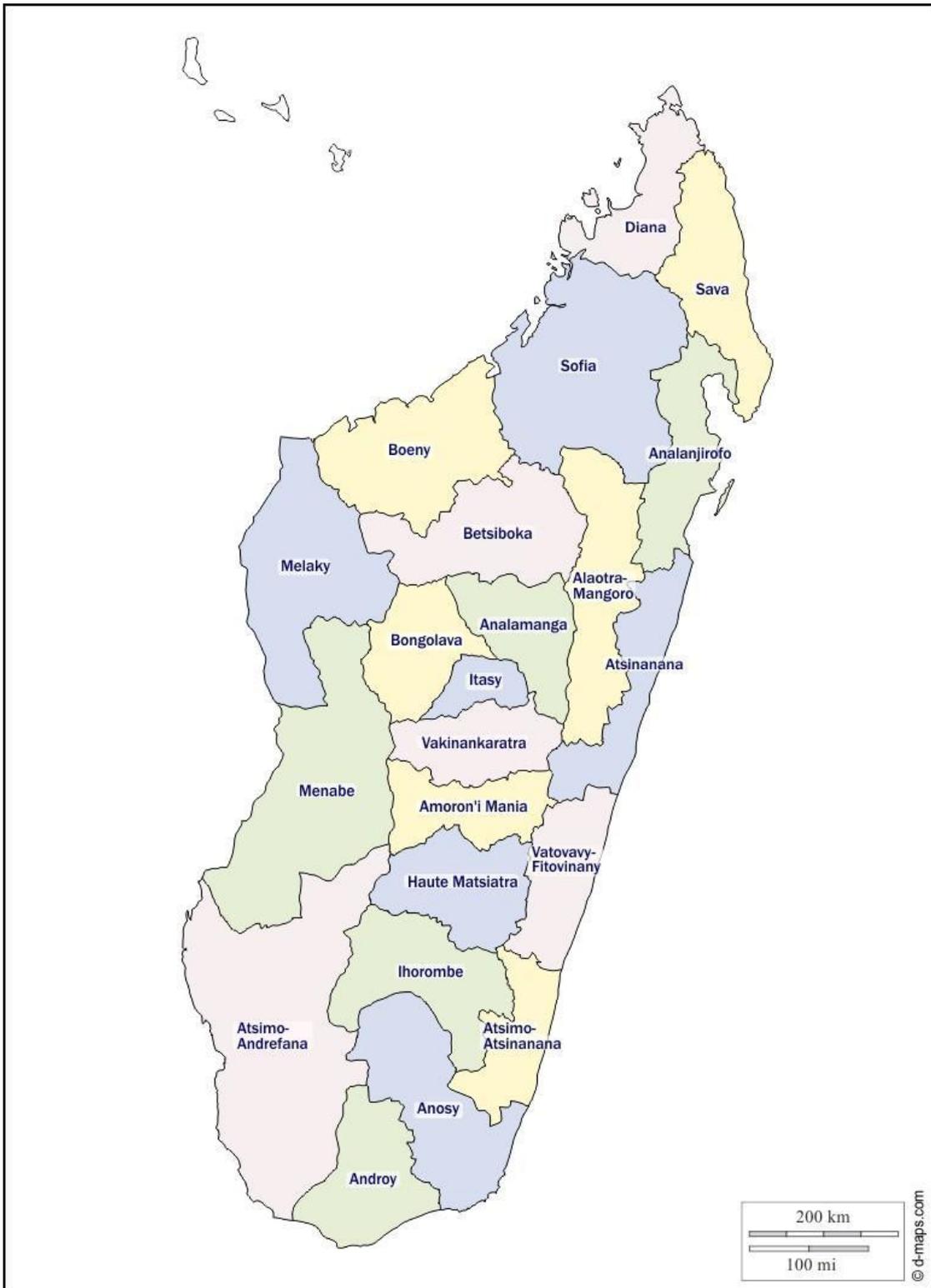
MADAGASCAR: KEY FIGURES

Table 1: Madagascar in figures

DATA TYPE		
General Country Data: Data Type	Sources - Years	Sources - Years
Surface area	587,295 km ²	
Total resident population 2016	24.4 million	CIA World Factbook (2017)
Female population of childbearing age (15-49 years)	23%	ENSOMD 2012-13
Population aged 10 to 24	32%	ENSOMD 2012-13
Demographic growth rate	2,7 %	ENSOMD 2012-13
Rural population	80%	ENSOMD 2012-13
Urban population	20%	ENSOMD 2012-13
Population aged under 25 years	64 %	ENSOMD 2012-13
Population density	41.40 inhabitants / km ² .	ENSOMD 2012-13
Composite fertility rate	5 children per woman	ENSOMD 2012-13
Composite fertility rate (CFR) in rural areas	5.5 children per woman	ENSOMD 2012-13
Composite fertility rate (TFR) in urban areas	3.3	ENSOMD 2012-13
CFR according to household standard of living	7.9 for the poorest 2.8 for the richest	ENSOMD 2012-13
Percentage of girls who have had their first sexual intercourse before the age of 15	14%	ENSOMD 2012-13
Percentage of women who had their first sexual intercourse at the exact age of 25	96%	ENSOMD 2012-13
Basic socio-economic indicators		
Economy: Data type	Sources - Years	Sources - Years
Percentage of workers with fragile employment	80%	AfDB, Africa Outlook Report (2017)
Share of the manufacturing sector in GDP	14.8 %	WB (2017)
State indebtedness (% of GDP)	43.2%	WB (2017)
Economic growth rate	4.5%	AfDB, Africa Outlook Report (2017)
Public debt as % of GDP	39.7%	Order of Chartered Accountants - 2016
GDP per capita (USD)	391	
Education: Data Type	Description	Sources - Years
Literacy ratio of women aged 15-19	0.96	ENSOMD 2012-13
Girls' primary school attendance ratio	1.05	ENSOMD 2012-13
Girls/boys secondary school attendance ratio	0.86	ENSOMD 2012-13
Girls/boys attendance ratio at tertiary level	0.73	ENSOMD 2012-13
Health: Data Type	Description	Sources - Years

Percentage of mothers consuming foods rich in vitamin A	76.7 %	ENSOMD 2012-13
Teenage fertility rate (15-19 years)	163 per thousand	ENSOMD 2012-13
HIV prevalence rate (15-24 years)	0.16%	ECB2013
Health: Data Type	Description	Sources - Years
Percentage of women who have heard of OF(45-49 years)	19%	ENSOMD 2012-13
Percentage of mothers consuming iron-rich foods	50.30%	ENSOMD 2012-13
Rate of births attended by qualified personnel	44.30%	ENSOMD 2012-13
Percentage of exclusively breastfed children	41.90%	ENSOMD 2012-13
Percentage of women who received postnatal care within 24 hours of birth	36%	ENSOMD 2012-13
HIV prevalence among MSM	14.70%	ECB 2013
Maternal mortality ratio per 100,000 live births	478 Per 100,000 live births	ENSOMD 2012-13
	353 Per 100,000 live births	Estimates – MMEIG 2015
Life expectancy at birth	65.9 years	CIA World Factbook (2017)
	M: 64.4 years F: 67.4 years	
Child mortality rate	42 per thousand	ECB 2013
Percentage of women in union using a modern FP method	33.30%	ENSOMD 2012-13
	38.9%	TRAC PF 2017
Unmet family planning needs	16.4%	TRAC PF 2017
	17.7%	ENSOMD 2012-13
Knowledge of women of childbearing age regarding the clinical signs of obstetric fistula and the fact that obstetric fistula can be cured	11%	ENSOMD 2012-13

Figure 1: Map of Madagascar



EXECUTIVE SUMMARY

Introduction: This report provides the results of the evaluation of the 7th cooperation program between the Government of Madagascar and UNFPA with an initial amount of USD 74.5 million for the period 2015-2019. It presents the progress made through the program's interventions towards achieving the results and outputs set out in the CPD and CPAP 2015-2019. This report identifies and analyzes the achievements, weaknesses, lessons learned and reveals the factors that facilitated or hindered the achievement of results in order to propose orientations and recommendations for the 8th program. The program intervention framework that is the subject of the evaluation focuses on quality sexual and reproductive health services, adolescents and youth, gender equality and women's empowerment, and population and development dynamics to contribute to poverty reduction.

Objectives and scope of the evaluation: Overall, the objectives of the evaluation are to (i) review the extent to which the design and implementation of the 7th program are appropriate given the country and international context, (ii) analyze results, performance, and sustainability of interventions, (iii) determine response capacity, strategic alignment including coordination of interventions with the UNS and added value in order to draw lessons to provide a set of clear and forward-looking options leading to strategic and actionable recommendations for the next programming cycle. The results of the evaluation are intended for UNFPA, the Government of Madagascar, implementing partners and other stakeholders, for decision-making and to guide future programming.

Evaluation methodology: The adopted methodology is in line with the guidelines of the UNFPA headquarters manual "*How to design and conduct a country program evaluation*". The evaluation of the 7th program is based on the set of questions dealing with the criteria of relevance, effectiveness, efficiency and sustainability for the analysis of the four program components, and the criteria relating to strategic alignment, added value and response capacity for the analysis of UNFPA's strategic positioning.

The Evaluation Reference Group (ERG) was set up to monitor the evaluation from the design phase to the finalization of the report with the UNFPA Madagascar Country Office. The evaluation methodology was discussed and validated by the ERG and UNFPA which includes (i) the sample of stakeholders, implementing partners and beneficiaries met from the stakeholder mapping, (ii) the evaluation questions, the evaluation timeline as well as the data collection tools.

The evaluation methodology combined qualitative and quantitative data collection methods, including (i) literature review, (ii) stakeholder interviews¹ (iii) site visits and observations, (iv) focus group discussions with beneficiaries in UNFPA's three regions of focus.

The evaluation team systematically triangulated the collected data. The evaluation matrix made it easy to consolidate "*evidence-based*" findings. This matrix links the assumptions to be tested with the indicators corresponding to the evaluation questions. The team encountered a number of difficulties throughout the evaluation process, including the unavailability of certain key players due to the political situation. However, this limitation was mitigated by an in-depth analysis of available documents and other sources of information.

Main results according to the evaluation criteria

Relevance: The 7th cooperation program between the Government of Madagascar and UNFPA has incorporated the needs of the population into its strategic and operational programming with the participation of key stakeholders and with due regard for the specific situation of the areas of intervention and focus. It is well in line with the national priorities defined in the National Development Plan (2015-2019) and in sector policies,

¹ Staff from UNFPA office, UN agencies, technical and financial partners (TFPs), government and non-governmental implementing partners (NGOs) at national and regional levels

United Nations Development Framework (UNDAF), and UNFPA Strategic Plans 2014-2017 and 2018-2021, the latter aligned with the SDGs.

Effectiveness: At program level, the expected results are broadly met for the 4 program components.

In the area of sexual and reproductive health, UNFPA has helped to improve the provision of reproductive health (RH) services, including family planning (FP), through the development of policy and strategy documents on RH and FP, the rehabilitation of health facilities, the provision of materials, equipment and health inputs, the training of providers in EmONC integrating GBV/ARH and support for human resources (midwives). The national contingency plan and ORSEC plans at regional directorate and health district level have been developed with UNFPA support to respond to humanitarian emergencies. The referral system has been strengthened but requires improvements to ensure effective utilization by the population. UNFPA support made it possible to provide medical care for the 4,355 WVOFs. Relapses during interventions deserve to be analyzed and resolved during the development of the 8th program.

In terms of family planning, UNFPA contributed to the increase in contraceptive prevalence rate in Madagascar from 33% (2012) to 39% (2017). The RH/FP Act facilitating adolescents' and young people's access to FP information and services has been enacted. UNFPA supported the country's commitment to the PF2020 global initiative, the commitment to increase the budget for the purchase of contraceptives through advocacy and dialogue, the establishment and operationalization of FP model centers.

With regard to adolescents and young people, UNFPA support allowed to strengthen the availability and use of facilities for young people, including a youth and employment center offering information services in ARH and FP. More than 92,000 young people in school and out-of-school settings have been sensitized. The development of documents to improve young people's access to RH/FP services is part of UNFPA's support. Yet, scaling up comprehensive sex education, which is just kicking off, remains a major challenge for the 8th program.

Concerning gender equality and women's empowerment, UNFPA contributed to the drafting of a preliminary version of the bill on the fight against GBV, the strengthening of GBV service facilities, the development of policy, strategic and operational documents for the fight against GBV, and the establishment of various mechanisms to strengthen the fight against GBV, such as national and regional platforms and men's groups. Platform revitalization is an aspect to be considered for the next program.

With regard to population dynamics, the General Population and Housing Census (RGPH) was carried out 25 years after the last census. SNISE has been reactivated and periodic NDP monitoring reports are available. A Demographic Dividend Team is in place and operational. The improvement of birth and death registration has started but its proper functioning remains a challenge especially the coverage of maternal death registration.

Efficiency: The human and financial resources allocated to the program are sufficient to meet the objectives pursued, given the high utilization rates of these resources and the generally satisfactory operational results. The regular guidance provided by the country office has borne fruit as the utilization and absorption rate has increased over the years of the period despite the delayed start-up in the beginning of the program period.

The volume of human and financial resources is adequate and sufficient to provide the necessary support to partners for strategic planning. However, local monitoring in all intervention regions remains a challenge. The absence of a permanent UNFPA team at regional level restricts the effectiveness of coordination activities. Direct payment by banks to beneficiaries hinders the smooth running of activities, although there has been a noticeable improvement in some implementing partners switching from direct payment to payment in advance following a capacity assessment.

Sustainability: *In the area of Reproductive Health*, the choice of implementation strategies adopted by UNFPA, and the establishment of capacity-building mechanisms for the permanent transfer of technical, administrative and financial skills at all levels, appear to guarantee the sustainability of the outcomes after UNFPA's withdrawal. However, national ownership remains weak in the enforcement of the various documents that have been developed, some of which still need to be institutionalized. Furthermore, it is important that the country honors its commitment to ensure the continuity of the contraceptive supply currently guaranteed by UNFPA.

As regards young people and adolescents, UNFPA's support for the establishment of youth centers and its advocacy for the signing of a tripartite agreement between MJS, MID and UNFPA for the provision of space for the location of youth centers is a guarantee of national ownership of the approach to ensure the sustainability of interventions.

In the gender equality and women's empowerment area, the results of UNFPA's support in drafting laws against GBV and strengthening coordination in the fight against GBV, including in humanitarian settings at national and regional level, and the implementation of integrated service models including the identification, response and reintegration of women victims of GBV through the Ministry in charge of population, remain sustainable after the end of the program.

In the field of Population Dynamics, UNFPA's technical, financial and strategic support for the RGPH3, the production of a practical manual for integrating data into development documents, the granting of study and training scholarships to INSTAT students, assistance with the design and dissemination of civil registry forms and the revitalization of SNISE will help to ensure the sustainability of interventions after the end of the program.

Strategic alignment:

The CPAP objectives and its implementation through annual work plans reflect the priorities of UNFPA's strategic plan to support disadvantaged and vulnerable groups through collaboration with public institutions and civil society.

Apart from interventions that benefit women, several actions in favor of young people have been carried out. UNFPA, through South-South cooperation, strengthened knowledge transfer that bridged gaps by linking the demand and supply of technical skills, experience and technologies in line with the 2014-2017 Strategic Plan.

UNFPA has supported the establishment and operationalization of a multi-sector coordination mechanism chaired by the Ministry of Economy and Planning (MEP), at central level and in its three regions of concentration, in charge of coordinating all UN agencies with regard to Sustainable Development Goals (SDGs) and "Delivering As One" (DAO), and ensuring the synergy of actions under the Madagascar National Development Plan.

UNFPA contributes to the implementation of the UNDAF through its outputs and outcomes, participation in various joint projects with other UN agencies, effective and dynamic participation in several thematic groups and sub-groups from 2015 to the present day, and participation in different review meetings. Finally, following the mid-term review of the CPAP, the program was realigned with the new 2018-2021 Strategic Plan.

Response capacity:

The country office has shown flexibility in response to changes in the country context, needs and national priorities. Faced with these various changes, UNFPA set up multi-sector coordination mechanisms and developed capacity-building strategies, which were judged to be effective adaptation strategies while ensuring continuity of service. In humanitarian emergencies, UNFPA was able to provide assistance to victims thanks to its ability to adapt, with the provision of kits to health facilities and/or beneficiaries, capacity building to ensure that the needs of young people were taken into account, and the response to problems of gender-based violence in humanitarian settings. With the adoption of UNFPA's new Strategic Plan, the program has aligned itself with the plan's orientations to contribute to the achievement of 3 transformative results. Following the recommendations of the mid-term review, the office showed its flexibility in changing the terms of payment of implementing partners and updating the results framework and resources.

Comparative advantages and value added: The lack of a UNFPA exit strategy makes it impossible to measure the results observed in the various components of the country program that could have been achieved without UNFPA support. However, specific support for (i) the reparation and socio-economic reintegration of women victims of GBV and WVOF into their communities, (ii) investment in the supply of contraceptives, (iii) data integration into development policies and programs, (iv) conducting large-scale surveys (RGPH3), (iv) supporting a functional multi-sector coordination mechanism between state and civil society partners are specific interventions that could be credited to UNFPA and are demonstrated as comparative advantages.

Key findings

At strategic level

National statistical data are present in the main UNFPA initial programming documents (CPD and CPAP) without specific mention of regional data. However, the selection of three focus regions was based on the specific regional population indicators and was well documented. UNFPA has demonstrated real added value in the four components of its program, due to its great capacity for dialogue and advocacy.

There is no human resources plan in the CPAP that covers all components individually in the three intervention regions, which considerably restricts the effectiveness of actions. The coordination of activities with the IP's regional managers and the ministries' technical staff is not very tangible in the local monitoring of interventions.

The strategy of decentralizing activities is either ineffective or inefficient, as AWP's are signed in the capital, resulting in financial and activity prioritization that does not enable objective choices to be made at regional level.

In terms of reproductive health/family planning, UNFPA has invested a lot in strengthening EMONC services but overall support to maternity remains insufficient to achieve the desired changes. A lot of action is focused on repairing obstetric fistula and not on prevention. UNFPA remains the main promoter of family planning in Madagascar and has provided support in all areas, especially in the supply of inputs, apart from its support in the quality and quantity of care offered and the promulgation of the RH/FP law.

With regard to young people and adolescents, UNFPA's support has increased access for young people, even in rural areas, to information on sexual and reproductive health. Awareness raising by young peer educators and ambassadors has had a positive effect on behavior change among their peers. However, young people's access to quality services and their involvement in the various interventions is still low. Sex education has borne its first fruits, yet, not particularly accessible during humanitarian emergencies.

Where gender equality and women's empowerment are concerned, UNFPA contributes to the elimination of GBV and has advocated measures to protect victims, by (i) supporting the introduction of a specific law to combat GBV and the effective dissemination of GBV-related laws among the population and stakeholders in the regions where it operates, and (ii) operating in rural areas and in the most vulnerable zones that are difficult to access geographically. The quality of service provided by CECJ, a support facility for GBV victims, has been improved, both in normal and humanitarian settings, in collaboration with members of multi-sector GBV platforms. However, other partners' investment in CECJs remains minimal. As part of its preventive and gender-promotion approach, UNFPA has been working to involve young boys and men in the southern regions in particular, while avoiding their involvement in the Dahalo phenomenon.

With regard to population and development, UNFPA carried out a number of actions that helped operationalize the SNISE through decrees and capacity building. However, data reporting mechanisms remain a big challenge. UNFPA contributed to the integration of population dynamics, sexual and reproductive health, gender equality and women's empowerment into development planning at national, sector and regional levels through capacity-building for technical staff at MEP and INSTAT, and the production of a practical manual on methodology. Data integration mechanisms are insufficient and government staff are changing due to political instability.

Key recommendations

At strategic level, UNFPA should (i) develop a robust business case specific to each of the 3 transformative results for the preparation of the next country program, including the commitment pact; (ii) take into account situational statistical data relating to each strategic component (and transformative results) and those of the intervention regions of the 8th country program during planning, in order to better monitor and evaluate the impact of interventions on the indicators in these zones, and to better prioritize interventions for vulnerable groups (rural women, people living with disabilities, etc.); (iii) Maintain dialogue and advocacy with the Government of Madagascar and with institutions and other development partners to achieve Madagascar's development objectives and the goals of the ICPD and the SDGs; (iv) Ensure UNFPA's presence in the regions where interventions are concentrated to monitor and supervise activities; and (v) Ensure that the regions have their own AWP's signed by the Government and UNFPA to facilitate funding and implementation of activities.

As for reproductive health/family planning, UNFPA should support (i) better availability and quality of maternal and neonatal health services and FP/RH services, especially in the most remote areas, including during humanitarian emergencies, and (ii) national capacity-building to improve the quality of EmONC services,

With regard to young people and adolescents, UNFPA should support improved access for adolescents and young people to quality AYRH information and services, including family planning, by (i) improving national capacity and strategies to implement sex education, and (ii) continuing to strengthen the commitment and involvement of the government, young people and civil society to accelerate the capture of the demographic dividend.

On the issue of gender equality and women's empowerment, UNFPA should advocate with the various stakeholders to bolster prevention actions against GBV and child marriage by (i) supporting the approval and dissemination of the specific law and the enforcement of existing legal and regulatory texts with the relevant ministries; (ii) supporting the operationalization of GBV platforms, GBV care services and men's networks; (iii) redefining with the Ministry in charge of population the extension of GBV interventions to the national level and remote areas, including the CECJ; and (iv) promoting gender, particularly the inclusion of young boys in care, especially in the southern regions.

With regard to population and development, UNFPA should (i) support the improvement of SNISE data feedback mechanisms, the collection of civil registry records (especially for deaths), and the collection of data from partners; (ii) support capacity-building for INSTAT and MEP staff at central and regional levels in terms of data integration and publication of studies, papers and data.

Lessons learned: This evaluation identifies as key lessons learned the enhancement of national ownership, the pursuit of regional programming and planning and the intensification of the effective implementation of regional plans, the pursuit of capacity building of implementing partners to contribute to the fulfillment of results.

CHAPTER 1: INTRODUCTION

This final evaluation report of the 7th Cooperation Program between the United Nations Population Fund and Madagascar (2015-2019) first presents the objectives and scope of the evaluation before a review of the context in which this program was implemented, with its main characteristics, after a reminder of those from the previous cycle (2008-2013). This includes the status and financial analysis of the program. Next, the report presents a review of the evaluation process and methodology, followed by the findings, conclusions according to the basic evaluation criteria (relevance, effectiveness, efficiency, sustainability) and UNFPA's strategic positioning (strategic alignment, response capacity, added value). Each criterion is presented with a set of evaluation questions to help define its scope of investigation. Finally, the report presents conclusions and makes recommendations to guide the next country program and improve Madagascar's development programs.

The main users of the results of this evaluation will be the duty bearers and right holders. These are the UNFPA Executive Board, the UNFPA operational offices (Country Office, Regional Office for Southern and Eastern Africa, headquarters divisions), the Government of Madagascar including their regional and sector divisions as well as other national and development partners.

In line with UNFPA Executive Board decision 2009/18, all UNFPA programs, in particular country programs, must be evaluated at least once during their cycle.² This evaluation is part of this logic with a view to contributing to strengthening transparency and accountability vis-à-vis the UNFPA Executive Board, donors, partner governments and beneficiaries. The lessons learned from the evaluation will also contribute to the preparation of UNFPA's 8th country program.

1.1. OBJECTIVES (GLOBAL/SPECIFIC) OF THE COUNTRY PROGRAM EVALUATION

The purpose of this evaluation is to assess, as systematically as possible, all the activities implemented in the 7th cooperation program between Madagascar and UNFPA in the areas of Sexual and Reproductive Health, Youth and Adolescents, Gender Equality and Women's Empowerment and Population Dynamics.

1.1.1. General objective of the Evaluation

The general objective of the Country Program evaluation is to improve UNFPA's accountability to government and stakeholders and to contribute evidence that will inform the design of the next country program.

1.1.2. Specific Objectives

The specific objectives of the evaluation are:

- (i) To evaluate the relevance and contribution of the country program to national development outcomes;

² DP/FPA/2009/18

- (ii) To present an independent evaluation of the progress of the program towards achieving the expected outputs and outcomes (results) set out in the results framework of the country program document;
- (iii) Provide an appraisal of the positioning of the Madagascar Country Office among development and national partners, considering its capacity to respond to national needs while adding value to the country's development results;
- (iv) Assess to what extent the implementation framework enabled or hindered the achievements of the results chain, i.e., what worked well and what did not;
- (v) Highlight key lessons from past and current cooperation and provide a set of clear and forward-looking options leading to strategic and solid recommendations for the next programming cycle.

1.2. SCOPE OF THE ASSESSMENT

Evaluation of the 7th Country Program systematically focuses on the Country Office's contributions to the progress of development results in Sexual and Reproductive Health, Youth and Adolescent Reproductive Health, Gender Equality and Women's Empowerment, Data Production, and Use of Data for Decision-Making.

The evaluation covers all UNFPA interventions from 2015 to 2019 at central/national level and, especially those that benefited from the specific interventions: these are the Androy, Atsimo Andrefana and Vatovavy Fitovinany regions. However, the last year of 2019 is not taken into account in the assessment of the achieved results. The evaluation covers all outputs defined within the program results framework and their contribution to the results of the strategic reference frameworks.

1.3. METHODOLOGY AND PROCESS

1.3.1 Evaluation methodology and approach

1.3.1.1 Conceptual framework of the evaluation

The adopted methodological approach is compliant with the guidelines of the UNFPA manual "*How to design and conduct a country program evaluation*" and adapted to the context of the program and Madagascar. Schematically, this methodological approach can be summarized as in the graph below:

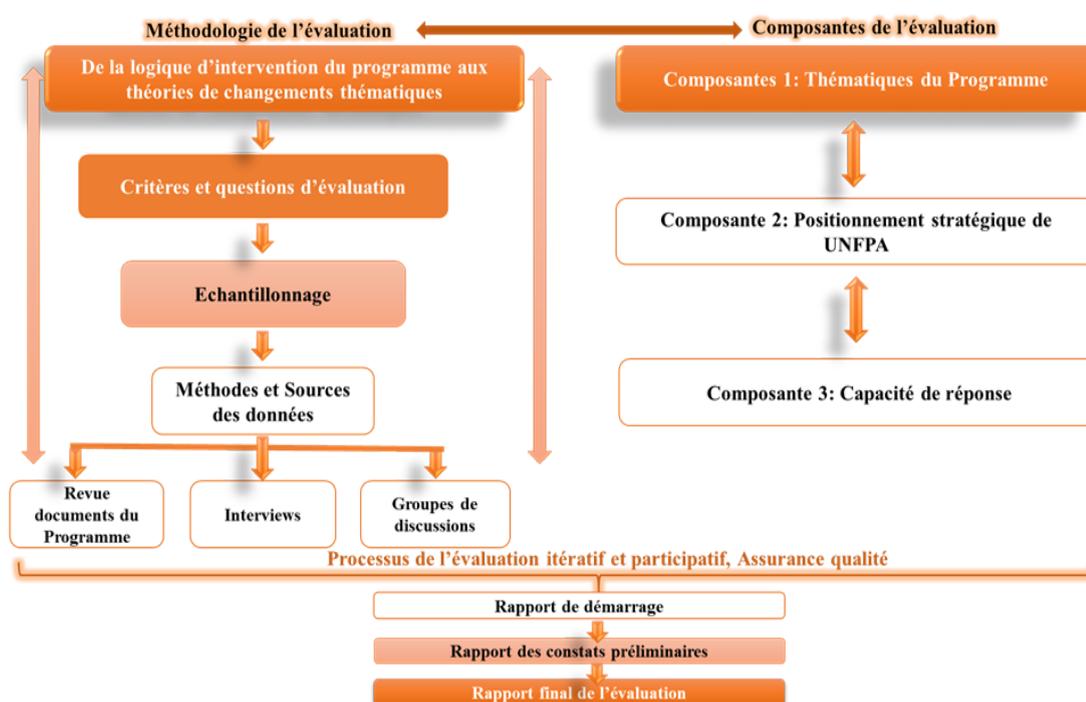


Figure 2: Conceptual framework of the evaluation methodology

In accordance with the terms of reference, the evaluation team adhered to the standards set by the United Nations Evaluation Group (UNEG). Team members complied with the ethical guidelines for evaluators in the UN system and the Code of Conduct.

