

Mid-term evaluation of the Maternal and Newborn Health Thematic Fund

Phase III 2018-2022

Zambia



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MID-TERM EVALUATION OF THE MATERNAL AND NEWBORN HEALTH THEMATIC FUND PHASE III, 2018-2022

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FOREWORD

Since 2008, the MHTF has served as the UNFPA flagship programme on maternal and newborn health. Now in Phase III, the MHTF has widened its scope to contribute to the broader sexual and reproductive health and rights agenda impelled by the International Conference on Population and Development's (ICPD) Programme of Action. Joining the momentum built up around the necessity of a greater focus on the newborn period along the continuum of care, and recognizing the indivisible interconnections between maternal and neonatal health (MNH), it changed its name to the Maternal and Newborn Health Thematic Fund in 2018. Its goal is to enable every woman, adolescent girl and newborn to have equitable and accountable access to quality sexual, reproductive, maternal and newborn health and rights by strengthening health systems in countries with a high burden of maternal morbidity and mortality, thus contributing to the global target of having fewer than 70 maternal deaths per 100,000 live births by 2030 (Sustainable Development Goal 3, Target 1).

The mid-term evaluation of the MHTF (Phase III) was conducted as an independent assessment of the performance of the MHTF in providing catalytic support through country-owned and -driven interventions in order to improve maternal and newborn health and rights in 32 high-mortality countries. The evaluation covers the period from 2018 to 2021 and provides learning to feed into the implementation of the MHTF in its current phase. It also informs the reflection on the strategic directions and operating model for the MHTF post 2022.

The evaluation highlights the significant and tangible contributions of the MHTF to country health systems and shows how the MHTF model (a combination of seed funding, links to established global partnerships, and technical support) enables programme countries to access guidance and support to upgrade relevant national approaches in order to meet global standards. In fact, the MHTF brings value across a significant range of technical areas and delivers considerable thrust with a limited package of resources, opening, in countries, specific entry points for health systems strengthening and for the integration of SRHR-MNH services. With the MHTF, UNFPA is a credible partner, taking the lead in midwifery, and is consistently valued for its responsiveness and strategic investments as well as for its knowledge products and technical guidance in maternal, newborn and adolescent health.

However, the MHTF faces a number of challenges that have started to constrain its impact, or will do so in the future. The evaluation points, in particular, at the need to engage with communities to address barriers to access, to overcome delays, to improve accountability and to better ground MHTF investments with affected populations. To fully exercise its catalytic effect, the evaluation also shows how important it is for the MHTF to further engage national leadership for MNH in order to target the resource mobilization needed to take technical advances to scale. This is key to support greater institutionalization of the MHTF systems strengthening investments.

I am confident that the lessons learned and the recommendations highlighted by this mid-term evaluation will help to further enhance the contribution of UNFPA and the MHTF to maternal and newborn health. The evaluation results are also particularly relevant as UNFPA channels its efforts to help health systems recover from the COVID-19 pandemic so that progress continues to be made in advancing sustainable development and promoting the health, rights and well-being of mothers and newborns to ensure that no one is left behind.

Marco Segone

Director

UNFPA Evaluation Office

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ABBREVIATIONS AND ACRONYMS

ANC	Antenatal care
ASRH	Adolescent sexual reproductive health
BEmONC	Basic emergency obstetrics and newborn care
CAC	Comprehensive abortion care
CEmONC	Comprehensive emergency obstetric and newborn care
CO	Country office
COVID-19	2019 novel coronavirus/Corona virus disease/SARS-CoV-2
CP	UNFPA Country Programme
DHO	District health office
EASRO	East and Southern Africa regional office
EmONC	Emergency obstetric and newborn care
FCDO	Foreign, Commonwealth and Development Office (UK)
GBV	Gender-based violence
GDP	Gross domestic product
GFF	Global Financing Facility
GIS	Geographic Information System
GRZ	Government of Republic of Zambia
H6	A group comprising six United Nations health agencies (WHO, UNAIDS UNFPA, UNICEF, UN Women, World Bank)
HIV	Human immunodeficiency virus
ICM	International Confederation of Midwives
IDM	International Day of the Midwife
IPC	Infection prevention and control
LARC	Long-acting reversible contraceptive
MAZ	Midwives Association of Zambia
MDG	Millennium Development Goal
MDSR	Maternal death surveillance and response
MHTF	Maternal and Newborn Health Thematic Fund
MMR	Maternal mortality ratio
MNH	Maternal and newborn health
MoH	Ministry of Health
MPDSR	Maternal and perinatal death surveillance and response
MVA	Manual vacuum aspiration
NGO	Non-governmental organization
OB/Gyn	Obstetrics/gynaecology
PAC	Post-abortion care
PHC	Primary health care
PHO	Provincial health office
PMTCT	Preventing mother-to-child transmission of HIV
PPE	Personal protective equipment
PPFP	Post-partum family planning
PPH	Post-partum haemorrhage
QI	Quality improvement
RMNCAH	Reproductive, maternal newborn, child and adolescent health
RMNCAH&N,	Sexual, reproductive, maternal, newborn, child and adolescent health - and nutrition

SDG	Sustainable Development Goal
SGBV	Sexual and gender-based violence
SMAG	Safe Motherhood Action Group
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection
TWG	Technical working group
UHC	Universal Health Coverage
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization
ZAGO	Association of Gynaecologists and Obstetricians

GLOSSARY OF TERMS

Term	Definition	Source
Child marriage	Child marriage is any formal marriage or informal union where one or both of the parties are under 18 years of age. Each year, 12 million girls across the world are married before the age of 18. Complications in pregnancy and childbirth are the leading cause of death in girls aged 15-19 globally.	https://www.girlsnotbrides.org/about-child-marriage/ https://www.girlsnotbrides.org/themes/health/
EmONC: Emergency obstetric and neonatal care	<p>A standard of care to manage obstetric complications. EmONC designated facilities must have skilled attendants covering 24 hours a day, seven days a week, assisted by trained support staff.</p> <p>Basic EmONC (BEmONC) includes seven capacities or signal functions: (1) parenteral treatment of infection (antibiotics); (2) parenteral treatment of post-partum haemorrhage (uterotonic drugs like oxytocin); (3) parenteral treatment of pre-eclampsia/eclampsia (anticonvulsants like magnesium sulphate); (4) manual removal of the placenta; (5) removal of retained products following miscarriage or abortion; (6) assisted vaginal delivery, preferably with vacuum extractor; and (7) basic neonatal resuscitation care.</p> <p>Comprehensive EmONC (CEmONC) includes these seven capacities/ signal functions plus the provision to conduct a caesarean section/surgery and to administer safe blood transfusions.</p>	https://www.unfpa.org/feature-d-publication/implementation-manual-developing-national-network-maternity-units
Integrated MNH and SRHR	This term refers to the integration of maternal and newborn health (MNH) and sexual and reproductive health and rights (SRHR) information and services. Note that the evaluation will not utilise the acronym for reproductive, maternal, newborn, child and adolescent health, as child health is not part of the scope of the evaluation. The MHTF encompasses focus areas related to MNH and SRHR interventions, including family planning, preventing mother-to-child transmission of HIV, prevention of HIV/sexually transmitted infections (STIs), and cervical cancer prevention and screening. A focus on adolescents cuts across all MHTF interventions related to MNH and SRHR.	https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA-MHTF-WEB.pdf
Maternal and Newborn health (MNH)	Maternal health refers to the health of women during pregnancy, childbirth, and the postnatal period (42 days following birth). Newborn health focuses on improving care around the time of birth, the first 24-48 hours following birth and in the first four weeks of life.	https://www.who.int/health-topics/newborn-health#tab=tab_1 https://www.who.int/health-topics/maternal-health#tab=tab_1

Term	Definition	Source
		Accessed from World Health Organisation accessed February 27, 2021
Maternal and perinatal death surveillance and response (MPDSR)	MPDSR is a continuous cycle of identification, notification and review of maternal deaths with recommendations made to improve care. The full cycle also includes follow-up of actions taken to improve quality of care and prevent future deaths.	https://www.who.int/maternal_child_adolescent/epidemiology/maternal-death-surveillance/en/
Maternal mortality ratio (MMR)	The number of maternal deaths during a given period per 100,000 live births during the same period. The global maternal mortality target (to reduce maternal deaths to at least as low as 70 per 100,000 live births) was agreed in 2015 in a consensus paper on Ending Preventable Maternal Mortality (EPMM) and adopted as the Sustainable Development Goal (SDG) target (SDG indicator 3.1.1). Maternal mortality is usually estimated or measured less frequently than other basic health indicators (every 3 to 5 years) and evidence would be strengthened where country civil registries and vital statistics systems were strengthened. There is a tendency in many countries to underreport maternal deaths.	Health statistics and information systems: Maternal Mortality Ratio World Health Organisation accessed 25 Feb 2021.
Newborns/ neonates	A newborn or neonate is a baby in its first 28 days of life. About 75 per cent of neonatal deaths occur in the first seven days of life and a third of these on the day of birth. Neonatal deaths are primarily caused by birth injuries and asphyxia, preterm birth, post-partum infections and birth defects.	https://www.who.int/news-room/fact-sheets/detail/newborns-reducing-mortality Ending Preventable Newborn Deaths and Stillbirths, 2020-2025, UNICEF, 2020
Obstetric fistula	Obstetric fistula is a serious childbirth injury. It is a hole that has opened between the birth canal and bladder and/or rectum and is caused by prolonged, obstructed labour without access to timely, high-quality medical treatment. It leaves women leaking urine and/or faeces and can lead to chronic medical problems, social isolation and deepening poverty.	https://www.unfpa.org/obstetric-fistula
Perinatal death	A death that occurs between 28 weeks of completed gestation and the first seven days of life.	
Sexual and gender-based violence (SGBV)	SGBV refers to harmful acts directed at an individual based on their gender. It is rooted in gender inequality, patriarchal norms and harmful practices. SGBV is a violation of human rights and a life-threatening health and protection issue. It is estimated that one in three women will experience sexual or physical violence in their	https://www.unhcr.org/uk/gender-based-violence.html

Term	Definition	Source
	lifetime. During displacement and times of crisis, the threat of SGBV significantly increases for women and girls.	
SRHR	A comprehensive range of services to enable every person to achieve sexual health and well-being. Services include contraceptive services; maternal and newborn care; prevention and control of STIs, including HIV; comprehensive sexuality education; safe abortion care, including post-abortion care; prevention, detection, and counselling for SGBV; prevention and treatment of infertility and cervical cancer; and counselling and care for sexual health and wellbeing	Guttmacher Lancet Commission on SRHR: https://www.guttmacher.org/guttmacher-lancet-commission/accelerate-progress-executive-summary# This definition was endorsed by WHO and UNFPA: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)30901-2/fulltext
Stillbirth	A baby born with no signs of life at or after 28 weeks of gestation. There are different types of stillbirths. More than half of all stillbirths for example occur during labour and birth. Some are most likely very early neonatal deaths. The majority are preventable.	Ending Preventable Newborn Deaths and Stillbirths, 2020-2025, UNICEF, 2020
Young people, youth and adolescents	Child: a person under 18 years of age, as defined by the United Nations. Adolescent: a person aged 10 to 19 years, as defined by the United Nations. Young person: a person between 10 and 24 years old, as defined by WHO. Youth: a person between 15 and 24 years old, as defined by the United Nations. The United Nations uses this age range for statistical purposes but respects national and regional definitions of youth.	UNESCO (2018) <i>International technical guidance on sexuality education: An evidence-informed approach</i>

EXECUTIVE SUMMARY OF THE OVERALL MID-TERM EVALUATION OF THE MHTF PHASE III (2018-2022)

PURPOSE AND SCOPE OF THE EVALUATION

Ending preventable maternal deaths is one of three transformative results of United Nations Population Fund (UNFPA) and includes an emphasis on the integration of sexual and reproductive health and rights (SRHR) with maternal and newborn health (MNH) services. The Maternal and Newborn Health Thematic Fund (MHTF) was first established in 2008 and, now in its third phase, is closely associated with this transformative result. Unfortunately, global progress on maternal and newborn mortality reduction is not on track to meet the 2030 Sustainable Development Goal (SDG) targets and has been further affected by the health, social and economic effects of the global COVID-19 pandemic.

The MHTF delivers technical and financial support in 32 high burden countries to create catalytic and accelerated progress in one or more of four priority technical areas: midwifery, emergency obstetric and newborn care (EmONC), maternal and perinatal death surveillance and response (MPDSR) processes, and the prevention and treatment of fistula and other obstetric morbidities. The MHTF also contributes to the UNFPA presence and leadership of maternal health at the global level.

This evaluation assesses the MHTF progress against its 2018-2022 Business Plan and identifies key lessons and challenges to support its future evolution. In particular, the evaluation considers the extent to which the MHTF has contributed to strengthening health systems, improving quality of care, and advancing equity, human rights and accountability to stakeholders in partner countries. The evaluation also assesses the extent to which the MHTF supports the scaled up integration of SRHR-MNH services, reflecting the well-established and critical role of universal access to quality SRHR services as essential to achieving MNH.

METHODOLOGY

The evaluation identifies the contribution made by UNFPA and applies a theory-based approach in order to analyse the intended results of UNFPA support. It also takes into account the larger health system factors and economic and social determinants affecting MNH. The evaluation team adapted the MHTF theory of change to incorporate all aspects of UNFPA support and developed a series of nine detailed evaluation questions to set out and define the areas of research. Associated with each question, key causal assumptions were tested via indicators using primary and secondary data gathered, analysed and presented by the evaluation team.

Data collection was structured around six country case studies (Benin, Sudan, Uganda, Zambia, Bangladesh and Togo) involving a range of methods and sources including document review, country-focused interviews and group discussions and, where feasible (given COVID-19 legal and public health restrictions), site visits and observation. Data were also collected through key informant interviews with global and regional stakeholders, through a comprehensive review of relevant documents and data sets at the global and regional levels and through an online survey completed by respondents from the MHTF partner countries. The evaluation followed a structured plan for analysis and triangulation of the data to respond to the nine questions.

MAIN FINDINGS

As one of the few United Nations funds and programmes supporting midwifery, with the MHTF, UNFPA has succeeded in raising the profile and standing of midwives at the global and country levels. The UNFPA partnership with the International Confederation of Midwives (ICM) is a key asset that amplifies its credibility with partner governments, supporting the alignment of national policies with international standards. MHTF investments and expertise have led to global policy products and practical benefits supporting midwifery development in countries beyond the MHTF. Professional

development is a long-term process, and the key challenge for the MHTF and its partners remains how to put midwifery policies into action at scale, particularly with limited resources. Furthermore, while UNFPA is ambitious in its aim to eradicate gender disparities, action taken in countries to ensure midwives have a seat at the table to effect policy change is inconsistent. Nonetheless, MNH partners recognize midwifery support as a central pillar of the MHTF and a critical driver of other technical priorities (namely EmONC, fistula and MPDSR) as well as a crucial strategy for effective integration of SRHR and MNH services despite a lack of holistic programming in some contexts.

The MHTF has championed the development and application of the EmONC network model in selected partner countries using an innovative health systems strengthening approach based on consensus building around standards of care, the rationalization of EmONC facility distribution, and routine facility monitoring. The phased approach of the EmONC network offers an objectively verifiable model for elaborating service delivery standards that can be adapted to each country context. Viewed by key informants as rigorous and credible, this methodology – and the MHTF application of it - enables a concrete step forward in EmONC and MNH systems strengthening that creates leadership opportunities in partner countries and opens a pathway to improving quality of care. Two limitations affect the long-term sustainability of the MHTF investments in EmONC. The first is the limited consideration given so far to including the community level as a structured part of care networks. The second is the challenge of sustainability through the institutionalization of the monitoring process associated with quality improvement and without which the benefits of the model will be difficult to maintain. An additional challenge for the MHTF, given the range of countries it supports (including many that do not implement the EmONC network approach), is to balance a flexible and country responsive approach to EmONC support while also ensuring sufficient links to larger health system reform processes.

Sustained MHTF partnership has enabled MPDSR processes to be somewhat embedded across a range of health systems contexts and is valued by country governments and partners. MHTF technical and financial resources enable countries to develop MPDSR strategies, implement national and subnational committee structures and produce periodic reports. The MHTF has also participated in the development of new indicators for measuring the implementation of MPDSR in countries. While notifications of maternal deaths tend to be increasing, the sustained institutionalization of MPDSR has been difficult to achieve and progress varies depending on country leadership and commitment. Although exceptions can be identified, death audit/review findings are underutilized in most countries, which is indicative of a problem with the process itself rather than with MHTF technical support. The challenges faced in strengthening MPDSR systems stress the importance of demand creation and community engagement for better outcomes from SRHR-MNH integrated service investments as well as the need to maintain systematic action to encourage earlier attendance by women at the health facility and build trust between providers and beneficiaries of care.

UNFPA has made a clear contribution at both the global and national levels towards increasing the commitment of governments and partners to end fistula. As lead for the Global Campaign to End Fistula, UNFPA/MHTF effectively coordinates an advocacy and knowledge sharing agenda that has helped to maintain fistula as a global priority. At the national level, the strategic positioning of UNFPA is enhanced by its partnership with governments and its convening role, which has advanced national strategies to end obstetric fistula. Building capacity for fistula treatment and care is the main thrust of programming in countries and tangible progress has been made through strategies linking competent surgeons with clients, with mobile teams, and with service delivery camps. However, in most countries, these services remain donor-dependent and have yet to be mainstreamed into the health system. Efforts to rehabilitate and reintegrate survivors into communities are at early stages overall. The rise in iatrogenic fistula (caused by medical treatment) is an emerging issue globally and requires renewed attention to safe surgical services and quality of care throughout all components of the MHTF.

The MHTF has been able to support integration of SRHR and MNH services to some extent and there is tangible evidence of progress in the integration of family planning into maternal health services across the care continuum. The MHTF supports each country to define the scope of integration between SRHR and MNH services according to their own opportunities and service priorities. However, integration of post-abortion care is inconsistently addressed. Moreover, the MHTF support to integrating both adolescent SRHR and sexual and gender-based violence (SGBV) is at an earlier stage of evolution and this task seems to be considerably harder as it requires midwives with an expanded skillset, more time and space (privacy), and attitudes that are respectful and non-judgemental. At the centre of the integration process, the midwife is a critical lynchpin to expanding access to a full range of SRHR and MNH services for women and girls. Yet, efforts to support midwifery-led integration are obstructed by weak infrastructure and a lack of equipment, two structural health system failures that the MHTF can only partially tackle. An important emerging challenge is the need to balance the opportunity and vision to develop a comprehensive approach to women's health across the life-course without increasing the risk of overburdening midwives and associated health systems.

The MHTF is oriented towards equality, human rights and values associated with ensuring equitable access to services for all women and girls but with uneven results so far. MHTF interventions supporting service access (midwifery training, EmONC and fistula) have resulted in expanding service delivery to underserved geographic areas and vulnerable populations, while also maintaining a spotlight on relevant social and economic determinants affecting MNH. However, the MHTF does not have a defined or explicit approach or process for identifying those most at risk or the most vulnerable. The MHTF lacks a framework for defining and operationalizing rights-based principles in programming, which leads to inconsistent application in country-based activities, including, for instance, varying attention to the need for respectful care. Because of limitations in the integration of SRHR and MNH, MHTF activities are less effective in ensuring that adolescent girls and women are empowered to access a full range of SRHR services, especially contraception, post-abortion care and, where legal, safe abortion services.

The MHTF method of combining technical knowledge, seed funding, and global partnerships in order to support country partners to tackle particular SRHR-MNH technical areas is a strength that positions it well to leverage catalytic results. The method allows the MHTF to provide high quality support in four critical technical areas and increases UNFPA credibility with country partners. The MHTF has produced an impressive range of global guidance, peer reviewed evidence papers and other policy documents. However, the potential behind many "catalytic" investments is still to be fully realized especially - but not only - given constraints to progress created by the ongoing COVID-19 pandemic (although these should be transient). Other stand-alone innovations and digital adaptations (such as mobile phone apps) have played a role in supporting results but are not, in themselves, necessarily catalytic or sustainable. The MHTF is currently addressing the twin challenge of firstly developing strengthened guidance that clearly defines what being catalytic means and secondly laying out the operational approach countries should take in order to build on and document catalytic effects more systematically.

The MHTF is benefitting from improved leadership and vision and the recently established Advisory Board supports more structured engagement with partners (including donors). These developments should help the MHTF address the several challenges it faces. These challenges include: positioning its strategic direction in relation to overarching UNFPA MNH; building SRHR-MNH integration across the life-course; overcoming bureaucratic constraints; and delivering clearer communication of results. Results data collected from countries tend to focus on outputs and build a cumulative picture of the MHTF activities, but they are less effective at helping identify the MHTF contribution to country-specific progress. The consequence is a difficulty in fully capturing the value of results achieved from the whole of the MHTF, including its strategic partnerships. The lack of community-facing links or investments into building demand for services is a visible gap, as are more

systematic interlinkages between the MHTF support to MNH investments and larger health systems strengthening and reforms.

UNFPA effectively used the MHTF to respond quickly and flexibly to the COVID-19 pandemic through programmatic efforts and reallocation of available resources to ensure continuity of essential SRHR and MNH services while protecting the safety of clients and providers. UNFPA

articulated a response in support of partner countries referencing key lessons learned from the West Africa Ebola outbreak, during which routine services were seriously disrupted causing high levels of preventable mortality, especially for women and children. The UNFPA/MHTF response included the development and dissemination of COVID-19-specific technical guidelines and protocols, the provision of personal protective equipment (PPE), other strategic support, such as transport vouchers for health personnel to get to work safely, and hospital triage support to ensure safe access to essential maternity services.

CONCLUSIONS

1. With the MHTF, UNFPA is a partner of choice providing visible and valued support to critical MNH priorities. The MHTF has evolved into a strong, focused and technically sophisticated tool for supporting MNH in the programme countries, especially in its four priority areas of midwifery, EmONC, MPDSR and fistula. The MHTF delivers support to programmes that are perceived to be of high quality, that address gaps in country health systems and that produce tangible results. At a global level, MHTF staff participate in and/or lead the development of a range of knowledge products whose impact extends beyond the 32 MHTF partner countries. It is a programme that delivers considerable thrust with a limited package of resources.

2. Midwifery is the anchor of the MHTF and the cornerstone of the UNFPA MNH response. Identified as the leading partner for midwifery, UNFPA has instigated major steps forward on the definition of midwifery practice (for example, standards of care, capacity and skills, and performance monitoring) that have been complemented by country-focused efforts to upgrade the education, training and deployment of midwives and initiatives to support their professionalization. The role of midwives is critical to promoting SRHR-MNH integration and to overcoming the three delays that lead to maternal mortality (delay in seeking care; in reaching the right level of care; in receiving the right care) particularly in promoting health-seeking behaviour among women and girls. However, the MHTF has not yet fully captured the pernicious effects of gender inequalities and power dynamics that affect health systems in programme countries.

3. The MHTF delivers value for money, both globally and for individual countries. Through leveraging global partnerships, deepening policy and technical coherence, and strengthening the quality of programme implementation, the MHTF has developed a programme model that delivers visible results and creates effective entry points for a range of interventions. To maximize these opportunities, the MHTF relies on a set of skills and a vision in the country office that are strong on systems strengthening, coordination, convening, advocacy and partnership building. Achieving optimal effects also relies on the country offices' ability to supplement the MHTF resources with core funds and to raise additional resources through engaging partners locally. At the global level, the MHTF has enabled UNFPA to influence the agenda on MNH and to deliver a wide range of policy and guidance products in all of the four technical areas that will influence MNH programming beyond the MHTF partner country context.

4. The MHTF is not clearly positioned within a holistic UNFPA MNH strategic framework. By focusing on four specific technical areas, the MHTF has carved out a defined expertise. However, at a global and organizational level, the MHTF is not aligned with or anchored in a UNFPA maternal

health strategy. As the main (but not the only) UNFPA programming vehicle into maternal health, this leaves a policy and strategy gap between the MHTF (as a programme delivering specific inputs) and the UNFPA MNH strategy at the global and organizational level. In turn, this gap makes it difficult to clearly identify the locus of UNFPA policy, strategy, and programming effort in relation to the transformative result of ending preventable maternal deaths. Meanwhile, at the country level, the issue is the agility of the MHTF, and whether it can position its interventions within a holistic SRHR-MNH strategy that is context specific to the programme countries themselves. The challenge for the MHTF is to maintain its technical focus (and well-defined offer of expertise and support), while remaining flexible to assist countries in addressing their priority needs in MNH.

5. If not addressed, critical gaps will limit the relevance and the sustainability of the MHTF investments. Investing in the supply of high-quality maternal services is necessary but not sufficient to ensure sustainable results. There is a need to engage with communities to address barriers to access, to overcome delays, to improve accountability and to better ground MHTF investments with affected populations. Furthermore, while the MHTF has helped countries identify and set standards for the supply-side and delivery of quality EmONC and related MNH services and care, it should also actively incorporate the views of women and girls and what they value in relation to SRHR-MNH integrated services, especially in relation to respectful care. While each of the four technical areas of the MHTF aims to influence and strengthen quality of care improvements, the indicators that enable quality of care measurement and tracking (especially including the experience of women who have been through the care of the health services) are insufficient and underutilized.

6. The MHTF has not yet been fully designed to deliver its “catalytic effect” systematically. The MHTF leverages its limited financial resources through investments which have, by and large, a catalytic potential and are, at times, catalytic when taken to scale with necessary leadership, sustained national commitment and resources. However, the MHTF is not sufficiently systematic in identifying or creating opportunities to engage national leadership for MNH in order to target the resource mobilization needed to take technical advances to scale. The realization of this catalytic potential depends on the ability of the MHTF to anticipate and prepare for the challenging shift from a relatively low-cost, intense technical process focused on developing a national policy or strategy to a much larger, longer-term, higher-spend, national scale-up of that policy. The absence of a strategy clearly positioned within the engineering of the programme itself and accompanied by a tried and tested toolbox to support the elevation of programme inputs in ways that generate the “catalytic effect” currently reduces the MHTF catalytic achievements.

7. The MHTF targets gender equality, human rights and equity, especially among adolescents, but does so unevenly. The MHTF has identified three rights-based principles upon which its strategy is based (accountability, quality of care, and equity in access), but it lacks a framework for defining and operationalizing rights-based principles in MHTF programming, which has led to uneven application of these principles in country-based activities, such as for quality of care. Furthermore, while the MHTF aims to target vulnerable women and girls through the application of the “leave no one behind” principle, it has yet to define or articulate an approach or process for identifying those most at risk or the most vulnerable. MHTF interventions supporting service access (midwifery training, EmONC and fistula) have resulted in expanded service delivery to underserved geographic areas and vulnerable populations. However, because of limitations in the integration of SRHR and MNH, MHTF activities are not as effective in ensuring that adolescent girls and women are empowered to access a full range of SRHR services.

8. Given its results and successes, the MHTF has considerable unrealized potential. The MHTF is a programme with a modest profile, whose strengths and accomplishments are not always well-

known. Not enough has been done, at UNFPA, to highlight its achievements, drive resource mobilization, position it strategically within a coherent MNH strategy and use the knowledge gained through the MHTF to help better shape the global agenda. This is also the consequence of a monitoring system that does not emphasize the use of a small number of readily available results indicators, which can be interpreted and presented in a manner that increases visibility for the MHTF in both UNFPA and the global arena. The MHTF image deficit, compounded by monitoring that lacks sufficient qualitative and contextual analysis, may also constitute an impediment to the mobilization of more funding and the pursuit of long-term engagement from partners. Ultimately, this may prevent the MHTF from being valued in relation to its actual contribution to maternal and newborn health, which this evaluation demonstrates is significant and multifaceted.

RECOMMENDATIONS

1 As the key UNFPA vehicle for SRHR-MNH integration and support, continue the MHTF and expand it into a new phase

The MHTF makes a visible contribution to maternal health in the countries where it is working and to the overall UNFPA maternal health response. The MHTF should continue into Phase IV with design adjustments taking into account the strategic and operational recommendations identified in this evaluation. In particular, an expanded theory of change should identify the larger landscape in which the MHTF operates and its specific contribution. Phase IV of the MHTF should serve as an opportunity to clarify the MHTF role and positioning in relation to other UNFPA investments into maternal health as well as the larger, global MNH landscape.

2 Position the MHTF within a comprehensive UNFPA maternal health strategy and action plan

The 2022-2025 UNFPA strategic plan is shaped around three transformative results, including ending preventable maternal deaths. In this context, it is not clear whether the MHTF is intended to serve as a limited, catalytic fund, channelling a specific set of technical and financial resources to defined elements of MNH, or is expected to encompass the entire UNFPA MNH programme (with other UNFPA programmes supporting important MNH results). Drawing on the MHTF experience, UNFPA should develop an organisational-level comprehensive maternal health strategy and action plan that clearly situates the MHTF and other UNFPA MNH efforts within a coherent organizational mandate with roles and responsibilities in relation to its objectives in maternal health and its broader remit on integrated SRHR-MNH.

3 Champion quality of care at the point of delivery, including respectful care

The MHTF approach to strengthening user-centred quality of care, including respectful care, is still at an early stage. The MHTF should invest in building country experience and global leadership on scaling up quality SRHR-MNH services at the point of implementation (from the user's perspective) and should champion respectful care especially, but not only, among midwives. This includes developing and integrating actionable programming into all MHTF technical areas and strengthening progress monitoring to enable lesson learning and scale-up of good practices.

4 Be more systematic about integrating community engagement across all MHTF activities

Community decisions about whether, when and how to seek care affect MNH outcomes. Currently, the main thrust of the MHTF has been focused on the supply of services. While the MHTF does not necessarily need to invest extensively in demand creation and community engagement itself, it should integrate and promote a more structured approach to community engagement as part of a broader strategy to generate increased demand for timely and accessible MNH services. This adjusted orientation should focus on increasing the timeliness and efficacy of decisions to seek care, to access family planning and SRHR services, to elect to deliver in a health facility, to build the interface of the midwife with the community, and to participate in death audits/reviews. It will require developing and deepening partnerships with others and investing in country office staff capacity and advocacy skills.

5 Engage partners, especially donors, more actively in the MHTF progress

The recently created Advisory Board is in the early stages of carving out its role and has been welcomed by partners. Donor engagement in the work of the MHTF, including as part of the Advisory Board, will foster visibility and support, as well as create potential opportunities in specific countries or settings. Over time, the MHTF should invest in the role and functioning of the Advisory Board in order to strengthen its accountability to funding partners, to increase its participation in shaping strategic direction and to support improved communication of results and performance.

6 Improve the strategic coherence and responsiveness of the MHTF

A key strength of the MHTF is its programme model, which offers countries access to strategic global partnerships, technical expertise and financial resources to seed-fund investments. The four technical areas promoted by the MHTF are insufficiently coordinated with each other however, and are not all equally well supported at the country level. In addition, as priorities evolve, the MHTF will achieve more traction with more flexibility in its programme model to respond to country priorities. It should thus aim to clarify and streamline the linkages and coherence among the four current technical areas. It should also consider options to selectively include other technical areas without sacrificing its well-defined programme model. The development of the MHTF Phase IV and associated theory of change creates an ideal opportunity to include these critical aspects.

7 Embed the focus on midwifery and the health workforce environment across the MHTF

As a key entry point and “gateway” to women’s health across the life course, midwives and the larger health workforce environment in which they operate constitute tangible health systems strengthening investments. The experience of women and girls highlights the role that skilled health personnel play in their perception of what quality care is. The MHTF progress and leadership on midwifery and the health workforce environment continue to create a key entry point for MNH. This should be further developed in Phase IV by investing more in embedding midwifery into community and primary care, integrating more focus on respectful care, and investing in health systems reforms, including the EmONC network expansion.

8 Invest more in MHTF core added values: SRHR-MNH integration and promoting catalytic results

The MHTF has two core element features that add value. The first is the fact that it is uniquely focused on integrating SRHR and MNH services and has made good progress in this area. The second is that the emphasis on driving catalytic results is integral to its delivery model and a cornerstone of the MHTF approach. In both these areas, the MHTF has made visible but

inconsistent and insufficiently documented progress. In Phase IV, the MHTF should develop detailed and actionable guidance for country offices to support design, partnership development, and implementation. This should include promoting, documenting and communicating on SRHR-MNH integration and the MHTF catalytic role.

9 Refine results monitoring to improve understanding and communication about the MHTF added value in different contexts

Although detailed, the current results-oriented monitoring (ROM) system does not easily enable the MHTF to identify and communicate its results and contribution as a United Nations programme working in an often crowded field. The MHTF should adapt its current approach to track fewer, more immediately relevant results that can support a clear narrative about the MHTF contribution and value-added in varied settings. The results-oriented monitoring system should have a greater focus on perceptions of change among stakeholders by supplementing a shorter indicator framework with reporting that makes use of qualitative information on the MHTF contribution to, and progress toward, outcomes. This would support increased understanding about what is working, where and why.

10 Invest in innovative funding approaches to attract an expanded donor base

The MHTF should develop a comprehensive funding model and financing plan to support Phase IV. The plan should be linked to its new programme of work and be well situated within a UNFPA maternal health strategy in order to enable the MHTF to address (and reverse) declining commitments, as well as the negative effects of onerous financial management processes. The plan should also foresee innovative funding options to generate country engagement and commitment to SRHR-MNH integration, for example through matching arrangements. Innovative funding modalities could extend the value of MHTF resources, leverage additional funds from core and other partner sources, and help open up additional programme priorities.

Read the **evaluation report** of the Mid-term evaluation of the MHTF Phase III, 2018-2022 [here](#)



INTRODUCTION OF THE CASE STUDY

Mid-term evaluation of the MHTF Phase III, 2018-2022

The purpose of the mid-term evaluation is to assess the performance of the Maternal and Newborn Health Thematic Fund (MHTF) in providing catalytic support through country-owned and driven interventions to improve maternal and newborn health and rights in 32 high-mortality countries.¹ It will assess the contribution of the MHTF to strengthen health systems through its focus on:

- Four components of health systems: workforce, service delivery, health information systems, leadership and governance
- Four integrated technical areas: midwifery, emergency obstetric and newborn care (EmONC), maternal and perinatal death surveillance and response (MPDSR), obstetric fistula and other morbidities.

It will also assess the MHTF contribution to:

- Increased equity in access to sexual reproductive health and rights (SRHR) information and services, including for those furthest behind
- Improved quality of care
- Higher accountability
- The promotion of gender equality and human rights in the context of maternal and newborn health (MNH).

The evaluation has two principal objectives:

1. **Analyse how and to what extent** UNFPA support to MNH has been guided by the theory of change and results framework as set out in the MHTF Phase III Business Plan (2018-2022)² and assess the progress made thus far in the implementation of the MHTF strategic interventions in the four overlapping and mutually reinforcing MHTF outcomes.
2. **Facilitate learning and capture good practices** from the MHTF across its components and areas of health system strengthening to inform the implementation of the MHTF current phase, other ongoing programmes with a link to MNH, as well as UNFPA future programmatic interventions in support of MNH and broader SRHR.

While the results of the mid-term evaluation are expected to feed into the implementation of the MHTF through the end of its current phase, they will also inform the reflection on strategic directions, programmatic scope as well as the operating model for the MHTF post 2022.

Temporal and geographical scope

The evaluation will cover the period since 2018 under the current MHTF Business Plan (2018-2022). Its geographical scope includes all 32 countries in the five UNFPA regions of operation where MHTF interventions are currently being undertaken: Western and Central Africa; Eastern and Southern Africa, Asia and the Pacific, Arab States, and Latin America and the Caribbean.

Evaluation questions

The evaluation examines nine evaluation questions.

¹ The global midwifery programme works in over 100 countries & the global Campaign to End Fistula supports 55+ countries (including all 32 MHTF countries). This expanded remit beyond the MHTF partner countries will be explored further in the evaluation.

² <https://www.unfpa.org/pcm/node/18565>

Table 1: Evaluation questions by area of investigation

Evaluation Questions
Area of Investigation 1: Midwifery
Evaluation Question: To what extent has the MHTF contributed to ensuring the education, training, and deployment of an adequately skilled/competent, motivated, and sustainable midwifery workforce?
Area of Investigation 2: Emergency obstetric and newborn Care
Evaluation Question: To what extent has MHTF supported ministries of health to design, strengthen and scale-up a national network of referral maternity facilities capable of providing quality SRHR services and MNH care, including EmONC?
Area of Investigation 3: Maternal and perinatal death surveillance and response
Evaluation Question: To what extent has the MHTF contributed to firmly establish the main components of the MPDSR programme; to support its implementation at national scale; and to increase the notifications of maternal deaths and strengthen the quality of maternal death reviews and implementation of the “response” component?
Area of Investigation 4: Obstetric fistula and other obstetric morbidities
Evaluation Question: To what extent has the MHTF contributed to the capacity of governments to develop, implement and monitor national strategies for ending fistula cases that are founded on: prevention, access to quality treatment of fistula cases and other obstetric morbidities, and social reintegration of obstetric fistula survivors?
Area of Investigation 5: Integrated MNH and SRHR
Evaluation Question: To what extent has the MHTF contributed to a strengthened integration between maternal health and sexual and reproductive health and rights with a view to achieving quality service delivery, increasing client satisfaction, and stimulating greater public demand for SRHR services?
Area of investigation 6: Equitable and accountable access
Evaluation Question: To what extent has the MHTF contributed to strengthening the availability and quality of health service delivery and health information system to meet the diverse and differentiated needs of the women, newborns, and adolescent girls including in the lowest wealth quintiles, living in hard-to-reach areas, facing discrimination (based on identity, ethnicity, and/or faith) and living with disabilities?
Area of investigation 7: A catalytic role
Evaluation Question: To what extent has the MHTF fulfilled its catalytic role enabling UNFPA to ‘punch above its weight’ in support of MNH outcomes and integration with SRHR?
Area of investigation 8: MHTF governance and management
Evaluation Question: To what extent have MHTF management mechanisms and internal coordination processes contributed to the overall performance of the programme. Specifically, how have these facilitated: (i) resource mobilization for the MHTF; (ii) efficient and effective collaboration with other UNFPA programmes; (iii) the integration of MNH within country programmes; and (iv) an effective oversight and guidance by the MHTF Advisory Committee?
Area of investigation 9: COVID-19
Evaluation Question: To what extent has the MHTF been able to respond to emerging and evolving needs of national health authorities and other stakeholders at national and sub-national level due to the COVID-19 pandemic?

1.1.2 Country case studies

The evaluation is structured around a series of country case studies, augmented by global and regional data collection. A case study-centred approach allows for the exploration of the MHTF in

widely differing contexts and settings. The MHTF takes different shapes or paths depending on UNFPA interaction with other health actors and formulates responses to opportunities and barriers in different ways depending on a range of variables that are country specific.

The specific purpose of the case studies is to investigate the design and implementation of interventions under Phase III of the MHTF, and to assess the results achieved within the specific context of programme countries. The evaluation encompasses four *field-based* country case studies (Benin, Sudan, Uganda and Zambia) and two *desk-based* country case studies (Bangladesh and Togo) mapped in Figure 1. The case studies are not intended to present a statistically valid sample, nor are they representative of the entire population of programme countries.

Figure 1: Map of field and desk-based country case studies



The designations employed and the presentation of material on the map do not imply the expression of any opinion whatsoever on the part of UNFPA concerning the legal status of any country, territory, city or area or its authorities, or concerning the delimitation of its frontiers or boundaries.

Countries were selected for the field and desk studies to provide a set of variable examples of MHTF support in different regions and with varying MNH indicators. For example, some countries had high maternal mortality ratio (MMR) and/or neonatal mortality ratios (NMR) despite declining fertility. Some countries also offer a mix of conflict and humanitarian contexts, differing access to development assistance for health, or other factors that added nuance or complexity.

Objectives of the field country case studies

The field-based country case studies aim to provide insights into the evaluation questions and a comprehensive nuanced picture of programme actions and their results. They allow the evaluation to explore the evaluation questions in greater depth than would be possible in desk studies. The country case studies are not individual programme evaluations at country level. Their objectives are to:

- Provide input for answering the evaluation questions and causal assumptions
- Triangulate data collected from other sources and respondents with qualitative and quantitative information collected in country
- Identify lessons learned.

Approach and methodology

Each field country case study uses a theory-based evaluation approach based on the theory of change and causal assumptions developed for UNFPA activities related to MNH. The theory of change is described in detail in the Section 1.4 below. The causal assumptions form the basis of the Evaluation Matrix (Annex I) and enable the evaluation to determine the contribution of UNFPA to MNH outcomes in the theory of change.

The data collection methods used in each field country case study are:

- Identification and review of core documents at country level, including country programme (CP) documents and annual workplans, programme review and evaluation documents, monitoring and progress reports, national plans and programmes, minutes of coordination meetings and documents produced by other bilateral and multilateral agencies supporting maternal and newborn health
- Review of financial data regarding programme investments
- Key informant interviews with a wide range of stakeholders at national level (Annex 2)
- Visits to programme and service delivery sites, including interviews with service providers, managers and community members
- Interviews and, where possible, group discussions with individuals accessing SRHR and/or MNH services
- A debriefing workshop with participation by UNFPA country staff. This allowed the evaluation team to present preliminary observations and receive feedback on any gaps in the collected data, factual errors or misrepresentation.

The evaluation also uses other methods, including an online survey of key stakeholders, interviews undertaken at global and regional level and a comprehensive global document and data review to ensure coverage of all elements of the MHTF.

The resulting evaluation data was analysed and interpreted jointly by the evaluation team. Each element of evidence was recorded in the evaluation matrix (Annex 1) in relation to relevant evaluation questions and causal assumptions. This allowed the evaluation team to triangulate evidence from different sources and to develop the findings presented in Section 3.

MHTF overall theory of change

This section presents the overall theory of change for the MHTF as developed during the inception phase, updated during data collection, and refined during the analysis and reporting stages of the evaluation. The theory of change presented here attempts to capture all the different ways in which the MHTF provided catalytic support through country-owned and driven interventions to improve maternal and newborn health and rights in vastly differing contexts and at different levels (global, regional and national).

In this sense, nowhere has the evaluation team seen this theory of change implemented in its entirety. In fact, the theory of change encompasses a wide range of activities and a multi-layered chain of results, which are difficult to implement effectively and to sustain given the current staffing and financial resources available to UNFPA in the different MHTF programme countries.

The MHTF theory of change (Figure 2) should be ‘read’ from the bottom to the top and from left to right. The MHTF specific inputs, activities, outputs, and outcomes are presented within a larger landscape, while the chain of effects is clearly demarcated within a blue-lined box. Expected COVID-19 effects are laid out in purple and describe how the UNFPA strategy and programmatic guidance on responding to COVID-19 is expected to impact specific areas of the MHTF. These identify the

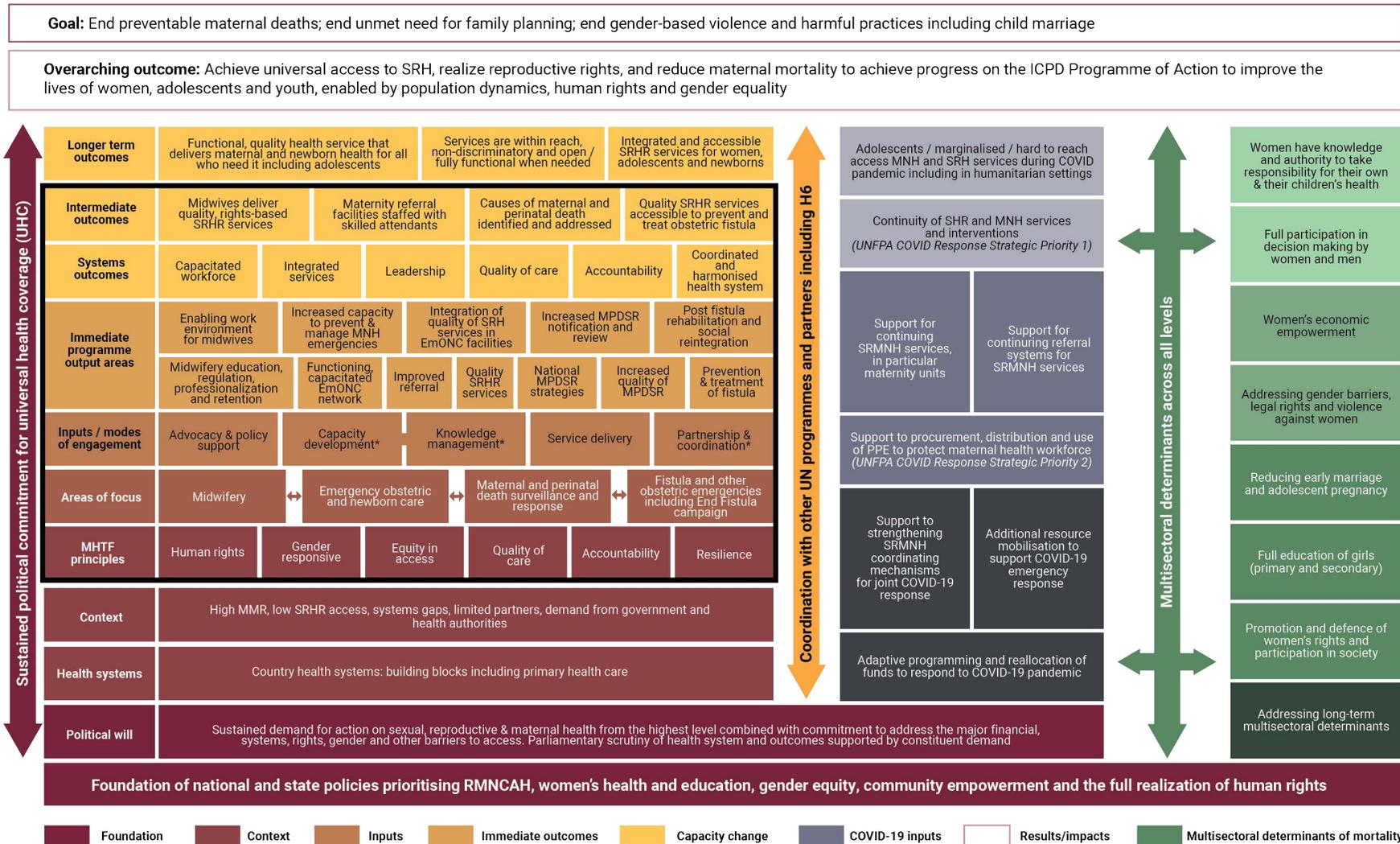
relevant UNFPA policies, the activities undertaken, and the outputs and outcomes expected. The broader social and economic determinants that affect MNH outcomes (and which the evaluation does not assess) are laid out in green on the right-hand side. The vertical arrows identify three critical cross cutting dimensions: political will, coordination across all stakeholders, and multisectoral determinants. The specific chain of effects is explained in Table 2.