1.3.1.2 Evaluability

This diagnostic of evaluability is the systematic process used to identify whether UNFPA's intervention through the Country Program is suitable for evaluation, and whether the evaluation is justified, feasible and likely to provide useful information. In fact, the Country Program could be evaluated substantially thanks to all the necessary conditions.

Table 2: Program Evaluability

Evaluability domain	Evaluability criteria	Findings
Theory of change or logic model	<ul style="list-style-type: none"> • Relevance • Adaptation • Consistency 	<p>There is a consistent intervention logic, with intervention strategies that are relevant to the issues facing the country and the Malagasy people.</p> <p>The factors related to the issuers of SRH, FP, EMONC, Adolescent and Youth, Gender Equality and Women's Empowerment and Population Dynamics are clearly or explicitly identified. And all this on the basis of objective evidence and contextual analysis.</p> <p>The country program has clear goals, objectives and results and shows levels of activities, financial resources, results and strategies.</p>
Existence and availability of information	<ul style="list-style-type: none"> • Availability and Accessibility of Information (documentation and 	<p>The Country Program has the necessary information on the intervention and the implementation context through semi-annual reports, regional assessments and annual reports. In addition, there is useful</p>

relevant	data) on Country Program interventions <ul style="list-style-type: none"> ● Relevance of documentation including reports and program reviews 	present in the program indicator matrix. This data is fed through the monitoring and information collection system with well-defined responsibilities, resources and periodicity. A set of indicators has been introduced since 2017 to better assess the program's performance and its partners'.
Enabling context	<ul style="list-style-type: none"> ● Stakeholder Interest and Involvement ● Availability of resources and capacities ● Coordination and management of the evaluation 	The level of stakeholder involvement and perspectives in the program are high. And this can be demonstrated by their participation in planning and monitoring workshops. Stakeholders have resources and capacity to participate in evaluations in terms of time and knowledge. An Evaluation Reference Group has been established to ensure the continuous involvement of stakeholders throughout the evaluation process.

1.3.1.3 Theories of change

The Theory of Change reflects the conceptual and programmatic approach adopted by UNFPA during the program period. Its reconstruction was done by program component (see Annex 9). As a result, theories of change were developed in a participatory manner between the evaluation team and UNFPA program staff, with a view to gaining a better understanding of the intervention logic, and above all the mechanisms and assumptions underlying the achievement or attainment of the different levels of results (outputs, immediate outcomes, overall impact).

These reconstructions played a crucial role in the analysis of the collected data, in the formulation of findings, and finally in the development of the conclusions and the wording of strategic and operational recommendations. The aim was, on the one hand, to explain the extent to which the program's interventions yielded the observed/reported results; the contributions, or not, to the outcomes (changes); and to determine the factors explaining them and other potential contributing factors, on the other hand.

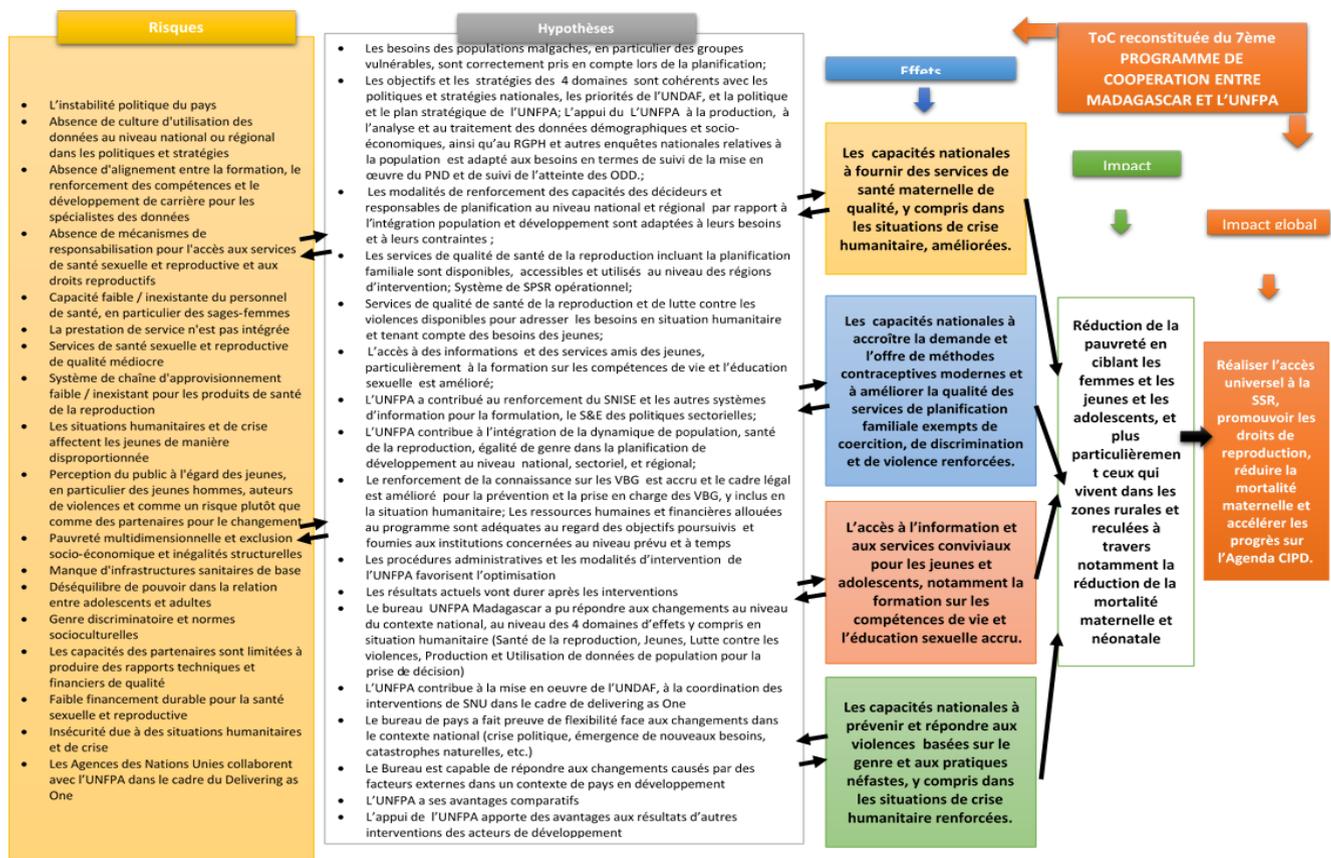


Figure 3: Reconstruction of the Theory of Change

1.3.1.4 Evaluation Criteria and Questions

In accordance with the CPE (Country Program Evaluation) methodology outlined in the UNFPA Evaluation Office handbook on country program evaluation guidelines provided in the Handbook: "How to design and conduct a country program evaluation at UNFPA" (2013), the evaluation was based on a number of questions (evaluation questions) covering various criteria.

The evaluation adopted the criteria defined by the UNFPA Evaluation Policy for country program evaluations, which are based on those of the UNEG (United Nations Evaluation Group) and the OECD/DAC principles for development evaluation. These are: Relevance, Effectiveness, Efficiency and Sustainability. The evaluation also analyzed the strategic positioning of the office in line with the guidance provided in the Handbook. UN Swap was integrated into the evaluation from the design and implementation stages right through to the production of results.



Figure 4: Evaluation Criteria

After discussion with the reference group, the evaluation team selected 10 questions to focus its data collection and analysis work:

Programmatic analysis:

Relevance

EQ1: To what extent do the objectives of UNFPA's 7th country program in Madagascar correspond to the needs of the Malagasy population (particularly those of vulnerable groups), and how have their needs been aligned throughout the program implementation period with national and international priorities, and UNFPA's strategies at international level?

Efficiency

EQ2: To what extent have the outputs of the Country Program Action Plan been achieved and how have they contributed to the achievement of results?

Effectiveness

EQ3: To what extent have the human, financial and administrative resources allocated to the program favored or hindered the production of the observed results?

Sustainability

EQ4: To what extent are UNFPA-supported interventions through its country program likely to last beyond the end of the interventions?

Strategic alignment:

EQ5: To what extent does UNFPA Madagascar's support to partners comply with the directions of the 2014-2017 strategic plan: capacity development, support for disadvantaged and vulnerable groups, support for youth, and promotion of South-South cooperation?

EQ6: To what extent has the UNFPA Madagascar Country Office contributed to the operations of the UN Country Team Coordination Mechanism: is the program in line with UNDAF, and does UNFPA coordinate the activities of other UN Agencies in the country as part of "Delivering As One" for Unity in Action? (**Coordination and complementarity with UNCT**)

Response capacity

EQ7: To what extent has the Country Office been able to respond to changes in the Madagascar context in relation to national needs and priorities?

EQ8: To what extent has the UNFPA Madagascar Country Office been able to respond to changes caused by external factors in a developing country context during the implementation of the 7th Country Program?

Added value

EQ9: To what extent could the results observed in the different components of the country program have been achieved without UNFPA support?

EQ10: To what extent has the support of UNFPA's 7th country program in Madagascar benefited the results of the interventions of other development actors?

The links between the questions and the evaluation criteria is presented in the following table.

Table 3: Links between the questions and the evaluation criteria

Criteria	EQ1	EQ2	EQ3	EQ4	EQ5	EQ6	EQ7	EQ8	EQ9	EQ10
Relevance	X									
Efficiency		X								
Effectiveness			X							
Sustainability				X						
Strategic alignment					X	X				
Response capacity							X	X		
Added value									X	X

1.3.1.5 Sampling

Right from the start, a mapping of the 7th program's stakeholders was produced. This was used as the basis for sampling to select the stakeholders to be interviewed: implementing partners, beneficiaries of interventions and other entities (development partners, other UN agencies). In accordance with the evaluation policy, the relevant and open participation of partners (stakeholders) has been ensured throughout this evaluation process of the UNFPA Madagascar Country Program in such a way that they benefit as much as possible, from the integration of those who have both rights and duties during planning, design, implementation and decision-making.

The sampling methodology used is the "reasoned choice", and on this basis, a stratification³ was made based on the 7th Country Program's intervention components. Depending on the interventions implemented, the intervention areas have been selected accordingly based on specific criteria (program investment volume; accessibility of the intervention area; thematic coverage of Country Program components; innovation and strategic interest of the intervention). Stakeholders, including beneficiaries, were chosen according to the principles of the rights-based approach and gender.

³ Stratification is the process of dividing the general population into homogeneous subgroups prior to sampling. Here the strata are the types of partners (Beneficiaries and certain members of civil society who are the rights holders, the State who is the bearer of obligations and responsibilities and the other partners who support the State)

Table 4: Distribution of interviewed entities by component at central and regional levels

	Sexual and Reproductive Health	Adolescents and young people	Gender Equality and Empowerment	Population dynamics	Management Structure	TOTAL
Central level						
People Interviewed	45	07	20	22	13	107
Group interviews	2	2	2	3	4	13
Entities interviewed	13	3	4	6	1	27
Androy Region						
People Interviewed	7	3	6	3	2	21
Focus Groups	2	2	2	0	0	6
Entities interviewed	6	3	3	3	1	16
Atsimo Andrefana Region						
People Interviewed	11	3	7	3	2	26
Focus Groups	4	2	2	0	0	8
Entities interviewed	5	3	3	2	1	14
Vatovavy Fitovinany Region						
People Interviewed	10	7	10	3	0	30
Focus Groups	5	6	4	0	0	15
Entities interviewed	7	4	3	3	0	17
Total Interviewees	73	20	43	31	17	184
Total Focus Groups	11	10	8	0	0	29
Total Entities interviewed	31	13	13	14	3	74⁴

The evaluation organized the programming activities (by projects and programs) of the UNFPA Madagascar Country Office around the thematic areas set out in the 2015-2019 Country Program document in the first instance.

Subsequently, these clusters⁵ grouped into thematic areas according to projects and programs were the subject of a deliberate (reasoned) sampling based on the identification of beneficiary target groups and the volume of activities. The consulting team conducted 184 interviews (out of 184 planned in the start-up phase through reasoned choice) and 29 in-situ focus groups (out of 29 planned). The choice in the start-up phase was deliberately reasoned according to the time constraints and the budget of the evaluation. During field visits, the opportunity with beneficiaries allowed for more focus groups. In addition to this, 27 entities were visited (these are the 15 implementing partners and 12 other development partners).

⁴ The number of entities visited corresponds to the number identified in the mapping, i.e., 27 out of 29 entities identified. The total of 74 entities visited is a double count of the entities in the regions. For example, the regional directorates of ministries and the local offices of implementing partners were counted as entities in separate categories. This double counting was necessary to show evidence.

⁵ The cluster sampling technique involves dividing the population into groups or clusters, as the name suggests. With this technique, a number of clusters are randomly selected to represent the total population, then all units included within the selected clusters are included in the sample.

(Source : Portail statistique. <http://www.statcan.gc.ca/edu/power-pouvoir/ch13/prob/5214899-fra.htm>). Here the clusters are the 4 thematic areas, namely: RH, Adolescent and Youth, Gender Equality and Women's Empowerment, and Population Dynamics.

1.3.2 Phases of the evaluation process

The evaluation of UNFPA Madagascar's 7th country program was carried out in five phases in accordance with the Evaluation Guide: preparatory phase, design phase, field phase, reporting phase, and phase of response, dissemination and management follow-up.

The **preparatory phase** (April 2018) took place within the timeframe required for the preparation of the evaluation. During this phase, the terms of reference for the evaluation were developed. The reference group (responsible for monitoring the progress of the evaluation) and the evaluation team were also set up.

The **start-up phase** (June 12, 2018) allowed the evaluation team to structure the evaluation exercise around a list of questions discussed and validated by the evaluation reference group and to produce an inception report for this purpose. In this report, the evaluation team defined its strategy of data collection and analysis in the field.

The **field phase** (18 June - 25 July) resulted in field data collection by the evaluation team. It ended with a meeting to share the preliminary results of the evaluation with the country office staff (19 July) and then with the members of the evaluation reference group (31 July).

The **drafting phase of the evaluation report** led to the preparation of a provisional final report, the collection of feedback from the UNFPA country office, the presentation of the preliminary results to UNFPA staff (August 8, 2018), the collection of comments from UNFPA staff, the preparation of the second version of the provisional final report, the collection and integration of comments from UNFPA into the new version of the report, the sharing of the document with members of the ERG, the finalization and submission of the final report.

During **the dissemination and follow-up phase**, the evaluation report will be published on the UNFPA website following quality assessment. UNFPA units concerned by the report's recommendations will make their response to these recommendations known in a document

(response de gestion) which will also be published on the UNFPA website. A follow-up of the implementation of the recommendations will be conducted one year after the publication of the report.



Figure 5: Summary of the main phases of the evaluation

1.3.2.1 Field data collection

In terms of data collection methods and techniques, the evaluators used four main methods: documentary analysis, in-depth semi-directive interviews with key informants (focal points, field workers, program managers, implementing partners, other stakeholders involved in program implementation and other strategic partners), focus groups (mainly with direct program beneficiaries) and direct observations of the structures in the program implementation sites. Using the evaluation matrix (see Appendix 2), each method specifically corresponds to one or more evaluation questions.

Primary data was collected using interview guides that were administered by the consultants independently to key informants, during focus group discussions with beneficiaries, and from field visits. The specific interviews were carried out according to the time spent collecting the information contained in the guides. Secondary data are derived from reports of various studies, documents and other technical and administrative reports made available to evaluators by UNFPA and other implementing partners.

1.3.2.2 Tools and methods used for data collection and analysis

Literature review : The literature review started from the inception phase of the evaluation. It covered key documents, provided by UNFPA and other partners, both at national and local level, including strategic documents, national policy documents, biannual and annual reports related to UNFPA thematic activities or interventions. Documents including financial data from the UNFPA information system were shared and reviewed.

The literature review continued during the field and synthesis phase. This helped to complete the documentation that was not available during the start-up phase. During this phase, the evaluation team particularly focused on :

- Annual work plans (AWP) for each program component;
- Relevant strategic government documents, including national policies and strategic policy frameworks;
- Monitoring data available at the country office;
- Annual reports of the Country Office;
- Documents describing and defining the relationship between UNFPA and its in-country partners, such as implementing partner reports or memoranda of understanding (MoUs) with development partners or Government;
- Evaluations of interventions supported by UNFPA or other partners in Madagascar.

Individual and group interviews: Semi-structured key informant interviews were used to gather information from a variety of stakeholders. Individual and group interviews were conducted. The evaluation team conducted individual and group interviews in Antananarivo with UNFPA country office staff as well as representatives of key UNFPA partners at central level and in the three regions visited, namely Atsimo-Andrefana, Androy, and Vatovavy Fitovinany (government partners, non-governmental organizations (NGOs), donors, etc.). In total, the team conducted approximately 184 individual interviews and 4 group interviews for the four components.

Field visits/Observation: Field visits were important to enable the evaluation team to directly observe UNFPA-supported intervention sites such as health facilities, Youth Corners, youth centers, and Legal Advice and Counselling Centers (CECJ) in the sites chosen for this evaluation.

Focus groups: Focus groups were used to collect information from homogeneous groups that benefited from interventions (the rights holders). Thus, women of childbearing age including young girls, women victims of GBV, women victims of (and/or repaired from) obstetric fistula, and young men. These focus groups were conducted according to the directions developed during the design phase, and according to the intervention components. The process was carried out using a participatory approach to promote the expression of women, men and young people involved in one way or another in the cooperation program.

Triangulation: Reliability was ensured through the triangulation of data and methods (using the convergence of multiple data sources and data collection methods) and adherence to the UNFPA Evaluation Manual (*How to Design and Conduct a Country Program*

Evaluation at UNFPA). This triangulation was based on the systematic cross-referencing of data and information sources as well as the systematic cross-referencing of data collection tools and methods (desk review, individual and group interviews, focus groups, direct observation).

1.3.2.3 Data analysis, interpretation and validation :

Data analysis began during the data collection phase and continued throughout the evaluation process until the production of the final evaluation report of the Madagascar Country Program. This enabled us to quickly identify emerging issues, integrate updated information, confirm understandings and gather feedback that informed all findings and conclusions, and facilitated relevant recommendations. The evaluation matrix provided the guiding structure for data analysis. Ongoing dialogue between the evaluation consultants and the evaluation manager on these issues allowed adjustments to be made as and when needed.

In addition to content analysis and descriptive, quantitative, qualitative and comparative analyses of the collected data, the analysis and interpretation of the collected data were performed using a triangulation of data, sources, tools and approaches, and validation techniques, notably for purposes of consistency. Qualitative approaches were enriched with quantitative approaches. An iterative validation process involving cross-checking of information and sharing of collected data with resource persons was instituted to ensure the quality of the data to be analyzed. Debriefing meetings with the country office and discussions with the Reference Group (review of the inception and interim reports) also provided opportunities for feedback to consolidate the analysis.

1.3.2.4 Challenges encountered

The evaluation team encountered several challenges throughout the evaluation process, particularly during the field data collection phase, including:

- The unavailability of some key players. The evaluation period coincided with the transition period of the Government of Madagascar, which resulted in a change of Chief (Prime Minister) and members. This affected the staff of Ministries from central to decentralized level, and has impacted the availability of some government stakeholders. For example, some regional directors and department heads were not only unavailable, and others were newly appointed. However, some steps have been taken to address this issue through the triangulation of information.
- Insufficient or delayed access to monitoring documents and data from implementing partners. Some documents could not be made available to the evaluators despite many efforts to get them, in particular monitoring reports and disaggregated and specific data from health facilities.

1.3.2.5 Limitations of the evaluation

The limitation of this evaluation might be the absence of a control/buffering area to allow us to rigorously attribute to the program the changes observed in the areas where the program is implemented. Consequently, the method used to assess changes in the implementation areas consisted of pre- and post-program measurement, mainly based on program indicators. However, the theories of change that have been developed may have helped, to some extent, to strengthen the analysis of the contribution of program interventions to these outcomes and to identify likely confounding factors.

1.3.2.6 Ethical Considerations and Code of Conduct

Standards to ensure the protection and respect of participants as well as their confidentiality were applied throughout the process of this evaluation. Participants were informed of their rights after an explanation of the purpose and objectives of the evaluation mission. All semi-structured interviews and discussions were conducted with the consent of the participants. The independence of the evaluators was clearly explained and the participants were assured of the confidentiality of the comments at the beginning of the interview before obtaining their consent. The choice of participants for the focus groups was made in collaboration with the implementing partners, to ensure the rights holders were effectively included. The entire process of the assessment was gender-sensitive, using context-specific localities, regions and an analysis of people's roles as described in the approach to integrating gender and human rights into evaluations⁶. Conclusions and recommendations were made

based on findings, judgments and lessons learned, appropriately reflecting the quality of methodology, procedures and analysis used in data collection and interpretation. The team complied with the evaluation manual, which provided guidelines on how to design and conduct a country program evaluation, a useful tool to reach consensus on the terminology and methods used in the evaluation and the stated results.

CHAPTER 2: COUNTRY CONTEXT

2.1 DEVELOPMENT CHALLENGES AND NATIONAL STRATEGIES

2.1.1 Political context

An island state in southern Africa, located in the Indian Ocean east of Mozambique, Madagascar is the 5th largest island in the world with a surface area of 587,000 km² and 24.8 million inhabitants in 2016. The establishment of the Senate in February 2016 completed the establishment of all the democratic institutions of the Fourth Republic⁷.

The political crisis that broke out in Madagascar in 2009 put a serious economic slowdown in Madagascar. After nearly five years of socio-political crisis, Madagascar was able to successfully organize, in the last quarter of 2013, presidential and legislative elections, thus enshrining its return to constitutional order and the concert of nations. This long crisis has resulted in a decline in economic and social performance and a deterioration of the infrastructure and governance situation affecting the implementation of the program. Madagascar's economic situation remains worrying because despite all its natural wealth, the country is still among the poorest in the world.

The country ended up being considered a fragile State in 2013, according to the methodology common to the Multilateral Development Banks (AfDB and World Bank), based on the average of the indicators of the evaluation of the policies and institutions of the countries (EPIP). The country continues to face several priority challenges arising from the effects of fragility that were set out in the State Overall Policy (PGE), approved by the National Assembly in May 2014 and operationalized through the development of a medium-term National Development Plan (NDP) (2015-2020). After a new political crisis in the first half of 2018, on Monday June 11, 2018, Madagascar appointed a "consensus" government whose mandate is to manage the country's business until the next general elections in November of the same year. Madagascar's political crises have led to an "eternal restart" of institutional governance, and the needs of the population are not really taken into account in political resolutions. Poverty is worsening while the country holds enormous wealth.

2.1.2. Economic situation

The Malagasy economy has gradually recovered since the return to constitutional order in 2014. The resumption of public investment, with the return of external financing, and the opportunities offered by access to external markets have boosted local activities, particularly in the public works, construction and manufacturing sectors. The economic growth rate, which has exceeded 4% since 2016, reflects this trend (compared to an average annual growth of 2.7% during the period of political crisis from 2009 to 2013).

⁶ United Nations Evaluation Group. Mainstreaming Human Rights and Gender Equality in Evaluations – Towards a UNEG Guidance Document. March 2011

⁷ World Bank 2018

Madagascar, however, remains very exposed to climate hazards, which makes it difficult to fight poverty. In 2017, the agricultural sector, the main source of income for more than 80% of the population, suffered the particularly severe effects of natural disasters. Rice production is estimated to have decreased by 20% compared with 2016. In fact, the majority of the population has not benefited from the improvement in the economic situation: the extreme poverty rate, measured on the basis of USD 1.9 (in purchasing power parity-PPP) remains high at 76.2 percent in 2017.

The year 2017 was marked by a sharp rise in inflation which reached 9% in December, representing the highest price increase in seven years. This situation is due to the rise in food prices linked to the drop in rice production.

In contrast, as one of the world's leading vanilla producers, Madagascar has continued to benefit from the surge in vanilla prices on the international market. The export revenues from vanilla helped to limit the external current account deficit, preserve the value of the local currency and build up a correct level of foreign exchange reserves.

The medium-term economic outlook is broadly positive with GDP growth expected to exceed 5%. However, uncertainties around the upcoming presidential elections to be held at the end of 2018 could have negative effects on growth. These elections are also an opportunity to break the cycle of political crises and keep reforms in place to foster inclusive and sustainable growth⁸.

2.1.3. Social Context

The political crisis of 2009 had effects on the social context of the Malagasy populations. It is estimated that there was a loss of approximately USD 6.3 billion between 2009-2013⁹, or 15 times the public spending on health. Starting in 2015, the Government instituted a national social protection policy whose main objective is to reduce the number of Malagasy living in extreme poverty by 15% (MPPSPF, 2015, p.15), targeting both assistance and social security policies.

Between 2000 and 2014, there was a general improvement in the level of social inclusion, mainly due to the significant decline in infant mortality, by about 50% during that period. This is likely the result of specific maternal and child health policies implemented since the late 1990s, including free immunization (which covers 78% of children) and vitamin distribution.

The level of exclusion remains significantly higher in rural areas than in urban areas. The poor quality of schools, clinics and other public services in the Malagasy rural areas confirms the urgent need to address these specific forms of exclusion in the country. As a result of the rural exodus caused by inadequate public services and increasing poverty, human exclusion is gaining ground in the capital city, Antananarivo. The factors of human exclusion confirm the preponderance of undernourishment and poverty in the genesis of exclusion; their contribution has increased over time and exceeds 80% in the country in 2014.

2.1.4. National development strategies

At the end of a long social, political and governance crisis that ended in 2014 with the new democratic elections, Madagascar adopted a new orientation of economic and social development focused on inclusive growth and sustainable development. This new option has materialized through the implementation of a National Development Plan (NDP) initiated in 2015 and which will end in 2019.

⁸ World Bank 2018

⁹ African Development Bank

Madagascar's national SDG prioritization report was developed to be both inclusive and participatory, rebalanced by integrating all dimensions of sustainable development. With support from the MAPS (mainstreaming acceleration and policy support) mission, the government has aligned national strategies to the SDGs prioritizing health, education, decent jobs, governance, industrialization, agriculture, food security, environment and climate change. The country has selected 64 of the 105 prioritizable targets out of the 169 targets of the 17 SDGs.