Following the MHTF theory of change (Figure 2), the specific segments of the theory of change to be evaluated have been extracted and are magnified in Figure 3 in order to map the placement of the evaluation questions and corresponding assumptions thus linking the theory of change directly to the evaluation matrix available in Annex 1.

Table 2: A key to help read the refined MHTF theory of change

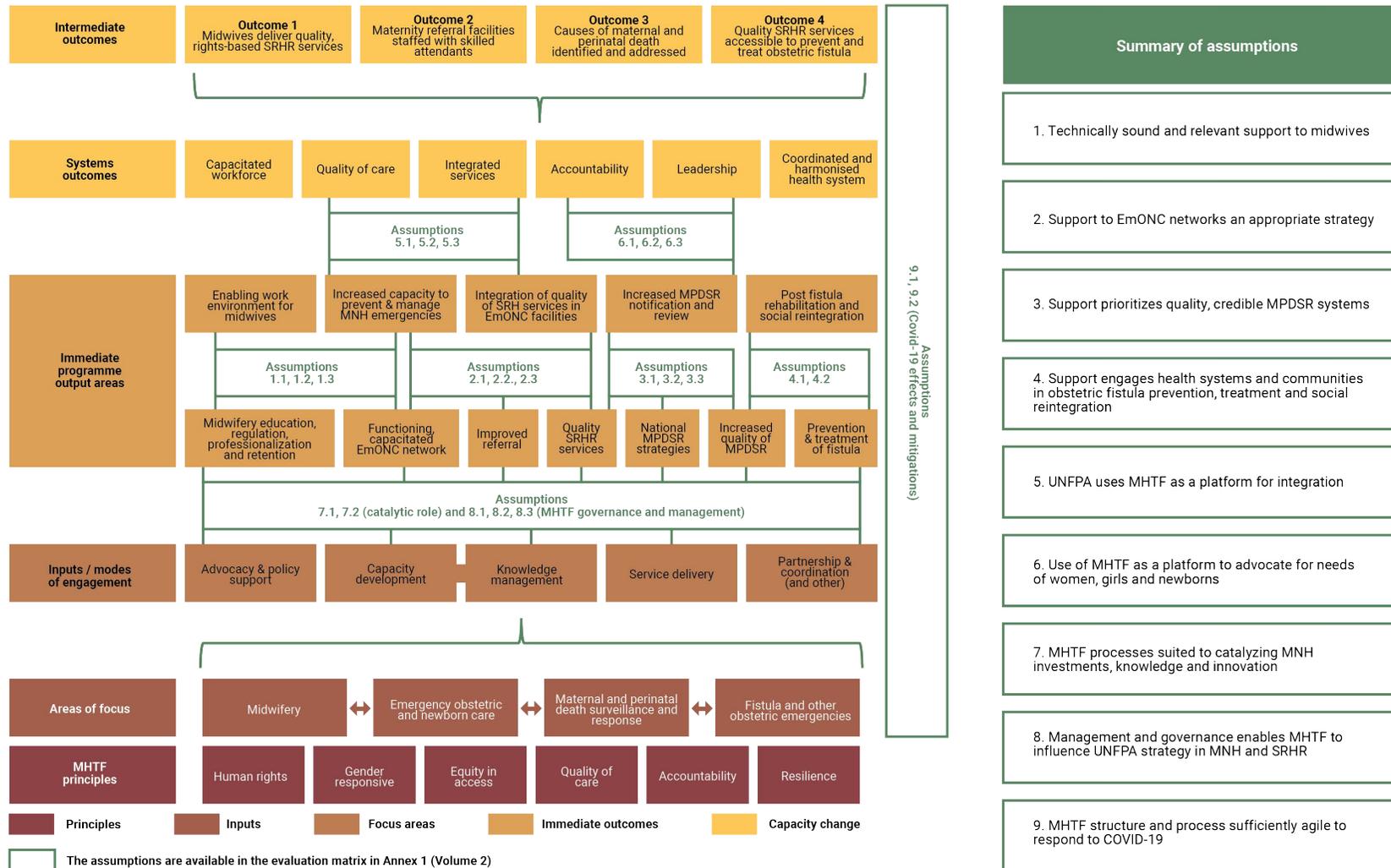
Line of the theory of change (from the bottom)	Explanation
Foundation	The institutional setting, range of laws, and public policies that are the foundation of every country's approach to governance, health and welfare.
Political Will	The presumption that countries are invested in SRHR and maternal health and have the will to engage across political levels to improve outcomes.
Health Systems	A recognition of the health system that will be in place in all countries at national and sub-national levels. The MHTF will engage in some elements of some health systems building blocks but largely its efforts are based on what is already in place.
Context	The specific context that MHTF partner countries share.
MHTF Principles	The principles that shape the approach taken by the MHTF in developing and implementing its activities and support.
Areas of Focus	The four major and inter-related areas of engagement around which the MHTF focuses its work.
Inputs/ Modes of Engagement	The five modes of engagement which together define the main vehicles for the types of support and specific inputs provided by the MHTF.
Immediate Programme Output Areas	These are the expected direct outputs from MHTF inputs and a critical chain of effect to make visible and assess.
Systems Outcomes	The broader outcomes expected to result from programme outputs and which MHTF will aim to shape and contribute towards.
Intermediate Outcomes	The outcomes linked to the four areas of focus identified in the MHTF Business Plan.
Longer-term Outcomes	The strategic outcomes towards which the MHTF is contributing.
Over-arching Outcomes	The long-range outcomes identified in the MHTF Business Plan change model.
Goal	UNFPA organisational goals laid out in the UNFPA strategic plan, 2018-2021.

Figure 2: Overall theory of change for UNFPA support to maternal and newborn health



* In practice, capacity building and knowledge management were often treated in financial and activity reports as interchangeable. They have been linked here to reflect that. No expenditure was badged as 'coordination'. The fifth MOE was usually just 'other' and was small.

Figure 3: Focused MHTF theory of change with evaluation assumptions mapped out



Carrying out the field-based case study in Zambia

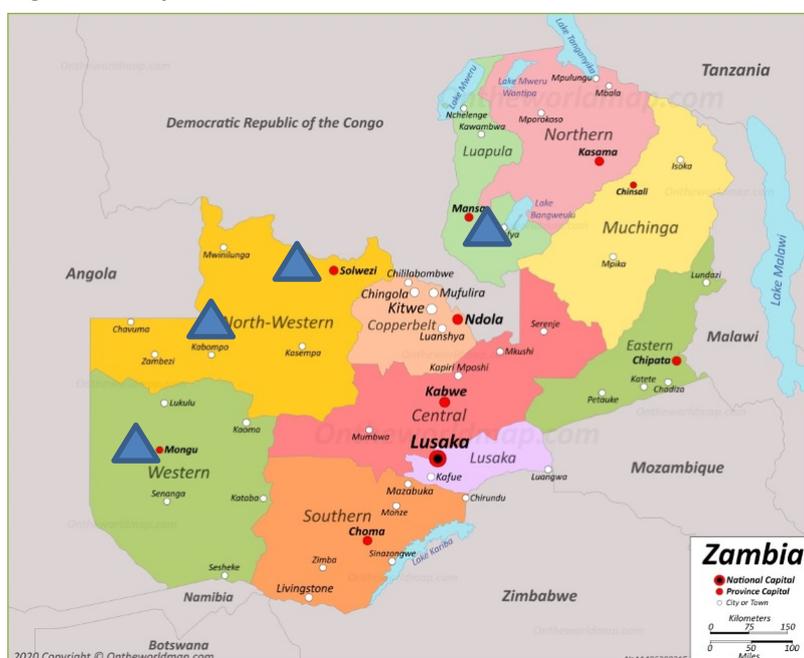
Data collection activities

The Zambia country case study mission was carried out by a team composed of one international consultant and one national consultant in September 2021. The mission was initially set to start in late June 2021; however, the Government of Zambia imposed a lockdown that lasted several weeks. Data collection, therefore, started in late July and was extended to mid-September due to the continuation of the lockdown. The country case mission was carried out virtually, as the team was prohibited from conducting in-person meetings. Therefore, no visits were undertaken to hospitals or health centres to interview service providers and community members. The case study mission was preceded by a review of documents provided by the Zambia UNFPA country office (CO). These were supplemented by documents gathered by the team where relevant (see Annex 4).

The evaluation team carried out interviews with key stakeholders for UNFPA activities and support to MNH (Annex 2), notably:

- The UNFPA Zambia staff including the country representative and programme and technical specialists in MNH, family planning, adolescent SRHR, primary health care (PHC), finance and monitoring and evaluation
- Senior policy makers and managers at the Ministries of Health (MoH) at the national and provincial level
- Civil society organizations working on or adjacent to MNH
- Staff of UNICEF

Figure 4: Map of Zambia



▲ = sites included in the evaluation

Limitations

The Zambia case study was undertaken at a time when the COVID-19 pandemic made most aspects of travel and in-person meetings very difficult. As a result of this situation, two important limitations in the evaluation approach and methodology are noted with mitigating factors.

Firstly, as the evaluation took place during the second year of the COVID-19 pandemic, a number of challenges and restrictions remained in place. The international consultant was unable to travel to Zambia. Internet connectivity and Zoom links had an effect on the ability of the evaluation team – especially the international consultant – to connect with the MoH and other stakeholders during the data collection period.

Secondly, the team was unable to conduct site visits to facilities representative of service provision in MNH and sexual and reproductive health (SRH) care as would normally be the case in this type of evaluation. Due to this limitation, the evaluation team had no contact with individual users of the services.

In mitigation, the team increased efforts to expand the document review and triangulate data from a wide range of sources. Despite the limitations identified, the evaluation team is confident that the data collected supports the validity of the findings reported in Section 3. The data and information collected are presented in the evaluation matrix in Annex 1.

NATIONAL MATERNAL AND NEWBORN HEALTH CONTEXT AND PROGRAMME RESPONSE

Zambia: Context and health setting

Zambia is a landlocked country in southern Africa that is ethnically diverse, with more than 70 ethnic groups. It is the biggest copper producer of Africa, with an economy that is vulnerable to price fluctuations in the global copper market. Zambia had an estimated population in 2021 of 19.1 million with an annual growth rate approaching 3 per cent; the population is projected to reach 49 million by 2050. Zambia is categorized as having ‘medium human development’ and is ranked 144 out of 189 countries in the Human Development Index.³ According to the United Nations Population Division,⁴ the percentage of population in urban areas has grown from approximately 20 per cent in 1963 to 44 per cent in 2018 and is projected to be over 50 per cent by 2030.

Despite economic growth, a 2015 poverty report estimates 60 per cent of Zambians live below the poverty line, with extreme poverty levels of 42 per cent in rural areas and over 60 per cent for female-headed households. The same report indicates that Zambia has a 2014 Gini coefficient of 0.65 and Zambia has poor human development indicators.⁵ Among key development challenges that Zambia is facing are severe income, gender, geographical inequalities and insufficient support to the most needy. In addition, Zambia, like other countries in the sub-region, experience extreme weather conditions such as localized floods, prolonged dry spells, rising temperatures, with effects that worsen disease outbreaks, such as cholera, typhoid, and dysentery.

³ United Nations Development Program, *Human Development Indices and Indicators: 2018 Statistical Update*, New York, 2018

⁴ <https://population.un.org/wup/Country-Profiles/>

⁵ UNFPA, *Country programme document for Zambia. 2016-2020*, 2015

The long-term development agenda in Zambia is guided by the National Vision 2030 which aims to transform the country into a middle-income prosperous nation by 2030.⁶ The National Health Plan 2017-2021 calls for a focus on the provision of a continuum of care with particular emphasis placed on the strengthening of health systems and services using the primary health care approach.⁷ There are urban and rural disparities for several selected reproductive, maternal, newborn, child and adolescent health (RMNCAH) indicators, with rural areas faring worse than urban areas. Reducing reliance on external assistance will be challenging given the current level of Government of Republic of Zambia (GRZ) financial resources, the stagnation of economic growth in recent years, and the extent of existing inequalities in Zambia.

Social and economic determinants of maternal health

In 2019 the MoH and WHO jointly conducted a study to assess the level of inequalities related to the social determinants of health. The study assessed how a person's opportunity for health is influenced using key health domains and related core indicators along which health inequalities are commonly examined. It has demonstrated that health inequalities continue to persist and are evident between provinces, and also across subgroups of the population of different socioeconomic status, age, education level, employment, occupation, place of residence and sex which can all impact access to services and population health status. In particular, for women and girls, negative gender and social norms and unequal power relations impede equitable access to SRH and HIV services. Poor quality of care, including disrespectful care, inadequately resourced community support systems and limited male involvement also contribute to inequitable access and utilization of SRH and MNH services, affecting maternal health outcomes.

Brief outline of the Zambian health system

Health services in Zambia are provided by the government as well a number of non-governmental and private sector organizations, such as the Churches Health Association of Zambia (CHAZ), mining companies, private facilities and traditional healers. The public and essential health care services of the government are delivered through five standard types of health facilities: health posts, health centres, and the 1st, 2nd and 3rd level referral hospitals distributed throughout the 10 provinces and 105 districts in the country. Health planning and service delivery is decentralized to the districts with support from provinces and normative guidance from the national level. A key part of the current national health plan is to support the strengthening of PHC services, including the community component and referral system.⁸

The delivery of high-quality health services in Zambia is constrained by the concentration of health infrastructure in urban areas, inadequate funding for drugs and medical supplies, a weak supply systems and poor working conditions that have resulted in the attrition of human resources. The attainment of national goals in health is hampered by a high disease burden resulting from high prevalence of communicable diseases, including malaria, HIV and AIDS, tuberculosis and sexually transmitted infections (STIs). In particular, the HIV and AIDS epidemic has a substantial impact on maternal and infant mortality and morbidity also continue to affect Zambia.

⁶ Republic of Zambia, *Zambia Vision 2030*, 2006

⁷ Republic of Zambia, *Zambia National Health Strategic Plan, 2017-2021*, undated.

⁸ Republic of Zambia, *Zambia National Health Strategic Plan, 2017-2021*, undated.

Overview of maternal and newborn health in Zambia

Maternal and newborn data and trends

The MMR remains high at 278 deaths per 100,000 live births (ZDHS 2018),⁹ although it has shown substantial decline from 591 deaths per 100,000 live births over the past decade. Women living in urban areas are more than twice as likely to give birth at a health facility, as compared to women in rural areas. While most deliveries in rural areas (66.5 per cent) were at home, most deliveries in urban areas (79.0 per cent) occurred at a health facility. Skilled birth attendance was estimated at 80 per cent in 2018. Overall use of modern contraception has not significantly changed over the past five years. Of currently married women aged 15-49, 45.6 per cent of married women reported using modern contraception, as compared to 35.6 per cent of all women.¹⁰ Unmet need is estimated at 20.9 per cent;¹¹ with highest levels seen in Western Province at 27 per cent. Overall, 39 per cent of women age 15-49 experienced either physical or sexual violence. Twenty-six per cent of women experienced only physical violence, 3 per cent experienced only sexual violence, and 10 per cent experienced both physical and sexual violence. Teenage childbearing has declined from 34 per cent in 1992 to 29 per cent 2018; however, there has been no change between 2014 and 2018, indicating a lack of progress.

Financing maternal and newborn health in Zambia

After a period of steady increases in government spending on health in Zambia, per capita health spending decreased between 2013 and 2016, although it is back on the rise. (

Figure 5) Health expenditures as a percentage of gross domestic product (GDP) fell during the same time frame to less than 4 per cent, and have slowly inched back up to 5 per cent, not yet achieving over 7 per cent level at the beginning of the century (

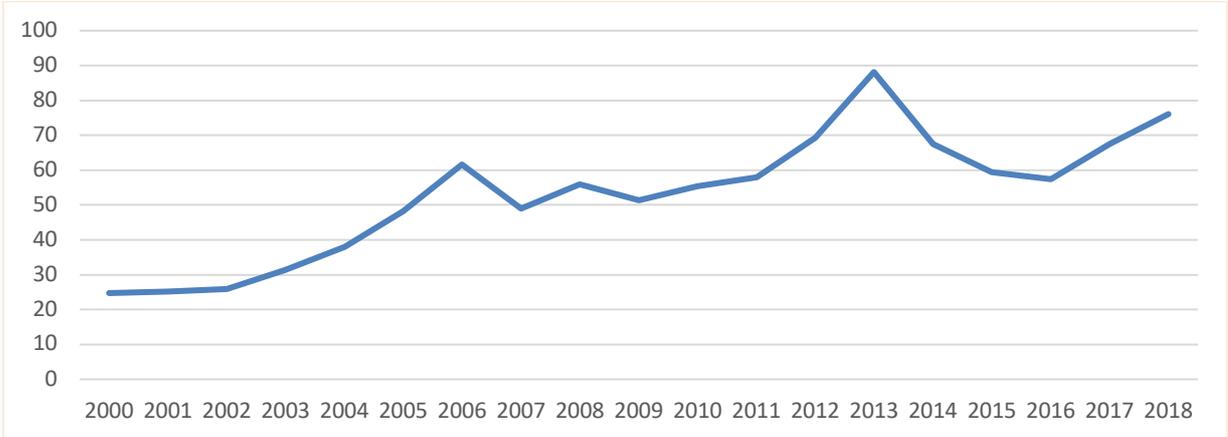
⁹ All data is taken from the Zambia DHS 2018 unless otherwise noted.

¹⁰ <https://fp2030.org/zambia>

¹¹ Ibid.

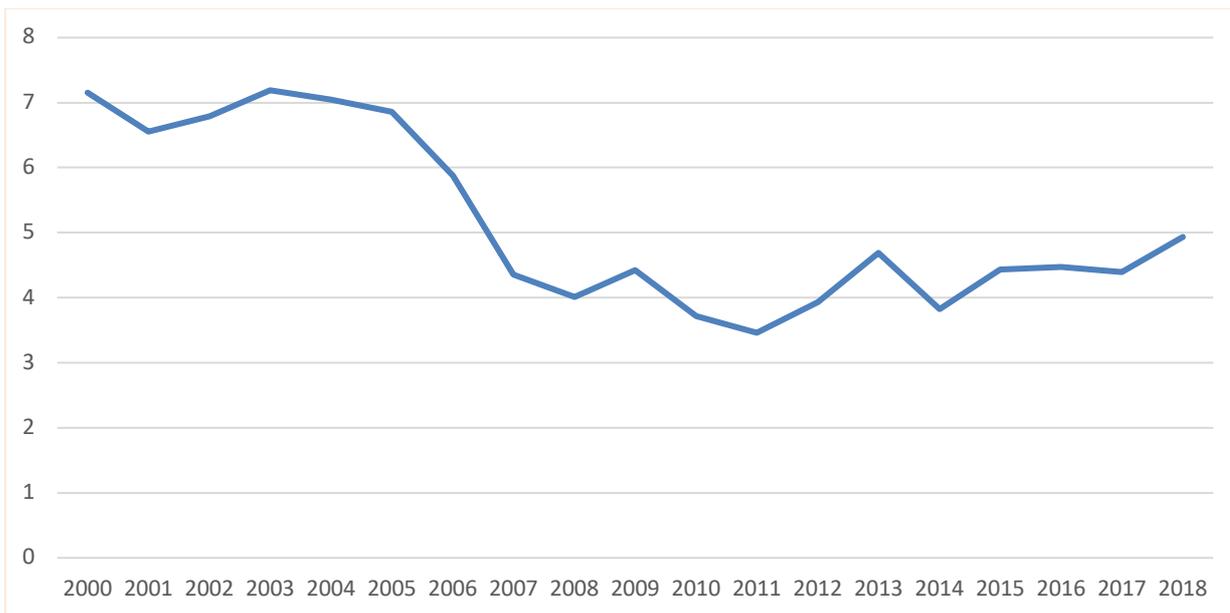
Figure 6).

Figure 5: Government spending on health in Zambia (per capita health expenditures in USD (in 000s))



Source: World Health Organization Global Health Expenditure database (apps.who.int/nha/database).

Figure 6: Current health expenditures in Zambia as per cent of GDP), 2000-2018.



Source: World Health Organization Global Health Expenditure database (apps.who.int/nha/database)

In 2016, GRZ developed its first health care financing strategy (2017-2027) to support moving towards universal health coverage (UHC) for Zambia.¹² The strategy is aimed at addressing a range of challenges, such as low and erratic funding to the health sector in relation to needs, low contribution of domestic revenue and limited prospects for growth, and heavy dependence on external (and unpredictable) assistance by development partners. The plan proposes increasing private sector participation, including public-private partnerships, capturing household payments and channelling them efficiently in prepayment and pooling arrangements; and continued engagement with cooperating partners in financing the health sector. A key focus is to advocate for increases in the share of government funds allocated to the health sector and to mitigate financial hardships by households in seeking health services.

UNFPA maternal and newborn health programme priorities in Zambia

Strategic orientation and programmatic approach

The period for the mid-term evaluation of MHTF coincides with the end of UNFPA Zambia 8th Country Programme (CP) 2016-2020, which has been extended one year to 2021 in order align with GRZ national planning processes. The strategic goal of UNFPA in Zambia is to strengthen SRH information and services by women and girls and enhance government capacity to implement a multi-sectoral population programme focused on reproductive health and rights, population and development, and gender equality. The CP8 outlines three main programmatic areas: SRH (through a human rights-based approach and including HIV and gender-based violence (GBV), adolescents and youth, population dynamics. Gender equality and women’s empowerment, previously a separate thematic area, was mainstreamed throughout the programme. The UNFPA approach is intended to address critical issues in SRH in Zambia, including high maternal mortality, despite some decline; continuing high HIV prevalence, particularly in women; and significant unmet family planning needs. Additional issues include challenges within both the health and community support systems; obstetric fistula

¹² Republic of Zambia. Health financing strategy: 2017-2027 – towards universal Health coverage for Zambia. 2016.

remain a significant problem, as does gender based violence (GBV) including intimate partner violence (IPV).

A major priority within the UNFPA approach is to build commitment and capacity within the Ministry of Health (MoH), the core line ministry with which UNFPA works at both national and sub-national levels for SRH. In line with leaving nobody behind, UNFPA selected provinces and districts for support based on poverty and poor SRHR indicators. UNFPA prioritizes the strengthened integration of SRH services and GBV prevention and support services and targets young people aged 15-24 years and women of reproductive age, including those in hard-to-reach communities. Through CP8, UNFPA began to address the needs of persons with disabilities in more intentional manner.

UNFPA Zambia budgets and expenditures

In 2020, the UNFPA Zambia programme expenditures were approximately USD 8 million, of which 72.6 per cent was spent on “integrated SRHR” services, followed by 18.3 per cent for population dynamics, 6.6 per cent for adolescents and youth and 2.5 per cent on gender equality. UNFPA Zambia has seen a decrease of 13.7 per cent in programme expenditures between 2018 and 2020. The core funded budget (resources allocated from UNFPA headquarters) rose between 2018 and 2020, and the percentage of funding that core resources represent within the overall budget correspondently increased to 23.9 per cent, almost a quarter of the programme expenditures.

Table 3: Distribution of UNFPA Zambia expenditure across programme areas and divided by core and all sources of programme funding, 2018-2020

Programme Area	2018	%	2019	%	2020	%	2018-2020	%
Integrated SRHR Services	7,642	82.6	6,212	76.9	5,802	72.6	19,666	77.6
Adolescents and Youth	583	10.8	634	7.8	525	6.6	1,742	6.9
Gender Equality		15.4	252	3.1	202	2.5	454	1.8
Population Dynamics	1,030	4.3	976	12.1	1,458	18.3	3,464	13.7
Total	9,265		8,074		7,987		25,326	100
Of which, UNFPA Core Funding	1,763	19.0	1,897	23.5	1,910	23.9	5,570	22%

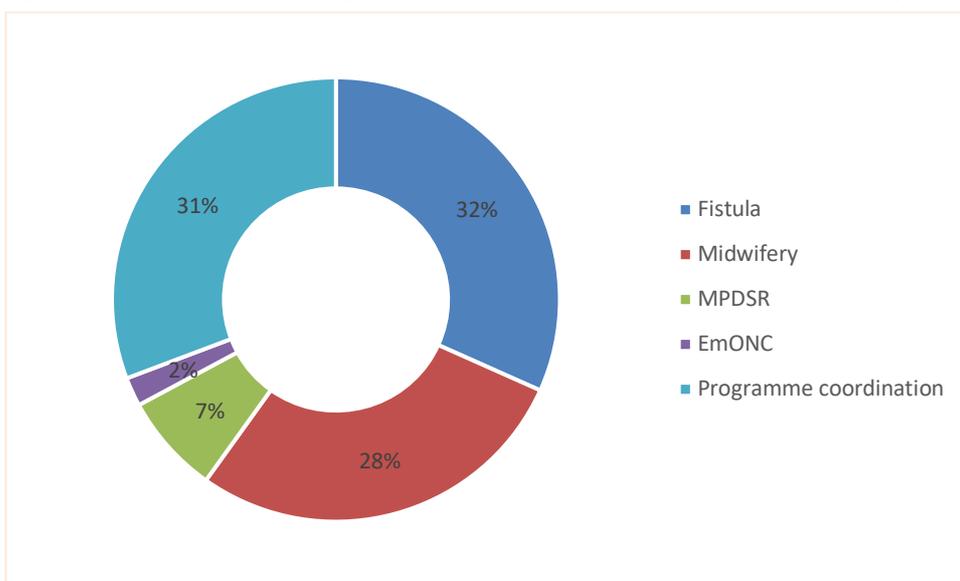
Table 4 shows MHTF expenditure as a proportion of all UNFPA Zambia expenditure by year. The MHTF expenditures represents 7.5 per cent of the overall budget for Integrated SRHR services and 2.7 per cent of total programme expenditures between 2017-2019.

Table 4: UNFPA Zambia total programme and MHTF expenditures (USD, in 000s) by year

Year	Total UNFPA expenditure USD	MHTF expenditure USD (%)
2017	8,705	200 (2.3%)
2018	9,265	251 (2.7%)
2019	8,074	247 (3.0%)
Total	26,044	699 (2.7%)

Figure 7 shows the distribution of resources across the four main technical areas of the MHTF in Zambia. Fistula (32 per cent) accounts for the greatest share of MHTF investments during the three-year period, followed by programme coordination¹³ (31 per cent) and midwifery (28 per cent). MPDSR and EmONC have accounted for a much smaller share of MHTF resources.

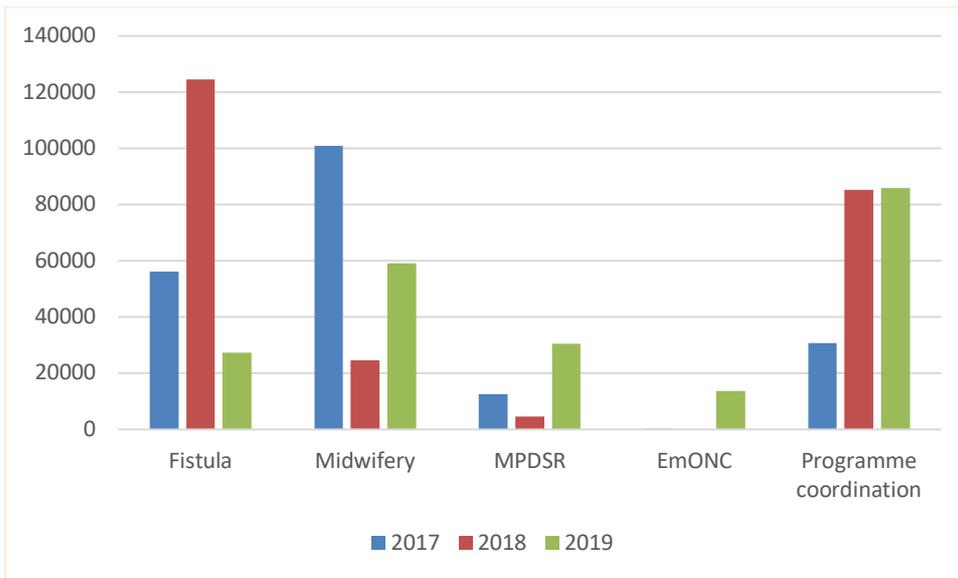
Figure 7: Total MHTF funding across the four MHTF technical focus areas (2017-2019)



Distributed by year, the share of expenditures for fistula increased dramatically in 2018, accompanied by the decrease in midwifery expenditures (Figure 8). In 2019, midwifery and MPDSR expenditures outpaced fistula, indicating a shift in emphasis for MHTF resource allocation. This can be explained by the entrance of the Fistula Foundation in Zambia with expanded resources.

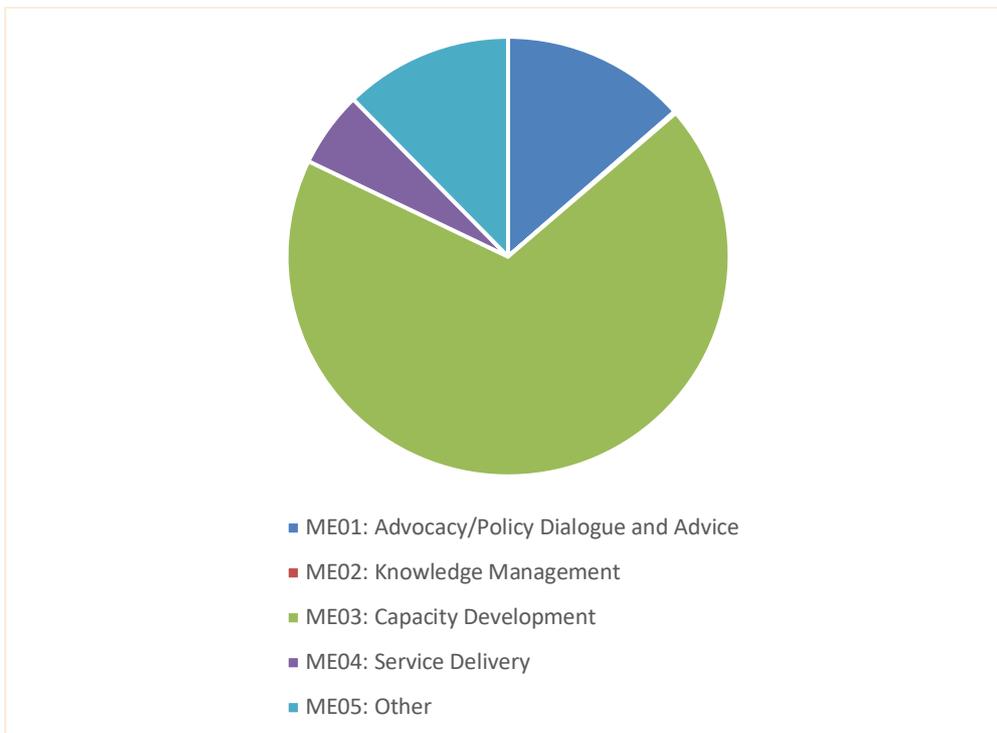
¹³ Programme coordination mainly supports the costs of the fistula analyst who is responsible who manages MHTF work planning and reporting processes across all content areas. Unlike other offices that assign the costs of coordination across all technical areas, UNFPA Zambia has kept it as its own category of expense.

Figure 8: Disbursed MHTF funds (USD) across the four technical focus areas by year, 2017-2019



UNFPA delivers across five modes of engagement. These require different kinds of inputs and effort. While financial spending is not always a reflection of time, effort, importance or scale of result, it can be indicative of the focus of UNFPA work in the country. Figure 9 shows the distribution of total MHTF spending over three years suggests that capacity development is by far the most important to MHTF results in Zambia, followed by advocacy and policy dialogue.

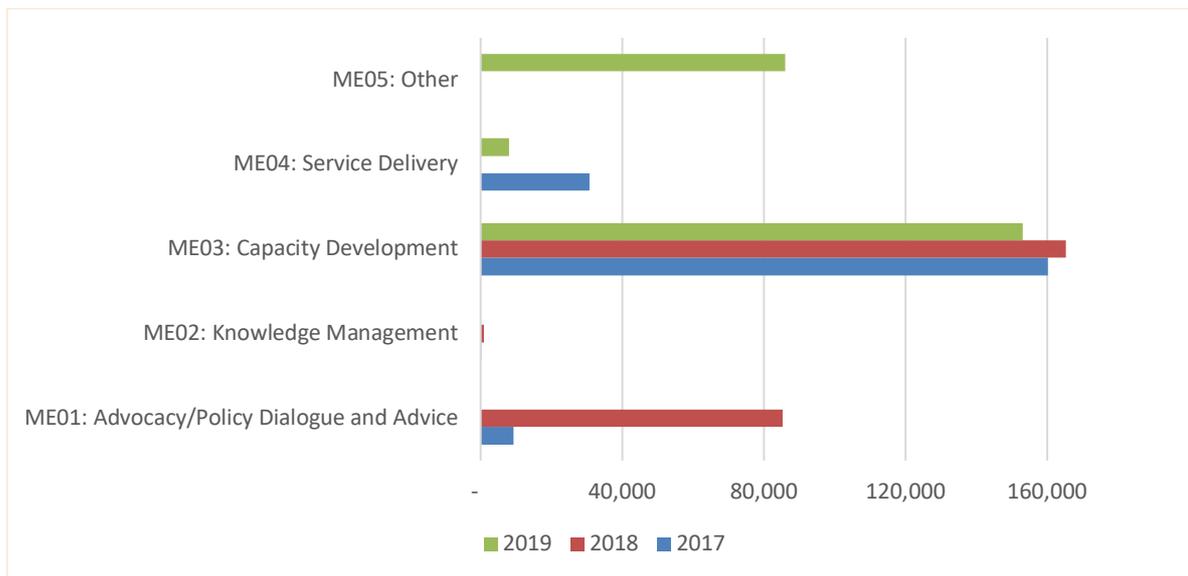
Figure 9: The cumulative distribution of investments across the modes of engagement, 2017-2019



Breaking this down by year highlights the priority given to capacity development. There was a major increase in resources allocated to policy development in 2018. Shifts in the other categories are more

difficult read and are likely due to changes in how expenses were tagged rather than a major strategic shift in programming. Nevertheless, very little was allocated for knowledge management across the three-year period. (The category “other” tracks the expenses allocated for overall programme coordination.)

Figure 10: The distribution of MHTF investments across the four modes of engagement, 2017-2019



Key coordination and implementing partners

Donor commitments for development assistance related to SRH was estimated to be over USD 300 million in 2017.¹⁴ With an annual budget of USD 8 million, UNFPA represents a fairly small player in the overall landscape for SRH in Zambia.

CASE STUDY FINDINGS

Midwifery

In Zambia, UNFPA has contributed to an improved policy and regulatory environment for midwifery through its work to update the Midwifery Act and to revise the scope of practice regulations. Progress has been made in strengthening education through curriculum development and support to selected midwifery schools. In addition, through support to the Midwives Association of Zambia (MAZ), UNFPA has helped establish an important platform for professionalization of the midwifery cadre. An important contribution has been the development of guidelines and training materials for midwives on respectful care. Less focused attention is on addressing workforce issues and strengthening the overall system to monitor training and deployment needs of midwives to support SRH and MNH services. Capacity building activities are effective, but do not extend beyond the provinces where UNFPA provides ongoing support for implementation. The holistic midwifery strategy promoted by MHTF has guided activities in Zambia to a point but has only partially been implemented to its full effect.

For details of the evidence supporting findings in Section 3.1, see Annex 1: Assumptions 1.1, 1.2 and 1.3

¹⁴ Kibira, D. et al. Donor commitments and disbursements for sexual and reproductive health aid in Kenya, Tanzania, Uganda and Zambia. Public Health, 20 April 2021. Accessed from: <https://doi.org/10.3389/fpubh.2021.645499>

Updating the midwifery scope of practice

A major focus of MHTF activities in Zambia has been to support the Nursing and Midwifery Council, the regulatory body tasked with setting midwifery standards aligned with international standards. Improving access to skilled birth attendants requires removing restrictive barriers for the practice of midwives for ensuring quality standards regarding the skills and competencies required for the certification of midwives. In 2019, UNFPA supported the council in its effort to repeal and replace the 1997 Nurses and Midwives Act which serves as the foundation for the regulation of education, registration and licensing for the profession. This Act included an updated scope of practice for midwives to define the range of roles, functions, responsibilities and activities which a certified midwife is authorized to perform.

UNFPA also supported the MoH to develop and disseminate the National Human Resources for Health Strategic Plan 2018-2024. This plan incorporates the need for skilled birth attendants and community health workers as necessary and places midwifery as a priority in solving the health challenges in the country. While UNFPA has made an important foundational contribution, a strategy has not been developed to track needs-based deployment and retention of midwives on a national basis and to inform planning.

Promoting respectful care by midwives in maternity care

Addressing maternal morbidity and mortality requires getting at reasons that impede women's and girls' access to safe motherhood services, including the barriers resulting from gender inequalities and poor quality. Studies in Zambia have pointed to the need to improve and institutionalize respectful care in maternity services to encourage women to seek services and delivery in health facilities. Disrespect and abuse include provider behaviours such as physical and verbal abuse, non-consented care, undignified care, discrimination and bias, and even abandonment or detention in care. MHTF funding enabled UNFPA to partner with MoH and others, including the MAZ, to develop Respectful Care Guidelines and a training manual for facilitators to implement the guidelines. UNFPA also supported MAZ to conduct the first training using these materials. These guidelines are a first in the region and can serve as a model for other countries to integrate human rights in maternity care through advocacy and support for respectful care. While relatively new, the guidelines are an important advocacy tool to bring attention to the need for quality, client-centred care. A remaining challenge for these guidelines and other policies is the lack of resources within the MoH to fully implement recommendations to support capacity-building and deployment of competent midwives throughout the country.

Strengthening midwifery education through the consolidation of curricula and support for schools and training faculties

UNFPA assisted the MoH in a major effort to consolidate several curricula into one, comprehensive curriculum for midwifery. Prior to this consolidation, there was much confusion about which curriculum to use. Working with the General Nursing Council (the MoH arm responsible for curricula review), MHTF resources supported a situational analysis to review what existed and the gaps, and sponsored a stakeholder consensus meeting, followed by a series of meetings for content realignment and development. An important aspect of the curriculum revision was to establish a certificate programme to enable high school graduates to enter midwifery without first requiring a nursing degree, thus increasing the pool of candidates who can become midwives.

UNFPA engagement was important for ensuring that the curriculum was aligned with global standards and incorporated emerging issues related to respectful care, GBV, adolescent health and people living with disabilities. However, advocacy by UNFPA to incorporate MHTF-promoted content related to "First Time Young Mothers" in the curriculum was seen as superfluous by the MoH, given already existing interventions for safe motherhood and teen pregnancy. The curriculum review process began in 2019, but its completion was delayed by COVID-19; the next step is for a validation meeting, followed by the lengthy process for developing and aligning instructional materials,

including procedure manuals and training guides. UNFPA engagement in these processes is considered vital. In the words of one key informant, UNFPA offers “double barrel” support by providing both technical and financial expertise to ensure that midwifery competencies are defined in accordance with international standards.

UNFPA has also used MHTF resources to improve the quality of education by ensuring that midwifery schools are adequately equipped and that practical training sites are available and fully functional at all levels of the health system. UNFPA has strengthened the capacity of midwifery schools in the three provinces in which they work, Western, North-Western and Luapula, through conducting training of trainers for tutors, supporting education forums and updates, setting up skills laboratories, and procuring teaching equipment such as practice models (‘Mama Natalie’) and textbooks. The schools have also been supported with access to computers and access to the internet. This material support is greatly appreciated and credited with helping to increase the capacity of the schools to train and deploy competent midwives.

In addition, MHTF funded the tuition fees for students to attend a one-year, in-service “short course” at the midwifery schools in the three UNFPA-supported provinces. The tuition support enables the schools to attract students from within the province and have them stay in their home areas after training. UNFPA helps to follow up the midwives once they have completed training and also provides support for refresher training when needed. For example, the Solwezi Nursing and Midwifery School (in North-Western Province) has supported 97 trained midwives for in-service deployment and has received positive reports from health facilities regarding their performance. Nevertheless, the issue of human resource capacity persists. One key informant likened it to “having a bucket with a hole that water is seeping through.” Retention issues continue to be a challenge with those trained leaving the public sector for further education and opportunity. While MHTF resources are directed to the provinces where women are more likely to be assisted by a traditional birth attendant, the aforementioned lack of a strategy and system for needs-based deployment continues to be a gap.

Strengthening capacity and professionalization of midwives

UNFPA has supported the continued development of MAZ to represent midwives and help raise the profile of midwifery. MAZ, created in 2011, is the sole professional organization of midwives and counts 1,000 members (representing 25 per cent of the 4,000 midwives in Zambia). UNFPA has supported the development of the strategic plan for MAZ and has advocated with the MoH to enable MAZ representatives to participate in the development of the Respectful Care Guidelines and other platforms, such as MPDSR national meetings and for curriculum reviews and development. MHTF resources have supported the International Day of Midwives (IDM), an annual commemoration of the important contribution of midwives in primary and reproductive health care. In 2020, IDM was a forum for the launch of the State of the World Midwifery Report in Zambia. These commemorations are also opportunities for the professional education for midwives, by organizing symposia in conjunction with IDM. Although intended to showcase midwifery for advocacy and resource mobilization, reporting for IDM activities are focused more on inputs rather than outputs or outcomes, making it difficult to assess return on the investment of time and opportunity costs for these logistics-heavy events.

The support provided to MAZ by UNFPA has aided the organization to establish itself and be seen as a credible partner in advancing maternal and reproductive health care in Zambia. There are important issues that remain. Midwifery does not get the same level of attention in the provinces where UNFPA is not active. Other partners provide support for reproductive, maternal, newborn, child, adolescent health and nutrition (RMNCAH&N), but do not prioritize the role of midwives. Further, the MoH focus is on public sector midwives, with less attention to the training needs of those in the private sector. Coordination between the MoH and MAZ is hindered by the lack a system to share information on where training and mentorship has taken place, making it difficult to address

midwifery needs at the provincial or district level. The lack of a Chief Midwifery Officer within the MoH to directly work with MAZ on these issues is a hindrance to more robust coordination on matters relating to midwifery.

Partial implementation of MHTF holistic midwifery strategy

The current global MHTF strategy for midwifery (2018-2021) sets forth a holistic approach to ensure equitable access to quality midwifery services and care (Figure 11).