2.1.5. General poverty of the population

INSTAT's latest poverty survey is the 2012 Millennium Development Goal Monitor. In Madagascar, poverty is essentially a rural phenomenon. The average gap between rural and urban poverty is 28 points. Poverty affects a significant proportion of the Malagasy population and predominates especially in rural areas where the vast majority of the working population lives. The latest INSTAT estimate reveals that in 2012, about 71.5% of the population was poor, 77.3% in rural areas and 48.5% in urban areas, based on an average annual income of 1,388,000 Ariary. Extreme poverty (level of consumption or income well behind the poverty line) hits 56.5% of the population with an average annual income of 328,160 Ariary, or less than 1,000 Ariary per day. This phenomenon affects more rural areas (62.1%) than urban areas (34.6%). The average annual consumption per capita is estimated at 404,000 Ariary. It is higher in urban areas than in rural areas, especially in the Androy Region, which is less than 200,000 Ariary.

In 2012, the Androy and Atsimo Atsinanana Regions had the highest poverty rates: 96.7% and 93.1% respectively. Over time, poverty affects more than half of the population. It intensifies especially during the period of political crisis: the poverty rate reached 80.7% in 2002 and 76.5% in 2010¹⁰.

2.1.6. Sexual and Reproductive Health

The maternal mortality ratio has been on a declining trend since 1990. Indeed, this rate is 478 per 100,000 live births (ENSOMD 2012-2013) in recent years, compared to 498 per 100,000 live births¹¹ in 2008-2009. However, the MDG target of 127 per 100,000 live births is far from being met. According to estimates in studies by the World Bank, the maternal mortality ratio went from 778 to 353 maternal deaths per 100,000 live births between 1990 and 2015.

According to ENSOMD 2012-2013, only 44% of women receive assistance from a qualified health professional and 38% give birth in health facilities. In parallel, there is a shortfall in Caesarean section operations compared with the minimum recommended by the WHO, with a rate of births by Caesarean section equal to 1.9^{12%} as opposed to 5%.

In addition, the United Nations estimates that 2 to 3.5 million women and girls worldwide are living with obstetric fistula. This is a complication directly linked to childbirth that can be avoided by a timely Caesarean section.

In Madagascar, more than 50,000 women and girls suffer from obstetric fistula and are awaiting reconstructive surgery. 4000 women¹³ aged between 15 and 49 suffer from this debilitating disease every year. In addition, one in 20 women has obstetric fistula because of the poor quality of obstetric care and 94% of women of childbearing age report not knowing the clinical signs of obstetric fistula. Furthermore, only 11% know that obstetric fistula can be cured.

¹⁰ National Millennium Development Goals Monitoring Survey (ENSOMD) in 2012.

¹¹ DHS IV (2008 - 2009)

¹² (DHS IV) 2012-2013

¹³ ENSOMD 2012 -2013

2.1.7. Family planning

Despite the progress recorded, contraceptive prevalence in Madagascar remains insufficient with a rate of 38.9%¹⁴ (versus 29% in 2008 and 19% in 1997). Unmet family planning (FP) needs fell from 25.6% in 1997 to 18% in 2012 and 16% in 2017¹⁵. In addition, the provision of immediate postpartum family planning services is not yet sufficiently popularized, as very few providers have the capacity to provide these services. In 2016, the number of regular users¹⁶ was 1,662,030, of whom 10,954 were between the ages of 10 and 14; 218,459 from 15-19 years old; 447,726 20-24 years old; and 984,891 25 years old and above. Regarding the number of new users, there are 631,604 of whom 8,580 are aged 10 to 14 years old; 132,117 are aged 15 to 19 years old; 231,699 20-24 years old; and 277,208 are over 25 years old.

2.1.8. Youth and Adolescents

The issue of sexual and reproductive health among young people remains a taboo subject limiting information dissemination channels. The rate of early marriages in Madagascar is among the highest in the world. One in two girls is married or in a union before the age of 18, despite the Marriage Act, according to which the marriage of two people, one of whom is under the age of 18, is illegal. This situation is closely linked to early pregnancies, which affect one in three girls in Madagascar. In addition, pregnancy¹⁷ and childbirth are the major cause of adolescent deaths in the country. Of the 10 women who die daily from complications related to pregnancy or childbirth, 3 are adolescent girls aged 15 to 19. In addition, more than 17% of girls in the 15-19 age group have had their first sexual intercourse by the age of 15.

Madagascar is ranked among the top 13 countries to have the highest prevalence rate of early pregnancy in the world, according to the World Atlas ranking in 2015. In Madagascar in particular, "163 out of 1,000 pregnancies involve teenage girls aged 15 to 19¹⁸ years old". In Madagascar, HIV prevalence among the adult population is low, rising from 0.02% in 1989 to 0.13% in 2007, and to 0.4% among adults aged 15-49 and 0.16% among young people aged 15-24 in 2011¹⁹. This prevalence is low among the general population with an epidemic concentrated within the groups most at risk: men who have sex with men (MSM), injectable drug users (IDU), sex workers (SW) and young people. The basic behavioral and biological survey carried out in 2010 gives a prevalence level of 14.7% among men who have sex with men (MSM).

2.1.9. Humanitarian

Southern Madagascar has been hit by drought and famine for decades, but national strategies have so far failed to significantly build resilience. In addition, with out-of-season rains in 2016 - 2017, several regions of the country were flooded. Between 2015 and 2016 and during the first half of 2017, the El Niño and La Niña weather phenomena affected Madagascar and the impacts of Cyclone ENAWO were considerable.

A "state of emergency" was declared during this period. This fragile context, exacerbated by the insecurity reigning throughout the country as a result of banditry attributed to the "Dahalo", continues to endanger not only the population, but also the humanitarian actors trying to bring aid to the most vulnerable populations. This catastrophic humanitarian situation has severely affected the lives of many women and children, increasing their vulnerability and the risk of excess maternal and child mortality.

¹⁴ TRAC 2017

¹⁵ TRAC 2017

¹⁶ Ministry of Health GESIS data

¹⁷ ENSOMD 2012-2013

¹⁸ ENSOMD 2012 2013

¹⁹ UNAIDS, UNAIDS estimation is done through the use of SPECTRUM software. ³⁶ Prime Minister's Office, Ministry of Economy and Industry, Development Cooperation Report 2009-2010 Madagascar, September 2010.

As a result of the drought caused by El Niño, some 1.14 million people in southern Madagascar are currently food insecure, of whom 665,000 are severely food insecure. This situation was triggered by a significant drop in food production over the last three agricultural seasons, due to erratic rainfall since 2012 and severe drought. A very large part of the population has serious qualitative and quantitative deficiencies, while new households with mild or moderate food insecurity are likely to gradually switch to an emergency situation.

2.1.9. Gender Equality and Women's Empowerment

Violence against women and gender-based violence are in general, almost common, not least in Madagascar. One in three women has experienced some type of violence in the last 12 months (Atsimo Andrefana, 27.5%; Androy, 31%; Vatovavy Fitovinany 43%) according to ENSOMD reports (2012-2013), and nearly 45% of women accept domestic violence. These acts of violence are very often unreported. This explains why more than 73% of women victims of violence have never attempted to seek assistance or even report acts of violence.

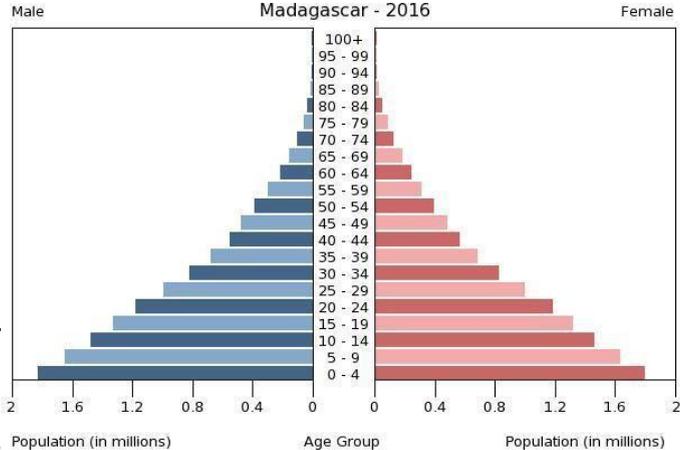
Madagascar is committed to mainstreaming the gender dimension in all its development interventions and to implementing specific policies and programs to reduce inequalities between women and men. The MPPSPF is therefore responsible for strengthening gender promotion mechanisms at government level. UNFPA, as leader of the Gender and Human Rights Thematic Group within the UNS in Madagascar, is aligning its action plan with the national side, whose interventions are to be evaluated in this 7th program.

2.1.10. Population dynamics

The Malagasy population reached 24,968,118 million in 2018²⁰ according to estimates, and its growth continues at a high rate, estimated at 2.72% per year by the National Institute of Statistics. As a result, the Malagasy population is extremely young, with the under-25s accounting for over 60% of the population. In the meantime, life expectancy at birth continues to increase and now reaches 64 years.

The dependency ratio therefore remains very high, at around 80% in 2015 (compared with 95% in 2000), preventing Madagascar from benefiting from the demographic dividend at present. However, there are disparities between regions of the country: the dependency ratio is higher in rural areas (105.4) than in urban areas (67.3), with the southern regions having a rate of more than 100 (INSTAT, 2014).

Figure 6: Age pyramid of the Malagasy population



Source: 2017 CIA World Factbook and other sources

This age pyramid illustrates the age and gender structure of the Malagasy population. The shape of the age pyramid is gradually changing according to trends in fertility, mortality and international migration.

According to the United Nations Population Fund (UNFPA), the extreme youth of the population is a major challenge, since it entails considerable investment needs in social sectors such as education, health, infrastructure, but at the same time it opens a window of opportunity for the country to benefit from the demographic dividend... The demographic transition has begun, but it is at an initial stage characterized by a decline in mortality and fertility. However, the composite fertility rate is still high (about 4.5 children per woman), and the contraceptive prevalence rate of about 38.9% is slightly higher than the regional average.

The continuing high fertility rate can be explained by the early age of marriage and pregnancy in Madagascar, with half of women aged 25-49 having entered into their first union before the age of 19, and 10% before the age of 15, despite the fact that the official legal age of marriage is 18. Statistics also indicate that adolescent fertility is very high, with 163 per thousand (UNFPA).

The urbanization rate is now close to 40%. While the country's population has almost quadrupled since the 60s, the population of the capital Antananarivo has increased sixfold, according to ATD Fourth World (2012), which estimates that a third of the capital's inhabitants are living in extreme poverty, escaping statistical surveys and occupying undeveloped urban areas in extreme conditions of unsanitation. Faced with the rapid rural exodus, investment in urban infrastructure has not kept pace with growing needs, and access to basic services is increasingly problematic. Precarious housing ("slums" or "plastic bag houses") has become widespread in Antananarivo. In 2011, the budget of the capital was USD 4 per capita per year, 7 times less than the city of Dakar (World Bank, 2011).

Migration flows are moving towards cities, especially towards regional capitals. The creation of manufacturing plants and university campuses has encouraged travel, especially to the capital. But migration between regions still seems low.

As for inter-regional migratory flows, the movement of people to more productive rural areas (with their agricultural and mining potential) changes the spatial redistribution of the regional population. Mobility is therefore very high in the Antananarivo region, while it is lowest in the Fianarantsoa and Toamasina regions.

Migration is mainly driven by working-age adults and women who migrate more than men, especially at younger ages. The average age of migrants is 29.6, slightly younger for women than for men²¹.

2.2. ROLE OF EXTERNAL ASSISTANCE²²

One of the Malagasy government's main tasks today is to implement the National Development Plan, whose three pillars are: improving governance, promoting economic recovery and widening access to basic social services. To achieve this, the government received, at the Donors and Investors Conference held in Paris in December 2016, a commitment of USD 6.4 billion to implement development projects (from 2017 to 2020). Financial support came from the African Development Bank, the World Bank Group and the United Nations Development Program (UNDP). Added to this was a USD 3.3 billion investment package announced by the private sector.

Following the return of peace in the country, the International Monetary Fund (IMF), which had withdrawn its aid during the crisis years, gave its support as follows: establishment in June 2014 of a Rapid Credit Facility (RCF) of USD 47 million; in November 2015, agreement of a new RCF of USD 47 million, followed by a program to support the necessary economic reforms (Staff Monitored Program, SMP); after a first mission in March 2016, completion of a second mission (June 2016); and the conclusion of an agreement in principle for a three-year program (2016-2019) backed by a RCF of USD 310 million. On July 27, 2016, the IMF Executive Board approved a 40-month arrangement under this Extended Credit Facility for Madagascar in the amount of around USD 304.7 million.

²¹ Mid-term evaluation report. UNFPA Madagascar 2017.

²² Inception report reviewed at mid-term 2017

In December 2015, the World Bank approved a USD 55 M credit to Madagascar for budget support. It continued its support as follows: in February 2016, agreement given to Madagascar to access the IDA Turnaround Facility; support to Madagascar for an estimated amount of USD 690 million for the period from 2016 to 2018.

Other donors include: The European Union with a National Indicative Program (INP) of € 518 million for the 11th European Development Fund (2014-2020). Madagascar should also benefit indirectly from ERDF funds; the African Development Bank (AfDB), in addition to the African Development Fund (ADF XIII), should provide additional support of USD 80 million in additional resources due to the AfDB's classification of Madagascar as a "fragile country".

Japan joins this long list, and is about to grant a USD 500 million concessional loan for the extension of the port of Tamatave. Finally, the United States is returning to Madagascar with the AGOA (African Growth and Opportunity Act) suspended since 2009.

2.3. UNFPA'S COUNTRY PROGRAM FACING DEVELOPMENT CHALLENGES

UNFPA provides support at national and/or central level for overall actions. In consultation with United Nations system partners and in order to maximize the impact of the program, special attention was paid to three regions (Atsimo Andrefana, Anosy and Vatovavy Fitovinany) based on the results of the analysis of a set of indicators that reflect priority needs in terms of maternal health, SRH/ARH services, combating gender-based violence and combating STIs and HIV, among others.

Investment under the 6th UNFPA program (2011-2013) amounted to USD 25.1 million (or 92% of the estimated amount). This contribution increased from the initial 62.5% to 67.4% and that of the government was multiplied by 6 (from USD 1M to USD 6M). NGOs mobilized USD 1.8 million. Sexual and Reproductive Health accounted for the bulk (USD 17.9M, 65.9%) of the 2008-2011 CPAP expenditures. The total budget for the 7th UNFPA program (2014- first half of 2018) was USD 22,371,076 million. As a result, UNFPA's contribution to Madagascar between 2011 and 2018 was USD 47 million.

Table 5: List of indicators for the three intervention regions of the 7th UNFPA program

INDICATORS/REGION	Vatovavy Fitovinany	Atsimo Andrefana	Androy
Total Population	1,425,600	1,296,000	712,800
Rural population	1,050,667	955,152	525,334
Young population (15-24 years)	470,448	426,690	235,224
Poverty Rates	79.6	93.1	96.7
Childbirth in a health facility %	12.8	32	21.7
Births assisted by qualified staff %	17.2	39.5	25.2
EMONCB GAP	9	10	5
EMONCC GAP	3	2	1
Unmet FP needs	17.6	18.8	11,8
Composite fertility rate	6.1	6	8.4
Teenage pregnancies with live births (%)	45.5	54.5	53.8
Contraceptive prevalence rate	31.9	25.3	5.6
Women victims of domestic violence in %	67.8	39.1	40.2

HIV Prevalence rate %	0	0.34	0.06
Women (15-24 years) with knowledge on prevention in %	39.7	38.5	28.9
Men (15-24 years) with knowledge on prevention in %	47.2	49.1	31.8
Prevalence of STIs reported by women aged 15 to 49 years old	2.5	8.7	1.1
Prevalence of male-reported STIs 15 to 49 years old	6,6	15.9	8.8

CHAPTER 3: UNFPA'S RESPONSE AND PROGRAM STRATEGIES

UNFPA works in partnership with governments, other institutions and civil society to advance its mission. Two frameworks guide its activities: The Program of Action adopted at the 1994 International Conference on Population and Development; and the Sustainable Development Goals (SDGs), a set of seventeen targets aimed at eradicating poverty, protecting the planet and ensuring that all human beings live in peace and prosperity.

UNFPA, the United Nations Population Fund, works around the world in 156 countries to build a world where every birth is wanted, every birth is safe, and every young person's potential is realized.

UNFPA has been working in Madagascar since 1978 and is currently implementing its seventh cooperation program with the Government of Madagascar. UNFPA promotes national execution by aligning its interventions with national priorities to ensure national ownership.

The 7th cooperation program between Madagascar and UNFPA was approved in January 2015 and its action plan for the period 2015-2019 was signed between the government and UNFPA in March 2015.

UNFPA Madagascar works in partnership with the Malagasy Government and other partners (NGOs, civil society) according to the Program Document.

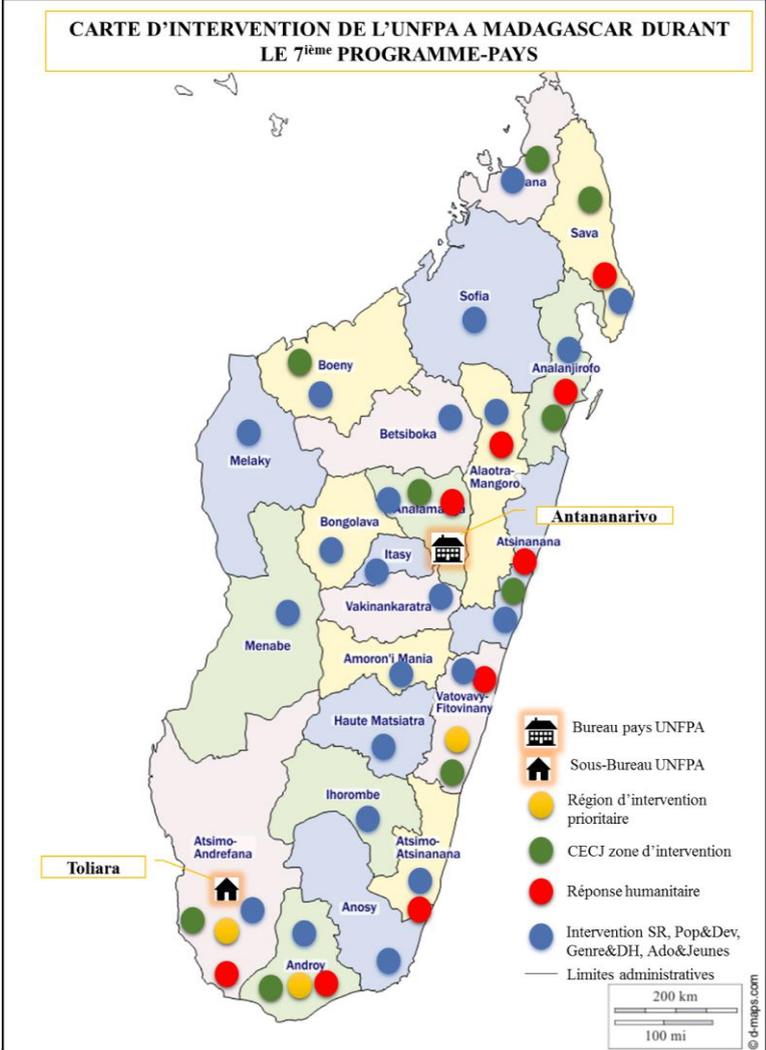
In line with UNFPA's strategic plan for 2018-2021, the Fund's focus areas are: (i) reproductive health (ii) youth and adolescents (iii) gender and (iv) data generation and population dynamics.

UNFPA focuses its efforts on several areas that have the greatest impact on the lives of women and young people.

The program has 5 outputs, including: (i) Output 1: Improved national capacity to provide high-quality maternal health services, including in humanitarian crisis situations. (ii) Output 2: Strengthened national capacity to increase the demand for and supply of modern contraceptive methods, and to improve the quality of family planning services free of coercion, discrimination and violence. (iii) Output 3: Increased access to youth-friendly information and services, including life skills training and sex education. (iv) Output 4: Enhanced national capacities to prevent and respond to gender-based violence and harmful practices, including in humanitarian crisis situations. (v) Output 5: Stronger national capacity to produce, analyze and disseminate disaggregated population data and use it as evidence-based information for policy and decision-making processes.

With regard to the regions and areas of intervention, UNFPA provides support at the national and/or central level for overall actions. In addition, UNFPA provides specific support to 3 regions of concentration: Vatovavy Fitovinany, Atsimo Andrefana and Androy.

Figure 7: 7th Country Program intervention map²³



3.1 UNFPA'S STRATEGIC RESPONSE

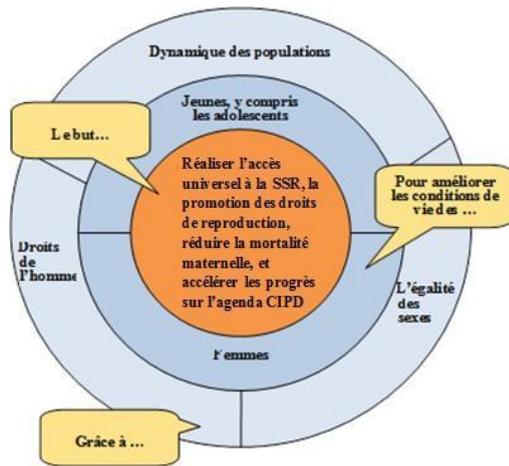
Based on the recommendations of the evaluation of the 6th program as well as the priorities set out in the new "Overall State Policy", the United Nations Development Assistance Framework (UNDAF) for the 2015-2019 period and the UNFPA strategic plan for the period 2014-2017, the seventh Program aims to *reduce poverty by targeting women and young people and adolescents, particularly those living in rural and remote areas through the reduction of maternal and neonatal mortality*. In order to bridge the gaps, the program targets the following priorities, with due consideration for social and cultural factors: (i) improving access to

increasing young people's access to information, sex education and services, (ii) preventing teenage pregnancy against gender-based violence; (iv) ensuring the collection, use, analysis and dissemination of data on the population.

Then, the country program was aligned with the 2014-2017 Strategic Plan, then with the one of 2018-2021. The 2014-2017 Strategic Plan aimed to contribute to universal access to reproductive health, the promotion of human rights, the reduction of maternal mortality and family planning, as indicated by the target of the 2014-2017 UNFPA Strategic Plan (Figure 8).

Figure 8: UNFPA Strategic Plan Target, 2014-2017

²³ The CECJ intervention areas supported under the 7th Program are in Antananarivo, Mahajanga, Toliara, Sakaraha, Ambovombe, Taolagnaro, Manakara, Mananjary. In addition, temporary listening centers were supported as part of the response to humanitarian emergencies in Antalaha and Maroantsetra.



3.2 UNFPA RESPONSE UNDER THE COUNTRY PROGRAM

3.2.1 Lessons Learned from the Past Program (2008-2013)

CPAP 2008-2011 (6th Country Program) covered three focus areas (or “components”): (i) reproductive health, (ii) population and development, and (iii) gender. For each of these components, the expected effects of the previous CPAP (or "outputs") were respectively: (i) the population, particularly the most vulnerable groups, have access to and use quality reproductive health and family planning services; (ii) increased use of reliable socio-economic and demographic information disaggregated by sex and age on population and development, for the purposes of developing, managing, monitoring and evaluating national, decentralized and sector strategies and programs (PDSS, PSN, PANAGED...) to implement the MAP and the MDGs; (iii) a legal and socio-cultural environment conducive to the reduction of abuses against women, the elimination of traditional practices that negatively affect women and the promotion of responsible parenthood. Following the socio-political and economic crisis, UNFPA has extended its cycle in line with the UNDAF, which initially covered the 2008-2011 period.

In terms of **Sexual and Reproductive Health**, UNFPA's contribution was to improve access to quality basic emergency obstetric and neonatal care (31% of deliveries in health centers in 2012 versus to 28% in 2009 in areas supported by the program). But it turned out that the low absorption capacity of the government prevented the desired effects from being achieved.

When it comes to family planning, an excessive focus on the supply of contraceptive methods has contributed to downplaying other important elements of family planning, in particular socio-cultural barriers to the use of services.

With regard to **adolescents and young people**, UNFPA has built national capacity in the area of adolescent and youth reproductive health by supporting the drafting of a law against child marriage, the development of a sex education program to be integrated into school curricula, the establishment of 22 youth-friendly health centers in 2012, versus 14 in 2010, and peer education, the creation of a youth-friendly web page, "Tanora Guarantee", and the monthly publication of a page devoted to young people in newspapers and youth-friendly spaces; the organization of the National Youth Symposium, with strong multi-sector and civil society involvement, which initiated the process of updating the National Youth Policy, incorporating the Symposium's recommendations.

As concerns **gender equality and women's empowerment**, the program contributed to the establishment of an institutional environment conducive to the promotion of gender equality. It has therefore also contributed to the establishment of gender-sensitive legal and regulatory instruments at national and regional levels, institutions to pilot actions to combat gender-based violence (GBV), and a mechanism to monitor access to justice and combat GBV.

As for the socio-economic situation of the most vulnerable women (women victims of fistula, GBV), the contribution of the program remained relatively small to improve their living conditions in a sustainable way. Even support for increased participation by women in public affairs seems to have yielded little in the way of results. The final evaluation of the 6th program highlighted the fragility of UNFPA-supported women's networks. The Legal Advice and Listening Centers (CECJ) have remained too dependent on external funding to ensure the sustainability of their outcomes.

In the field of **Population Dynamics**, mention should be made of the program's support for capacity-building among implementing partners. But the political crisis of 2009 led to the suspension of the General Census of Population and Housing project, and the cessation of activities on the interrelations of population dynamics at both central and decentralized levels.

3.2.2 UNFPA response under the 7th Country Program (2015-2019)

The program is in its fourth year of implementation. It was amended following the mid-term review carried out in 2017, aligning with UNFPA's new 2018-2021 strategic plan, including the 3 transformative results.

UNFPA's strategic response through its intervention logic addresses the development challenges of the Republic of Madagascar presented in chapter 2. This response fits perfectly within the 2015-2019 UNDAF (United Nations Development Assistance Framework); **it is based, through the outputs of the CPAP, on the synergy, coherence and logical links that exist between the current program (2015-2019), the UNDAF and the 2014-2017 UNFPA Strategic Plan.** The adjustments made in light of the review's recommendations have enabled better alignment with the new 2018-2021 Strategic Plan and improved targeting of interventions. In addition, the results matrix and resources framework has been updated to take account of the recommendations of the program's mid-term review, resulting in a revised program planning and monitoring and evaluation matrix (output indicators and targets).

Furthermore, in collaboration with the government, the office has set up a set of indicators (at national and regional level) for program monitoring (21 indicators in line with the 3 transformative results of the 2018-2021 strategic plan have been developed) to enable monitoring of program and partner performance.

The outputs of the CPAP 2015-2019 are actually linked to the UNDAF outcomes and the UNFPA Strategic Plan.

Output 1, "Stronger national capacities to provide quality maternal health services, including in humanitarian settings," contributes to UNDAF outcome 3 and outcome 1 of the 2014-2017 UNFPA Strategic Plan.

Output 2, "Strengthened national capacity to increase the demand for and supply of modern contraceptive methods and to improve the quality of family planning services free from coercion,

discrimination and violence", contributes to UNDAF Outcome 3 and UNFPA Strategic Plan Outcome 1.

Output 3, "Increased access to information and social services for young people and adolescents, including life skills training and sex education", contributes to the UNDAF Outcome 3 and Outcome 2 of the UNFPA Strategic Plan.

Output 4, "Stronger national capacities to prevent and respond to gender-based violence and harmful practices, including in humanitarian crisis settings," contributes to the UNDAF Outcome 2 and Outcome 3 of the UNFPA Strategic Plan.

Output 5, "Enhanced national capacity to produce, analyze and disseminate disaggregated population data and use them as evidence-based information for policy and decision-making processes", contributes to UNDAF Outcome 1 and UNFPA Strategic Plan Outcome 4. Linkages with UNDAF and the UNFPA Strategic Plan are clearly established.



Figure 9: The links between the intervention logic and the strategic plan and then UNDAF

3.2.3 Financial structure of the program

A review of the financial structure of the 7th country program between UNFPA and the Government of Madagascar enables us to assess its efficiency, by linking the ambitions expressed for each output with the funds allocated to it.

The projected budget at the end of the cycle was USD 74.5 million: USD 27 million from regular resources and USD 47.5 million from co-funding and/or other resources, including regular resources. The projected budget at the end of the cycle was USD 74.5 million: USD 27 million from regular resources and USD 47.5 million from co-funding and/or other resources, including regular resources. UNFPA had pledged USD 14 million in regular resources for the current cooperation program with the Government of Madagascar, subject to the availability of funds. Within these resources, UNFPA undertook to mobilize an amount of USD 5.8 million in other resources, subject to donor interest, with clear reference to the country program's resource mobilization plan.

A total of USD 22,371,076 was made available between 2015 and the 1st half of 2018 for the current cooperation program with the Government of Madagascar. UNFPA's contribution therefore increased by 62.58% of the amount of the initial commitment. The amount mobilized over the four years (2015-2018) is USD 3,113,596 (or 14% of the overall envelope); USD 15,592,405 (70%) comes from UNFPA's regular resources and USD 3,665,075 (16%) from other sources. Table 6 shows that regular resources showed a downward trend from 2016 to 2018. As for mobilized resources, a significant increase was observed from 2015 to 2017, and the 1st half of 2018 looks promising, as the amount mobilized is already higher than in 2016.

Table 6: Budget type by funding source (2015-2018)

Budget	2015	2016	2017	2018	Total
Regular resources	4,990,000	3,653,900	3,548,505	3,400,000	15,592,405
Other Resources	847,650	1,267,732	934,758	614,936	3,665,075
Resources mobilized	104,011	752,536	1,428,782	828,267	3,113,596
Total	5,941,661	5,674,168	5,912,045	4,843,203	22,371,076

Source: Cognos of 07/09/2018

The evolution of resources mobilized between 2015 and 2017 has grown over the years, unlike regular resources, which are decreasing, as are other resources. The same logic was followed in 2018 as Regular Resources fell from USD 3,548,505 in 2017 to USD 3,400,000 and Other Resources from USD 934,758 to USD 614,936. On the other hand, in the first half of the year, resources mobilized already represent USD 828,267, or 58% of the amount for 2017, which suggests a good outlook. The 2018 amounts are all partial as they reflect those of the first half, so they are subject to change.

For the 2015-2017 period, the financial utilization rate varies between 95% and 96%, which confirms the good performance of the program in terms of capacity. For the period 2018, the utilization rate at the time of the evaluation was around 63% (as of July 30, 2018). The performance of the financial utilization rate of the program is assessed on an annual basis, and the average of this rate between 2015 and 2017 is 97%.

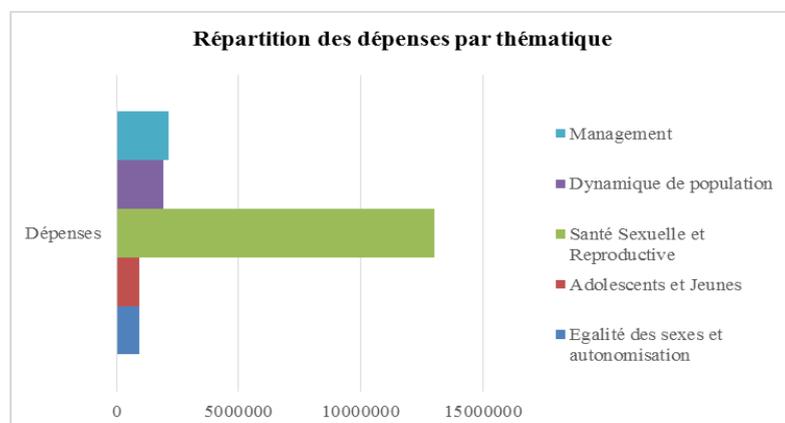


Figure 10: Breakdown of expenditure by component, 2015-2017

The figures show the importance UNFPA attaches to sexual and reproductive health in general. It accounts for the bulk (USD 13,024,452 or 69%) of CPAP 2015-2017 expenditure. This unequal distribution of the budget among the four components is a choice deliberately made by the Organization to better reduce

maternal and neonatal mortality with a view to achieving universal access to SRH, promoting reproductive rights, reducing maternal mortality and accelerating progress on the ICPD Agenda in line with the 2014-2017 Strategic Plan. The budgets for the other components are as follows: Youth and Adolescents (USD 915,080, 5%), Gender Equality and Women's Empowerment (USD 934,774, 5%) and Population Dynamics (USD 1,909,397, 10%).

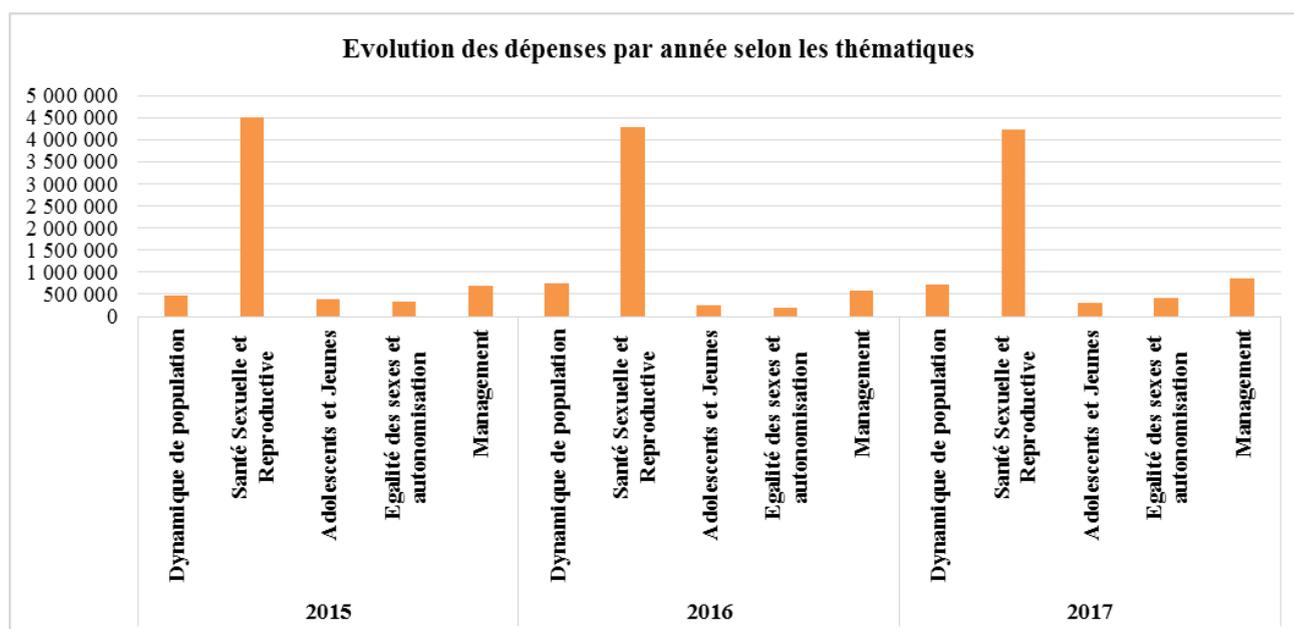


Figure 11: Evolution of expenditure by year and by component (Million USD)

The evolution of expenditure shows a slight regressive trend in spending on the Sexual and Reproductive Health component, even though it is the largest (USD 4,741,161 in 2015, USD 4,456,926 in 2016 and USD 4,542,711 in 2017). The evolution is the same for the Adolescents and Youth thematic area and for Population Dynamics. In contrast, the Gender Equality and Women's Empowerment thematic area grew from USD 332,251

in 2015 to USD 433,475 in 2017. Spending in 2018 shows good prospects, with a 62% absorption rate for all components at the year's halfway point.

Table 7: IP absorption rates by program outcome (2015-2017)

Source: Atlas 2018, UNFPA

	2015	2016	2017	Average 2015-17	2018 (Jul 18)
Sexual and Reproductive Health	95%	96%	93%	95%	67%
Adolescent and Young People	98%	94%	97%	96%	77%
Gender Equality and Women's Empowerment	96%	91%	97%	95%	48 %
Population dynamics	97%	98%	111% ²⁴	102%	43%
Total	96%	95%	99%	97%	62%

The table above shows the absorption rates of IPs by program output (2015-2017 and July 2018). The absorption rate averages 97% between 2015 and 2017. It varied throughout the period. This variation depended on the years and disbursements made in the execution of activities, and is very satisfactory overall. As a result, UNFPA has an excellent performance in terms of financial absorption. The absorption rate of implementing partners in the Population Dynamics component (Outcome 4) is the best performing (102%), ahead of the Adolescents and Youth component (Outcome 2) at 96%. The absorption rate was 62% in the first half of 2018, with 43% for the Population Dynamics component, 67% for the Sexual and Reproductive Health component, 48% for the Gender Equality and Women's Empowerment component and 77% for the Adolescents and Youth component. The rates are very appreciable.

²⁴ The rate above 100% in 2017 stems from the fact that when the Pilot Census was carried out in 2016, the fund allocated by USAID for this activity was not yet available and was pre-funded by UNFPA. At the time of

the fund transfer in 2017, the corresponding amount could no longer be recorded in ATLAS, even though the expenses related to this activity were paid back and therefore recorded for 2017.

CHAPTER 4: FINDINGS: RESPONSES TO EVALUATION QUESTIONS

For the sake of clarity, the answers to the evaluation questions are presented in detail below, by judgment criterion. Background information, detailed extracts and other information-gathering methods, including individual and group interviews, focus groups, site visits and analysis of findings by indicator criteria, are presented in Appendix 2 of this report, i.e., the evaluation matrix.

4.1 PROGRAM RELEVANCE

EQ1: To what extent do the objectives of UNFPA's 7th country program in Madagascar correspond to the needs of the Malagasy population (particularly those of vulnerable groups), and how have their needs been aligned throughout the program implementation period with national and international priorities, and UNFPA's strategies at international level?

Response Summary

Preliminary studies and data demonstrating the inclusive consideration of the needs of the population and their concentration *were used during CPAP programming.*

Overall, the results of the ENSOMD carried out in 2012-2013 (National MDG Monitoring Survey) were used in the program development process in the 3 thematic areas of Reproductive Health, Youth and Adolescents, Gender Equality and the Fight against Gender-Based Violence, with due regard for the main indicators. In addition, other thematic studies, both quantitative and qualitative, presenting the specific situation of the population were also used during the programming. This was a participatory process involving all stakeholders working in the population domain with their technical expertise and knowledge of the population's problems.

Moreover, the choice of regions was based on the regions' specific situation and conditions in humanitarian situations, again with reference to the main population-related indicators. Thus, the selection of UNFPA intervention areas and coverage of interventions in thematic areas are consistent with the identified needs and national priorities.

The CPAP and AWP of Reproductive Health, Youth and Adolescents, Gender-Based Violence targeted vulnerable groups during programming and implementation processes. These groups include women who are victims of violence, women victims of obstetric fistula, and women and youth in rural areas. In addition, women affected by natural disasters are among the beneficiaries of the program.

The objectives and strategies of CPAP's 4 focus areas are consistent with national policies and strategies, including the NDP and various sector policies, UNDAF priorities, and the 2014-2017 and 2018-2021 UNFPA strategic plan. The program was subject to a mid-term review in 2017 and subsequently aligned with the 2018-2021 Strategic Plan to contribute to the achievement of the transformative results. The AWP of the 5 program outputs are also in line with the priorities of the UNFPA and UNDAF strategic plan.

UNFPA's support for the production, analysis and processing of demographic and socio-economic data, as well as for the RGPH and other national population surveys, is tailored to the needs for NDP implementation and program monitoring and the achievement of the SDGs. This support is also consistent with the National Strategy for the Development of Statistics.

CJ1.1: The programming and planning process took into account the needs of Malagasy populations, especially the vulnerable groups

Regarding Sexual and Reproductive Health, the CPAP highlighted the needs of women of childbearing age based on an analysis of Sexual and Reproductive Health indicators, the main source of which was the 2012-2013 Millennium Development Goals Monitoring Survey (ENSOMD). These indicators relate to the high maternal mortality rate of 478,000 maternal deaths per 100,000 live births, the high rate of teenage pregnancies (34%) and the high rate of home births (61%) in rural areas and finally a slightly increasing contraceptive prevalence rate (33% in 2012), not to mention the poor quality of care due to the lack of qualified health workers, especially midwives. These needs of women of childbearing age, including in humanitarian situations, are then taken into account in the AWP relating to SRH. The program through the SRH component prioritized the most vulnerable and marginalized groups by supporting the national policy of free maternal health and family planning services. This policy aims to reach people in even the most remote locations in Madagascar.

UNFPA worked with public institutions and civil society so that they could take into account the SRH and AYRH needs of women and young people in their respective AWP.

In addition, certain studies were also considered when designing the CPAP: these include the Health Input Security evaluation in Madagascar in 2012; the evaluation of the campaign to eliminate obstetric fistulas and refocusing of the strategic plan in 2014; the Reproductive Health Commodity Security and Quality of Family Planning Services Evaluation Report 2014;

For the Youth and Adolescents component, UNFPA focused specifically on young and adolescent groups and especially the most vulnerable based on their specific problems and needs in terms of sexual and reproductive health from the Millennium Development Goals Monitoring Survey (ENSOMD 2012-2013). Thus, the adolescent fertility rate increased, going from 148 in 2009 to 163 per 1,000 in 2012. The rate of early marriages in Madagascar is among the highest in the world. One in two girls is married or in a union before the age of 18, despite the Marriage Act, according to which the marriage of two people, one of whom is under the age of 18, is illegal. This situation is closely linked to early pregnancies, which affect one in three girls in Madagascar. In addition, pregnancy and childbirth are the major cause of adolescent deaths in the country. Of the 10 women who die per day as a result of childbirth, 3 are adolescent girls under the age of 19. In addition, more than 17% of girls in the 15-19 age group have had their first sexual intercourse by the age of 15. In Madagascar in particular, "163 out of 1,000 pregnancies concern teenage girls aged 15 to 19

", according to the Millennium Development Goal Monitoring Survey (ENSOMD) conducted in 2012-2013. These needs of young people and adolescents, including in humanitarian situations, are then taken into account in the AWP relating to YARH.

The humanitarian situation is one of the country's priorities, and the needs of women, young girls and vulnerable people have been identified and taken into account in the CPAP. It was noted that a quarter of its population, i.e., five million people, live in areas highly vulnerable to cyclones, droughts and floods. The resilience of communities affected by climate hazards remains low because of poverty.

As for gender equality and women's empowerment, the needs of the Malagasy population, particularly vulnerable groups such as young people and women, were correctly identified and taken into account during the planning phase, based on a situational analysis. The CPAP drew from the 2012-2013 MDG monitoring survey, concluding that 30% of women are victims of at least one domestic violence,

young women are 4 times more exposed to sexual violence than their elders, and 35% of perpetrators are neighbors or relatives, which is due in part to the tolerance of GBV in Malagasy society (45.2% of women and 46.3% of men find it normal for a husband to beat his wife).

In terms of population dynamics, the interventions of the 7th Country Program are adapted to the needs of the target populations, especially since the identification and planning of responses to these needs were done in a participatory manner based on national statistical data on population dynamics. The situational analysis also allowed to highlight the need to carry out a general census (RGPH) which constitutes a major source of information on the state and dynamics of the population and therefore makes it possible to know the size of the population of Madagascar, its distribution by administrative unit and its structure according to demographic, social and economic characteristics.

Thus, the selection of UNFPA intervention areas and coverage of interventions in thematic areas are consistent with the identified needs and national priorities.

The selection of UNFPA intervention areas under the 7th Cooperation Program with Madagascar was the subject of a comparative analysis of the regions based on socio-demographic indicators. The objective of this analysis was to support a number of regions in order to contribute to reducing "extreme poverty" through the fight against maternal mortality, the provision of reproductive health services, the provision of sexual and reproductive health services for young people and adolescents including the fight against STIs and HIV/AIDS, the fight against gender-based violence, the provision of disaggregated data for development planning, monitoring and evaluation of different programs. The approach consisted in collecting various indicators (mainly from the reports of the national MDG monitoring survey (ENSOMD) carried out by INSTAT) for each region, and classifying the regions on the basis of the priority to be given to each of the poverty indicators, and finally in assigning weightings to them. In the end, special attention was paid to three regions with their poverty rates, namely Atsimo Andrefana (93.1%), Androy (96.7%) and Vatovavy Fitovinany (79.6%). However, the statistical data of the three regions relating to the components covered by UNFPA are absent from the CPD although those at national level are mentioned. Alongside this coverage of the three regions, many of the components' interventions cover the whole country. These are the RGPH, capacity building workshops on the SNISE, INSTAT staff and the integration of the Population Dynamics dimension into development policies and strategies in the Population Dynamics component. The same applies to obstetric fistula repair operations, humanitarian emergencies, advocacy, institutional support, assistance for the development of policies, strategies and laws.

CJ1.2: The objectives and strategies of the 4 outputs are consistent with national policies and strategies, UNDAF priorities, and UNFPA policy and strategic plan. This is obvious in all components.

The objectives of the 4 components are closely linked to the national and international policy frameworks where the priorities are defined. At national level, they are in line notably with: (i) the State General Policy (PGE 2014) following priority axes such as "Strengthening governance, the rule of law and establishing equitable justice"; (ii) the National Development Policy (PND 2015-2020) in its axes 4 and 5.

Specifically, in the SRH component, the objectives and strategies are consistent with the Health Sector Development Plan (PDSS 2015 – 2019); the country's commitments to the Global Initiative FP2020, the Integrated Strategic Plan for the Safety of Reproductive Health/Family Planning Products in Madagascar (2016 – 2020) on its various axes; the Budgeted National FP Action Plan 2016-2020; the National Strategic Plan for the Elimination of Obstetric Fistula in Madagascar. Similarly, interventions on Youth and Adolescents are consistent with the National Youth Policy, the development of which was supported by UNFPA.

With regard to the Gender Equality and Women's Empowerment component, the areas of intervention are consistent with the key policy and strategy documents, namely: the National Employment and Vocational Training Policy (PNEFP 2015-2019) and the National Strategy to Combat Gender-Based Violence 2017-2021. This component takes into account Madagascar's regional and international commitments for gender equality, in line with the needs of women, the protection of women, girls and vulnerable groups, in this case the Convention on the Elimination of All Forms of Discrimination against Women, the ICPD and Beijing Programs of Action, and the Millennium Development Goals. As regards the Population and Development component, the support of the 7th Program was consistent with the National Strategy for the Development of Statistics of Madagascar 2008-2017 in its various axes, and with the decree on the organization of the SNISE and its Manual of Procedures and Organization.

At international level, the 4 components comply with the ICPD goals, the Sustainable Development Goals (SDGs), the 2015-2019 UNDAF and the Beijing Platform for Action. The health sector approach implements both the Maputo Plan of Action and the Roadmap for Maternal and Newborn Health.

UNFPA has specifically targeted vulnerable and marginalized groups as a priority for SRH. CPAP Output 1 and Output 2 contribute to Outcome 1: “Sexual and Reproductive Health” of the UNFPA Strategic Plan 2014-2017 and UNDAF Outcome 3. Output 3 contributes to UNDAF Outcome 3 and Outcome 2 of the UNFPA Strategic Plan. Output 4 contributes to the UNDAF Outcome 2 and Outcome 3 of the UNFPA Strategic Plan.

Output 5 contributes to UNDAF Outcome 1 and Outcome 4 of the UNFPA Strategic Plan.

The 7th program focused in particular on building national capacities with a view to sustainability. Capacity building has also been planned as a separate activity for each component, for example, in maternal health services, family planning and obstetric fistula management.

In terms of targets, the most vulnerable and marginalized groups are male and female survivors of GBV, victims of obstetric fistula, women in humanitarian situations, and rural youth and adolescents.

CJ1.3: UNFPA's support for the production, analysis and processing of demographic and socio-economic data, as well as for the RGPH and other national population surveys, is tailored to the needs for NDP implementation and program monitoring and the achievement of the SDGs. The need to align the SNISE with the NDP and the SDGs has been identified through the shortcomings in the way the system operates.

The strategies supporting the collection and processing of demographic and socio-economic data are consistent with the needs to monitor the NDP and the achievement of the identified SDGs. And this by highlighting the logistical difficulties of accessing remote populations in the field, and the availability of reliable, up-to-date data from all administrative levels, which are often without decentralized authority.

With regard to the coherence of demographic and socio-economic data collection and processing, needs have been clearly identified in the UNFPA intervention design document, in order to better calibrate programmatic investments according to the regional population profile, through the need to organize a new census.

Under output 5, INSTAT capacity building in data analysis, production and publication is planned. This concerns both the staff and the institution. In addition, the MEP, as the coordinating body responsible for the SNISE and therefore for monitoring the SDGs, has included capacity building in its work plan, including the integration of population dynamics into planning.

4.2 EFFECTIVENESS OF THE PROGRAM

EQ2: To what extent have the outputs of the Country Program Action Plan been achieved and how have they contributed to the achievement of results?

Response Summary

In the area of reproductive health, UNFPA has contributed to improving the supply of maternal health services, particularly in the target regions, by strengthening the technical platforms of EmONC centers, including the availability of midwives. A total of 150,901 women gave birth in health facilities including during humanitarian emergencies and 4,355 WVOF were repaired during the program cycle. With regard to family planning, UNFPA ensured the procurement of contraceptives, the adoption and enactment of the new SRH/FP law in 2018. FP delivery points have increased and 15 FP model centers have been operationalized. UNFPA supported the implementation of the SPSR Strategic Plan.

For adolescents and young people, UNFPA has operationalized 22 youth centers and youth networks; 92,000 young people have been sensitized on adolescent health. UNFPA supported the sex education program which was implemented in two pilot districts. Although the expected result is not achieved, the scaling-up process is currently underway and deserves to be considered in the 8th program.

In terms of gender equality and women's empowerment, UNFPA contributed to the availability of a draft bill on combating GBV and an Advocacy Strategy Document for the adoption of the same bill and the National Strategy to Combat GBV. It contributed to the establishment of 3 regional platforms with action plans to combat GBV in normal and humanitarian settings based on the National GBV Strategy. UNFPA's support was also highlighted by the operationalization of 8 centers that provide listening and legal advice services (CECJ) to 1,914 victims of GBV. There are 505 victims of GBV and women who have been repaired of obstetric fistula (WVOF) who have benefited from socio-economic reintegration through appropriate IGAs following awareness campaigns on their rights and on family planning. However, not all regional GBV platforms are operational, either at central or regional level. Several interventions to strengthen the support to GBV survivors have been carried out, and beneficiaries are satisfied with the services provided by the 4 CECJs in the districts.

In the field of population and development, UNFPA has contributed to strengthening the SNISE and other information systems for the formulation and M&E of sectoral policies. Efforts have been made to build the capacity of central-level entities and UNFPA's three intervention regions (Vatovavy Fitovinany, Atsimo Andrefana and Androy) to operationalize the system. The actions undertaken by UNFPA have made it possible to make the SNISE

operational through the production of national and regional reports. UNFPA contributes to the integration of population dynamics, reproductive health, gender equality in development planning at national, sector and regional levels. The capacity of 247 qualified staff (out of 250 planned until 2019, i.e. 99%) at the Institut National de la Statistique has been increased. In addition, 49 staff members from decentralized entities have been trained on population development integration, providing them with the necessary tools to establish evidence-based development plans and policy. In addition, several capacity-building workshops on the demographic dividend were organized for development players at central and regional levels, with a view to carrying out an in-depth analysis of the situation and the strategies defined in sectoral policies. The awareness-raising, recruitment and training phases took place for the achievement of the RGP3 between 2015 and 2017. The year 2018 was dedicated to the collection and reporting of data from the peripheries to the central level. It is noted that 22 health facilities contribute to improving birth and death registration by using civil registration records while providing training. However, a number of challenges hamper the smooth running of the civil registry, including difficulties in collecting data on the coverage of maternal death registration.

4.2.1 Sexual and Reproductive Health

In the area of Sexual and Reproductive Health, the 7th cooperation program between UNFPA and the Government provided for two outputs:

- Increased national capacity to deliver high-quality maternal health services, including in humanitarian settings
- Strengthened national capacity to increase demand for and supply of modern contraceptive methods, and to improve the quality of family planning services free of coercion, discrimination and violence.

The main implementing partners of CPAP outputs 1 and 2 are: The Ministry of Public Health, MSM. ; SALFA; the Central Pharmacy SALAMA, ASOS, FISA, Faculty of Medicine; and indirectly, partnerships have been established with the National Association of Midwives with the Ministry of Public Health, the Federation of the Traditional Royal Community of Madagascar, the Ampasimanjeva Medical Foundation and the NGO SISAL.

CJ2.1: Quality maternal health services are available, accessible and used in the regions of intervention.

In the absence of a nationwide survey analyzing population and health data, such as the "Demographic and Health Survey", the present evaluation will not be able to assess the situation of two indicators, namely the maternal mortality ratio and the skilled birth attendance rate. In addition, the program has made a significant contribution to improving maternal health by hitting the CPAP targets with regard to EMONCB and fistula repair. Indeed, 21% of basic health centers were able to provide basic emergency obstetric care while the target for the year 2019 is 20%. Regarding fistula repair, a total of 4,355 WVOFs were repaired during the four years of the program thanks to UNFPA support versus 4,000 planned in 2018, which results in the achievement of the objectives of output 1.

Regarding EMONCB and maternal health, the UNFPA program has already exceeded the initial target in terms of the percentage of health facilities offering the EMONCB service with the current figure of 21%, versus the 20% planned in 2019. In addition, UNFPA support allowed to contribute to the delivery of

150,901 women in health facilities in the intervention regions since the beginning of the program cycle.²⁵

Table 8: Births in the Health facilities in the 3 concentration regions (Androy, Atsimo Andrefana, Vatovavy Fitovinany)

Year	Delivery	Obstetric Emergency	C-section
2015	40,218	1,236	522
2016	46,890	1,164	563
2017	47,288	1,676	775
2018 (July)	16,505	609	327
Total	150,901	4,685	2,187

The country office supported **the updating of policy and strategy documents** with a view to improving access to and the quality of integrated EmONC services, with particular attention to gender-based violence. These include: (i) the National Reproductive Health Policy; (ii) the National Strategy on Universal Health Coverage; (iii) the Operational Plan of the Roadmap for Accelerating the Reduction of Maternal Mortality and Morbidity in Madagascar, including the Action Plan for Every Newborn (2015-2019);

The EMONC monitoring activities were carried out during the years 2016-2017 (see Figure 12). Similarly, for the year 2018, the development of the network of reference maternity units has been carried out in collaboration with other UN agencies in the 14 regions of Madagascar using the ACCES MOD/SIG software in order to properly distribute the EmONC centers geographically based on population density, accessibility and the area of influence of the EmONC facility. Figure 13 below shows an access card 1, 2, 3 and 4 hours from the maternity facilities of the EMONC network in one of the regions of the country (Androy). Moreover, the technical platform of the EmONC clinics has been strengthened through the rehabilitation of 8 CSBs, and all maternity units in the intervention regions have been provided with 105,370 delivery kits and supplies for caesarean sections. The supply of management tools, including 3,103 CPoN, 3,103 CPN registers, 10,000 FSSMN, 8,000 maternal health booklets and 134 advocacy manuals feature among the activities supported by UNFPA. In addition, several surgical units²⁶ were rehabilitated and equipped by the program following a needs assessment.