Figure 11: Programme components of the MHTF global midwifery strategy, 2018-2021



UNFPA has followed this model in Zambia, with the greatest focus on the components of regulation, education and association. UNFPA is lauded by the MoH for following its lead on where support is needed; however, much of the financing has been limited to the implementation of training, mentorship and materials, rather than to the development of national-level systems to plan for the recruitment, deployment and retention of the midwifery cadre.

Emergency obstetric and newborn care network

EmONC has not received the same level of resources or programmatic focus as the other MHTF components; instead, it has mainly been addressed through the midwifery and MPDSR components. The main accomplishment has been to conduct EmONC functionality assessments in supported provinces to guide investments in equipment, infrastructure and capacity building. These functionality assessments have contributed to strengthened service delivery in the provinces and districts where they were implemented. However, poor quality remains an important roadblock for women to access antenatal care (ANC), book facilities for delivery, and seek care in an emergency. MHTF has done a good job of assessing EmONC services but has not yet taken a broader strategic look at the effectiveness of mentorship and training on improving EmONC quality and access, through a holistic lens that addresses both supply and demand issues.

For details of the evidence supporting findings in Section 3.2, see Annex 1: Assumptions 2.1, 2.2 and 2.3

Providing evidence to inform EmONC plans and interventions

MHTF resources have been used to conduct “EmONC functionality assessments” to assess the readiness of facilities to deliver services according to international standards. These assessments were conducted in 2019 in the Central, Western and Luapula provinces and were designed to ascertain the availability of infrastructure, equipment, medical/surgical supplies and assessed the knowledge and skills among health facility staff to perform selected EmONC procedures, i.e., manual vacuum aspiration (MVA), cervical tear repair and use of anti-shock garments. The assessment covered 162 facilities in the three provinces and found similar gaps and problems, such as the lack of equipment and skills of staff to perform basic signal functions. The results have formed the basis of plans for equipment distribution and refresher training for providers in the provision of basic emergency obstetric and newborn care (BEmONC) services, such as comprehensive abortion care (CAC), neonatal resuscitation and provision of essential medicines, i.e., magnesium sulphate for eclampsia.

These functionality assessments were limited in both geography and scope. While the assessments identified concrete needs and then put in place plans to fulfil the immediate gaps, there are a range of other issues that were not addressed, such as the referral linkages for emergencies and client experiences with access and care. MoH stakeholders at provincial level appreciated these assessments; however, progress requires an approach that goes beyond the functionality of facilities to address broader needs.

Focus of MHTF support for EmONC is on capacity-building (training and mentorship)

Prior to the start of MHTF Phase III, UNFPA collaborated with UNICEF, WHO and others to update the EmONC Training Package (2016). The package calls for a two-week course (theory and practicum), plus four weeks of self-directed learning, followed by a structured mentorship program. MHTF investment during Phase III has included support for in-service training of providers and mentorship activities. UNFPA supported training via a short, “abridged” 5 to 7 days course for EmONC (for example, in Solwezi and Mufumbwe districts in North-Western province), presumably to lessen disruptions in service continuity at trainee facilities. This abridged course was described as providing nurses and midwives with basic information to manage emergencies.

UNFPA reporting on training included documentation on the numbers of providers trained; in 2019 UNFPA trained 37 health workers in EmONC, 25 midwives in the Helping Babies Breathe and Helping Mothers Survive modules, and 17 midwives and nurses in cervical cancer screening. However, there is no data to evaluate post-training results or competency ratings, either for the full or abridged courses. Anecdotal information from Mufumbwe District (North-Western Province) credits UNFPA training with improved access to EmONC and family planning services by increasing the number of available staff at health facilities.

“We’ve seen an impact on maternal death rates. I think the rates are going down because most of the staff have been equipped with knowledge and skills so that they are able to handle cases, identify complications and take action regarding women during delivery, post-delivery or antenatal. I think that is a significant role that UNFPA has played. They have also increased the number of qualified personnel in terms of midwifery care, and this has contributed to the drastic reduction of maternal and neonatal mortality rates as compared to the past when they were no training of such kind.” – MoH staff, Mufumbwe district

As much as UNFPA has supported selected districts to train staff, stakeholders noted the absence of a needs-based strategy to determine training needs and deployment. Decisions on training and mentorship are handled at the provincial level by the provincial health office (PHO), with UNFPA providing the financial inputs to support these activities. It is not evident that UNFPA sets its own priorities for funding EmONC apart from responding to specific MoH requests. Supporting capacity building in EmONC is also closely aligned with the midwifery component of MHTF; handling these

two components separately in reporting contribute to the lack of a clear picture and missed opportunities for synergies in both planning and monitoring results.

The role of mentorship in assuring quality of care

For over a decade, the MoH has embraced mentorship as a key intervention for ensuring quality of care following the training of service providers. Mentorship, as defined in MoH guidelines, consists of practical training and consultation to foster ongoing professional development of service providers. The process includes site visits by mentors for observation and coaching, review and discussion of client data, and the provision of feedback. UNPFA, through its partnership on the UNICEF-led, European Union-funded RMNCAH&N programme,¹⁵ supported the MoH to develop national quality improvement and mentorship guidelines and tools. While adopted at the national level, the rollout of the guidelines and tools were still in initial stages when the EU project ended in 2019, and these materials were not referenced by provincial and district stakeholders contacted for this evaluation. There appears to have been no effort to “connect the dots” and link MHTF-supported mentorship to these national guidelines. This is a missed opportunity to pursue a clear, overarching strategy for systematically building and sustaining capacity through mentorship and other quality improvement interventions.

As with training, mentorship planning and implementation is driven by the PHOs and their knowledge of the facilities and the people within their geographic areas. This is appropriate in a country like Zambia which has a strong national capacity in RMNCAH&N technical matters. MoH capacity is one of the reasons given by the Zambia country office to eschew the national EmONC network model promoted by the MHTF headquarters team and instead, follow the lead of the MoH to guide financial and technical resources for EmONC training and mentorship. UNPFA has used information gleaned from mentorship reports to inform and shape annual workplans with the MoH at provincial level. This has yielded some amelioration in quality of care, such as enhanced provider skills in managing emergencies and adhering to infection prevention protocols.

Mentorship is an ongoing quality improvement mechanism used in Zambia; however, UNPFA has not questioned the extent to which its practice is effectively targeting and effective in addressing the most strategic problems in access to quality EmONC services. Despite gains in coverage for ANC visits and deliveries in facilities, poor quality of care is believed by many stakeholders to be the major roadblock affecting demand for and access to EmONC services.

Maternal and perinatal death surveillance and response

UNPFA has played a critical role in the revitalization of the MPDSR process and for furthering government commitment towards its implementation. Key contributions made with MHTF resources included engaging with professional associations and other credible actors to inform a national plan and develop guidelines and protocols that are aligned with global standards. MHTF resources were used to support the functionality of the national MPDSR committee to conduct reviews as well as to roll-out the process to sub-national level. The MPDSR process is well-established in provinces that UNPFA supports as a result of MHTF-funded capacity building activities. Mortality reviews are becoming routine, although there is room for improvement through the addition of confidential inquiries. As one of several quality improvement (QI) processes in Zambia, inadequate attention has been given to assessing how MPDSR has synergies or overlaps with other quality improvement activities, an important consideration when considering strategies

¹⁵ Euro Health Group. 2020. Ex-post evaluation of the Millennium Development Goal Initiative accelerating progress towards maternal, neonatal and child morbidity and mortality reduction in Zambia (MDGi Programme): Final Evaluation Report.

for sustaining and mainstreaming the process. UNFPA Zambia has appropriately encouraged MPDSR committees and processes to look beyond the health sector and has engaged other actors, such as traditional leaders and the Ministry of Community Development. This is an important move towards addressing the challenges that cannot be addressed by the health sector alone.

For details of the evidence supporting findings in Section 3.3, see Annex 1: Assumptions 3.1, 3.2 and 3.3

UNFPA leadership in promoting the MPDSR process and planning

The MPDSR has been promoted by WHO and partners since 2013 as a key intervention for reducing maternal mortalities. UNFPA has been instrumental in supporting GRZ commitment to the comprehensive surveillance of maternal deaths as an important component for achieving its goal to reduce maternal mortality. MHTF investments over the past several years have enabled UNFPA to offer technical expertise and financial support to advocate for MPDSR and build the capacity of the MoH at national level and in selected provinces to manage the MPDSR process. UNFPA is seen as main partner that has most influenced the MoH with its technical and financial support, while bringing in other partners, and assuring committees are in place and functioning.

MHTF support intensified during phase III, in response to the declaration by the President (in May 2019) that the level of maternal and perinatal deaths was a national public health emergency. In 2019, UNFPA funded the Association of Gynaecologists and Obstetricians (ZAGO) to draft a position paper of strategic interventions which informed the development of a national MPDSR plan. This plan lays out the processes for reviewing maternal deaths, identifying the factors that contribute to the death and developing response plans to prevent recurrence. In 2020, UNFPA supported the review of national MPDSR guidelines in collaboration with a consortium of United Nations agencies helping with the process, i.e., WHO, UNICEF and the World Bank. The draft guideline, aligned with global standards, was validated and is awaiting printing and dissemination.

To strengthen MoH capacity in MPDSR, UNFPA trained 35 technical staff from the MoH and development partners, including members of the national MPDSR committee appointed by the Minister of Health. UNFPA has provided the resources to ensure weekly meetings by the national committee and to produce regular reports to share information what is being learned from the death reviews as well as the response plans. MoH stakeholders are clearly committed to the process and appreciative of the funds that have enabled it to *begin* the scale up of MPDSR in a manner that ensure routine implementation throughout the health system and according to standards. UNFPA has laid a solid foundation for the effective implementation of the MPDSR by MoH. However, the process remains dependent on MHTF resources and there is no evident plan to integrate it within the government budget.

MPDSR implementation progress and challenges

In addition to advocating for ongoing commitment to MPDSR at the national level, UNFPA has also used MHTF resources to implement the process at sub-national level in focal provinces where it conducts programmatic activities. MHTF resources have supported capacity-building of provincial and district staff to carry out facility-level orientations to MPDSR in Western, North-Western and Luapula Provinces. In addition, UNFPA has provided MHTF resources to close gaps that have been identified during reviews, e.g., additional training to upgrade providers' skills and procurement of life-saving drugs to prevent postpartum haemorrhage.

The process of death notification and review has been well established in the focal provinces. At facility level, a review takes place immediately when a death occurs. The facility reports the death to the district within 24 hours and the province and national levels are notified.

“Once notification is made, a date is set within one week to sit and review the deaths. So within one week they are actually able to sit as a team and review that death to come up with the factors that could have contributed to that death. When we have our meetings on

Friday, the facilities as well as the districts and provinces are able to report what they have done so far. Because it does not help just reporting numbers, we ask them to give us information on what they have done to address the gaps that were identified when they were doing those reviews. Thus reports are given every Friday to learn what the districts as well as the facilities have done to address the identified gaps. Reporting and implementation of activities is done consistently.” – MoH national staff

Maternal death audits were conducted regularly and in a timely manner, and facilities had developed action plans to address factors in maternal and perinatal deaths, although perinatal deaths reviews were just starting. The audits are becoming routinized and provincial staff are motivated as they see the process yield results. However, a major challenge is ensuring that the review process gets to the root of the problem so as to formulate appropriate recommendations. Providers are reportedly reluctant to look deeply at causes in case the finger points to them.

“We have noticed some gaps and are trying to work on that: at facility level, whenever a death is being reviewed there is fear. Do not get the depth and detail.” – MoH national staff

To address this issue, the MoH has requested UNFPA to assist it to conduct confidential inquiries as part of the MPDSR process. The country office has requested assistance from the East and Southern Africa regional office (ESARO), as there is experience within the region to draw upon. MPDSR implementation is also challenged by frequent staff turnover, incomplete medical records, limited resources/finances, lack of essential commodities and difficulties in communication due to poor connectivity and/or large distances between the provincial, district and facility personnel.

MPDSR as a standalone process

MPDSR is essentially a QI process yet does not appear to be linked to other QI efforts that have historically been driven by individual projects and partners, such as USAID, Jhpiego and the World Bank, which have worked in different geographic areas as assigned by the MoH. MPDSR appears to have been designed as a standalone activity rather than as one among many quality improvement efforts focused on improving coverage, quality, equity, and access to care to reduce preventable maternal and perinatal morbidity and mortality. This strategy makes sense as a laser focus is often needed for a new process in order to ensure its initial uptake. However, there is great potential for inefficiencies and overlap among all the different QI processes, which has possibility to hinder scale-up and sustainability down the line.

A harmonized QI approach that includes MPDSR is made more difficult through the patchwork of resources and the disparate activities across and within provinces. On the positive side, there is a solid foundation being laid by the MoH to strengthen MPDSR and other QI processes, which supports the identification of problems and solutions and to build resilience and self-reliance at the facility level, especially in the context of a limited financial resources.

Integrating a multi-sectoral perspective in MPDSR

At the provincial level, officials spoke of the role UNFPA played in enlarging the MPDSR process to engage traditional leaders and representatives from other sectors, including the Ministry of Community Development. The effort to broaden the process beyond the health sector is seen as unique to UNFPA and fosters a more holistic response to the problems identified.

“The ‘multisectoral MPDSR’ had alerted everybody to rise to the challenge and do their part in terms of maternal health. For instance, the Ministry of Community Development is now talking about women empowerment because we realise that sometimes women do not seek care because they do not have resources... So now they are looking at taking village banking issues right there at the community level so that women can have resources where they can be able to be empowered and make decisions.” - MoH provincial staff, North-Western Province

Fistula and other obstetric morbidities

UNFPA has played an important and leading role in the national effort to end fistula in Zambia. Through its advocacy and programming, UNFPA has garnered the commitment and action from the MoH and other partners to raise awareness and support fistula repairs for approximately 5,000 women for over a decade. With phase III MHTF funding, UNFPA contributed to the development of a draft operational plan to end fistula, which provides a broader, holistic strategy that includes increased attention to the successful reintegration of fistula survivors in their communities. MHTF resources have been mainly used to support fistula repair in camps, an approach that is not sustainable, as it is dependent on outside resources. UNFPA attention to fistula prevention seems incidental and is not afforded the same level of intentional programming as repair. Given the trends of rising teen pregnancy and the risks adolescent girls face with early childbearing, the lack of linkages between fistula and family planning is a gap. UNFPA has not yet taken advantage of the entry of the Fistula Foundation as a critical partner providing support focused on fistula repairs to identify new priorities and shift MHTF resources to advance fistula care in other meaningful ways.

For details of the evidence supporting findings in Section 3.4, see Annex 1: Assumptions 4.1 and 4.2

UNFPA a major leader in national fistula leadership and strategy

UNFPA has played a lead role in Zambia in advocacy and programming to end fistula for more than a decade. UNFPA is credited with successfully gaining the commitment of the MoH to incorporate fistula repairs as part of its safe motherhood program. UNFPA has utilized funding from the MHTF to raise awareness about obstetric fistula, mainly associated through annual commemoration of the International Day to End Obstetric Fistula, engaging high-level government officials (such as the Permanent Secretary of Health and the First Lady) to sensitize other about the issue. UNFPA had been the main development partner for the MoH in matters related to fistula until 2017, when the Fistula Foundation brought in significant resources for fistula programming to expand the network of fistula providers. This new influx of resources has necessitated additional coordination and alignment across the activities conducted by different partners.

Thus, in 2019, UNFPA supported the MoH to convene a three-day consultation, which resulted in the draft Operational Plan to End Obstetric Fistula (pending approval). An important aspect of the plan was to consider how to blend two programme models into one agreed-upon and broadened approach for use in Zambia. An explicit aspect of this “Zambia End Fistula” model is the engagement beyond the health sector to include the sectors for social protection, employment and education as needed to implement a holistic programme approach for fistula, particularly for the prevention and reintegration components. The plan is also intended to foster coordination between the two major actors supporting the MoH, although it has not been in place long enough to assess its effectiveness and impact in this regard.

Focus is mainly on capacity-building for surgical repairs at provincial level (with less attention to prevention and rehabilitation)

In 2020, UNFPA reported that its support has “translated” into the performance of approximately 5,000 fistula repairs since 2005 (although it is not clear if these repairs were directly financed by UNFPA or a result of its coordination). Under the Zambia 8th CP (2016-2020), UNFPA had set a target of 3,800 fistula repairs, with over 2,500 performed as of mid-2019. The majority of repairs supported by UNFPA are conducted in camps, organized by PHOs, using MHTF resources channelled directly to the supported provinces and guided by an annual workplan process at the provincial level.

These camps are generally hosted by an equipped and functional facility capable of providing surgical services and recovery. For example, UNFPA supported camps at Mansa General Hospital in Luapula Province and at Solwezi General Hospital in North-Western Province to serve clients from multiple districts. Camps are well-coordinated events. The PHO organizes community-based volunteers to

identify and refer clients who need the operation, and then mobilizes visiting surgeons to provide additional technical support and mentorship for the local team. Fistula clients usually stay for two or more weeks following surgery, with their immediate financial and housing needs taken care of. MHTF resources cover the costs of transport, treatment, food, supplies and other exigencies for the camps, without which they would be unlikely to occur.

UNFPA has contributed to fistula prevention through the MHTF midwifery and EMONC components, as well as through its work to promote community awareness about the importance of ANC visits and delivering in facilities. However, prevention activities are implicit and not focused on in an intentional or comprehensive manner.

“We’ve done fistula treatment without mainly paying a lot of attention to community and health worker engagement regarding the prevention of fistula. It might look that you are mopping but you have an open tap. If we could have close linkages between activities we have been undertaking on repair with prevention, we will be winning both ways.” – MoH national staff

UNFPA has trained community-based volunteers, such as Safe Motherhood Action Groups (SMAGs), in the importance of ANC and early booking for facility deliveries. While UNFPA and the Fistula Foundation have advocated for actions to address early marriage and teen pregnancy, there was little mention during stakeholder interviews regarding the critical role of family planning in preventing obstetric fistula, potentially signalling a gap in the overall prevention strategy. Moreover, as more births take place in facilities, there has been a greater incidence of C-sections, bringing with it an attendant increase in complications, such as iatrogenic fistula. Since consideration of iatrogenic fistula is still a relatively new issue globally, there are not yet standard definitions of the condition. Moreover, repairs might require a different skill set or protocol. Stakeholders in Zambia are looking for UNFPA to lead on this issue and have called for more study of this phenomenon to establish the extent and causes of the problem in the country.

One of the more devastating aspects of fistula is the social isolation that women with fistula suffer. Many are forced out of their families to find ways to support themselves while dealing with the stigma that comes with hygiene challenges related to the condition. After surgery, women may heal fully, partially or not at all. Care is needed after fistula surgery, including follow-up medical care, counselling and psychological support, social and family support and economic recovery strategies. UNFPA has begun to address this by supporting tracking exercises to assess the well-being of fistula survivors; three such exercises were conducted with MHTF resources: two in Western Province in 2019 and 2020 and one in Luapula Province in 2018. The tracking was organized by the PHOs in collaboration with district health offices (DHOs). In Western province, tracking included training of SMAGs, which resulted in increasing their capacity for case identification and referral. The major result was to identify those clients whose repair was not successful and needed additional surgery. However, despite the understanding that more assistance is required for these women, the PHOs and health facilities dedicated to performing fistula have limited resources to address non-clinical needs.

UNFPA has long advocated for a multisector approach and understands the need for a broader set of interventions that go beyond the health sector. UNFPA and the MoH have indicated that the way forward is to reach out to other line ministries to collaborate and establish linkages for the social reintegration of fistula survivors. However, this has yet to be organized and the reintegration component of the fistula programme model remains undeveloped in Zambia.

A shift away from camps towards routine services is just beginning

UNFPA and its partners are committed to the institutionalization of fistula care; however, it has yet to be incorporated into the government budget as a routine line item within safe motherhood. With the assistance of UNFPA and the Fistula Foundation, the MoH Safe Motherhood Working Group has drafted a road map that includes the priority to establish at least one hospital capable of serving as a referral site for repairs for districts within the province. In the meantime, UNFPA continues to finance

fistula camps in the provinces it supports. The one exception is in Luapula province, where MHTF resources enabled Mansa General Hospital to establish a functioning fistula ward capable of offering routine services. The Fistula Foundation has shifted its focus from camps to providing support to a network of seven hospitals with resources from the Johnson & Johnson Foundation. The Fistula Foundation's annual level of resources for fistula are equivalent to the entire MHTF annual budget, of which fistula is just one component. In the eyes of MoH stakeholders, it would be helpful to have a more differentiated set of strategies, with each organization playing to its comparative advantage. While UNFPA was once the clear leader in fistula repair, it no longer has the resources to both maintain support for repair camps (which are currently unsustainable) while attending to other important emerging issues in fistula.

SRHR and MNH Integration

UNFPA is an important advocate and voice on the integration of SRH with HIV, SGBV and MNH services and has ably promoted the principle of client-centred care in work to advance the concept of integration with national frameworks, policies and guidelines. UNFPA has effectively used the MHTF platform to ensure activities, such as the midwifery curriculum, adequately consider content related to integrated services. Further, UNFPA deliberately tries to “stitch together” different donor-funded activities in an attempt to offer an integrated package of SRHR services in focus provinces. Poor quality remains the biggest challenge towards achieving the vision of integrated services; yet quality has not risen to the level of a strategic component within the MHTF. Further, UNFPA is not taking advantage of its role as a leader in both midwifery and family planning to advance post-partum family planning (PPFP) programming in order to strengthen linkages across the continuum of care and support healthy timing and spacing (or limiting) of pregnancies.

For details of the evidence supporting findings in Section 3.5, see Annex 1: Assumptions 5.1, 5.2 and 5.3 and Assumption 8.3

A long record of advancing the integration of a package of SRHR services, mainly through non-MHTF resources

UNFPA is recognized as the leading partner for the MoH regarding the integration of SRHR (including MNH), HIV and SGBV in Zambia. Through its core funding and major projects, UNFPA has strengthened the government focus on primary health care through integration. At the level of policy, UNFPA has provided financial and technical assistance to the formulation of policies that advocate for integrated service delivery, such as the National Health Strategic Plan (2017-2021); the Road Map for HIV Prevention 2017-2021; National Guidelines for SRH, HIV and SGBV Services Integration and many others.