²⁵ (Results monitoring 2017)

²⁶ ATU surgical unit at CHUGOB in the Befelatanana Maternity Hospital with equipment, ATU corridor at CHU GOB, surgical unit at CHRR d'Ambovombe Androy with equipment, surgical unit at CHRD Mahitsy with equipment and supplies.

Figure 12: Execution of essential EMONCB functions in health facilities

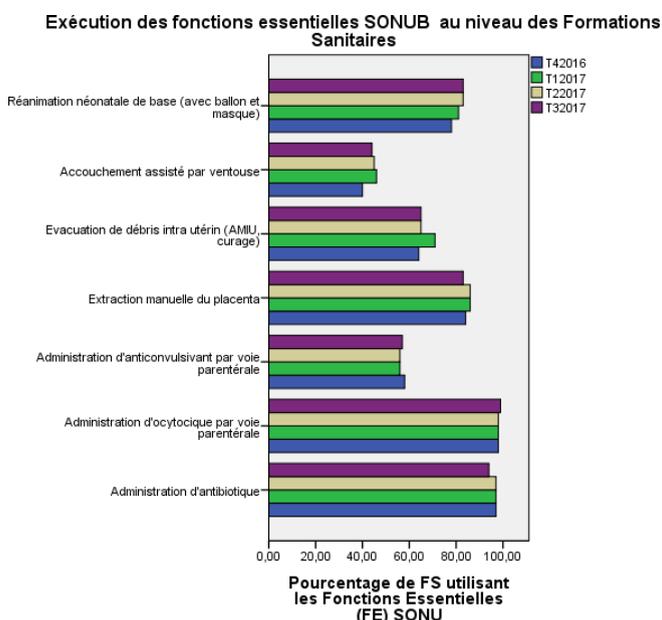


Figure 13: Physical accessibility card for EMONC maternity hospitals (Androy)

Androy

Formations sanitaires

- SONUB Potentielle (6)
- ▲ SONUB Fonctionnelle (0)
- ⊕ SONUC Potentielle (1)
- ⊕ SONUC Fonctionnelle (1)
- Autres maternités (46)

Temps de voyage

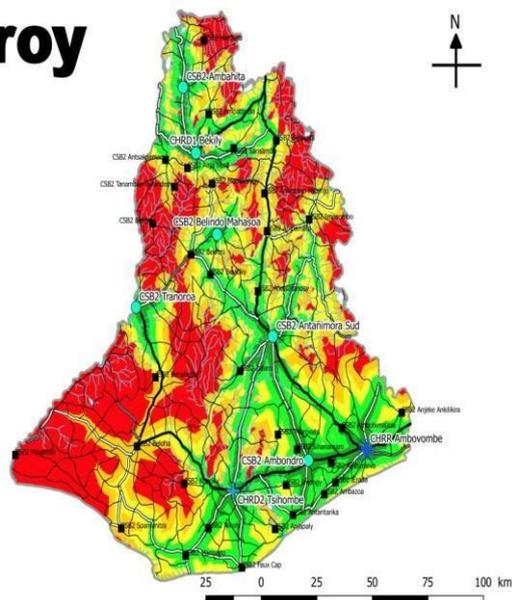
- < 1 heure
- 1-2 heures
- 2-3 heures
- 3-4 heures
- > 4 heures

Routes

- Routes nationales
- Autres routes
- Pistes/sentiers

Hydrographie

- Lac
- Rivière
- Limites régionales



Five EMONC units have been rehabilitated and nine have been equipped with kits and equipment. 54 health workers were also trained in EMONC and PFPP, 36 trained in AYRH and 22 trained in GBV with UNFPA support in the three intervention areas, and efforts were made to improve the referral versus referral system.

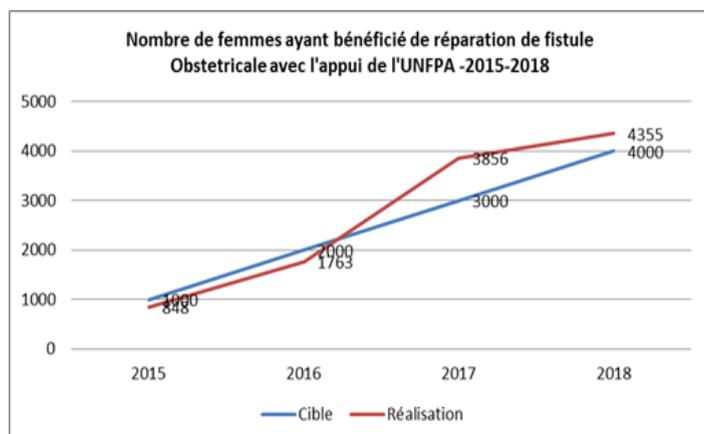
A district in a UNFPA intervention region has been equipped with two ambulances (tuk-tuk) to ensure referral of pregnant women about to give birth and obstetric emergencies to the hospital in Toliara. The optimal use of these transport equipment still remains a great challenge with 21 obstetric emergencies referred to health facilities since 2016.

With regard to the referral system in collaboration with the matrons, the initiatives with the support of UNFPA involved the signing of an agreement between the Ministry of Health and the matrons. In this way, 41 matrons and 50 leaders of royal and traditional communities in the Vatovavy Fitovinany and Atsimo Andrefana regions were trained in the danger signs of pregnancy and childbirth. One of the results observed was the referral by 21 matrons (CHW) of 107 pregnant women to 6 CSBs, and 2 during the period from April to June 2018 for delivery. A district in a UNFPA intervention region has been equipped with two ambulances (tuk-tuk) to ensure referral of pregnant women about to give birth and obstetric emergencies to the hospital in Toliara. The optimal use of these transport equipment still remains a great challenge. Indeed, a total of 21 obstetric emergencies have been referred to the health facilities since 2016.

As for fistula, UNFPA, in collaboration with other partners, including civil society, are all working in synergy in the intervention area. The program has invested heavily in the prevention, treatment and socio-economic reintegration of women victims of obstetric fistula through active research of women and care. In this regard, 4,355 women benefited from surgical repair during the 4 years of the program, and 18 surgeons and 18 qualifying interns were trained. These activities have had a considerable impact on beneficiaries, as they have shown their satisfaction with the free treatment. We have also seen the first signs of a change in the behavior of female victims, who are no longer hiding in order to be cured of the disease, and are now arriving directly at hospitals²⁷ following the awareness campaigns. A supply of medical inputs from health centers for the repair of 800 cases of Women Victims of Obstetric Fistula (WVOF) was also

recorded.

Figure 14: Evolution of the number of fistula patients receiving repair



Regarding the quality of fistula

surgeries, surgeons pointed out that many women return for relapses. For example, in the hospital of Ampasimanjeva, according to the chief medical officer, in 2017, of the 121 women operated on for obstetric fistulas, 46 had relapses and returned for repairs, i.e., a percentage of 38%. The number varied from 2 to 8 times for repairs after relapse.

Different reasons

may be at the origin of these facts: (i) women who have been repaired once they have returned home have not followed the hygienic precautions recommended upon discharge from hospital, and FP prevention has not been properly observed in order to achieve a pregnancy until after two years; (ii) malnutrition, because in general, WVOFs are small in size and underweight, (iii) the quality of the operation is inadequate, especially during campaigns when the number of WVOFs is high.

UNFPA has improved basic midwifery practice by supporting the training of 60 trainee midwives in maieutic practice. In addition, the country office recruited 35 midwives from referral hospitals and basic health centers in the three program intervention regions, who were able to carry out 2,936 deliveries in their duty stations. Also in this area, the curriculum for the initial training of midwives has been updated and strengthened on the basis of the ICM/WHO standard. This curriculum is currently implemented in 3 medical schools in the country. The 6 IFIRPs and the Faculty of Medicine have been provided with medical equipment and teaching materials; 44 ANSFM and ONSFM midwives from the 3 intervention regions have been trained in leadership/advocacy/communication; 41 midwives from the CSB2 in Tulear have been refreshed in the management of complications in the delivery room; 8 doctors and 9 midwives have received training of trainers in EmONC through e-learning modules; 28 midwifery supervisors were trained in Competency-Based Teaching (CBT) by international experts in collaboration with the ICM on midwifery practice before duty.

In order to improve the performance of newly recruited midwives in EMONCB CSBs in UNFPA intervention areas, midwifery teachers provided “**mentoring**”²⁸ for newly assigned midwives.

In addition, 75 teaching doctors and midwives have been trained in EMONCB and other training methods in these 3 faculties, in partnership with USAID/MCSP.

²⁷ Cases of four young women in the Mananjary CHRD who have just been operated on during the field visit.

²⁸ Mentoring refers to an interpersonal relationship of support, exchange and learning, in which the mentor invests their acquired experience and expertise in order to foster the development of newly recruited midwives who have skills to acquire and professional goals to achieve.

The National Register of Midwives has been updated with a view to the availability, deployment and retention of midwives. The Order of midwives has been supported in the census and research of midwives; the midwife training curriculum on maieutic courses is available. The program also equipped the IFIRP Competence Laboratory, the Faculty of Medicine and internship sites in Antananarivo and the FP/CPN/CPoN laboratory of the Befelatanana Maternity Hospital.

The external factors that hinder the improvement of midwifery practice are mainly the existence of some private midwifery schools that do not have accreditation, nor do not fully use the WHO/ICM curriculum and which leads to poor performance of graduates and could lead to poor quality of maternal health services. It is therefore important to reframe and involve the private sector in the next programming cycle while ensuring proper coordination.

In terms of maternal death surveillance and response (MDSR), progress is weak. Indeed, as far as coordination is concerned, the National Maternal Death Surveillance and Response Committee (MDSR) is confined to the health sector, and despite its revitalization, the effectiveness of the maternal death reviews carried out up to the transmission of the forms to the central level still remains a challenge. The program supported the supply of 399 guidebooks for providers to conduct maternal death reviews and the training of regional and district reproductive health managers in the 8 regions, including those in the 3 intervention regions. The results of the Monitoring of the 4 quarters²⁹ revealed that among the 154 maternal deaths recorded, 50 deaths (32.5%) were reviewed and 52 review sheets (33.7%) were transmitted to the central level. As a result, the cause of death is mainly hemorrhage. In the three UNFPA-supported regions, the SDMR situation is illustrated in the table below. In Androy and Atsimo Andrefana, it was found that more than 80%³⁰ of recorded maternal deaths were reviewed against only 4%³¹ in the Vatovavy Fitovinany Region.

Table 9: MDSR situation in the three concentration regions

Region	Registered MDs	Reviews	Percentage
Androy	4	4	100%
Vatovavy	10	8	80%
Atsimo Andrefana	45	2	4%
Total	59	14	23.7%

The RH BCC strategy is available: UNFPA has supported the development of RH communication materials and the organization of international days and national events. Additionally, 5,000 posters and 5,000 brochures on the 7 danger signs during pregnancy; 4,000 posters on the symptoms and hospitals for obstetric fistula (OF) management were produced; 1 awareness-raising spot on OF was produced - 20 TV and 40 radio broadcasts; 3,000 leaflets on behaviors to adopt after OF repair were designed and printed; 3 radio dramas of 7 episodes on FP were produced and broadcast in the intervention regions; 2 spots on family planning targeting families and young people were produced; 10,000 brochures on comprehensive modern contraceptive methods were reprinted and disseminated;

The 7th program supported the implementation of **advocacy and social mobilization activities** through the organization of events: (i) international days and national events for the promotion of RH, FP, the fight against OF; the 8th of March; (iii) CARMMA Week; (iv) World Midwives' Day; (v) International Day for the Elimination of Obstetric Fistula.

²⁹ (4th 2016, 1st, 2nd and 3rd quarter 2017)

³⁰ Androy: 4 reviews carried out/4 maternal deaths recorded in the FS, 4 reviews of maternal deaths carried out in the FS; Atsimo Andrefana Region: 08 reviews carried out/10 maternal deaths recorded in the FS

³¹ Vatovavy Fitovinany: 2 maternal death reviews performed/ 45 maternal deaths recorded

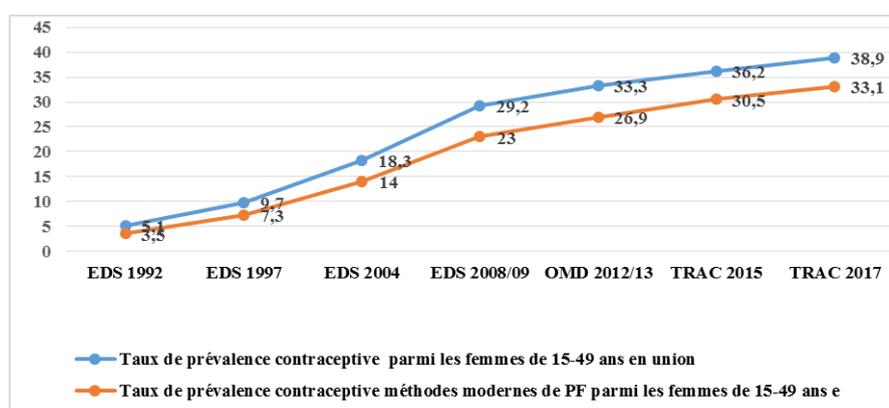
With regard to monitoring of actions, the analysis carried out by the team of evaluators revealed that local monitoring of interventions, which would enable a qualitative change in UNFPA's interventions, was insufficient, and that the insufficiency of referral facilities was noted.

CJ2.2 Quality family planning services are available, accessible and used in the intervention region: The objectives set for program output 2 have generally been achieved. Indeed, the contraceptive prevalence rate among women in unions (CPT) increases from 29% to 39%, of which 39% is the program's target to be achieved in 2019. With regard to program outputs, the percentage of service delivery points with no contraceptive stock-outs in the last three months is 95% if the forecast was 90% in 2018. The percentage of service delivery points offering at least 5 contraceptive methods is 90%, while the forecast was 71% in 2018.

UNFPA support for family planning and SPSR revolves around CPAP Output 2: Stronger national capacity to increase demand and supply of modern contraceptive methods and improve the quality of family planning services free from coercion, discrimination and violence.

UNFPA has been and remains the **main promoter of family planning** in Madagascar. Its support and contribution have borne fruit if we analyze the program's objectives and the graph below. The TPC is currently equal to 39% while the target CPAP outcome is 38% in 2019. However, with this trend, there is a risk that the country will not achieve the 50% TPC target it set in its PF 2020 commitment. For this purpose, the increase should be 2 points per year.

Figure 15: Evolution of the modern contraceptive prevalence rate (source: TRAC FP 2017)



With regard to contraceptive coverage³², the table below shows a gradual evolution

Table 10: Evolution of contraceptive coverage

Year	Number of RUs of modern FP methods	Contraceptive coverage rate in % (CCR)
2015	1,547,864	27.6
2016	1,662,030	29.25
2017	1,835,336	32.3
2018 - August 2018	1,954,511	31.9

Source: Ministry of Health GESIS data

32 The contraceptive coverage rate is calculated by dividing the number of women who regularly use contraceptive products by the number of women of childbearing age. Data are collected from health facilities and taken from the Ministry of Health's GESIS

In the program's intervention regions, **the CCR increased from 2015 to 2017**. Indeed, in both regions, the rate almost doubled, rising from 7.8% to 14.61% for Androy; and from 17.4% to 31.4% in Atsimo Andrefana. On the other hand, the rate increased from 28.9% to 31.3% for Vatovavy Fitovinany with a rather small change³³.

The analysis of **unmet needs** also allows to analyse UNFPA's contribution. Currently, fewer than two in ten women (16%) have unmet contraceptive needs compared with 19% in 2012. There is a significant difference between the proportion of women who need to space out births and the proportion who need to limit the number of offspring (9% vs. 7%). Unmet contraceptive needs are highest among women aged 45-49 (24%), with these needs geared towards birth control (21%). In terms of unmet needs for birth spacing, the youngest women (15-19 and 20-24) have the highest proportions (11% and 14% respectively). Needs are more focused on birth spacing.

Evolution of the indicators of Program Output 2

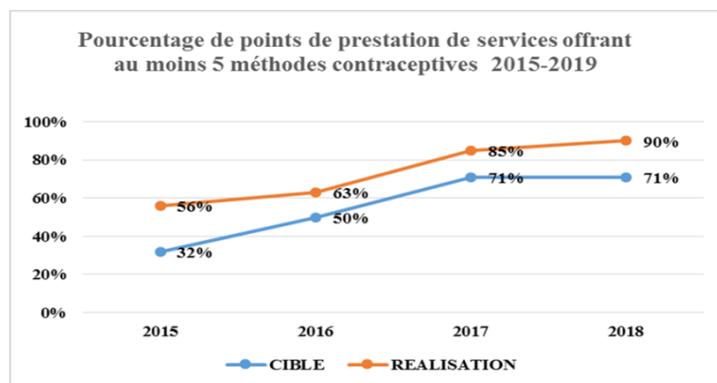
Table 11: Percentage of service delivery points without contraceptive stock-outs in the last three months

Output 2 Indicator 2

Figure 16: Percentage of service delivery points offering at least 5 contraceptive methods 2015-2019

Source: CPAP Monitoring and Evaluation Matrix

Indicator 1: Percentage of service delivery points without contraceptive stock-outs in the last three months			
Year	2015	2016	2017
TARGET	94,60%	95%	95%
ACHIEVEMENT	94.90%	94.90%	94%



The table and graph above show the positive evolution of two indicators in relation to contraceptive availability and service provision.

For indicator 1, UNFPA-supported outputs will be further developed in the section **regarding the operationalization of the SPSR system**.

For indicator 2, "Percentage of service delivery points offering at least 5 contraceptive methods", even the 2018 situation is around 90%, with a forecast of 71%.

In this context, UNFPA's support is focused on **FP capacity building**, consisting of training/upgrading for (i) 224 health workers in three regions of concentration³⁴, including those in FP model centers in PFI including the youth approach, the rights approach and long-lasting methods; These activities were carried out in collaboration with other financial partners, following an update of the PFI training curriculum and the provision of FP supplies; (ii) 180 student midwives and doctors trained in FP; (iii) 40 CHWs trained in FP4 in the 4 FISA intervention communes (Androy region); and (iv) 20 ASs from the Stars MSM CSBs in

the Atsimo Andrefana region trained in Long Term Methods.

In addition, **15 FP model centers**³⁵ have been created and are operational in the 3 intervention regions and in the Analamanga region, in collaboration with the Ministry of Health and NGOs such as FISA. In this way, the Ministry of Health is supported through the rehabilitation and provision of office furniture, equipment and audio-visual materials. The FF model centers³⁶ also serve as practical training centers for FP training.

³³ Source: UNFPA annual reports data

³⁴ Atsimo Andrefana, Vatovavy Fitovinany and Androy

³⁵ 15 model centers of which 04 are located in the Analamanga Region, 05 in the Atsimo Andrefana Region, 04 in the Vatovavy Fitovinany Region, and 02 in the Androy Region

In addition, the program contributed to improving access to FP/STI/HIV services for vulnerable populations and remote and isolated areas in the 3 intervention regions through community-based strategies in partnership with FISA and MSM. In this sense, FP services targeting vulnerable populations in Analamanga have been provided through mobile buses in collaboration with MSM. Advanced outreach strategies were carried out in landlocked and remote areas of the 3 regions of Atsimo Andrefana, Androy and Vatovavy Fitovinany by the teams of MSM and FISA.

The program contributed to the increase in demand for FP by supporting the annual celebration of the FP campaign in 2015 with awareness-raising on the prevention of early and unwanted pregnancies.

UNFPA supported the availability of strategic and operational documents as well as the establishment and operationalization of an SPSR system in the country.

In addition, **a national FP coordination committee** involving all stakeholders is operational and meets regularly once a month. This committee regularly discusses the evolution of the implementation of the activities of the PF budgeted national action plan (PANB) including the SPSR. The logistics sub-committee responsible for quantifying needs and monitoring stocks of contraceptive products is also functional. Members are made up of all FP stakeholders, and a meeting of this FP logistics sub-committee takes place each month. In addition, the Health Inputs Logistics Management Committee (CGL) responsible for mobilizing resources and advocating for SPSR as well as the Health Inputs Logistics Management Technical Unit (UTGL) are operational and coordinate the quantification of products within partners. CGL and UTGL supported the advocacy for the introduction of new contraceptive brands such as Sayana Press and Implanon NXT, as well as action research related to the introduction of Implanon NXT in the pilot districts of Moramanga and Antsirabe II.

Furthermore, **the program supplies the full range of contraceptives** for the public sector and NGOs like FISA, SALFA and MSM. A budget line equal to 100 million ariary for the purchase of contraceptive products was opened in 2006 by the State. This amount dropped during the political crisis in 2009; and in 2017, it only increased by 1%, whereas the State had committed to an increase of at least 5% per year.

Following advocacy activities carried out with the Ministry of Finance and Budget and the Ministry of Public Health by UNFPA and other partners, the Ministry of Public Health has pledged, starting in 2018, to increase the budget allocated to the purchase of contraceptive products by 100% per year for 5 years.

Despite the commitment made by the State, the increase in the budget allocated by the government for the procurement, storage and distribution of contraceptive products is still low. The FP National Committee is functional and should follow up on the implementation of the commitments and continue advocacy activities to increase this allocated budget.

The results of the advanced outreach strategies carried out in the remote and isolated areas of the 3 regions of Atsimo Andrefana, Androy and Vatovavy Fitovinany by the MSM and FISA teams are palpable and reveal that, thanks to the partnership with the NGO FISA, 3,150 cases of STIs among high-risk vulnerable groups in Atsimo Andrefana have been treated and 3,500 MLDs for the poorest population in Antananarivo have been inserted; 9 mobile integrated SRH services were provided and 4,960/6,000 clients, 56% of them young people and 44% adults, benefited from FISA activities.

In partnership with the NGO MSM, 8,499 RH/FP services were provided, including 4,066 clients for long-term and permanent FP methods through MSM mobile teams in 270 sites; 18 Districts, 4 Regions; 25,853 clients were served by the 47 Star CSB, including 2,090 for long-term methods in the 3 regions of Atsimo Andrefana, Vatovavy Fitovinany and SAVA; 1,976 RH/FP services, including 1,518 clients benefiting from long-term and permanent methods, were serviced via the 2 mobile buses in Antananarivo's poor neighborhoods. 47 Stars CSB from the public sector were supported by UNFPA as part of the Young Mother project to improve the use and quality of RH/FP services.

³⁶ A FP model center is a facility that receives specific - technical and financial - support so that it can reflect best practices in FP and comply with quality standards for integrated services, in terms of reception infrastructure, human resources and equipment, range of contraceptive products and integration of FP/HIV/SMI/SRA services with a focus on adolescents and young people.

With the support of UNFPA, the new FP law laying down the rules governing RH/FP **is currently under adoption.** To this end, the FP Law Committee under the leadership of the Ministry of Health was set up with the support of UNFPA, and advocacy actions were carried out through the organization of two round tables on the importance of the demographic dividend and the revolutionary role of FP. This advocacy was conducted respectively with the association of women MPs under the leadership of the President of the Senate, and with the Government under the leadership of the Prime Minister. To compensate for the postponement of the vote on the bill at the Senate, UNFPA supported the organization of a dinner with MPs to discuss the subject and the crucial role of family planning for the socio-economic development of the country.

On December 12 and 13, 2017, the law was voted by the Senate and the National Assembly after amendment and withdrawal of Articles 22 and 23 on therapeutic abortion. In its article 21, with a view to protecting, respecting and realizing the right of everyone without any discrimination or coercion, to the practice of FP, the new law provides free access of sexually active adolescents, married or not, to family planning advice and services. Law No.2017-043 was promulgated by the President of the Republic on January, 25 2018.

UNFPA and other partners supported the Ministry of Health in the development of the law's implementation decree, currently awaiting validation by the Government Council and the Cabinet, as well as the development of the operationalization plan for the RH/FP law.

UNFPA also supported advocacy with traditional leaders and influential groups during a day of reflection on RH/FP, followed by the dissemination of the new law to decentralized local authorities, journalists, service providers and young people in Ambovombe Androy, to create a normative and organizational environment conducive to access to rights-based FP information and services for all, especially adolescents and young people.

UNFPA and the H6+ group continue to carry out advocacy with the Ministry of Health for the legalization of therapeutic abortion as part of the reduction of maternal mortality.

Level of operationalization of the SPSR system

Regarding the operationalization of the SPSR system, with the support of UNFPA, **the 2016-2020 Integrated Strategic Plan of FP and SPSR is available** and being implemented with a view to strengthening the multisector public and private partnership. The plan served as the basis for the development of the 2016-2020 FP Budgeted National Action Plan (PANB) relating to Madagascar's commitments to FP 2020. In this context, information and awareness-raising meetings were held with donors, international NGOs, local NGOs and elected officials from the 22 regions, the private sector and sector ministries (MJS, MEN, MPPSPF, MJ, MC and MFB), on the Integrated FP and SPSR Strategic Plan and Madagascar's commitments to FP 2020.

UNFPA invested heavily in capacity building for the logistics management of SR products. **CHANNEL software**, an electronic logistics information management tool, was promulgated by UNFPA to improve the logistics data collection system, and is currently the national logistics information management tool for all health products in Madagascar. The new version of the CHANNEL software (Malagasy Channel) was launched towards the end of 2014 and its implementation was extended to 15 regions in 2015 versus 07 regions in 2014. In this regard, 392 health workers, logistics managers and decision-makers at central level and in 7 regions³⁷ are trained in the new version of CHANNEL and 136 health workers including 20 logistics managers and 19 pharmacists have been trained on the use of the new version of CHANNEL.

The process of integrating the management of health inputs at SALAMA (storage and distribution) has been improved thanks to (i) the necessary revision and harmonization of maximum and minimum stock levels for all RH drugs, and (ii) the creation of the logistics committee, which brings together all central-level technicians involved in the management of RH products on a monthly basis.

³⁷ Sava, Diana, Menabe, Melaky, Haute Matsiatra Ihorombe, Alaotra Mangoro

An integrated monitoring/surveillance and formative supervision system has been introduced in the annual regional health development plans.

165 FP providers trained in Supply and Inventory Management (SIM) and FP products in 5 SDSPs³⁸ to ensure security; 22 regional managers and 38 managers from 19 districts trained in the supply chain; 2 RH/FP logistics technicians took part in sharing supply chain experiences; 19 managers trained in logistics management; UNFPA supported the training of SALAMA central purchasing office staff in the Logistics Information and Management System (SIGL) and capacity-building in quantifying RH product needs.

The national supply of contraceptives was ensured by UNFPA with the support of SALAMA to transport the products from the central level to the health districts. UNFPA has contributed to **the supply of the full range of contraceptives in the country**, provided 323 new FP sites (public and SALFA) with FP kits, supported the reproduction of FP management materials, and contributed to the opening of 128 MLD sites. Twenty officials from the Ministry of Health were trained to use the Impact 2 software, which is designed to collect FP data and provide decision-makers with an indication of the impact of existing FP activities and the planning of future interventions.

A budgeted national procurement plan for RH products is available. Workshops to quantify the need for RH products were also organized with funding from the program. Manuals on the quantification of health input needs and the management of health inputs for health workers at different levels have been improved and duplicated into 200 copies. In addition, storage capacities for RH/FP products have also been upgraded at all levels. Additionally, executives from the Ministry attended international workshops on generic drugs substitution in Addis Ababa; the CHANNEL Software Focal Points training Workshop in Ouagadougou in 2015; and the Supply Chain Maturity Workshop in Nairobi in 2018.

As far as coordination is regarded, monitoring and evaluation, supervision activities were carried out jointly at regional level. In addition, the database software at the Family Health Directorate (DSFa) has been updated to better integrate the EMONC, Fistula and training components. However, the regular updating of data and the use of data for decision-making remain a challenge. H4 and GTTL meetings are held on a regular basis.

As for evaluations, an assessment of the introduction of the NXT implant in the pilot districts (Moramanga and Antsirabe II) has been carried out, and the recommendations have been used for planning purposes. UNFPA supported the provision of FP data collection and management tools through the updating and reproduction of individual FP consultation forms, registers, order forms and delivery notes for RH products.

The strengths of the program's implementation are i) the continued existence of the national coordination meeting; ii) the financial contribution made by partners, in addition to that of the State, to the purchase of RH products in relation to national needs; iii) the existence of a national supply system ; iv) the integration of health products from vertical programs including contraceptive products and maternal health products into the SALAMA channel. However, it should be noted that the distribution system does not ensure the transport of reproductive health products from the central SALAMA purchasing office to the CSB level. There is no means of transport at health district level to ensure the transport of products to health centers in the event of a shortage threat, and this remains a major challenge.

³⁸ SDSP Vohipeno, Manakara, Mananjary, Ifanadiana, Maroantsetra

CJ2.3: Quality reproductive health and anti-violence services available to meet needs in humanitarian situations, with due regard for the needs of young people

In the field of humanitarian response, the country office has built the country's capacity to integrate reproductive health and the fight against violence in humanitarian situations. To this end, the contingency plan was updated annually as provided for in the CPAP, integrating reproductive health and the fight against violence.

Thanks to the MISP, 984 pregnant women with obstetric complications and their newborns were saved thanks to C-section operations and post-operative care; 296 obstetric complications were treated free of charge; 17,099 pregnant women benefited from safe deliveries. Among comprehensive sexual and reproductive health services, the use of family planning has taken over to strengthen the resilience of these women in the post-natal period.

As part of humanitarian emergencies, 32,225 dignity kits were delivered to pregnant women in the South during the Great Famine. Following fires in two districts; 162,583 boxes of MISOPROSTOL, 756 vials of CHLORHEXIDINE, STI/HIV testing were also delivered to health facilities. 3 CSBs were provided with medical delivery kits, a hospital was provided with laparo caesarean kits. Accommodation sites in the capital, in the Androy region and 2 districts in Alaotra Mangoro region received dignity kits, blankets and individual hygiene delivery kits. A dozen health facilities in the capital were also supplied with rape medical care kits. Measures to accompany the use of Misoprostol have been reinforced, and a draft strategy is available. 149 regional and district officials from the decentralized entities covering 80 health districts spread over 15 regions most vulnerable to climate shocks carried out an analysis of the humanitarian situation and vulnerability at regional and district level in relation to SARCOF and MADA weather forecasts and the actual reality linked to the impacts of "El NINO".

As regards GBV control, sub-clusters for GBV control at national and regional level have been established. GBV sub-clusters have been activated in the regions of SAVA, Atsimo Andrefana, Androy as well as at national level. In SAVA and Atsimo Andrefana, in Ambovombe, capacity building in the collection of data on GBV through the support of 02 data managers respectively based in Ambovombe and Antalaha, the establishment of an electronic database, with management tools, for the compilation of data collected by community relays was carried out. 30 member institutions of the national GBV sub-cluster are trained on GBV prevention and response in humanitarian settings; mapping of GBV sub-cluster stakeholders was available and distributed to members, as well as an Action Plan developed with input on the contingency plan. During the 2017 humanitarian crisis, 10,980 people were sensitized on GBV in general and during humanitarian crises. There was engagement of community leaders from the 8 districts affected by severe food insecurity in the south, with community leaders, mayors, medical officials, police and gendarmerie in the 7 districts affected by Cyclone ENAWO. 90 state and non-state actors (police, gendarmerie, health, various associations and NGOs) received capacity-building to prevent and respond to GBV and set up a collaborative framework between the different entities involved in GBV victims' care. One of the strong points in the prevention of and response to GBV was the strengthening of communication in times of humanitarian crisis by the NGOs Gender Links and Bel Avenir.

Nevertheless, partner buy-in is insufficient. The implementation of some platforms is hampered by the lack of office space and equipment, which means that meetings only take place occasionally. In addition to the lack of members, the technical, organizational and financial difficulties of the few regional platforms observed during the field visit meant that they were able to operate on an ad hoc basis to the limit of their resources. Coordination has been strengthened both among GBV responders and between the various humanitarian clusters.

4.2.2 Adolescent and Young People

The evaluation of the Adolescents and Youth component is carried out according to Outcome 2 to assess progress and the achievement of expected results in line with UNFPA's Strategic Plan, and to measure the impact of actions on beneficiaries under Output 3. Outcome 2: *“Increased priority given to adolescents, especially young adolescent girls, in national development policies and programs, including through the provision of comprehensive sex education and sexual and reproductive health services”* contributes to UNDAF outcome 3.

CJ2.4: Access to youth-friendly information and services, particularly life skills training and sex education, is improved by the operationalization of 22 youth centers and other actions for young people and adolescents. Overall, more than 92,000 in-school and out-of-school young people were made aware of the sexual and reproductive health of adolescents and young people during the 7th program. The sex education program was introduced in the country, piloted in two pilot locations where more than 3,000 students were covered. An assessment for scaling up at national level was also conducted. The scaling-up exercise started this year 2018 with the training of 66 top trainers from 7 regions.

The main implementing partners for CPAP Output 3 are: (i) the Ministry of Youth and Sports (MJS); (ii) the Ministry of Public Health (MSP); (iii) the Ministry of National Education (MEN); (iv) the Ministry of Population, Social Protection and the Promotion of Women (MPPSPF), and FISA Madagascar.

To achieve output 3, the following strategies have been adopted: (i) raising awareness and informing out-of-school young people and adolescents, especially in rural areas, about the issues of early marriage, early pregnancy and STI/HIV; (ii) supporting the integration of sex education into school curricula; (iii) advocating increased investment in young people, especially girls and marginalized youth (including young sex workers and young people living in the streets).

A mechanism was developed following the training of 20 young peer educators per youth center and 10 per youth spaces to sensitize their peers on adolescent and youth reproductive health. Young people and teenager-friendly communication materials on various themes have been produced and disseminated. In addition, several youth networks have been created to ensure accessibility of information.

In particular, the number of youth spaces has risen from 0 in 2015 to 13 in 2018; youth centers have increased from 4 in 2015 to 6 in 2018, which are networked with youth-friendly health centers during the 7th program. A mechanism was developed following the training of 20 young peer educators per youth center and 10 per youth spaces to sensitize their peers on adolescent and youth reproductive health. In addition, several youth networks are in place to ensure accessibility of information. Overall, more than 92,000 in-school and out-of-school young people were made aware of the sexual and reproductive health of adolescents and young people during the 7th program. In addition, youth networks are attractive to young people because 21,900 young people are sensitized on social networks through the Facebook page Tanora Garan'Teen (TGT). About 5,000 young people were sensitized by the Network of Young Ambassadors engaged in AYRH (called TANORA IRAY). More than 700 young people improved knowledge on the demographic dividend and contributed to the development of the youth resolution on peacebuilding based on the pillars of the demographic dividend during the International Youth Day in Fianarantsoa; more than 3,000 young people had improved knowledge on menstrual hygiene.

Percentage of school districts implementing a sex education program in line with international standards

Thanks to the support of UNFPA, despite the fact that sexuality is still a taboo subject in Madagascar, the sex education program was introduced and tested in two pilot locations in Atsimo Andrefana and Vatovavy Fitovinany in 2015 where more than 3,000 students were served. An assessment for scaling up at national level was also conducted.

"Madagascar undertook alongside 19 other countries to offer CSE services to Malagasy adolescents and young people. To do so, in 2015 the DCI/MEN designed the Framework document for sex education (COES) based on international guidelines for CSE and incorporating socio-cultural realities, regional specificities, economic situations, pedagogical context, as well as international guiding principles on sex education... The country has a national youth policy and this is an asset because it reflects the country's strong will and commitment to young people.

In addition to the COES, the guide for integration into the school curriculum, manuals for teachers and parents, the training curriculum from 2014 to 2018, and the communication document for parents concerning the Sex Education Program, available in Malagasy and French versions, have been prepared and used.

Based on the COES, a "Sex Education Program" called PES has been designed to introduce SE in schools. As a result, a CES integration guide for all subjects taught at each level of study and based on the PPO was prepared by the DCI/MEN team in 2015. The purpose of this guide is to provide teachers and educators with the tools they need to carry out the CSE with their students. As for parents, a document specifically intended for them has been prepared by the DCI/MEN. In fact, following an implementation monitoring mission by the DCI/MEN, it was recommended that a document be produced for parents to inform them of the content of the CSE, including the themes conveyed, in order to avoid any prejudices and misinterpretations relating to sexuality, which is still a taboo subject in Madagascar", extract from the evaluation report on the implementation of comprehensive sex education in the two pilot sites.

The evaluation of the implementation of the Comprehensive Sex education (CSE) program in two pilot sites demonstrated its relevance and adaptation to the objectives of this program: 176 educators from two pilot sites were trained on comprehensive sex education and more than 3,000 students were sensitized.

Regular follow-ups were indeed carried out in 2016. In 2017, an evaluation of the experiment was conducted with a view to scaling it up nationwide. The evaluation demonstrated its relevance and adaptation to the objectives of this program: 176 educators from two pilot sites were trained on comprehensive sex education and more than 3,000 students were sensitized. A training plan for teachers and educators was developed; 100 documents of the Sex Education program were produced. However, the partners argued that the Ministry of National Education was not part of the partnership for the direct implementation of UNFPA; this generated some susceptibilities because everything must go through the Ministry of Youth and Sports.

The results were satisfactory and a start of the gradual scaling-up occurred in 2018. In this regard, the training of 66 top trainers from 7 intervention regions was carried out. The next steps would be to carry out the training of local educators by the top trainers and teachers delivering the sex education program planned for the next school year 2018.

Advocacy to increase investment in young people and especially girls and marginalized youth: the National Youth Policy is available. The adolescent and youth reproductive health training curriculum for non-health workers was developed jointly with the Ministry of Public Health and all relevant entities. The Peer Education Approach is coordinated through the launch of the Peer Education Harmonization document. Coordination between the three supported directorates of the Ministry of Education has been strengthened. The program also contributed to the development of the national AYRH strategic plan and the update of AYRH training curricula for health and non-health workers.

An effort has been made to improve the performance reporting mechanism in the intervention sites, following the training of 40 regional and central resource persons. However, according to the partners, the national ownership of the implementation of these tools is still low.

CJ2.5: Enhanced participation of young people in the peacebuilding process

Since the implementation of the project in January 2018, improved cohesion has been observed in the target communities thanks to the establishment of dialogues for peace and conflict management in the eight intervention municipalities with the involvement of young people and women. To date, 130 stakeholder dialogues and 42 community leader meetings have been conducted. Similarly, one solidarity, cultural and sporting activities were organized by communities involving different groups, and 30 conflicts were settled through community platforms.

Despite cultural barriers that prohibit them from speaking in public, women and young people have integrated mixed community platforms and can express themselves in different meetings. Community platforms are made up of 72% women and young people.

In addition, 16 women's groups, 16 youth groups and 16 men's peace messenger groups formed under the project were able to raise awareness among 156³⁹ young people, 681 women and 911 men, whose knowledge of peace was improved.

Peace-building is one of the projects that has proved its effectiveness thanks to the results in terms of numbers of young people; these young people who voluntarily manage to put in their efforts to take part in establishing peace in society are one of the project's success stories. Unfortunately, the project is still in its infancy and the impact is still difficult to assess.

4.2.3 Gender equality and women's empowerment

In the 7th Cooperation Program, Outcome 3 was the direct effect of the UNFPA Strategic Plan associated with the Gender Equality and Women's Empowerment component, and which made it possible to assess progress and the achievement of the expected results of actions on the beneficiaries of this plan. It is worded as follows: *“Progress achieved on gender equality, empowerment of women and girls, reproductive rights, including the most vulnerable and marginalized groups”*.
».

The Gender Equality and Women's Empowerment component was associated with only one output, namely output 4: “Strengthened national capacities to prevent and respond to gender-based violence and harmful practices, including in humanitarian crisis situations”, and contributes to UNDAF outcome 2.

National capacity to prevent and respond to gender-based violence and harmful practices

³⁹ Data from 5 peace messengers from the municipality of Ebelo. The other data is still under processing.

CJ2.6 National institutions, including civil society, have increased capacities for the prevention and management of Gender-Based Violence (GBV). The objectives provided for in the Program in relation to output 4 of the CPAP program are almost achieved. Indeed, a bill to combat violence is currently available and 19,914 victims of GBV have been taken care of by the units supported by the Program in both development and humanitarian situations. The target for 2019 is 16,500.

Program Output 4 was implemented in partnership with the Ministry of Population, Social Protection and the Promotion of Women (MPPSPF), the Ministry of Technical Education and Vocational Training (METFP), NGOs Search For Common Ground, Bel Avenir and Gender Links

The Program contributed to the improvement of the legal and institutional context for the fight against GBV through advocacy for the development of legislation, the development of policy documents, as well as technical and institutional capacity building for the prevention and the care of victims.

UNFPA supported the development of a **specific bill to combat GBV**. This bill advocates protective measures for victims and witnesses and provides for additional penalties to strengthen the fight against impunity. The law is currently being discussed within the Criminal System Reform Commission. In addition, the text establishing the CECJ has been initiated and UNFPA has also facilitated the preparation of the bill ratifying the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women. An advocacy plan for the adoption and implementation of the various texts relating to GBV is available. With the support of UNFPA, the national strategy to combat GBV is currently available.

The Listening and Legal Advice Centers (CECJ) are mechanisms set up by the MPPSPF to fight against GBV. Its main activities are to provide psychosocial support, medical or legal referral to GBV victims. They also work for the prevention of GBV through the awareness of the population on human rights. UNFPA supported the actions of the 8 CECJ⁴⁰, five of which are located in the 3 regions of concentration of interventions. To ensure the quality of service of these entities, UNFPA supported the technical training of CECJ staff in terms of psychosocial care, data collection and management, and the administrative and financial management of an CECJ. Institutionally, the CECJs have received furniture, IT equipment and solar generators. It is worth noting that the awareness-raising activities carried out by these facilities are still inadequate, due to limited resources and the population's lack of knowledge about the available GBV services.

As regards the coordination of GBV responses, the program has supported the establishment and operationalization of national and regional GBV **platforms** within the Ministry of Population, Social Protection and the Promotion of Women. It is made up of entities involved in the management of GBV (Public Health, Public Security, Gendarmerie, Justice, Population), National Education, Youth and Sports, Communication, CECJ, as well as civil society organizations. Its mandate is to coordinate and harmonize all actions at regional level in the prevention and fight against GBV. Five strategic areas have been developed in the platform's action plan, including the prevention of acts of violence; legal, medical and social response; rehabilitation and socio-economic reintegration of GBV survivors; coordination and monitoring and evaluation; optimization of results through support measures, in accordance with the National Strategy for the Fight against GBV. To strengthen the actions of the platforms, three protocols and four guidebooks have been developed and provided. The capacities of the members of the platforms have been strengthened to ensure the provision of quality services and holistic care for victims.

⁴⁰ Toliara, Sakaraha, Ambovombe, Mananjary, Manakara, Mahajanga

At regional level, the members of the platforms are made up of decentralized technical services such as the Regional Directorate of Youth and Sports, DRPPSPF, Gendarme, Police, Health, Justice, Education and development partners, among others: child protection network, Association of Elders.

The establishment of platforms has strengthened **the synergy and complementarity of the actions of the stakeholders** with due respect to their specificities. Indeed, this mechanism facilitates the wide transmission of messages not only in the local area but also in the respective areas of each platform member, the publicizing of the services provided by the CECJ, the reporting of cases of violence in the partners' areas of intervention, the resolution of problems by these members as the case may be, for example, legal guidance and medical referral. The actual operationalization of the platforms remains a major challenge for the next programming period, considering the problem of limited resources and organization.

The Program supported the establishment of **men's networks for constructive engagement** of boys and men in the fight against GBV. The men's network brings together men as traditional leaders, opinion leaders, religious leaders, to engage in peer-to-peer advocacy and awareness-raising at community level to promote the fight against GBV.

The program has strengthened the partnership between ministries and civil society, and a partnership with the Judicial Police has been developed to strengthen the care of GBV victims as part of the **Support Project for Security Sector Reform in Madagascar (ARSSAM)**. Following the implementation of this project, the number of cases handled by the judicial police increased by 48%, and the speed with which GBV cases are processed has improved: 65% of GBV cases have been referred to the public prosecutor's unit, and 40% of victims have won their case after reporting cases of GBV against them.

The development and dissemination of the GBV case management guide has enabled judicial police personnel to increase their knowledge of legal texts on the prevention and repression of GBV cases and to improve their professional practices on reception, hearing and investigation techniques for GBV victims as well as research and processing of GBV-related information. The development of GBV data collection tools and the provision of office and IT equipment has enabled 20 judicial police units to speed up the processing of GBV cases and to have data that will serve as a basis for reporting, planning and advocacy.

When working with the community, a good relationship with traditional leaders helps to facilitate message transmission at community level (Ampanjaka, Sojabe or others). They are influential people in society and can help convince conservative people to change their behavior and have a Men's Network Action Plan. This Plan prioritized the involvement of these community leaders in achieving the commitments of men's networks. **With respect to training and capacity-building**, 29 health workers have been trained in the medical management of sexual violence; 64 social workers from DRPPSPF and CECJ have been trained in the GBV data collection and processing; 300 judicial police officers of all ranks, 1,559 leaders and 200 women and young community leaders have been trained in GBV case management. The CECJ, the supported health centers and the judicial police could take care of 19,914 victims of GBV in both normal and humanitarian settings. This figure includes 3,750 women and girls survivors of GBV in humanitarian situations who received psychosocial care and were provided with dignity kits.

Awareness-raising initiatives have been carried out to inform the population about the services available and about the prevention and fight against GBV, using appropriate communication channels and awareness messages and tools. The increase in the number of GBV victims seeking support from care centers is one of the results of the awareness campaign.

Socio-economic reintegration for victims of GBV and women recovering from obstetric fistula (WVOF) is part of the program's interventions. A total of 505 women (182 were victims of FO, 251 survivors of GBV, and 72 vulnerable women and teenage mothers) benefited from Income Generating Activities (IGA) support. They also received information about their rights and family planning. It was observed that the implementation of reintegration activities was sometimes unsuitable for WVOFs. Indeed, the training conditions, which last more than ten days in the city while the women come from distant locations and leaving their families behind, were not always suitable for some WVOFs. Moreover, the selection criteria for women victims of gender-based violence did not make it possible to target the most vulnerable.

With regard to **Monitoring and Evaluation and Information System**, a database is available in each CECJ and with the Judicial Police with the ARSSAM project. Moreover, the management and quality of the databases of some centers still remain a challenge⁴¹. Formative supervision by the MPPSPF and/or regular capacity building is necessary.

4.2.4 Population dynamics

Evaluation of the "Population dynamics" component is carried out in line with Outcome 4 of the UNFPA Strategic Plan, to measure the impact of actions on beneficiaries and assess the progress and achievement of expected results. Outcome 4: "*Strengthened national and international development policy agendas through the integration of population dynamics and their links with sustainable development, sexual and reproductive health, reproductive rights, HIV and gender equality*" contributes to UNDAF Outcome 1.

The 7th cooperation program between UNFPA and the Government provided for a single output in terms of Population Dynamics. Output 5 is entitled: "Enhanced national capacity to produce, analyze and disseminate disaggregated population data and use them as evidence-based information for policy and decision-making processes".

The main partners in the implementation of output 5 of the CPAP are the Ministry of the Economy and Planning, through the Directorate of Overall Planning, the Directorate of Program Monitoring and Evaluation, the Directorate of External Economic Cooperation and the National Statistics Institute.

a) UNDAF Outcome Indicator 1: Existence of up-to-date RGPH data; Strategic Plan Indicator: Madagascar has or has not organized, analyzed and disseminated a national household survey to estimate key populations and use reproductive health indicators (over the last five years); CPAP Outcome Indicator: Census data collected, processed and analyzed and results published and disseminated.

⁴¹ An example is the CECJ Mananjary, where the victims attending the CECJ are all registered as new cases.

CJ2.7 SNISE and other information systems for sector policy making, M&E have been strengthened

The General Housing Census was implemented during the period of the 7th cooperation program between Madagascar and UNFPA. As the process is underway, updated data is not yet available at the time of the final program evaluation. However, the results are expected before the end of 2019. Despite the delay in implementing this activity, due to various administrative and financial constraints, the enumeration that was initially scheduled for 2016 was only carried out in 2018.

According to the partners, UNFPA's role in producing and disseminating results is highly appreciated, and so is its role in managing other surveys. A number of other partners, such as USAID and the World Bank, participated in financing and carrying out this RGPH3 alongside UNFPA. A census mapping database is available. Data collection for the entire data set (enumeration) has been completed, and the questionnaires have been sent to the central level. Updated data on RGPH are expected before the end of 2019, a preliminary results report that presents overall results is expected to be released before the end of 2018. Final data as well as thematic analysis reports will be available in 2019.

In the last 5 years, no issuance of the periodic household survey (EPM) and the demographic and health survey (DHS) has been carried out.

As part of the institutional capacity-building of INSTAT, UNFPA has paid the tuition fees of 13 student demographers and 3 Malagasy statisticians since the start of the 7th program to enable them to carry out high-quality data collection and analysis (on RGPH, various surveys), and 247 qualified staff (out of the 249 planned up to 2019, i.e. 99%) at the National Statistics Institute have had their skills upgraded.

According to the interviewees, skills management at INSTAT remains a major challenge. The status of INSTAT staff means that qualified personnel seek other employment opportunities in the private sector or in other institutions that covet them. However, the lack of skilled staff has a negative impact on the production of quality data.

The capacity of central and regional officers involved in M&E has been strengthened. For example, 22 M&E officers have been trained in SRISE (these are Regional Development Directors (DDR) and/or Monitoring and Evaluation Officers (RSE)). In addition to this, 37 participants were trained and the SNISE Indicators were updated and validated for the year 2017.

However, according to the interviewed partners, the data feedback system that feeds the SNISE suffers from malfunctions due to various reasons linked to the lack of geographical accessibility of certain regions and locations, a shortage of qualified and committed personnel for the smooth running of this system, and finally the non-use of modern technology by data producers. In some regions, regional development plans are not available and this leads to difficulties in operationalizing and monitoring the integrated regional monitoring and evaluation system.

According to the people we spoke to, data is not readily available, and it is a real challenge to get reliable program monitoring data from the implementing partners. And this does not facilitate the use of data and the production of documents based on data analyses. The capacity of the Ministry of Economy and Planning in charge of the SNISE to carry out quality checks of data from other ministries is weak. Similarly, the Ministry's Regional Departments have weak capacity to publish monitoring reports with reliable, high-quality data. In addition, the interviewees testified that there is weak collaboration between SNISE and INSTAT.

UNFPA's financial support does not allow for an in-depth overhaul of SNISE to improve administrative data collection and inform its indicators. Data feedback is costly, and UNFPA and other players should include it in their data collection planning, particularly in areas with difficult access. UNFPA does not take the opportunity to use existing training centers to include the module on data processing and publication in order to better train students with a view to improving the supply of staff.

UNFPA contributes to the integration of population dynamics, reproductive health, gender equality in development planning at national, sector and regional levels.

UNFPA contributes to the integration of population dynamics, reproductive health, gender equality in development planning at national, sector and regional levels. This was achieved by supporting the Ministry of the Economy and Planning in updating the handbook on population integration in the development process, designed for all stakeholders to be an inseparable tool in any kind of development planning.

The 2015-2019 National Development Plan was finalized in 2015. This document deals with population dynamics and, in particular, takes into account demographic trends and projections in the definition of development goals.

Capacity building served 37 participants from UNFPA partner institutions. These participants were sensitized on priority beneficiaries and knowledge of the SDGs for Madagascar and the SNISE. Staff from 51 decentralized agencies and departments were trained to integrate population development into development plans and programs. They now have the skills and tools to establish evidence-based development plans and policy.

UNFPA supported the Ministry of the Economy and Planning in updating the handbook on population integration in the development process, designed for all stakeholders to be an inseparable tool in any kind of development planning. Despite capacity-building sessions for stakeholders, the ability of regional staff to incorporate the population dimension into development plans and programs is limited by their basic profiles and skills.

In addition, several capacity-building workshops on the demographic dividend were organized for development agencies at central and regional levels, with a view to carrying out an in-depth analysis of the situation and the strategies defined in sector policies. Madagascar is among the first five African countries out of the 55 countries of the African Union to integrate the demographic dividend for its economic growth. Technical and financial support for the implementation of the demographic dividend process is provided by UNFPA and USAID-HP+. The synergy of actions between the two partners facilitates the achievement of the result in order to benefit from the demographic dividend.

It is worth noting that there are insufficient statistics to analyze the involvement of young people in the decision-making process and in the design, monitoring and evaluation of development policies and strategies. Not all UNFPA intervention regions have a roadmap.

Program managers, and monitoring and evaluation officers at central level and in UNFPA's 3 regions of intervention have had their skills upgraded and have been equipped, following the training courses on planning, monitoring and evaluation and on integrating the population dimension into programs that have been organized for them, and thanks to the practical manuals on population integration and monitoring and evaluation made available to them.

4.3 PROGRAM EFFICIENCY

EQ3: To what extent have the human, financial and administrative resources allocated to the program favored or hindered the production of the observed results?

Response Summary

The human and financial resources allocated to the program are sufficient to meet the objectives pursued, given the high utilization rates of these resources and the generally satisfactory operational results. The high utilization and absorption rate is due to planning sessions and periodic reviews held annually with implementing partners. There were delays in the start-up of certain activities at the beginning of the period, due to a lack of understanding of UNFPA's requirements, which required local support during the early stages, and to recurrent institutional changes on the government side. The level of education and the insufficient number of government partners contribute significantly to the poor quality of deliverables submitted for approval. The volume of human and financial resources is adequate and sufficient to provide the necessary support to partners for planning (at strategic level), but not for local monitoring purposes in all intervention regions. Because not only is it not sufficient but it is not optimally distributed in the regions of intervention of the country program.