In focal provinces and districts, UNFPA has promoted service models of care that integrate ANC and facility based delivery, basic EmONC services, comprehensive family planning, HIV counselling and testing, and antiretrovirals for pre-exposure prophylaxis and treatment. Much of this has been achieved through the regional SRHR/HIV Linkages Project and its follow-on, the “2gether4SRHR” programme, which started in 2018 and adds an SGBV focus. In 2019, UNFPA, with UNAIDS, UNICEF and WHO, provided technical leadership and financial support for the development and pre-testing of a training manual for service providers in SRHR, HIV, SGBV services integration. The target groups go beyond health care providers at facility level and includes community volunteers, such as SMAGS, as well as legal support personnel and policy makers and managers.

Within this context of a broader portfolio of integrated programming, UNFPA has complemented and contributed to RMNCAH&N policy and programming with MHTF resources. During MHTF phase III, UNFPA supported the MoH to develop the RMNCAH&N Road map for 2018-2021 which was developed to accelerate actions to help meet the targets of the National Health Strategic Plan and its focus on the provision of a continuum of care through health systems strengthening of primary care.

UNFPA used the opportunity to strengthen the midwifery curriculum (Section 4.1) to ensure that it featured an integrated approach and ensured that it incorporated content related to SGBV, adolescent health and people living with disabilities.

UNFPA advocates robustly for integration at every opportunity. The country office is appreciated for “doing its homework” and laying out the rationale for an integrated package to the MoH and donors.

“UNFPA makes sure donors understood – adolescent health and SRHR, issues of respectful maternity care. They defined a package, and said, ‘If you want us to intervene (in the Central and Western provinces, this is the package.’ They were convincing and we see their influence. There was enough strategic thinking so that the donors listened and saw a logical approach to linking everything together to advance maternal health.” – United Nations agency staff

Despite strong commitment to integration by UNFPA, challenges remain to fully integrate SRH and MNH services

Integration has allowed the Zambia country office to leverage resources from many programmes to promote a client-centred approach that puts individual needs in focus. However, there is a gap between the aspirational ideal of integrated services and actual implementation in practice. For example, UNFPA has been promoting a “supermarket” or one-stop centre model of service delivery whereby a client can receive everything she needs – ANC, HIV screening, contraception, etc. The MoH is interested in seeing the one-stop centre model work, but it is dependent on location and the relative strength of the health facility system and management. This model often does not function because of staff shortages. Health facilities, thus, “fall back” on the segmentation of services during the week (i.e., Monday is for family planning, Tuesday for child health, and so forth).

UNFPA has contributed a great deal to the “what” of integrating SRH and MNH through advocacy, and the development of policies, guidelines, training materials and tools, all of which frame the vision of the ideal integrated service. However, the “how” or operationalization of integration requires ongoing attention and accountability for the ensuring an enabling environment, especially at the facility level. UNFPA contributed to the “how” through capacity development, particularly of midwives, to advance integrated services in selected districts within North-Western, Western and Luapula Province. This focus on integration in these provinces was considered by stakeholders as unlikely to have occurred without the continued commitment by UNFPA (irrespective of the source of funds). However, quality of care remains a key challenge in the full delivery of an integrated package, let alone for each of the individual service delivery component, (i.e., EmONC, ANC, family planning, adolescent sexual reproductive health (ASRH), etc.). Scaling up the vision of an integrated package of services requires quality improvement processes that are sufficiently mainstreamed and owned by the government (as discussed in Section 3.2 and 3.3).

Integration as a strategy to foster linkages across programmes

There is an abundance of examples of how UNFPA knits together resources from different donors and programmes to pursue a vision of integrated SRHR and MNH in Zambia. For instance, youth are a focal point for identifying linkages across SRH, MNH, HIV and SGBV with key activities supported by a range of development partners such as the UK (for family planning and ASRH), Sweden (2gether4SRHR), and the MHTF anonymous donor (Comprehensive Abortion Care ACCESS project). MHTF funding is used to complement these activities in the UNFPA-supported provinces, although the country office admits to the difficulties of phasing actual support so that the different streams of funding come together in an efficient manner. An example is the training of midwives in CAC from one funding source, with MVA kits provided via another: because the latter came too late following the training, the skills gained by the midwife were lost and retraining was required.

Missed opportunities to advance post-partum family planning within the MHTF activities

PPFP strategies have gained importance within the reproductive health community as critical to addressing unmet need for family planning. As coverage for ANC has increased and more women are delivering in facilities, good opportunities exist for reaching women with information and services to support healthy birth intervals and their contraceptive options. In 2015, WHO updated its medical eligibility criteria to allow for immediate postpartum insertion of intra uterine devices and implants; both are long-acting reversible contraceptive (LARC) methods that require specialized counselling and clinical competencies to ensure right-based quality of care. Promoting PPFP is more than just ensuring that facilities have a family planning clinic alongside maternal health services within a facility. PPFP information and services encompass a range of contact points and providers within facilities and communities and requires the establishment of effective linkages.

Despite the MHTF Phase III Business Plan calling for an increased focus on integration, UNFPA has not included PPFP within its portfolio of activities supported with MHTF resources. This appears to be due to the fact that resources are limited and stretched thin.

“If the MHTF can supplement funding for family planning, we would be very happy as it would be supporting the capacity of the same midwives that we are working with...It would ensure that she can do all the things – family planning, MPDSR, EmONC – as part of an integrated approach.”
– UNFPA Zambia country office staff

Plenty of potential linkages exist but are not being fully exploited within the UNFPA Zambia portfolio of SRH, HIV, SGBV and MNH activities. UNFPA conducts family planning training in capacity building activities for midwives and supports activities to sensitize communities on the importance of family planning. In North-Western Province, UNFPA has worked with traditional chiefs as family planning and maternal health champions. Other partners are working with the MoH on training providers in LARCs and PPFP. Further, PPFP has been identified as a priority by the MoH-led Family Planning Technical Working Group and will be featured in the GRZ country commitment for the FP2030 partnership. UNFPA is co-lead for FP2030 planning along with the MoH and USAID and is in a unique position to offer leadership on the topic. Stakeholders are looking to UNFPA to “take PPFP to the next level” with the MoH given its central role in the midwifery education.

“They can build capacity in PPFP and be sure that they (MoH) are providing these services; they can monitor and bring Zambia on the map to say that we did this. To mainstream PPFP, UNFPA is key.” – INGO staff, Lusaka

Strengthening access and equity

UNFPA adheres to the principle of “leaving no one behind;” it has underpinned UNFPA advocacy and policy development in Zambia to influence national frameworks and guidelines so that gender and other barriers that impede equitable access are well considered and addressed. UNFPA also targets its MHTF and other resources to the geographic areas where the needs are greatest, taking on the difficult job of “high hanging fruit,” i.e., reaching those that are hardest to reach, such as those living with disabilities, women with fistula, and vulnerable girls. UNFPA assistance at provincial level has resulted in visible gains in access, especially through its direct support of midwife scholarships and placements in underserved facilities. All of these efforts are implemented within the context of a human rights-based approach. However, a clear framework on how to operationalize human rights principles and standards within MHTF programming is absent.

For details of the evidence supporting findings in Section 3.6, see Annex 1: Assumptions 6.1, 6.2 and 6.3.

Advancing equitable access through advocacy and policy dialogue

In its Vision2030, GRZ has put forth the goal for Zambia to achieve middle-income status by 2030, including reducing poverty and inequalities, and ensuring equitable access to primary health care. With MHTF resources, UNFPA has provided relevant technical and financial support to ensure the

needs of the most vulnerable are taken into account in the development of key RMNCAH&N policies. UNFPA supported MoH to develop the aforementioned RMNCAH&N Road Map (Section 3.5), which lays out strategies to strengthen health systems to achieve the Sustainable Development Goals (SDGs) in health. The road map articulates the many challenges faced by Zambia to improve equitable access to the continuum of RMNCAH&N services, including inequities in access between urban and rural areas, low coverage of skilled health providers in relation to population, poor health infrastructure, weaknesses in the supply chain, and inadequate quality assurance mechanisms.

The road map also highlighted inadequate community involvement for RMNCAH&N activities, and the need for a more robust effort to address gender and other social and cultural norms that impede equitable access to services by women and girls. In response to this particular need, UNFPA utilized MHTF resources in 2019 to finalize and disseminate its first RMNCAH&N communication and advocacy strategy geared towards increasing coverage and utilization of services. The strategy outlines audience-specific behaviour change goals, strategy and messages geared to addressing barriers specific to different audiences (policy makers; women of reproductive age, men and youth; service providers, etc.)

MHTF resources directed to three provinces (Luapula, Western and North-Western) where the needs are the greatest.

In line with the principle of leaving nobody behind and as an indication of its intention to reach those most in need, UNFPA has prioritized working in selected provinces and districts based on poverty and poor SRHR indicators, mainly through capacity building and targeted service delivery support. UNFPA is appreciated by provincial health leaders as the “only organization that directly supports human resources” through its work for midwifery scholarships and internships for girls from poor, underserved districts. Through its package of technical and financial assistance in targeted service delivery, UNFPA is credited with contributing to improvements in access and reductions in maternal mortality in low-performing districts. In 2020, a mid-term review of the National Health Strategic Plan confirmed that gaps in between urban and rural areas are closing, justifying the approach UNFPA has taken to target assistance to difficult areas.

Addressing the needs of the most vulnerable

UNFPA directs its resources and inputs towards meeting the needs of vulnerable populations, as evident in national documents that have been developed with UNFPA support, such as the aforementioned RMNCAH&N communication and advocacy strategy which, for instance, calls for ensuring that maternal health services are accessible to all clients, including the physically challenged and persons with learning disabilities. The adolescent health strategy, which UNFPA contributed to, also includes a distinct focus on adolescents with special needs, although the ability to take action in this area is hampered by gaps in understanding regarding the extent and type of disabilities faced by this group.

Beyond advocacy, UNFPA has begun to address the needs of people with disabilities more directly. UNFPA has supported the development of modules on disability to incorporate into nursing and midwifery curricula in order to improve the provision of disability-sensitive services by health care providers and to strengthen the linkages between communities and health facilities. UNFPA has initiated a collaboration in 2019 with the Zambia Library for Persons with Visual Impairment to support mainstreaming of disability within the country programme. This work is in its early stages but is evidence of UNFPA commitment to match its rhetoric with action.

UNFPA activities to end obstetric fistula are, by definition, geared to addressing the SRH-MNH needs of vulnerable women and girls (Section 3.4). MHTF investments incorporate gender perspectives in UNFPA efforts to address the underlying causes of fistula (early marriage and teen pregnancy) and to restore the dignity and empowerment of fistula through its activities aimed at increasing awareness of the condition and providing support for reintegration of survivors.

Pregnancy among adolescent girls remains a stubborn problem in Zambia, at 29.2 per cent overall and much higher for those from poor families and with no education (per 2018 ZDHS). UNFPA has prioritized this vulnerable group as a major area of focus for programming and for additional resource mobilization. This is demonstrated in UNFPA programmes that operate in the focal provinces, where MHTF investments complement the emphasis on vulnerable youth, mainly in midwifery and fistula activities. UNFPA partners, especially those at the provincial level, clearly credit UNFPA with a commitment to improve equitable access and meeting the needs of the most vulnerable.

Catalytic support

The MHTF has been a catalytic programme in Zambia, mainly through the use of resources to advance the technical focus areas as strategic priorities within national policy and programming frameworks. The MHTF has been a useful platform by leveraging evidence and credibility at global level and utilizing it to enhance UNFPA leadership in maternal health. UNFPA has clearly stimulated commitment and action in Zambia in the areas of fistula, MPDSR and midwifery. However, there has not been sufficient attention to assessing how the MHTF investments might change in response to an evolving and dynamic programme landscape that includes new partners and changes in donor priorities, as is clearly the case for the fistula component. Likewise, UNFPA does not explicitly address expectations about sustainability and mainstreaming of programmes that have been catalysed with MHTF resources, especially in the context of the constrained fiscal space in Zambia.

For details of the evidence supporting findings in Section 3.7, see Annex 1: Assumptions 7.1, 7.2 and 7.3.

Bringing others on board to support solutions in SRH and MNH programming.

UNFPA has used MHTF resources in Zambia to catalyse commitment and programming aligned with the priorities and technical solutions identified by MHTF. The country office approach to being catalytic uses its convening role and participation in the national planning process to advocate for the inclusion of high-impact interventions to shape the response on SRH and MNH matters.

“I can say that if you convince the MoH that there is a problem in a particular area of maternal health, i.e., fistula, and you see the government itself raising the issue, that is a very big win.” – other UN agency staff

The catalytic process in Zambia has been aided by the MHTF platform which sets strategic priorities and enables the country office to take the lead at the country level and bring along other partners without having to “reinvent the wheel” to frame issues and design interventions. This has been especially true for midwifery and fistula, given the strong strategic underpinnings offered through the MHTF global platform. A major example of the catalytic effect of MHTF is found in its effort to mainstream the MPDSR process within the MoH. By pursuing a systematic approach, UNFPA has ensured that committees are in place at national and provincial levels that have remained committed to conducting regular maternal death surveillance and review meetings, as well as starting the process for perinatal reviews. MPDSR would not be as far along without the steadfast support by UNFPA fuelled by MHTF resources.

UNFPA raised initial awareness and commitment by MoH to the problem of obstetric fistula as well and paved the way for other partners to engage in the effort. The initial work supported by MHTF and the Campaign to End Fistula opened the door for the Fistula Foundation to establish a foothold in Zambia and expand its efforts to what is now described by the MoH as a co-leading role (with UNFPA) in strategic efforts to eliminate fistula.

“Now the Fistula Foundation is also taking the lead and bring resources to the table and support camps and mentorship. Room for all of us – not encroaching in our space, but additive.” – UNFPA Zambia staff

Country office staff value bringing in additional partners on board as a means for increasing strategic influence overall on a particular issue. However, in the case of fistula, the country office appears to be grappling with the perceived downside to losing its unique and primary position as the leader in fistula. At present, there is not a dynamic view of how to adapt the use of catalytic funding when success is achieved in a particular area, especially if it is so closely identified as the purview of UNFPA.

Being catalytic requires strong coordination and planning

There is less evidence that MHTF investments have been catalytic for EmONC. While the MoH has indicated that it has adopted technical approaches promoted by UNFPA in provinces not supported by UNFPA, this could not be confirmed by the evaluation. Effective planning and coordination mechanisms are required for catalytic efforts to be taken up and mainstreamed by others. Coordination is presently stronger at national level than provincial level, affecting the ability to ensure that interventions are adopted and scaled with resources outside of UNFPA control.

MHTF resources supported an initial pilot of the Safe Delivery App, a free smartphone application developed by the Maternity Foundation to provide easy access to evidence-based and up-to-date guidelines on BEmONC services. Several nurses were trained in its use, and the innovation seems timely in light of the COVID-19 pandemic. However, there was no documentation about the results from the pilot and whether or how it might be applicable to future programming efforts in midwifery education and support.

Catalytic nature of MHTF investments impeded by “constrained fiscal space” in Zambia

The term “constrained fiscal space” is used by stakeholders in Zambia to convey the government’s lack of financial resources, due to high debt and inadequate revenue, to implement the government budget. This has been an issue for the past few years, resulting in provinces and districts getting a small fraction of the funding they had planned on receiving from the government. This has exacerbated the shortage of human resources, especially midwives, and has affected the implementation of routine, ongoing service delivery, social mobilization and quality assurance activities. This also has resulted in greater dependence by the government on limited resources from development partners. In this context, the ability for funding to be catalytic and result in the mainstreaming of new practices becomes even more unlikely than in normal times.

The country office has also had to deal with its reduced funding, following a change in strategic focus to a Foreign, Commonwealth and Development Office (UK) (FCDO)-funded RMNCAH&N project and the need to adjust support for targeted service delivery in affected provinces. The availability of MHTF resources, however limited, have become even more important to enabling the MHTF to maintain support for maternal health activities, without which the UNFPA maternal health portfolio and its attendant influence would greatly diminish. The conditions for sustainability of programme interventions have diminished since 2018, and the MHTF response has not yet adapted to this reality in its catalytic approach.

MHTF governance and management

The MHTF provides an effective platform for UNFPA to engage in maternal health and provide technical inputs to the MoH. It is well aligned with national needs and priorities and has “punched above its weight” by achieving visible results with limited resources. The MHTF is a critical piece of the UNFPA portfolio in Zambia, as without it, UNFPA would lose its ability to influence the national agenda in maternal health. Given its tight situation of funding, the MHTF lacks bandwidth to take on important cross-cutting thematic areas, such as quality of care or integration, in a deliberate or focused way. The country office lacks regular or systematic feedback on existing plans and seeks

more connection to and guidance from MHTF colleagues at global and regional level to foster more dynamic and effective programming.

For details of the evidence supporting findings in Section 3.8, see Annex 1: Assumptions 8.1 and 8.2, and Assumption

UNFPA programme aligned with national government priorities and decision making

As noted throughout this report, UNFPA has used MHTF resources to support a combination of national level strategy, policy and planning processes and documents (for example, the RMNCAH&N road map and communication strategy, the midwifery curriculum, the fistula costed implementation plan) as well as implementation support in selected districts in three underserved provinces. MHTF investments are well aligned with the Zambia National Health Strategic Plan 2017-2021 and its efforts to promote safe motherhood and contribute reduction of maternal and perinatal deaths.

MHTF resources frequently complement other country office resources (from core and/or other programme resources from other partners) and support the implementation of the overall UNFPA country programme. Although it is a relatively small portion of overall funding, MHTF remains an extremely important and relevant stream of funding for UNFPA in Zambia. Even though MMR has been decreasing over time, perinatal deaths have been on the rise in the past five years or so. Without the MHTF, UNFPA would cede its position to promote positive change in maternal health. The MoH is cognizant that MHTF resources have decreased, leading one official to opine that the level of technical input, including that from outside Zambia, has been reduced as a result.

Nevertheless, UNFPA has worked to link up all of its resources so that the limited funding is as efficiently utilized as possible. For a relatively small fund, it has had visible results, made possible through integration of the four technical areas *within* the MHTF as well as integration of the MHTF with *other* SRH programming (Section 3.5). While there are some areas that lack strategic cohesion and linkage across different technical components (such as quality improvement), overall, UNFPA has managed their limited resources effectively.

Strategic decision making under the MHTF

UNFPA staff acknowledge that funds are limited and meant to be catalytic; however, they spoke of finding it difficult to address systemic issues as a result. In their view, the needs are great and require a lot of investment in capacity building in order to see the level of results that are expected. There is not agreement among staff about how to manage this tension between the size of the problem, such as strengthening the midwifery workforce, and the level of resources available to tackle it. When it comes to midwifery, some staff suggested it was possible to reduce work in this area because the needs are huge and there is not the capacity to support scholarships for every nurse-midwife who wants to go to school.

“The priority should be to support the strategic areas at the national level and strengthen the linkages between the National Midwife Association and the MoH.” – UNFPA Zambia staff

The generation of evidence via targeted assessments has been successfully utilized by UNFPA in Zambia to inform strategies and plans to expand EmONC services (Section 3.2). However, the task of identifying and analysing other relevant sources of data, such as from DHIS, is not given adequate attention to inform MHTF programming.

“What I have noticed is that there is the push to collecting the data at the service delivery point make use of it and make the decisions, but with very little analysis and reflection. There is a need to strengthen routine data collection, analysis and reporting. Hopefully MPDSR can be used as a process for this; for every woman that dies, there are many others. We need to begin to use the data at the service delivery point level. This could help with iatrogenic fistula if this were recorded systematically.” – UNFPA Zambia staff

The main mode of operation for the MHTF is capacity building and it tends to be oriented to supply-side issues, such as working with the MoH to strengthen the health system and facilities. Less attention is provided to working with other sectors on the social determinants of maternal health. Reasons given for the supply side focus were twofold – a combination of donor preferences and an issue of staff capacity to address issues outside of health. Yet, UNFPA CO staff acknowledge that:

“We may never be able to change some of the outcomes if we do not take a holistic approach.” – UNFPA Zambia staff

Desire for more systematic review and input from regional office and headquarters

Country office staff seek additional engagement with colleagues from ESARO and headquarters on some of the strategic issues that are faced by those working on the MHTF, for example on how to fashion an exit strategy for different activities or technical components of the MHTF, as needs and priorities change. Also, there is not a systematic process within the MHTF to review plans, check in on how plans are progressing or not, provide advice and input, or to foster an exchange of information on issues or emerging best practices with other offices dealing with similar issues. The MHTF monitoring templates foster vertical (silos) reporting by country offices and make it harder to identify linkages and cross cutting issues affecting multiple technical components.

COVID-19

As part of the UNFPA response to the COVID-19 pandemic, the MHTF resources contributed to a UNFPA response that aimed to help Zambia maintain access to basic reproductive, maternal and newborn services. Technical guidelines supported health personnel to work safely and maintain essential SRH and MNH services; resources were shifted to support capacity building in infection prevention and control for midwives and other providers; community workers were sensitized on key messages regarding essential services and infection prevention and control (IPC); and personal protection equipment (PPE) and other equipment and supplies were distributed in UNFPA-supported provinces. UNFPA offered a flexible response through the reallocation of MHTF, and other resources earmarked in 2020. Many activities were disrupted and postponed until 2021, especially those pertaining to dissemination of guidelines, midwifery and fistula commemorations, and site visits for mentorship, supervision, or MPDSR.

For details of the evidence supporting findings in Section 3.9, see Annex 1: Assumptions 9.1 and 9.2

The COVID-19 pandemic in Zambia

The Zambian government has taken unprecedented measures to limit the spread of the COVID-19 virus, through successive major lockdowns that have restricted the movement of the population. The pandemic has already severely disrupted access to essential care, including lifesaving SRH services. For instance, projections from preliminary data from health facilities indicate there has been an increase in fertility rates, especially among adolescent girls. This is as a result of low use of services such as family planning and adolescent SRH, for fear of contracting COVID-19 in health facilities. The government has also recorded a notable increase in maternal deaths during peak infection periods and the pandemic has also exacerbated gender inequities and SGBV. Under lockdowns, incidences of violence have increased. Overall, the pandemic has worsened existing inequalities for women and girls and has deepened discrimination against other marginalized groups.

UNFPA acted quickly and flexibly to support essential SRH-MNH services

UNFPA was quick to respond to the COVID-19 pandemic and, with other partners, supported the MoH to produce the *General Guidance: Provision of Essential Public Health Services During the COVID-19 Pandemic (May 2020)*. This guidance called for the strategic shifts required by provincial

and district officers and facility in-charges to ensure patient and provider safety while delivering essential services, including SRH and MNH care, and treating COVID-19. UNFPA was also instrumental in supporting the MoH to develop more detailed guidance on RMNCAH&N services during COVID-19, intended for use by healthcare care providers delivering services to women of reproductive age, including adolescent, pregnant and lactating mothers, the newborn as well as children under the age of five. The technical guidance was prepared with support from ZAGO, with contributions from the Zambia Paediatric Association, Midwifery Association of Zambia, Medical Women Association of Zambia and cooperating partners for their input.

With UNFPA support, 69 midwives were deployed to primary health-care facilities to reduce gaps in workforce shortages and ensure continuity of essential services, contributing to 14,900 deliveries between October and December of 2020. In addition, UNFPA procured PPE and Infection Prevention and Control supplies that were distributed to support improved risk management in provision of services in four provinces (Western, North-Western, Luapula and Central).

MoH officials at national and district level highly appreciated UNFPA for policy and material support for essential services. A major contribution was to strengthen infection control procedures, by orientating health care providers on how to reorganize labour wards and how to handle patients who are infected with COVID-19. UNFPA also sensitized community-based volunteers on issues regarding infection prevention.

CONCLUSIONS

A small amount of funding has led to tangible results

With a small resource envelope and established technical focus areas, MHTF has delivered results that are seen as a valuable addition to the UNFPA portfolio of assistance, as perceived by health officials and other partners.

UNFPA has utilized a small amount of funding, less than USD 700,000 over a three-year period, to deliver tangible results in three of four technical focus areas of the MHTF. UNFPA leveraged its strong relationship and technical advisory role in SRH with the MoH to achieve visible results in two major ways: by working at national level on policy, plans and curricula and by supporting the implementation of activities in targeted provinces. Through the MHTF, UNFPA has contributed to positioning midwifery as a key cadre required for the delivery of integrated SRH and MNH services, establishing high-level commitment to the MPDSR process, and supporting a revitalized strategy to guide holistic programming in fistula care.

MHTF interventions in Zambia are well-grounded in the broad vision to deliver an “integrated package of rights” but linkages to other programmes are not fully exploited

Integration is a key strategy for UNFPA to meet the needs of the most vulnerable women and girls for client-centred SRH and MNH, HIV, and SGBV services. However, UNFPA does not explicitly exploit its unique position as a leader in family planning *and* maternal health to foster a strong PFP component as part of the MHTF response.

MHTF embraces opportunities to support integration wherever possible, such as by ensuring maternal health policies, guidelines and other materials reflect content supporting the continuum of care and promote equitable access by vulnerable populations. For example, MHTF work in fistula is linked to efforts that underscore the vulnerability of young girls from early marriage and pregnancy. However, fistula prevention efforts are relatively silent on the role of family planning and PFP is an underutilized strategy in MHTF programming.

MHTF has catalysed change but has not yet adapted strategies to initial successes to take strategies and change to the next level.

Small MHTF investments have leveraged important changes in maternal health policy and programming and have served to catalyse action in areas that had not received adequate attention before (midwifery, MPDSR and fistula). However, MHTF strategies have not adjusted to initial successes and the entry of new partners in order to remain dynamic and continue to foster change. Nor has the MHTF adequately incorporated sustainability considerations within programming.

As a catalytic fund, the MHTF has been successful in getting things started and generating action with respect to its key technical focus areas. However, now that there has been some good success, two gaps have emerged. The first is the need to evolve strategies in response to changes in the environment. For example, the scope of the Fistula Foundation work in fistula repair has increased in Zambia, yet UNFPA continues to support fistula repairs via camps and has not taken the opportunity to revisit its strategy on how best to use its limited MHTF funds for fistula and, in particular, to address emerging issues such as iatrogenic fistula and reintegration. The second gap pertains to the necessity of moving beyond the initial catalytic effect of a programme to the development of specific strategies that foster the transition of funding responsibility to the government to ensure the eventual sustainability of the intervention. This is especially important to sustain the important gains made in MPDSR and midwifery.

The well-defined focus of the MHTF offers both advantages and limitations

The MHTF construct as outlined in the Business Plan for phase III strategically guides investments and activities at the country level and facilitates programming by the country office in the MHTF four focus areas. However, within this model, cross-cutting issues, such as quality of care and integration, are not explicitly addressed.

The main advantage of the MHTF lies in the provision of guidance and evidence to support programming at country level, without the country office having to “reinvent the wheel.” The MHTF partnership at global level facilitates access, by country offices, to technical guidance from global partners. The partnership with the International Confederation of Midwives (ICM) has guided midwifery education and association strengthening, and the Global Campaign to End Fistula has led the way on concepts related to reintegration. In general, using tools available at the global level has contributed to important assessments conducted at country level to inform strategies and plans.

However, the well-defined focus areas obfuscate important linkages, for example between the midwifery, EmONC and MPDSR components of the MHTF, especially in relation to quality of care. Poor quality is acknowledged by UNFPA and its partners as a key bottleneck to improved maternal health outcomes, even when there has been improvement in availability and coverage of services. Iatrogenic fistula is a case in point (where increased access to caesarean sections has resulted in maternal morbidities from botched surgery). Quality improvement is a cross cutting intervention for SRH-MNH services, yet there is no overall strategic or coherent map for how to promote, scale and foster linkages among different quality improvement efforts, including in MPDSR. Capacity building and mentorship activities, while counted as outputs throughout MHTF reports, they are not linked to a larger, overarching outcome related to quality of care.

UNFPA leadership role in maternal health would be severely limited without the MHTF platform and resources

MHTF investments have enabled UNFPA to engage in significant manner with the MoH and other partners in maternal health and to enhance its leadership role.

MHTF provides an organizing framework for UNFPA to address the “one of the three zeros” or transformational results in the organization’s strategic plan, i.e., zero preventable maternal deaths by

2030. Without the MHTF investments, UNFPA would have little opportunity to increase awareness of and commitment to fistula, midwifery and MPDSR in a significant way. Putting these issues on the Zambia map has been highly appreciated by the MoH, as the main partners of UNFPA, and has enhanced the reputation of UNFPA too.

OTHER MATERIALS FROM THE EVALUATION

Available on the UNFPA Evaluation Office [website](#)

- Evaluation report
- Evaluation one-page brief (En, Fr)
- Executive summary (En, Fr)
- Evaluation presentation
- Annexes (Volume II)
- Country case studies (Benin, Sudan, Uganda, Zambia)
- Management response
- Evaluation Quality Assessment

Mid-term evaluation on the Maternal and Newborn Health Thematic Fund, Phase III, 2018-2021

Brief | Read the full report at unfpa.org/evaluation

Ending preventable maternal deaths is one of the three transformative results of UNFPA and includes an emphasis on integration of sexual and reproductive health and rights (SRHR) with maternal and newborn health (MNH) services. The Maternal and Newborn Health Thematic Fund (MNHTF) delivers technical and financial support in 32 high burden countries to create **analytic and accelerated progress** in midwifery, emergency obstetric and neonatal care, maternal and perinatal death surveillance and response processes, and the prevention and treatment of fetal and other congenital conditions.

This evaluation assesses the extent to which the MNHTF Phase 3 has contributed to **strengthening health systems, improving quality of care, and advancing equity, human rights and accountability to stakeholders** in partner countries, as well as its ability to **scale up integration of SRHR into MNH services**.

DATA COLLECTION METHODS

- 32 countries
- 6 country case studies
- Field sites: Sudan, Uganda, Zambia, Benin, Tanzania, Togo
- 180+ interviews
- 239 survey respondents
- 750+ documents reviewed

CONCLUSIONS

- With the MNHTF, UNFPA is a partner of choice providing **visible and valued support** to critical MNH priorities, with midwifery as the anchor of its interventions.
- The MNHTF **delivers value for money** for individual countries and enables UNFPA to influence the MNH agenda globally.
- The MNHTF is **not clearly positioned** within a holistic MNH/MNRI strategic framework.
- It **did not address critical gaps** (such as community engagement and quality of care measurement) that limit the relevance and sustainability of the MNHTF investments.
- The MNHTF **emerges to limited financial resources** effectively, but has not yet been **fully designed to deliver its 'catalytic effect'** systematically.
- The MNHTF **addresses gender equality, human rights and equity**, especially among adolescents, but **does not**.
- The MNHTF **successes contrast** with its low profile at UNFPA where its **significant and multifaceted contribution** to MNH remains insufficiently heard.

RECOMMENDATIONS

- As the key UNFPA vehicle for SRHR/MNH integration and support, **continue and expand the MNHTF** into a new phase
- Position the MNHTF within a **comprehensive UNFPA maternal health strategy and action plan**
- Champion quality of care at the point of delivery**, including respectful care
- Be more systematic about integrating community engagement** across all MNHTF activities
- Engage partners**, especially donors, more actively in the MNHTF progress
- Improve the strategic coherence and responsiveness** of the MNHTF
- Embed the focus on midwifery and the health workforce environment** across the MNHTF
- Invest more in MNHTF core added value:** SRHR/MNH integration and promoting catalytic results
- Refine results monitoring** to improve understanding and communication about the MNHTF added value in different contexts
- Invest in innovative funding approaches** to attract an expanded donor base.

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Mid-term evaluation of the Maternal and Newborn Health Thematic Fund Phase III 2018-2022

Sudan

COUNTRY CASE STUDY

UNFPA Evaluation Office
2022

Évaluation à mi-parcours de la Phase III du Fonds thématique pour la santé maternelle et néonatale 2018-2022

Benin

ETUDE DE CAS

Bureau de l'Évaluation de l'UNFPA
2022

Mid-term evaluation of the Maternal and Newborn Health Thematic Fund Phase III 2018-2022

Uganda

UNFPA Evaluation Office
2022

Mid-Term evaluation of the Maternal and Newborn Health Thematic Fund Phase III, 2018-2022

UNFPA Evaluation Office
2022

UNFPA

ANNEX 1: EVALUATION MATRIX

Area of Investigation 1: Midwifery	
Evaluation Question 1: To what extent has the MHTF contributed to ensuring the education, training, and deployment of an adequately skilled/competent, motivated and sustainable midwifery workforce?	
Sub-questions:	
<p>a) How has the MHTF contributed to strengthening the enabling policy and regulatory environment for midwives, including reinforced regulation of midwives (output 2) and increased use of gender-sensitive policies, strategies and plans to recruit, deploy, and retain midwives (output 4), and policies to regulate the work environment for midwives, including supportive supervision, mentorship professional development, and assurance of a conducive and safe work environment (outcome 5)</p> <p>b) To what extent has the MHTF contributed to the capacities of a skilled and competent midwifery workforce, educated according to global standards and that meet national needs (output 1)</p> <p>c) To what extent has MHTF contributed to strengthening the capacities of midwifery associations to help raise the profile of midwifery, represent the professional needs of midwives, and provide professional support and continuing education? (output 3)</p>	
Evaluation criteria	<i>Relevance, effectiveness, efficiency, sustainability</i>
Rationale	Midwives play a central role as caregivers for women and their newborns throughout the continuum of care from pre-pregnancy to the post-partum period; and are positioned to provide comprehensive sexual and reproductive health information and services, including family planning, antenatal care, safe normal deliveries, basic EmONC, essential newborn care, prevention of STIs and transmission of HIV from mother to child, prevention of fistula and other morbidities, and prevention of female genital mutilation/cutting. To fulfil these roles, there is a need to strengthen midwifery education and training, enable and support midwife autonomy including ensuring midwives can work across their scope of practice, strengthen workforce policies and create a work environment that empowers midwives. These aims are central to achieving other outcomes of the MHTF, i.e., through expanded linkages with fistula prevention and elimination of female genital mutilation/cutting, in collecting, analysing, and using data as part of MPDSR; and the deployment of midwives in EmONC facilities.
Assumption 1.1: MHTF inputs regarding norms, standards, policies, and guidelines relating to midwifery address key gaps in existing policy and regulatory framework and environment for midwives at global, regional, and national level, including in MHTF partner countries	
Indicators:	
<ul style="list-style-type: none"> • National policies, strategies and plans to govern midwifery practice and workforce capacity development, including supporting midwife autonomy, gender-sensitive policies, strategies and plans to recruit, deploy, and retain midwives, midwifery included in Human Resource policies • Strengthened regulatory bodies that govern midwifery practice, certification, accreditation, monitoring and accountability and that regulate quality of care, client safety and satisfaction • Strengthened policies, guidelines and standards related to supportive supervision, mentorship, professional development, and a safe and conducive work environment • Views and experiences of partners and health authorities at global and national level regarding effectiveness of UNFPA leadership to advocate for evidence-based policies, strategies, plans and regulations 	

Assumption 1.1: MHTF inputs regarding norms, standards, policies, and guidelines relating to midwifery address key gaps in existing policy and regulatory framework and environment for midwives at global, regional, and national level, including in MHTF partner countries	
<ul style="list-style-type: none"> • Alignment of UNFPA policy inputs with MHTF core principles (equity, quality of care, accountability plus human rights and gender equality) 	
Observations	Sources of evidence
Support for midwifery protocols <ul style="list-style-type: none"> • UNFPA supported the development of Nursing and Midwifery Protocols, whose implementation is expected to facilitate improved quality of care across the country. 	UNFPA Zambia. 2018 Annual Report. 2019
<ul style="list-style-type: none"> • The regulatory body responsible for setting midwifery standards was supported by MHTF to review the Midwifery Regulatory Framework, Midwifery protocols and the incorporation of ICM standards and competencies into the curricula. This enhances the Council’s capacity to monitor quality of care. 	UNFPA Zambia. MHTF Achievements 2018-2020. Undated.
<ul style="list-style-type: none"> • UNFPA work with midwives has been quite robust, including working on midwifery regulation through the Midwifery Council, with the support of the global midwifery global programme. The MHTF was the first time to have such a program with a specific staff person assigned to steer the work with midwives. UNFPA received good recognition through that programme at country level with the programmes on midwifery education, strengthening the midwifery curriculum, and building the skills of educators in EmONC and other areas. 	Interview, UNFPA Zambia staff. August 2021.
<ul style="list-style-type: none"> • In partnership with MoH, UNFPA has been very supportive in supporting policy regulation regarding training of midwives, including issues of EmONC and issues of Sexual Reproductive Health. <i>“UNFPA has had a hand in almost all the policies that are in place.”</i> 	Interview, MoH staff. North-Western Province. September 2021.
Identifying human resources gaps in skilled birth attendance <ul style="list-style-type: none"> • UNFPA supported the development and dissemination of the National Human Resources for Health Strategic Plan (2018-2024) which details key approaches for addressing human resources for health challenges in the country, including the need for skilled birth attendants and the critical role of community health workers towards improving the availability of services. 	UNFPA Zambia. 2018 Annual Report. 2019
<ul style="list-style-type: none"> • UNFPA provided technical and financial support for the development and finalization of the Nurses and Midwives Strategic Plan 2017, including midwifery protocols. Also, UNFPA supported the Association to ensure that midwifery is well addressed in the Human Resources for Health Strategy 2018. • UNFPA has provided extensive support to strengthen the quality standards of midwifery in the country, the training of nurses and midwives, the expansion of midwifery posts and the retention of midwives (CO interview) and, as above, mechanisms to promote government accountability. Overall, the contribution of UNFPA to strengthening midwifery has been substantial, and highly likely to have contributed to declining maternal mortality in areas where it had been highest. (p. 27) 	UNFPA. UNFPA 8 th Country Programme Evaluation: Zambia 2016 – mid-2019. 2019.
Respectful Maternity Care <ul style="list-style-type: none"> • A key strategy to achieve Vision 2030 in Zambia is to address high maternal and newborn morbidity and mortality through an increase in the proportion of births attended by skilled birth attendants (SBAs). To do so will require addressing the deep-rooted gender inequalities that manifest in early marriages, adolescent pregnancy, and inadequate access to SRH services. <i>“Institutionalizing RMC in family planning, antenatal care (ANC), postpartum or postnatal care (PNC) and essential care for labour and birth (ECLB) will dignify maternity care and encourage women to delivery in health facilities.”</i> (p. 4) 	MoH, Zambia. Promoting Respectful Maternity Care in Zambia: Facilitator’s Facility-based Training Manual. 2020

Assumption 1.1: MHTF inputs regarding norms, standards, policies, and guidelines relating to midwifery address key gaps in existing policy and regulatory framework and environment for midwives at global, regional, and national level, including in MHTF partner countries	
<ul style="list-style-type: none"> • Disrespect and abuse (D&A) include seven different behaviours manifested by health providers: physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination, abandonment of care, and detention in facilities. Factors that contribute to D&A include individual and community-level factors, normalization of D&A, lack of legal and ethical foundations to address D&A, lack of leadership, lack of standards and accountability, and provider prejudice due to lack of training and resources. (p.4) • “Studies conducted in Zambia revealed several facts that emphasize D&A as a pressing problem in Lusaka, Kitwe and Ndola facilities: <ul style="list-style-type: none"> ○ D&A faced by women during labor poses a barrier to facility delivery ○ Beliefs related to health and future welfare of the baby and recovery and well-being of women in the post-partum period leading to restrictions on women’s diet and movement respectively ○ Many midwives confessing the mistreatment of women at health facilities during the labor period ○ Operational context not being conducive to allowing maternal autonomy and empowerment as advocated during midwifery training ○ Overwhelming condemnation of traditional beliefs and practices among the midwives because of the perceived negative impact they have on delivery outcomes ○ About 22% of women’s right to confidentiality and privacy were not adhered to, 42% women reported that there were no drapes or covering to protect their privacy and 19% indicated that there were no curtains or other visual barrier to protect woman during examinations ○ Providing non-dignified care including 63% of the women and/or companion not being allowed to observe cultural practices and 20% of the women being talked to in an impolite manner ○ 13 % of the women were discriminated based on specific attributes. This stems from women indicating that 19% of the service provider’s showed D&A based on any specific attributes and 6% of the service provider did not speak to women in a language at a level that they could understand ○ Onn average, 18% of the women had experienced physical abuse by a service provider during child birth⁸ ○ Prominent issues that led to ill-treatment included 43% of the women not provided comfort/pain-relief and 26% of the women were touched in a cultural inappropriate way ○ One in 10 (10%) of the women indicating that the service provider used physical force or abrasive behaviour claiming that food or fluid in labor were not medically necessary and separated woman from her baby.” (p.5) • The training manual includes activities and materials designed to promote increased support, advocacy and provision of quality, women-centred maternity care. It is designed for use by programme managers, supervisors, trainers, technical advisors and others who organize or facilitate trainings in SRH, EmONC, Helping Mothers Survive Bleeding After Birth Complete (HMSBABC), Healing Babies Breathe (HBB), Essential Care for Labour and Birth (ECLB) and pre-eclampsia and eclampsia. 	
<ul style="list-style-type: none"> • “Respectful Maternity Care (RMC) is a universal human right for every childbearing woman in any health system. Women’s experiences with providers of maternity care can empower and comfort them or inflict lasting damage and emotional trauma¹. Zambia has policies and laws, which protect the rights of women and children. It is imperative therefore, that these policies and 	<p>MoH, Zambia. National Respectful Care Maternity Guidelines. 2019.</p>

Assumption 1.1: MHTF inputs regarding norms, standards, policies, and guidelines relating to midwifery address key gaps in existing policy and regulatory framework and environment for midwives at global, regional, and national level, including in MHTF partner countries	
<p>laws are enshrined in reproductive, maternal, neonatal, child and adolescent health and nutrition (RMNCAHN) programmes and services to dignify maternity care and services at all levels of care.</p> <p>Against this background, the MoH partnered with the MAZ, UNFPA, Clinton Health Access Initiative (CHAI), Jhpiego and John Snow Incorporate (JSI) to develop the First Edition National Respectful Maternity Care Guidelines, which will promote respect for every woman’s humanity, feelings, choices, and preferences and uphold the reproductive rights of women and children in Zambia. The RMC Guidelines aim to end mistreatment and violence against women in reproductive health services and during childbirth in relation to violations, which occur in the wider context of inequalities, discrimination, and patriarchy system in Zambia.</p> <ul style="list-style-type: none"> • The institutionalization of RMC in RMNCAHN programmes in Zambia has the potential to increase institutional deliveries by skilled attendants. This will no doubt promote safe motherhood and contribute to reduction of maternal and perinatal deaths in accordance with the Zambia National Health Strategic Plan (NHSP), 2017 – 2021. RMC will further contribute to the attainment of the MoH’s Legacy 1: Reducing maternal and childhood illnesses by 2030. The NHSP supports the National Vision 2030, which expresses the Government commitment to address the Zambian people’s aspiration to develop the country to a prosperous middle-income nation by 20 by 20 by 30. The NSHP and therefore, plan envisions a prosperous country where all Zambians have access to quality health services” (p.3). 	
<ul style="list-style-type: none"> • MoH has put maternal health as a priority agenda in terms of policy, implementation, and other issues. Specifically, for the Ministry, I know we have nurses who are not midwives who are attending to maternal health services, particularly in rural areas. But it makes a very big difference if most of these were attended to by midwives who have been trained to provide the service and have the knowledge, skill and attitudes required. 	Interview, MoH service provider. August 2021.

Assumption 1.2: MHTF support to strengthening midwifery education programmes are technically sound and appropriate, responding to national needs, and aligned to national and global standards for midwifery education	
<p>Indicators:</p> <ul style="list-style-type: none"> • Number of midwifery schools (public and private) supported by the MHTF that are accredited by the government based on global standards set by WHO and ICM • MHTF support for midwifery education programmes aligns with national needs. • Examples of MHTF support to strengthen capacity¹⁶ of midwifery schools to provide quality pre-service training, including necessary teaching materials, commodities and equipment and incentives to motivate teachers and students • Examples of MHTF support for standardized, competency-based education programmes that bridge competency development trainings (i.e., in-service training, continuing education) for midwives and tutors • National midwife education programmes are aligned with global standards for competency-based training and accreditation • Views and experiences of partners, health authorities, and midwifery educators regarding the relevance, technical quality, and effectiveness of UNFPA support for midwifery education programmes. 	

¹⁶ The COM-B model of behaviour change (Mayne 2016) will be used to assess provider capacity based on three necessary conditions: 1) capability (necessary knowledge, skills, and attitudes to deliver quality care), 2) opportunity (having the necessary infrastructure, equipment, supplies and tools to deliver quality care), and 3) motivation (internal cognitive and emotional processes related to willingness and perceived personal benefit of providing good quality of services).