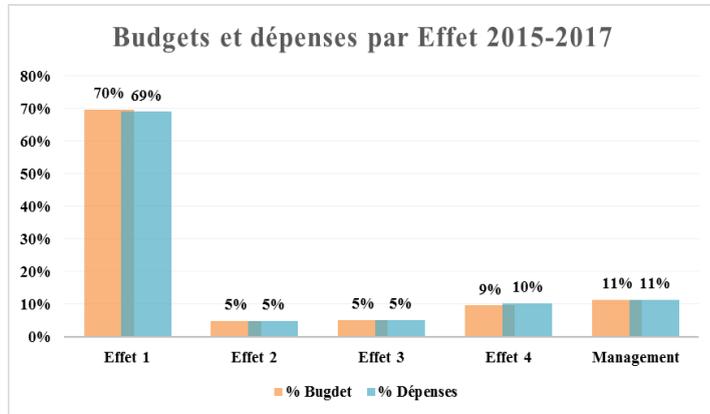
There is no permanent UNFPA team covering all the components individually in the three regions of intervention, and this considerably limits the effectiveness of local coordination and monitoring of actions. Direct payment to beneficiaries by banks hinders the smooth running of activities, although there has been a noticeable improvement in some implementing partners' changeover from direct payment to advance payment following a capacity assessment.

CJ3.1: The human and financial resources allocated to the program are sufficient to meet the objectives pursued, given the high utilization rates of these resources and the generally satisfactory operational results. The high utilization and absorption rate is due to planning sessions and periodic reviews held annually with implementing partners. There were delays in the start-up of certain activities at the beginning of the period, due to a lack of understanding of UNFPA's requirements, which required local support during the early stages, and to recurrent institutional changes on the government side. The human resources allocated to the program are adequate with regard to the achieved quantitative results, but are not optimally distributed across the country program's intervention regions.

Financial resources were allocated to the different components of the program as follows: 70% for Outcome 1; 5% for Outcome 2 and 3; 9% for Outcome 4; and 11% for Program Management. The proportion of expenditure between 2015-2017 follows the same distribution pattern for these allocated resources. The same applies to absorption rates, which are 95% for Outcomes 1 and 3; 97% for Outcome 2; and 102% for Outcome 4. Although the mobilized financial resources did not match expectations, it should be noted that the expenditure and use of these resources was judicious, so as to achieve a high level of completion of activities for each outcome.

Figure 17: Percentage of budget and expenditures by outcome between 2015-2017

Source: Atlas 2017



Delays in the start-up of activities have been experienced in the early stages, due to excessively long AWP approval times, according to interviews with officials from government institutions and implementing partners. The origin of this problem lies in the quality of the documents that partners submit for approval.

However, according to the literature review and some interviews, there is a poor grasp of UNFPA's requirements, which requires local support during the kick-off period. The level of education and the insufficient number of government partners contribute significantly to the poor quality of deliverables submitted for approval. This is why, over and above the program's impressive figures, there is a need for qualitative support to partners through local monitoring in each intervention region. According to the partners, it was agreed that collaboration between UNFPA and its implementing partners is good. There is national ownership of some initiatives through their commitment. The partnership with civil society organizations was also described as valuable.

The volume of human and financial resources is adequate and sufficient to provide the necessary support to partners for planning (at strategic level), but not for local monitoring purposes in all intervention regions. Because not only is it insufficient, but it is also not optimally distributed across the country program's intervention regions. UNFPA's central office in Madagascar employs 32 people who manage both the strategic and operational aspects. It has a sub-office in the Atsimo-Andrefana region, more precisely in Toliara, with a staff of 7 (1 person in each of the Gender Equality, Women's Empowerment, and Sexual and Reproductive Health components, and 1 person in charge of the other two components: Population Dynamics and Youth and Adolescents).

The UNFPA sub-office in Toliara is responsible for implementing and monitoring activities in the three regions where the 7th program is concentrated: Vatovavy-Fitovinany, Atsimo-Andrefana and Androy. However, the team is not permanently based in these regions. As a consequence, there is no permanent UNFPA staff covering all the components individually in the three intervention regions, and this considerably limits the effectiveness of local coordination and monitoring of actions.

In terms of communication, some materials are not adapted to regional dialects due to a lack of budget and of human resources to translate them. What's more, there is no behavior change communication strategy that ensures that the focus and channels are in line with ministry strategies in terms of adapting media, strategies and targets to the local level. The resource mobilization capacity of operational staff is weak when it comes to selling results, communicating results, and writing joint project proposals.

Literature reviews and interviews with officials from government institutions and implementing partners show that the volume of human resources at regional level is insufficient for close monitoring of beneficiaries and the use of investments in health facilities. Therefore, the relocation of human resources to the sub-office does not adequately meet the needs and challenges of UNFPA's areas of intervention in the four components of the program. The coverage of UNFPA's interventions is minimal compared with the changes we want to bring about in the districts and communes of the three concentration regions. For example, the CECJs do not extend their scope of action to the districts and Fokontany of the three regions of interventions.

CJ3.2: UNFPA's administrative procedures and intervention modalities have fostered the optimization of results. However, it is difficult for implementing partners to absorb them, given their weak technical capacities and the changes in leadership and technical staff in government ministries.

The efficiency of the program would also be closely linked to the quality and availability (technical expertise and proximity to human resources) of UNFPA support in the implementation of the program. Local strategic support is provided through the functional coordination mechanisms of UNFPA's interventions in the regions of intervention. This coordination is a clear political commitment through institutional anchoring. It is absent at district level. Technically speaking, it would appear that program management at UNFPA level is suffering because of the heavy workload involved in ensuring close follow-up with implementing partners. For this reason, a delay in the release of resources for partners under Outcome 1 and Outcome 3 has occurred, despite timely planning and contract signature. During interviews, these partners highlighted the insufficient number of local supervision and monitoring missions for financial and technical staff to regularly support the production of high-quality reports. Overall, partnerships are appropriate for the implementation of interventions.

The modalities of direct payment to the beneficiaries by the banks hinder the smooth running of the activities because it is necessary to organize the activity in an area where there is a bank and finish the activity before the closing time of the local bank. In addition, the rural populations who often participate in trainings do not all have identity documents. There has, however, been a noticeable improvement in the execution modalities for some implementing partners, who have switched from direct payment to advance payment following a capacity assessment. There are also some communication issues between the central level and the CECJ regarding changes to financial procedures. Therefore, the CECJs submit reports with delays which negatively impact the launch of their activities, and their financial absorption rates remain low. Interviews at central level and with the CECJs highlighted the capacity building needs of social workers in terms of database management and financial procedures. Interviews and program documentation review suggest low uptake of collected information (strategic and operational). Knowledge management to improve program performance and create an organizational learning environment is not optimal.

4.4 PROGRAM SUSTAINABILITY

EQ4 : To what extent are UNFPA-supported interventions through its country program likely to last beyond the end of the interventions?

Response Summary

The tools introduced to ensure the sustainability of the outcomes following UNFPA's withdrawal were the choice of implementation strategies adopted by UNFPA, and the creation of capacity-building mechanisms to ensure the transfer of ongoing technical, administrative and financial skills at all levels. Certainly, a significant transfer of skills will ensure the sustainability of achievements across the four outcomes. National ownership is still low, and should further improve if we consider ownership relative to the utilization of the various documents developed. Besides, some documents are not yet institutionalized, e.g., EmONC monitoring, the Mentor approach, and this is the reason for the low level of ownership and institutionalization of various concepts such as monitoring. However, the partners expressed concern about the continuity of the program with regard to the supply of contraceptives, which is currently provided by UNFPA, if the government does not take a stand.

With regard to young people, UNFPA's support for the establishment of youth centers and its advocacy for the signature of a tripartite agreement between MJS, the Ministry of the Interior and Decentralization and UNFPA for the provision of premises for youth centers is a guarantee of national ownership of the approach and to ensure the sustainability of interventions.

In the area of gender equality and women's empowerment, UNFPA has helped to revise and draft laws against GBV, and to strengthen coordination in the fight against GBV, including in humanitarian situations at national and regional level. Integrated service models covering the identification, response and reintegration of female victims of GBV through the MPPSPF have been operationalized to effectively combat GBV.

As regards Population Dynamics, UNFPA's technical, financial and strategic support has been substantial in the acceptance and implementation of the RGPH3. Moreover, support was provided for the production of a practical manual for data integration into development documents. UNFPA has significantly contributed to improving the production and use of reliable data through the provision of scholarships and training to 16 INSTAT trainees.

The update of the SNISE decree and the updating of its operational manual are highly sustainable actions supported by UNFPA to institutionalize the mechanism for the proper functioning of public policies, as well as support for the design and dissemination of civil registration forms.

CJ4.1: The current results will last after the interventions because the 7th country program has made considerable efforts in establishing the mechanisms that could provide long-lasting outcomes on the reproductive health system and therefore mitigate the political, socio-economic and humanitarian risks that could affect the results. In specific terms, this entails the choice of strategies adopted, the choice of implementing partners, capacity-building mechanisms, the contribution to the development and drafting of the main programmatic frameworks for medium- and long-term development of the Sexual and Reproductive Health sector, and the reinforcement of the health system.

The SRH strategies adopted, which will ensure the sustainability of results, involve building the capacity of health centers to provide quality emergency obstetric and neonatal services; supporting the Ministry of Health in deploying midwives in rural and remote areas; strengthening the surveillance and response to maternal deaths and the information and data management system; prevention, treatment and socio-economic reintegration of women victims of obstetric fistula; and advocacy, social mobilization and community participation on SRH issues, including early pregnancy. UNFPA has been continuously working with civil society and communities for better ownership to increase the attendance and demand for quality SRH and AYRH services. In its partnership with the government, UNFPA has strengthened the health system at all levels and ensured greater ownership.

Remarkable technical and managerial skills in the SRH component have been continuously transferred throughout the program and can be sustainably maintained after UNFPA assistance withdrawal. Examples include EMONC training in PFI, SR input management training for managers at all levels, monitoring and evaluation, and financial management. In discussions with the implementing partners, it was acknowledged that there must be a significant transfer of skills to ensure the sustainability of SRH achievements. Almost all of the strategies adopted in SRH Component Outputs 1 and 2 have been shown to have a sustainable outcome and will be able to continue after UNFPA's withdrawal. In addition, the interventions carried out, including capacity-building in reproductive health care facilities, are designed to guarantee the quality of services after UNFPA's withdrawal.

However, the partners expressed concern about the continuity of the program with regard to the supply of contraceptives, which is currently provided by UNFPA, if the government does not show full ownership of the initiative. It emerged that national ownership of the various developed documents and handbooks is still low. Some documents are not institutionalized, such as the EMONC monitoring, the Mentor approach and this would justify the weak ownership and institutionalization of these different approaches.

Regarding gender equality and women's empowerment, UNFPA has provided support for the revision and drafting of laws against GBV, and the definition and implementation of an advocacy strategy for its enforcement. And more substantially, UNFPA's intervention has been very significant in strengthening coordination for the fight against GBV, including in humanitarian settings. In response to gender-based violence, UNFPA has supported the implementation of integrated service models that include the identification, response and reintegration of women victims of GBV through the MPPSPF. Apart from this response, support in capacity building, supervision and monitoring of the providers of medical and psychosocial care, as well as legal services was provided. This was done through the development and extension of partnerships between ministries and civil society for the prevention of GBV and more specifically for the constructive engagement of boys and men.

During discussions with beneficiaries, it was unanimously pointed out that awareness-raising activities with community leaders were insufficient, and that the coverage of interventions was inadequate due to the lack of staff at the CECJs. In addition, it emerged that the implementing partners do not have any initiatives working specifically in their areas of intervention, without integrating other FP, SSR and AYRH services.

UNFPA's technical, financial and strategic support has been instrumental in the acceptance and implementation of the RGPH3 (currently in the data feedback phase). The data from this survey will be used for monitoring and evaluation of development programs at national, local and sector levels (health, education, etc.); gender analysis; poverty monitoring; updating of the sampling frame for future surveys (DHS, MICS, EPM, etc.); computation of additional indicators relating to: (i) maternal mortality; (ii) disability; (iii) civil registry, namely birth registration.

UNFPA supported the production of a manual for data integration into development documents. It's a practical tool that will help development agencies to take factual data into account in the design of policies and strategies in a sustainable way.

UNFPA has made a major contribution to improving the production and use of reliable data by supporting INSTAT through the implementation of a staff capacity-building strategy and the award of scholarships and training grants to 16 students trained at IFORD and ENSEA under the program.

The SNISE decree has been updated, and its operational manual revised, both of which are strong actions supported by UNFPA to institutionalize the mechanism for the proper operation of public policies.

Under the 7th program, civil registration forms have been produced and disseminated in the Republic of Madagascar, and these actions are sustainable.

4.5 STRATEGIC ALIGNMENT

EQ5: To what extent does UNFPA Madagascar's support to partners comply with the directions of the 2014-2017 strategic plan: capacity development, support for disadvantaged and vulnerable groups, support for youth, and promotion of South-South cooperation?

Response Summary

The objectives of the CPAP and its implementation reflect the priorities of UNFPA's strategic plan in terms of support for disadvantaged and vulnerable groups, through collaboration with public institutions and civil society so that they can take account of their needs in 4 areas, including humanitarian aid, in their respective AWP. In addition, people living with disabilities were not targeted both during CPAP programming and during implementation.

UNFPA, through South-South cooperation, fostered knowledge transfer that bridged gaps by linking the demand and supply of technical skills, experience and technologies in line with the 2014-2017 Strategic Plan. In addition, it should be noted that through the mid-term review of the CPAP, the cooperation program was realigned with the new 2018-2021 Strategic Plan and the 2030 Agenda.

CJ5.1: The objectives of the CPAP as well as its implementation reflect the consideration of the priorities of the UNFPA strategic plan in targeting disadvantaged and vulnerable groups in the CPAP and AWPs through collaboration with public institutions and civil society and the systematization of national capacity building during the program implementation period. In addition, there are specific activities dedicated to the youth dimension in the CPAP and AWP as well as several activities promoting South-South cooperation.

The support provided by UNFPA Madagascar to its partners meets the orientations of the 2014-2017 strategic plan in the choice of the most disadvantaged vulnerable groups through close partnership with the technical units of the ministries and civil society. In addition, following the mid-term review of the CPAP, the cooperation program was realigned with the new 2018-2021 Strategic Plan and the Sustainable Development Goals of the 2030 Agenda. The 2018 AWP focus on the three transformative results. UNFPA worked with public institutions and civil society so that they can take their needs in 4 areas, including humanitarian aid, into account in their respective AWPs. The interventions envisaged in the AWPs specifically target vulnerable and marginalized groups as a matter of priority, even though people with disabilities are not specifically targeted. And, capacity development has been the key element of the program and is reflected across the strategies of the different outcomes.

In the SRH component, women suffering from obstetric fistulas are taken into account, as well as women living in very remote and isolated areas, very poor and disadvantaged women, and those in emergency situations. In the Gender Equality and Women's Empowerment component, the most vulnerable and disadvantaged groups are: the victims of all types of violence and humanitarian crises, women victims of obstetric fistula, marginalized women, young people in rural areas. With regard to the youth dimension, through the operationalization of friendly centers for them both in rural areas (youth spaces) and urban areas (youth center), support for the implementation of comprehensive sex education, support for the operationalization of a network of young ambassadors is a sign of intensive support for the disadvantaged young people.

During the 2015-2018 period, UNFPA enhanced its participation in South-South cooperation through knowledge transfer, bridging gaps by linking the demand and supply of technical skills, experience and technologies in line with the 2014-2017 Strategic Plan.

As part of the SRH component, activities have been undertaken including collaboration between UNFPA and WFP for the provision of raw food to hospitalized women for the repair of obstetric fistula. Finally, the program mobilized CERF funds and funds from the Principality of Monaco/Andorra for the joint WFP-UNFPA humanitarian program in southern Madagascar. In addition to these efforts, UNFPA has supported several other initiatives, some of which relate to:

- The training of six surgical teams and 10 Malagasy surgeons in OF surgery technique with the University of Dakar.

- Partnerships signature with the Ministry of Health, the Dakar Faculty of Medicine, Mercy Ships, Operation Fistula Foundation, WFP, Surgeon International, local NGOs and the community to carry out OF campaigns.

With regard to population dynamics, South-South cooperation has been of paramount importance not only to build the technical capacity of INSTAT through ANSD in the implementation of census mapping but also to significantly reduce the resources necessary for the completion of the RGPH3. And, the Malagasy students supported by UNFPA were trained in Cameroon and Abidjan (8 at IFORD and 1 at ENSEA) and every year 02 (two) teachers from ENSEA Abidjan sponsored by UNFPA come to Madagascar to train 50 students from the INFA (School of Statistics).

Interviewed technical and implementation partners, as well as beneficiaries, testified that these exchanges were fruitful and a source of innovation.

EQ6 : To what extent has the UNFPA Madagascar Country Office contributed to the operations of the UN Country Team Coordination Mechanism: is the program in line with UNDAF, and does UNFPA coordinate the activities of other UN Agencies in the country as part of “Delivering As One” for Unity in Action?

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Response Summary

UNFPA contributes to the development of the implementation of the UNDAF, to the coordination of UNS interventions under the Delivering as One through effective and dynamic participation in several thematic groups and subgroups since 2015 to the present day. Firstly, all CPAP outputs have been systematically aligned with UNDAF outcomes. However, this coordination is not visible between the focal points working for the various UNS agencies at the Ministry of Youth. On the other hand, interventions on the civil registry, SNISE and coordination have not led to the search for complementarities with other UNS agencies. The overall and multisector coordination mechanism of the development partners of the 7th program is chaired by the MEP at central level and in the three regions of focus of interventions. This is a strong point because it highlights credibility and visibility, and allows strategic and operational exchanges.

The UNFPA office has made efforts to ensure that there is no duplication of actions with other UN agencies, while the synergy of actions, especially in the area of youth and reproductive health, still requires improvement.

CJ6.1: The UNFPA Madagascar office has actively contributed to the implementation of the UNDAF in order to align each of its country program outputs. And it has been involved in coordinating the UN's "Delivering As One" interventions and in working groups and joint initiatives within the UNCT framework, both as a member and leader of working groups.

UNFPA has made an effective contribution to the smooth operations of the United Nations system in Madagascar. Indeed, it has participated in several thematic groups and subgroups since 2015. The fund chaired the management and coordination group, i.e., the Program Management Team (PMT) in 2015, and also served as vice-chair in the management and coordination groups (UNCG and UN Communication Monitoring and Evaluation in 2017 and 2018). UNFPA's role has been particularly instrumental in youth support thematic groups, serving as the program's chair for four years in 2015, 2016, 2017 and 2018. The same is true for Gender Equality and Women's Empowerment, where UNFPA has also acted as chair for three successive years in 2016, 2017 and 2018. UNFPA also participated in the three UNDAF Outcome Clusters. The partners have recognized UNFPA's important role in the operations of the UNS thanks to the complementarity and synergy of its actions. UNFPA also actively participated in the technical working group on maternal and newborn health created following the launch of the H4+ initiative in Madagascar (now the H6+ initiative). In terms of SRH coordination and complementarity, the partners interviewed revealed that UNFPA and WHO work in a coordinated and complementary way on maternal and neonatal health. However, during discussions with government partners and some beneficiaries, it became apparent that there was a lack of coordination between the focal points working for the various UN agencies at the Ministry of Youth (e.g. UNICEF and UNFPA).

Furthermore, the same partners noted the constant absence of certain NGOs and technical representatives from other government ministries at the various meetings. In the Gender Equality and Women's Empowerment component, the interviewed collaborators believe that UNFPA has the necessary gender skills and has achieved satisfactory results through its interventions, nevertheless the interlocutors of the other UN agencies want them to share information on the progress of projects, during the meetings of agency heads for a synergy of interventions. In the Population Dynamics component, UNFPA interventions did not lead to the search for complementarities with other UN agencies, especially with regard to civil registration, the SNISE and coordination. On the other hand, synergies during the implementation of the RGPH3 gave good results to the progress of the process. After discussions with other UN agencies and government partners, potential synergies of UNFPA with UNDP and UNICEF can result in substantial support for the SNISE, civil registration, demographic dividend, GBV control and the production and integration of statistical data into public policies and development strategies.

UNFPA has also participated in many other joint projects: one on Security Sector Reform (SSR) which, by virtue of its mandate, is the agency that works on gender-based violence (GBV) issues; and the other on the establishment of community dialogue by establishing endogenous mechanisms, strengthening livelihoods and promoting behavior change for peace. In the latter project, UNFPA, by virtue of its mandate, is the agency working on issues relating to the promotion of YARH, gender equality and women's empowerment.

The Ministry of Economy and Planning (MEP) is the main responsible for the coordination of the 7th program. It also ensures the overall multi-sector coordination of development partners (CPAP 2015-2019) and all UN agencies under the Sustainable Development Goals (SDGs) and Delivering As One (DAO), and the consistency of actions with Madagascar's National Development Plan. UNFPA supported the establishment of this coordination mechanism chaired by the MEP at central level and in the three intervention regions. This multi-sectoral coordination is not only strategic, but also operational, as it involves quarterly field visits with UNFPA to monitor the implementation of activities, in addition to regular meetings. Thanks to this mechanism, each year there are harmonized AWP for each partner, which are systematically reviewed to improve planning, harmonize interventions and optimize resources. However, the regions do not have their own AWP signed with UNFPA, but instead follow the AWP of the ministries at central level. This entails financial and activity prioritization at central level, which makes it impossible to make objective choices at regional level. The coordination of activities with the IP's regional managers and the ministries' technical staff is not very tangible in the local monitoring of interventions. The lack of delegation of government authority from the central to the regional level does not facilitate the implementation of activities in the field, as it very often takes a long time for the AWP of regional directorates to be approved by the central level. In the same way, the central level reduces the volume of activities included in the regions' AWP for budgetary reasons which are often not shared. This, according to the literature review and interviews with implementing partners, reduces the effectiveness of regional interventions.

The coordination mechanism set up by the United Nations country team is a strong point because it strengthens their credibility and visibility. What's more, this coordination framework makes it possible to reach strategic and operational agreements, and to mobilize resources. It also ensures greater visibility of the United Nations as a whole and is a powerful tool to mobilize resources from donors.

CJ6.2: The Madagascar country office helped to avoid duplication and promoted synergies under UNCT

UNFPA was actively involved in the development of the UNDAF. Family planning, maternal health and reproductive health services for adolescents are all prioritized in the UNDAF as part of the United Nations system's actions in the country's development framework.

In RH, five interventions are carried out in collaboration with other UN agencies. These include training and equipment for EMONC facilities; cervical cancer screening; training on SDMR; support for youth-friendly health centers and facilities and the prevention and care for victims of gender-based violence.

UNFPA's work with young people and adolescents has not been synergistic with the work of UNICEF, so some duplication has occurred. UNDP and World Bank interventions with INSTAT and the Ministry of Economy and Planning were complementary to those of UNFPA.

In view of these facts, further efforts are needed to make sure that UNFPA's actions with other agencies are complementary, and to avoid duplication, especially in the area of youth, with due regard for the respective mandates of each agency.

4.6 RESPONSE CAPACITY

EQ7: To what extent has the Country Office been able to respond to changes in the Madagascar context with regard to national needs and priorities?

Response Summary:

The country office has shown flexibility in the face of changes in the national context, with staff shifts within the main implementing partner ministries, both management staff and UNFPA focal points in government agencies, by setting up coordination mechanisms and adapting AWP. Dynamically, the needs of young people were taken into account in emergency responses during cyclones, floods and droughts and a rapid technical and organizational response from UNFPA was provided to save lives. The content of AWP for the Population Dynamics component has changed significantly from one year to the next for all implementing partners.

CJ7.1: The country office has demonstrated flexibility in the face of changes in the national context with respect to the operations of government and factors related to climate change. This flexibility was dynamic through planning and monitoring activities and tools.

The country office has displayed flexibility in response to changes in Madagascar's political context, particularly in light of the post-crisis effects. UNFPA had to cope with the various staff shifts in the main implementing partner ministries, for both management staff and UNFPA focal points in government agencies. The creation of multi-sectoral coordination mechanisms and the development of capacity-building strategies have proven to be effective adaptation strategies. Partners interviewed indicated that these strategies ensure business continuity. Through intervention planning and review meetings organized within the coordination mechanisms, the AWP are adapted to the needs of the population. And this flexibility is provided for in the CPAP: "Each year, the Government and UNFPA will sign the annual work plans (AWP)... In case of emergency, UNFPA may, in consultation with the Government, reschedule activities to respond to issues that arise, in particular to save lives."⁴²

⁴² CPAP 2014-2019, page 19

Thus, under the SRH component, UNFPA has continued to collaborate with the public sector, in particular with the Ministry of Health, at both strategic and operational levels. Under Outcome 2, the needs of young people have been taken into account in emergency interventions, as young humanitarian leaders have raised awareness among their peers about personal hygiene and family planning. In discussions with implementing partners, the rapidity of UNFPA's response to save lives in humanitarian emergencies was raised. In fact, these changes have proven to be responsive to the new needs identified.

UNFPA has been able to adapt quickly during humanitarian emergencies. In concrete terms, during the ENAWO cyclone, UNFPA was able to provide assistance to ENAWO victims in terms of consultations, deliveries and caesarean sections, as well as offering SRH/FP services through mobile health teams. In the areas hit by cyclone ENAWO, support is provided to victims through community-based GBV mechanisms, i.e., psychosocial, legal and medical support to GBV victims in some districts, the creation of national and regional GBV sub-clusters (SAVA, Atsimo Andrefana, Ambovombe), capacity-building in the collection of data on GBV in the regions, and capacity-building in GBV data collection from 30 institutions, then identification of 7 care facilities in humanitarian situations.

Also, during the plague epidemic in 2017, UNFPA quickly supported the country by sending 4 doctors and 30 contractual midwives to respond to the plague epidemic in the 4 most affected districts, the allocation of "Emergency RH Kit" in 2 district reference hospital centers, and 1 emergency hospital. UNFPA also conducted a rapid survey of the impact of the plague on reproductive health services in Antananarivo and Toamasina. And to take into account the needs of young people and the intensification of the fight against gender-based violence (GBV) in humanitarian interventions, GBV sub-clusters were set up, with women and young community leaders trained in gender and GBV (including during humanitarian crises). As part of Outcome 4, the country office demonstrated great flexibility to adapt the content of the Population Dynamics component to post-crisis effects because of the strong advocacy for the Government's acceptance to implement the RGPH3 and the updating of the decree and then the operational manual of the SNISE. In addition, the content of the AWP for the Population Dynamics component has considerably evolved from one year to the next for all implementing partners, and particularly for the partner responsible for raising awareness of the need to integrate demographic and socio-economic data into planning, and INSTAT as responsible for carrying out the RGPH3. All this reflects UNFPA's flexibility to adapt to each situation according to the national context.

EQ8: To what extent has the UNFPA Madagascar Country Office been able to respond to changes caused by external factors in a developing country context during the implementation of the 7th Country Program?

Response Summary

UNFPA has shown itself to be flexible to changes caused by external factors in Madagascar. External changes to the program are the new policy directions to which the UNFPA Country Office should align as well as the new UNFPA Strategic Plan 2018-2021. As a result of micro-assessments, some payment modalities of implementing partners have evolved.

CJ8.1 The country office was able to respond to changes caused by factors external to the programs such as new policy orientations, recommendations from audits on stakeholder payment modalities, the adoption in September 2017 of the new 2018-2021 UNFPA Strategic Plan and recommendations from the mid-term evaluation.

UNFPA was flexible in the face of the country's introduction of the Universal Health Coverage (UHC) component during the 7th country program period, which was unpredictable in the beginning of the program. In addition, the program underwent a mid-term review in 2017 and was subsequently aligned with the new 2018-2021 strategic plan to help achieve the 3 transformative results. New guidelines have been adapted by the country office to further reorient interventions

Following the recommendations of the mid-term review, the office showed its flexibility in changing the payment modalities of the implementing partners. And as such, UNFPA carried out a micro-assessment in 2017 and was able to recruit new implementing partners based on their performance. As a result, some implementing partners have switched from direct payment to advance payment. They expressed satisfaction with UNFPA's ability to adapt to contexts and changes. In addition, a set of indicators was designed following the recommendation of the mid-term review, which allowed an update of the results framework and resources as well as the monitoring and evaluation matrix with all its corollaries (targets of the output indicators).

4.7 VALUE ADDED

EQ9: To what extent could the results observed in the different components of the country program have been achieved without UNFPA support?

Response Summary

UNFPA has several comparative advantages in the 4 thematic areas. This is true both strategically and operationally. Its contribution to the development and implementation of joint programs and projects is particularly appreciated by the other agencies of the UN system. The perception of UNFPA's added values by government, civil society and other development partners is high.

CJ9.1: UNFPA has comparative advantages and provides specific support that no other institution could provide in various areas, especially in the defense of vulnerable populations and is always ready to respond to the needs of vulnerable and marginalized groups even during humanitarian emergencies with particular attention to young people and adolescents.

UNFPA is the only agency to provide specific support in a variety of areas that no other institution can. These include its great capacity for dialogue and advocacy to elevate the objectives of the ICPD and the Demographic Dividend to be considered in economic and social development, its undisputed leadership in the fight against OF and GBV, its leadership in term of YARH, and its great expertise in data collection and analysis.

Another comparative advantage of the fund, and not the least, is the reinforcement of institutional sustainability by supporting capacity development, particularly in the public sector and with regard to the availability of reproductive health products, logistics and training.

Besides, UNFPA is the only institution that makes it a priority to improve the image of midwifery and transform the profession, so that it is well lived, well-practiced and well valued. Its outstanding capacity for dialogue and advocacy, and its intervention in the humanitarian field are also noteworthy, thanks to its remarkable stakeholder coordination mechanism.

In addition, UNFPA provides specific support that no other institution could provide in the defense of vulnerable populations and is always ready to respond to the needs of vulnerable and marginalized groups during humanitarian emergencies with particular attention to young people and adolescents.

Nevertheless, it should be noted that the absence of a UNFPA exit strategy makes it impossible to draw conclusions and measure the results observed in the various components of the country program that could have been achieved without UNFPA support.

EQ10: To what extent has the support of UNFPA's 7th country program in Madagascar benefited the results of the interventions of other development agencies?

Response Summary

Through the support it has provided to Madagascar under the 7th program, UNFPA has demonstrated proven expertise and clear comparative advantages in the 4 components of the program, compared with the results of other interventions by development agencies, since its interventions are complementary for the stakeholders (Ministry of Justice, Ministry of Public Health, Ministry of Police, NGOs, Fokontany, etc.).

CJ10.1: UNFPA's support brings advantages to the results of other development agencies' interventions by demonstrating recognized expertise and clear comparative advantages in the 4 components of the program through progress made at national level with respect to maternal health, family planning, population dynamics, socio-demographic data including data on sexual violence, and priority given to adolescents and young people.

UNFPA contributes benefits to the outcomes of other development agencies' interventions through UNDAF 2015- 2019 Outcome 3. These benefits are clearly visible in the choice of populations in the intervention areas, especially vulnerable groups who now access and use sustainable and quality basic social services.

In the area of Sexual and Reproductive Health, UNFPA has contributed to the implementation of several interventions in the SRH sector. These include, for example, the establishment of a framework for the operationalization and monitoring of the implementation of the PDSS 2015-2019 priorities (PMO/PDSS), with the creation of a pool of 67 managers to support the monitoring and implementation of priorities down to district level, and a functional evaluation system.

Several other comparative advantages can be mentioned. They include, among other things:

- UNFPA's position on SRH enables advocacy with the Ministry of Health on aspects such as the strengthening of EmONC and the position of midwives as key personnel to improve maternal health services in view of the initiatives undertaken with midwives in the actions of this program.
- UNFPA is the only fund that financially supports the fight against obstetric fistula during the program implementation period. In addition, it is the main fund that supports the purchase of contraceptives and family planning inputs. Interventions relating to the fight against obstetric fistula and repairs are free of charge thanks to UNFPA and model Family Planning facilities have been set up.

As regards Youth and Adolescents, in addition to its leadership on the demographic dividend, and the promotion of the youth ambassadors strategy in the prevention of pregnancies in schools, UNFPA is one of the few agencies to support **youth spaces in rural areas**.

As far as gender equality and women's empowerment is concerned, UNFPA is the lead agency that is committed to holistically addressing GBV in the UNS. It promotes the management of GBV cases and women victims of obstetric fistula. It created GBV platforms and sub-clusters in humanitarian situations, support CECJs, care and socio-economic reintegration of women victims of GBV and WVOF in their communities.

On the issue of population dynamics, UNFPA plays an important role through its advocacy of the RGP3 and its results. UNFPA plays a central role in conducting large surveys. Also, the country office has a great capacity for dialogue and advocacy to raise the ICPD goals higher, including those on the demographic dividend agenda. The existence of a functional multi-sector coordination mechanism between government and civil society partners, with the support of UNFPA, has encouraged the organization of participatory supervision missions at regional level, enabling endogenous corrective measures (from implementing partners) to be taken. UNFPA is one of the only funds that has supported the civil registration and statistics system in the three regions of interventions in Madagascar during the period of the program according to the state authorities.

CHAPTER 5: CONCLUSIONS

5.1. STRATEGIC LEVEL

Conclusion 1 (C1)

C.1	Priority level: 1	Origin: EQ1, EQ6, EQ7	Associated Recommendation: R.1
<p>Statistical data relating to each component at the national level are present in the two main UNFPA strategic documents, including the CPD and the CPAP. The selection of three concentration regions (Androy, Atsimo Andrefana, Vatovavy Fitovinany) was based on region-specific population indicators and was well documented despite the absence of region-specific data in the CPD and CPAP documents.</p> <p>The needs of the Malagasy population, particularly vulnerable groups, were taken into account during the overall planning process, through a participatory situational analysis based on national statistical data on population and development. And</p> <p>Similarly, CPAP has selected the regions where the 7th Program's interventions will be concentrated: Vatovavy Fitovinany, Androy and Atsimo Andrefana, given the poverty levels in these regions.</p>			

Conclusion 2 (C2)

C.2	Priority level: 1	Origin: EQ1, EQ2, EQ4, EQ10,	Associated Recommendation: R.2
<p>The country office has a strong capacity for dialogue and advocacy with the Government of Madagascar, with institutions, and with other development partners.</p> <p>UNFPA has played important roles in dialogue and advocacy for:</p> <ul style="list-style-type: none"> ● The adoption and implementation of RH/FP Laws. ● The institutionalization of EMONC Monitoring and consideration of the specific needs of vulnerable beneficiaries. ● The medical, psychological and socio-economic response provided to women victims of obstetric fistula. ● The humanitarian responses adapted to the needs of beneficiaries in terms of number and 			

situational adaptation.

- The drafting, monitoring, and revision of the GBV draft bill.
- Raising the awareness of policy-makers and development stakeholders so that the Demographic Dividend is taken into account in development planning.
- Acceptance and implementation of the RGPH3. Updating the SNISE operational manual. The production of the operations manual for the integration of data in development policies and strategies. This is the practical manual for data integration into development policies and strategies in Madagascar.

Conclusion 3 (C3)

C.3	Priority level: 1	Origin: EQ1, EQ2, EQ4, EQ10,	Associated recommendation: R.2
<p>UNFPA has demonstrated real added value in all four components of its program. In terms of SRH, UNFPA also contributes significantly to the country's supply of contraceptives, in the management of WVOF and in its interventions for young people, especially in rural areas. In terms of gender equality and women's empowerment through medical, psychologic and socio-economic support to women victims of obstetric fistula and victims of GBV. As for young people and adolescents, the added value has been demonstrated by the creation of youth spaces and corners in rural areas by offering a service package; then in population dynamics by supporting data integration, the operationalization of the SNISE and the completion of the RGPH3.</p>			

Conclusion 4 (C4)

C.4	Priority level: 2	Origin: EQ2, EQ3	Associated Recommendation: R.3
<p>The absence of a human resources plan in the CPAP, which covers all components individually in the three intervention regions, considerably limits the effectiveness of actions. Coordination of activities with regional PI managers and technical staff of ministries is not very noticeable in the close monitoring of interventions.</p>			

Conclusion 5 (C5)

C.5	Priority level: 2	Origin: EQ2, EQ6	Associated recommendation: R 4
<p>The strategy of decentralizing activities is either ineffective or inefficient, as AWP are signed in the capital, resulting in financial and activity prioritization that does not enable objective choices to be made at regional level.</p> <p>The regions do not have their own AWP signed with UNFPA, but instead align with the AWP of the ministries at central level. Therefore, the lack of delegation of authority from the central Government to the regional level does not facilitate the implementation of operational activities because of the too long duration of approval of the work plans of the Regional Directorates by the central level. The central level also reduces the volume of activity of the regions for unclear budget reasons and this reduces the effectiveness of regional interventions.</p>			

5.2. PROGRAMMATIC LEVEL

5.2.1 Reproductive health and family planning

Conclusion 6 (C6)/ SR 1

C.6	Priority level: 1	Origin: EQ2, EQ10	Associated Recommendation: R.5
<p>UNFPA has invested heavily in strengthening EmONC services, but overall support for maternity units remains insufficient to achieve the desired changes.</p>			

Many actions focus on repairing obstetric fistula and not prevention.

Sexual and Reproductive Health constitutes the bulk of CPAP 2015-2017 expenditures, i.e., 69% for a total amount of USD 13,024,452. In this distribution, the repair of women victims of fistulas occupy an important part. Fistula prevention and awareness activities remain on the sidelines. Despite the efforts, in general, the maternal mortality rate remains stationary. The rate of deliveries in health facilities remains low, due to poor quality of care and poor accessibility for women, especially those living in remote areas, even in humanitarian emergencies, and holistic care for women suffering from OF remains a problem.

Conclusion 7 (C6)/ SR 2

C.7	Priority level: 1	Origin: EQ2, EQ4, EQ10	Associated Recommendation: R.6
UNFPA remains the main promoter of family planning in Madagascar, and has provided support in all areas, especially in the supply of inputs, in addition to its support for the quality and quantity of open care and the FP law.			
UNFPA's support and added value remains remarkable in view of the SRH/FP expected results. Thus, even though the contraceptive prevalence rate has increased, unmet needs remains high; the use of long-term methods such as IUD still remains very low; the quality of services is poor; unfavorable social norms to FP persist.			

5.2.2 Youth and Adolescents

Conclusion 8 (C8)/ JA 1

C.8	Priority level: 1	Origin : EQ2, EQ4	Associated Recommendation: R.7
UNFPA support allowed to increase the access of young people, even in rural areas, to information related to their sexual and reproductive health			
Awareness actions by young peer educators and ambassadors have brought a positive effect to their peers in terms of behavior change; sex education has borne its first fruits. However, despite the strategies already undertaken for Adolescents and Youth, young people's access to quality services as well as their involvement in various interventions is still low. And sex education is not accessible to everyone, including adolescents and young people in humanitarian situations.			

5.2.3 Gender Equality and Women's Empowerment

Conclusion 9 (C9)/ ES AF 1

C.9	Priority level: 1	Origin: EQ.4	Associated Recommendation: R.8
UNFPA contributes to the elimination of GBV and has advocated for protection measures for victims, by supporting the provision of a specific law to combat GBV and the effective dissemination of laws relating to GBV to the population and stakeholders in the intervention regions.			
UNFPA contributes to the dissemination of regulatory texts relating to human rights, including gender. UNFPA supported gap analyses on existing texts, resulting in a compendium of texts on GBV, a preliminary version of the draft law on the fight against GBV, and a document outlining advocacy strategies for the adoption of the draft law. UNFPA has contributed to supporting all processes up to the current stage of drafting specific laws on the fight against GBV. Further advocacy is necessary for the advancement to the adoption of the			

specific law before disseminating it.

Conclusion 10 (C10)/ ESAF 2

C.10	Priority level: 2	Origin : EQ4, EQ10	Associated Recommendation: R.9
UNFPA contributes to the elimination of GBV, including in humanitarian situations, by improving the quality of CECJ services - a support structure for victims of GBV, by supporting coordination platforms, and by further supporting the care of victims of GBV and WVOF.			
<p>UNFPA supported the operationalization of CECJs through the MPPSPF by providing care to 19914 victims of GBV including in humanitarian situations (physical, sexual, psychological, economic violence). The actual mandate of the CECJ are obvious with regard to the prevention of GBV acts as well as the protection of survivors. Coordination mechanisms at national and regional level are weak and do not involve other development agencies in GBV response and prevention, and with regard to victims of GBV and WVOF. Similarly, there is no strategy in place to ensure the sustainability and effective participation in the socio-economic reintegration of GBV and WVOF.</p>			

Conclusion 11 (C11)/ ESAF 3

C.11	Priority level: 3	Origin: EQ4	Associated recommendation: R.10
UNFPA contributes to the elimination of GBV and harmful practices including child marriage in rural areas through the coverage of interventions in the most vulnerable and isolated areas; and to the preventive method through the involvement of young boys and men in the regions of the South in particular.			
<p>The coverage of interventions is consistent with identified needs and national priorities, as cases of domestic violence in the 3 regions are high (67.8% of women in Vatovavy Fitovinany, 40.2% in Androy and 39.1% in Atsimo Andrefana have suffered some type of violence). GBV victims in these areas are taken care of, but awareness to increase the attendance of CECJs by victims in very remote areas is very limited. Men's and boys' networks not sufficiently used to raise awareness for the prevention of GBV, and child marriage.</p>			

5.2.4 Population and development

Conclusion 12 (C12)/ PD 1

C.12	Priority level: 1	Origin: EQ1, EQ.3	Associated Recommendation: R.9
UNFPA has carried out a number of actions to make the SNISE operational, including the updating of Decree N 2015-521 of March 24, 2015, amending and supplementing certain provisions of Decree N 2008-524 of June 06, 2008, on the SNISE, and the revision of the SNISE procedure manual. Plus, several capacity-building actions have been carried out, including for the 22 regional monitoring-evaluation officers. However, data feedback mechanisms do not work optimally to feed the SNISE, SRISE, civil registries and the need for information from development partners.			
<p>Mechanisms to integrate SNISE (health), GBV, youth and RH data into the databases of the Regional Economic and Planning Departments are very weak, due to the weakness of data feedback mechanisms at Ministry level, which are experiencing technical difficulties.</p> <p>This weakness lies in the system of actors, tools and methods that interact at different stages of the information production process, i.e. the collection of individual or primary data; the aggregation; storage; sharing and analysis of data according to each locality. INSTAT and SNISE publications are few in number and their qualities must be improved.</p>			

Conclusion 13 (C13)/ PD 2

C.13	Priority level: 1	Origin: EQ1, EQ.3	Associated Recommendation: R.9
<p>UNFPA contributed to the integration of population dynamics, sexual and reproductive health, gender equality and women's empowerment into development planning at national, sector and regional levels through capacity-building for technical staff at MEP and INSTAT, and the production of a practical manual on methodology. Data integration mechanisms are insufficient and government staff are changing due to political instability.</p> <p>Capacity building of the technical actors of the MEP and INSTAT has resulted in the acquisition of technical capacities to conduct specific sector surveys and studies. Similarly, this collaboration with the MEP allowed to produce a technical manual for data integration into the country's political and strategic documents. However, the capacity of these actors are often insufficient to make publications. And the staff capacity building strategy is pending because of their quality and frequent shifts due to political instability.</p>			

CHAPTER 6: RECOMMENDATIONS

6.1. Strategic recommendations

Recommendation 1 (R1)

R.1	Priority level: 1	Origin: C.1, C.2, C.10, C.11, C.12
	Target(s): Country Office	
Recommendation	<p><i>Develop a specific robust business case for each area of the 3 transformative results for the development of the next country program, including the Compact of Commitment.</i></p> <p><i>Take into account the situational statistical data relating to each strategic component (and transformative results) and those of the intervention regions of the 8th country program during planning. This will make it easier to monitor and evaluate the impact of interventions based on the indicators in these areas.</i></p>	
Operational implications	<p>Introduce during the situation analysis specific indicators of the regions targeted by the program when designing the program, in order to have more of the specific needs of each region and therefore to better guide the choice of areas.</p>	

Recommendation 2 (R2)

R.2	Priority Level: 1 Country Office	Origin: C.1, C.2, C.3, C.4, C.5, C.6, C.7, C.8, C.9, C.10, C.11, C.12
Recommendation	<p><i>Maintain dialogue and advocacy with the Government of Madagascar and institutions and other development partners for the achievement of Madagascar's development objectives and the achievement of goals of the ICPD and the SDGs.</i></p> <ul style="list-style-type: none"> • Advocacy and dialogue for the adoption and implementation of the GBV Act • The institutionalization of EMONC Monitoring and consideration of the specific needs of vulnerable beneficiaries. • Expanding partnership and investments for medical, psychological and socio-economic response to women victims of obstetric fistula and GBV. 	
Operational implications	<ul style="list-style-type: none"> • Monitoring the integration of the demographic dividend into national policies and strategies. • Support the completion of major surveys in the next country program implementation period (National Demographic and Health Surveys, MICS Multiple Indicator Cluster Survey, SDG Monitoring Survey and other specific surveys) • Support the government in the use and dissemination of data integration techniques in its development policies and strategies with the available manual. 	

Recommendation 3 (R3)

R.3	Priority level: 1 Target(s): Country Office	Origin: C.3, C.4, C.5
Recommendation	<p><i>Ensure UNFPA's presence in areas where the interventions are focused to ensure monitoring and supervision of activities.</i></p> <p>Recruitment of additional staff in UNFPA intervention areas. i.e., interns, UNV, staff. And this, by covering all the components, more specifically Sexual and Reproductive Health, Gender Equality and Empowerment of Women, Adolescents and Youth, Population Dynamics, Communication (intern, monitoring officer (UNV)).</p>	
Operational implications	<p>UNFPA's presence will resolve problems of duplication of activities, improve coordination, facilitate monitoring and evaluation, and facilitate requisition and approval.</p>	

Recommendation 4 (R4)

R. 4	Priority level: 1 Target(s): Country Office, Africa Regional Office	Origin: C.5
Recommendation	<p><i>Regions must have their own AWP's signed between the Government and UNFPA. This would facilitate the financing and implementation of activities.</i></p>	
Operational Implications	<p>Establish a funding mechanism for activities based on regional AWP's to increase the efficiency and effectiveness of interventions.</p>	

This will allow to:

- Decentralize decision; Enable implementation of MoUs with regional development plans as UNFPA AWP does not consider regional plans, which are left on the sidelines
- Allow consideration of decentralized authorities (heads of region); Reduce the flow of requests
- Facilitate the use of district heads and their staff for decision-making; Facilitate the approval of activities at local level
- Value local resources; Have a multiplier effect on results and improve response capacity at local level
- Efficient use of funds

6.2. Programmatic recommendations

6.2.1 Reproductive health /family planning

Recommendation 5 (R5)/ SR1

R.5	Priority level: 1 Target(s): Country Office, Africa Regional Office	Origin: C6
Recommendation	<i>Strengthen strategies that aim to increase national capacities to improve the quality and accessibility of EMONC services</i>	
Operational implications	<ul style="list-style-type: none"> • Improve access to quality SR service for women, especially those living in the most remote areas, including in emergencies, through • The enhanced monitoring of EMONC centers and the institutionalization of monitoring • Develop of the mentor approach • Strengthening the technical platform of health facilities in EMONCB/EMONCC and medical treatment for OF; • Better awareness of the population and especially of men in the fight against Obstetric Fistulas. • The introduction of an integrated RH package for CHWs • Strengthening the partnership with CSOs, local associations for awareness • Improvement of the reference and counter-reference system • Introduction of OFPEC into the PMA of CSBs and CHWs, and of data into GESIS • Definition of the matron activity package in the most inaccessible landlocked areas 	

Recommendation 6 (R6)/ SR2

R.6	Priority Level: 1 Target(s): Country Office, Africa Regional Office	Origin: C7
Recommendation	<i>Strengthen strategies that aim to build national capacity to improve the quality and accessibility of RH/FP service for women</i>	

Operational implications

- Preparation of an investment case to advocate for the enforcement of the recently adopted and promulgated law on family planning and sexual and reproductive health.
- Enhance advocacy with government, parliament and partners for a gradual increase in the budget allocated to RH and family planning products
- Improving the performance of FP model facilities through regular monitoring
- Strengthening the supply chain and contraceptive management.
- Updating and implementation of the integrated strategic communication plan for BCC in RH/FP

6.2.2 Youth and Adolescents

Recommendation 7 (R7)/ JA1

R.7

Priority Level: 1 Target(s):
Country Office,
Africa Regional Office

Origin: C8

Recommendation

Strengthen strategies that aim to increase national capacities to improve the quality and accessibility to AYRH information and services for young people and adolescents
Improve adolescents' and young people's access to quality information and services, by:

- Strengthening collaboration with Non-Governmental Organizations, and Adolescent and Youth Organizations on AYRH issues;
- Improve the performance of Youth-friendly Health Centers.
- Increase youth involvement in the planning, implementation, monitoring of youth interventions and decision-making at all levels
- Reinforce the management of Youth spaces and centers
- Scaling up comprehensive sex education
- Consider the specific needs of girls in youth spaces and centers in rural areas and during humanitarian emergencies
- Build awareness among young people and adolescents
- Improving peer educator management
- Develop advanced community awareness strategies for parent-youth dialogue, comprehensive family sex education and prevention of unwanted pregnancies in partnership with community health workers, matrons, peer educators, teachers and religious leaders
- Continue increasing government, youth, and civil society commitment to invest in adolescent and youth sexual and reproductive health, family planning, to accelerate the capture of the demographic dividend

Operational implications

6.2.3 Gender Equality and Women's Empowerment

Recommendation 8 (R8)/ ES1

R.8	Priority Level: 1 Target(s): Country Office, Africa Regional Office	Origin: C.9
Recommendation	<p><i>Advocate with various stakeholders for the approval of the specific law on the fight against GBV and its dissemination, then for the application of legislative and regulatory texts and already existing regulations (regulatory texts, platforms to combat GBV, GBV monitoring mechanisms, etc.)</i></p>	
Operational implications	<p>In this regard, the office should:</p> <ul style="list-style-type: none"> • Identify bottlenecks, and determine effective solutions to enable the adoption of specific laws on GBV with partners. • Engage in stronger advocacy with stakeholders involved in the collaboration with the MPPSPF for the approval of specific laws on the fight against GBV and its dissemination. 	

Recommendation 9 (R9)/ ES2

R.9	Priority Level: 1 Target(s): Country Office, Africa Regional Office	Origin: C.10, C.11
Recommendation	<p><i>Strengthen the fight against GBV and child marriage by supporting the operationalization of GBV platforms and GBV care services and men's networks.</i></p>	
Operational implications	<p>In this regard, the office should:</p> <ul style="list-style-type: none"> • Support entities working in the fight against GBV to provide quality psychosocial and medical care services. • Strengthen the coordination of interventions in the fight against GBV and support the management of data on GBV through platforms and the with Ministry in charge of Gender. • Strengthen the fight against early marriage in partnership with GBV platforms and support facilities • Support the mapping exercise to identify areas where early marriage is high, in order to prioritize and better direct interventions in the fight against early marriage. • Redefine together with the Ministry in charge of Gender the efficient criteria of the entity that manages the CECJ. • Support the operationalization of men's platforms and networks. Support the socio-economic reintegration of women victims of GBV and reintegrated OF victims. Analyze the institutional context to properly manage the CECJ and to always get satisfactory results. • Develop a strategy for the institutional and financial sustainability of the CECJ in collaboration with the MPPSPF. • Conduct capacity building for CECJ actors and humanitarian players, and increase awareness with an integrated approach, for better multisector involvement and engagement in the fight against GBV 	

- Identify the stumbling blocks to the operationalization of the platforms and work with partners to find solutions.
- Develop a partnership with sister agencies to target women victims of GBV and OF in activities aimed at women's economic empowerment.

Recommendation 10(R10)/ES3

R.10	Priority Level: 3 Target(s): Country Office, Africa Regional Office	Origin: C.10, C.11
Recommendation	<i>Redefine the scope of GBV combat interventions with the MPPSPF through the national coverage of GBV management facilities, including the CECJ, when appropriate, especially in remote areas; gender promotion, especially support to young boys and especially in the southern regions.</i>	
Operational implications	<p>In this regard, the office should:</p> <ul style="list-style-type: none"> ● Support the MPPSPF to identify the remote areas for intervention, and define strategies and implementation of these extension activities. ● Support the MPPSPF in its efforts to promote gender equality in the education of young boys in the Androy, Anosy and Atsimo Andrefana regions, to prevent them from becoming future Dahalo, to be integrated into RH and FP outreach. 	

6.2.4 Population dynamics

Recommendation 11(R11)/PD1

R. 11	Priority level: 3	Origin: C.12
Recommendation	<i>Improve data feedback mechanisms under SNISE, the collection of civil registration records (particularly for deaths), and the collection of data from partners.</i>	
Operational implications	<p>UNFPA must provide support in (i) developing region-specific strategies, as the geographical accessibility of localities varies from region to region; (ii) improving the data feedback mechanism by strengthening the systems of data producers (including government systems), ensuring that the data fed into SNISE are reliable and of high quality; (iii) monitoring the program with implementing partners by ensuring UNFPA presence in the field.</p>	

Recommendation 12(R12)/PD2

R. 12	Priority Level: 3 Target(s): Country Office, Africa Regional Office	Origin: C.13
Recommendation	<i>Maintain capacity building of INSTAT and MEP at central level and in the intervention regions for purposes of data integration and publication of studies, papers, data, etc.</i>	
Operational implications	This can also be achieved by connecting INSTAT to research institutes specializing in publications. Also, it is possible to use the opportunity of training centers to introduce modules on data processing and publication to train students. In the same direction, the strategy of dissemination of data could be strengthened.	

APPENDICES *(produced separately)*

Appendix 1: Terms of Reference

Appendix 2: Filled Evaluation Matrix,

Appendix 3: Interview Guides,

Appendix 4: List of Atlas projects,

Appendix 5: Stakeholder mapping and List of persons/institutions met, Appendix 6: EPC program,

Appendix 7: Documents consulted

Appendix 8: CPAP Monitoring and Evaluation Planning Matrix 7th cooperation program between Madagascar and UNFPA

Appendix 9: Reconstruction of the Theory of Change

Appendix 10: List of Reference Group Members