Assumption 1.2: MHTF support to strengthening midwifery education programmes are technically sound and appropriate, responding to national needs, and aligned to national and global standards for midwifery education	
<ul style="list-style-type: none"> National programme plans include efforts to institutionalize¹⁷ (sustain) standardized, competency-based education of midwives Alignment of UNFPA policy inputs with MHTF core principles (equity, quality of care, accountability plus human rights and gender equality) Number of innovations developed to enhance midwifery education and continuous training 	
Observations	Sources of Evidence
<p>Midwifery Curriculum Development and Review</p> <ul style="list-style-type: none"> The General Nursing Council is responsible for curricula review. With support from MHTF, it reviewed four midwifery curricula and developed a BSc Midwifery curriculum that would prepare a well-trained and knowledgeable midwife to provide critical and effective maternity care. The MoH developed a pre-service Midwifery Mentorship training package for use in Midwifery schools to mentor students. (This was a follow-on to support provided by MHTF in 2015 to train five senior midwifery educators and supervisors as trainers of mentors.) In prior phases of MHTF (between 2014-2017), UNFPA supported the training and deployment of 230 midwives to work in rural areas in three UNFPA-supported provinces contributing to increased availability of skilled birth attendance at delivery. 	UNFPA Zambia. MHTF Achievements 2018-2020. Undated.
<ul style="list-style-type: none"> UNFPA provided technical and financial support to the MoH to revise the midwifery curriculum to align with international standards and to incorporate emerging issues such as GBV, adolescent health and people living with disabilities. In addition, Respectful Maternity Care Guidelines were adapted to foster quality of care during pregnancy and childbirth. 	UNFPA Zambia. 2019 Annual Report. 2020.
<ul style="list-style-type: none"> UNFPA efforts to advocate for “First Time Young Mother” issues in the midwifery curriculum were deemed by MoH to be already included within general interventions for safe motherhood and teen pregnancy. Therefore, in 2019 there were no significant changes at national level to impact on this thematic area for UNFPA. 	UNFPA Zambia. MHTF 2019 End of Year Annual Report. Undated.
<ul style="list-style-type: none"> Through UNFPA technical and financial contribution to MoH, the midwifery curriculum was revised to be aligned to international standards and incorporate emerging issues such as GBV, adolescent health and people living with disabilities, aimed at improving the quality of midwifery training and provision of quality Sexual Reproductive Health (SRH) services. In addition, Respectful Maternity Care Guidelines were adapted to foster quality of care during pregnancy and childbirth. Further, within the context of advancing equity and leaving no one behind, a disability inclusion module for pre-and in- service training of health care providers was developed, and selected information, education and communication materials developed in Braille to facilitate provision of SRH information to persons with visual impairment. 	UNFPA Zambia. 2019 Annual Report. 2020. p.2
<p>Strengthening capacity through training, mentoring and supervision</p> <ul style="list-style-type: none"> Through MHTF, UNFPA Zambia procured midwifery teaching models, set up clinical skills laboratories, strengthened skills of tutors (ToT), supported educators’ forums for skills and updates. Most important was the financing of the training (tuition fees) in one-year in-service course at midwifery schools in the three UNFPA-supported provinces to increase the number of skilled birth attendants. 	Interview, UNFPA Zambia staff. August 2021.

¹⁷ Institutionalization means that the Ministry of Education and/or Health has adopted UNFPA-supported curriculum changes as their own standard for midwifery education.

Assumption 1.2: MHTF support to strengthening midwifery education programmes are technically sound and appropriate, responding to national needs, and aligned to national and global standards for midwifery education	
<ul style="list-style-type: none"> • However, the issue of human resources is critical; “you have a bucket with a hole that water is seeping through. You can never say there are enough human beings. People leave basic Midwifery for more education, leave the public sector. So there is always a need for training for MWs; needs to be on-going.” • The midwifery and nursing professions have been upgraded with the introduction of the midwifery programme where someone can come straight from high school without first becoming a RN. • Mentoring and supervision can still go on without UNFPA support. Most institutions cry for equipment which would make support more sustainable as you can guarantee that most equipment will be there for 5 years. Through the FCDO programme in Western and Central Province, selected facilities have had equipment procured for EmONC services; however, this has been discontinued due to the funding cuts from the UK. 	
<ul style="list-style-type: none"> • In terms of capacity building, UNFPA has been very helpful supporting programmes for mentorship and skills for health workers. In training, for example, UNFPA supported short courses to increase the availability of midwives. “Human resources is a big problem for us, especially a shortage of midwives. In the provinces where they support us, we are able to work with them to identify nurses that are willing to undergo a training to become midwives and they undergo training.” 	Interview, MoH Zambia staff. August 2021.
<ul style="list-style-type: none"> • In 2018, 80 midwives were trained; 117 health care providers acquired skills and knowledge to provide basic EmONC services for mothers and their newborn babies. 	UNFPA Zambia. 2018 Annual Report. 2019
<p>Development of a comprehensive, curriculum for midwifery</p> <ul style="list-style-type: none"> • The MoH benefited from UNFPA funding as a regulator for curricula development and review. Previously, there were five different curricula for midwifery, and UNFPA supported the review and revision into one, comprehensive curriculum. “We had too many curricula; it caused confusion. Prior to this, one had to be a nurse to become a midwife. Not anymore, we now have midwives who start from high school and go straight into the midwife programme (3.5 years). UNFPA was handy to help evaluate this programme. [We have] just concluded the evaluation and now are revising the comprehensive curriculum. We will now have one curriculum that caters to everyone at each point. We came up with a road map to review; UNFPA supported a situational analysis about 1.5 years ago. Through situation analysis, we know what exists and what are the gaps. UNFPA sponsored a stakeholder consensus meeting to consult with others who were important. From there, we had another meeting for content realignment and add new concepts needed new content to add to core competencies. All these meetings were quite important to get the views of people.” • Unfortunately, the COVID-19 pandemic disrupted the road map. There are efforts underway to determine how to move forward with the validation meeting. Once this is done, there is the need to develop training materials, i.e., procedure for observations, procedure manuals, learner, and training guides. The process is lengthy, and it is halfway there for the comprehensive curriculum. • UNFPA provides “double barrel support.” They provide financial resources and technical expertise; they have helped to define the competencies and aligned with international standards. • Once the current curriculum process is complete, the government agency established for quality assurance will call for a mid-term and five-year revision to incorporate new training issues/create addendums. There will be a need to do gap analysis, consult 	Interview, MoH staff. Lusaka, Zambia. August 2021.

Assumption 1.2: MHTF support to strengthening midwifery education programmes are technically sound and appropriate, responding to national needs, and aligned to national and global standards for midwifery education	
<p>stakeholders, etc. It is a continuing process; it is one thing to do a curriculum, another thing to implement it. There is a need to take the teachers through the process.</p> <ul style="list-style-type: none"> “Research is needed to make the implementation science come to fruition.” Quite a lot of concept writing is to come back to UNFPA to deal with a particular issue. For example, future issues include: a rise in terms of key populations (“important for us – something there and people do not talk about it; need to see how nurses are appreciating it”); sign language, meant for a few, but now it is included in the curriculum. “We still need to do the M&E to see how things are executed and to produce as much data as possible so that we can make decisions based on evidence.” 	
<ul style="list-style-type: none"> EmONC has been incorporated in the midwifery and non-midwifery curriculum. 	<p>Interview, MoH staff. North-Western Province. September 2021</p>
<p>Support for Midwifery Schools, including tuition support for midwives</p> <ul style="list-style-type: none"> Funds are also used to support the training of midwives as skilled attendants. MHTF has supported tuition fees for nurses to ensure that nurses are trained according to international standards and stay in their home areas after training. Resources were provided to do the training, including demonstration models (Mama Natalie). The schools have been supported so that they have access to technology; for example, the school in Western Zambia was given textbooks for library and computers that can aid students in doing research on assignments. 	<p>Interview, UNFPA Zambia staff. August 2021.</p>
<ul style="list-style-type: none"> The MoH receives support for the training of midwives, especially in the areas that UNFPA is supporting. “This is good for us because they try to help us recruit local people from that particular area so that it's easier to retain them. So we do have midwives trained in some of these provinces and it ups the numbers in those provinces for trained midwives.” 	<p>Interview, MoH Zambia national staff. August 2021.</p>
<ul style="list-style-type: none"> UNFPA has provided scholarships for one-year midwifery training for nurses to upgrade to midwifery. The CO has also directly supported midwifery schools with library materials, computers, models and other requirements for the skills labs and general training. Field work found that the schools have benefited considerably (key informant interviews and site visits). UNFPA has also increased the carrying capacity of midwifery schools to increase the number of trained midwives. 	<p>UNFPA. UNFPA 8th Country Programme Evaluation: Zambia 2016 – mid-2019. 2019. p.27</p>
<ul style="list-style-type: none"> Apart from orientation, mentorship, and supervision, UNFPA has helped in the sponsorship of midwives in our facilities within Western Province. They not only sponsored midwives for one year’s training but also built capacity and skills to the tutors in the Midwifery college, they have provided books on midwifery to the college, they have provided equipment and models for the students to use and practice on and sharpen their skills and knowledge. 	<p>Interview, MoH staff. Western Province. August 2021.</p>
<ul style="list-style-type: none"> “The support that the College or the Department of Midwifery has gotten so far from UNFPA is overwhelming, starting from the inception of the midwifery programme at this institution in 2017. Without UNFPA, there would not be anything to talk about regarding midwifery. Everything that we used to start the programme was provided by UNFPA from the equipment to the library books; the classroom and even the mattresses that the first intake used was provided for by UNFPA. UNFPA has also been supporting our students; we have both in-service and pre-service but the ones that have benefited from the sponsorship are in-service students.” 	<p>Interview, MoH staff, Midwifery College. North-Western Province</p>

Assumption 1.2: MHTF support to strengthening midwifery education programmes are technically sound and appropriate, responding to national needs, and aligned to national and global standards for midwifery education	
<ul style="list-style-type: none"> • Midwifery students are made aware of the fistula programme in the province. “As a midwifery college, we’ve not been really involved much in fistula. Nevertheless, we are very much aware of the programme. There is sensitization on fistula and the curriculum has integrated the subject to sensitize our students.” • The midwifery school is incorporated in the health system and when issues related to maternal and child health are discussed, such as for maternal death surveillance and reviews, the school is involved and attends some of those meetings. “At first we were not involved very much, but these days, we are part of some of the review meetings.” • The Solwezi School of Nursing and Midwifery has contributed 97 midwives for in-service deployment; currently there are 50 pre-service students. “We believe and trust that after the training, they are more skilled than they were before. I say so because we get information from those health facilities, how they are contributing in those sites. I think that so far, we have not had complaints or any disciplinary issue regarding their practice. Therefore, we believe and trust that they are competent.” • UNFPA also continues the follow-up of the midwives once they have completed training and provides support via refresher courses. • UNFPA has supported the school since it opened in 2017; the infrastructure is old, the library too small for the number of enrolled students, even though it was renovated. There are inadequate funds for transporting students to practice sites and for other activities. 	
<ul style="list-style-type: none"> • UNFPA supports midwifery training since 2010. “We’ve been also helping the school in procurement of textbooks, models, procurement of the IRH which is the Integrated Reproductive Health so that the schools can have the capacity to provide the training, a complete training for reproductive health.” 	Interview, MoH staff, North-Western Province. September 2021
Assumption 1.3: Efforts to strengthen the capacity of midwifery organisations result in enhanced professionalization of midwives and increased opportunities for continuous professional education and career progression and support	
Indicators	
<ul style="list-style-type: none"> • Examples of UNFPA-supported costed strategic action plans for midwifery associations • Examples of UNFPA-supported communication, advocacy and resource mobilization activities geared to strengthen capacity of midwifery associations • Examples of capacity building actions by midwifery associations to provide continuous professional education, to build capacity of young midwifery leaders and to provide improved access to quality SRHR information by adolescents through social and traditional media • Views and experiences of global and national leaders and members of midwifery associations regarding relevance, effectiveness, and efficiency of UNFPA efforts • Plans to sustain capacity building efforts within midwifery associations are in place and being implemented 	
Observations	Sources of Evidence
Regional Conference on Midwifery <ul style="list-style-type: none"> • UNFPA supports the IDM each year to raise awareness about the critical role that midwives play in protecting maternal and reproductive health. • In 2019, the 4th ICM Africa Regional Conference was held in Windhoek, Namibia in September 2019. The theme for the conference was “midwives leading the way for quality and equity in Africa,” speaking to the challenges of delivering midwifery care in the vast and sparsely populated countries. The meeting was conducted by ICM in collaboration with UNFPA and Swedish International 	UNFPA Zambia Mission Report: ICM Africa Regional Conference, Windhoek, Namibia. 2019.

Assumption 1.3: Efforts to strengthen the capacity of midwifery organisations result in enhanced professionalization of midwives and increased opportunities for continuous professional education and career progression and support	
<p>Development Agency (SIDA) and attended by 250 participants, including 8 public and private sector participants from Zambia. The UNFPA Global Midwifery Strategy 2019-2030 was launched at the regional meeting.</p> <ul style="list-style-type: none"> In conjunction with the meeting, a training workshop was held on “Essential Care for Labour and Birth” (ECL&B), as well as two pre-conference activities. As 2020 was declared as the “Year of the Nurse and Midwife,” UNFPA COs received guidance at this meeting on how to showcase the work being done around midwifery to make the case for use in advocacy and resource mobilization “for the MHTF” and for writing excerpts for use in the State of World Midwifery report. 	
<p>International Day of the Midwife - 2019</p> <ul style="list-style-type: none"> The commemoration of the IDM was hosted by the Luapula Provincial Health Office in May 2019. The Minister of Health opened the meeting which was attended by 88 midwives. 	UNFPA Zambia. MHTF 2019 End of Year Annual Report. Undated.
<ul style="list-style-type: none"> The Minister of Health opened the 2019 IDM in Luapula Province (Mansa District), which was attended by the Provincial Minister, the Permanent Secretary, the District Commissioner, the ZUNO president, the UNFPA Country Representative, and the MAZ president. Awards were presented to 30 midwives from around the country for their contributions to maternal and child health services. MAZ presented to the province donations of Neonatalie (demonstration model) and the Anti-shock garment for use in midwife education. The IDM theme in 2019 was “Midwives Defenders of Human Rights.” 	UNFPA Zambia. Report on Scientific Conference and International Day for Midwives. 2019.
<p>International Day of the Midwife - 2018</p> <ul style="list-style-type: none"> The IDM theme in 2018 was “Midwives leading the way with quality of care” to highlight the role midwives play in assuring quality and respectful care. The IDM included a scientific meeting to share successes, challenges and the way forward in midwifery services. It was attended by MoH programme staff and directors, and partners from UNFPA, Jhpiego and PATH. The meeting was held in Livingstone and was attended by 196 midwives from 10 provinces. 	UNFPA Zambia. Mission report: Midwives Scientific Meeting and Commemoration of the 2018 IDM (draft). 2018.
<p>Support to the Midwives Association of Zambia</p> <ul style="list-style-type: none"> MAZ was formed in 2011, with the first elected members of the national executive supported by UNFPA. Before, it was an interest group under the union of nurses, but then the organization was formed and received support from UNFPA. There is only one midwifery association in Zambia with 1,000 members, although there are 4,000 midwives in country. It is voluntary membership. MAZ submits a workplan every year for UNFPA support. For example, UNFPA has supported the development of the strategic plan, annual commemorations to celebrate the IDM every year, scientific meeting every year, and other activities such as post-abortion care (PAC) trainings. UNFPA worked with MoH to advocate for MAZ to sit on the MPDSR national platform with UNFPA, in order to contribute to the discussions that are having to do with maternal and neonatal deaths. It also sponsored some members of the Association to international conferences, Africa ICM conference; supported MAZ to participate in development of respectful maternity care guidelines, “the first of its kind in Zambia.” UNFPA supported training in respectful maternal care in the provinces that they support (Northern, North-Western, and Luapula) and where MAZ works with them. They have also supported training in adolescent health in North Western Province, where there is a high incidence of teen pregnancies. UNFPA also supported the development of the midwifery curriculum; MAZ sits on the platform with support from UNFPA. When 	Interview, National NGO staff. Lusaka, Zambia. August 2021.

Assumption 1.3: Efforts to strengthen the capacity of midwifery organisations result in enhanced professionalization of midwives and increased opportunities for continuous professional education and career progression and support	
<p>midwifery tutors have their annual meetings, midwives are supported to sit in those meetings to align the curriculum through UNFPA.</p> <ul style="list-style-type: none"> • “UNFPA has strengthened our organization – supported the strategic plan; supported us with constitution, etc. IDM and Scientific conference. Guidelines – printed etc. and launched by MoH.” • UNFPA has assisted MAZ to mobilize resources; however, the strategic plan does not have a sustainability plan. Mentorship happens from the national level; however, the interviewee noted that strengthening mentorship capacity at provincial level would create a larger pool of mentors. • It was noted that advocacy for a Chief Midwifery Officer, responsible for working with MAZ directly, would help strengthen MAZ position to influence policy and amplify the voices of midwives in the process. Without UNFPA support, MAZ would not have participated in the curriculum review conducted by the Nursing and Midwifery Council. 	
<ul style="list-style-type: none"> • They have also created long-term systems on some of the programmes. For example, UNFPA identified that the training of the midwives is very key in the improvement of maternal health and are working with the Midwifery Association of Zambia and General Nursing Council to ensure that there is an up-to-date curriculum for the training of the midwives. UNFPA ensured that fistula is incorporated in the training curriculum for nurses and what that means is that the nurse will graduate from the nursing school and will know about fistula. “UNFPA are looking at the broader picture.” • “I know there are also other organizations working on midwifery, but I think UNFPA is the major organization that also worked on the curriculum. This allows the programme to continue even when there is no longer support from them.” 	<p>Interview, MoH service provider. Lusaka, Zambia. August 2021.</p>
<p>MAZ-MoH coordination issues</p> <ul style="list-style-type: none"> • In provinces where UNFPA works, midwives are prioritized, unlike the other provinces where other organizations provide support but do not prioritize maternal health or midwives. Another issue is that MoH prioritizes government midwives and there is a gap with support for private midwives. Also, when MoH supports midwives, some are members, and some are not; MAZ does not have reports on where mentorship/training has taken place. “It is a puzzle for us. We have to go through to the MoH, but it does not have data to help us move into the province. It would help to have better coordination between UNFPA, MoH and MAZ. Biggest challenge – we do not get funding through MoH. Our Association is not under MoH. We are independent organization that contributes to national services/programme. For us, MoH is looking at MWs working with them. For us, we are also looking at private/non-governmental organization (NGO) MWs. When we are collecting data. We have tried to push ourselves nearer to MoH, as most of the funding is under the MoH. The thing that is even more challenging is where trainings we want to do. They want to take the lead and send more trainees from government. It is difficult to leave space for private sector; when they usually ask us to send a list, it has to be government employees. For me, I find that to be a challenge. Goes through the provincial directors, but NGOs are not part of the planning.” • Another example of the need for better coordination was provided in this interview: “We had a 2-year project with ICM where we did a project to train 5000 MWs in helping mothers and babies survive. The mannequins were left in those provinces for resuscitation. Because of poor coordination, MoH is not working to ensure that mannequins are being used. MAZ does not have the capacity to follow-up.” 	<p>Interview, National NGO staff. Lusaka, Zambia. August 2021.</p>

Assumption 1.3: Efforts to strengthen the capacity of midwifery organisations result in enhanced professionalization of midwives and increased opportunities for continuous professional education and career progression and support	
<ul style="list-style-type: none"> • Retention of trained midwives has been challenging as their remuneration package is not high and there is little prospect for career development. Through the Midwifery Association UNFPA advocates for a better package. Further, UNFPA is supporting the MoH, the Nurses Council and the Midwifery Association to develop curricula at bachelors and master’s level at the University of Zambia to create the potential for career development within midwifery. 	UNFPA. UNFPA 8 th Country Programme Evaluation: Zambia 2016 – mid-2019. 2019. p.27

Area of Investigation 2: Emergency obstetric and newborn care

Evaluation Question 2: To what extent has the MHTF supported ministries of health to design, strengthen and scale-up a national network of basic level and referral maternity facilities staffed with skilled health personnel and capable of providing quality sexual and reproductive health services as well as maternal and newborn care, including EmONC?

- Sub-Questions:**
- How and to what extent does the MHTF contribute to the development of nationally aligned strategies and policies to define and monitor the national network of EmONC facilities and strengthen referral linkages?
 - To what extent has the MHTF contributed to the strengthened functioning of the national network of EmONC facilities to provide equitable, accountable, and quality SRHR services including through QI and monitoring processes?
 - To what extent does the MHTF contribute to strengthened capacities of skilled health personnel in EmONC facilities to provide equitable, accountable, and quality SRHR services?

Evaluation criteria	<i>Relevance, effectiveness, efficiency, sustainability</i>
Rationale	Women and newborns are at high risk of death and morbidity during labour, childbirth and the first week after birth. UNFPA activities to promote evidence-based policies and plans in support of increased access to equitable, accountable, and quality EmONC services aim to reduce maternal and newborn mortality and morbidity. UNFPA is building on lessons from previous MHTF phases to support planning and monitoring of the national network of EmONC facilities, strengthened QI processes, scale-up in additional countries, and to strengthen integration via further support to post-partum and post-abortion family planning and cervical cancer prevention.

Assumption 2.1: MHTF efforts at global, regional, and national level in evidence-based advocacy, policy dialogue, coordination, and knowledge management lead to national plans for a well-functioning national network of EmONC facilities with the capacity to provide quality SRHR services and maternal and newborn care, including EmONC

- Indicators**
- Alignment between global and regional evidence-based guidance and national strategies for defining, monitoring, and scaling- up of strengthened EmONC and SRHR services
 - Examples of MHTF advocacy and policy dialogue and partner coordination in support of national plans designed to strengthen and scale-up quality SRHR and MNH, including EmONC services within a well-defined network of facilities
 - Trends over time in proportion of population covered by a functioning EmONC network of facilities (within 2 hours travel time)

Assumption 2.1: MHTF efforts at global, regional, and national level in evidence-based advocacy, policy dialogue, coordination, and knowledge management lead to national plans for a well-functioning national network of EmONC facilities with the capacity to provide quality SRHR services and maternal and newborn care, including EmONC	
<ul style="list-style-type: none"> MHTF workplans include application of lessons learned (knowledge management) from prior phases to improve quality and support scale-up of services within countries and to new countries. Views and experience of health authorities and partner institutions at global, national, and sub-national level regarding relevance, effectiveness, and synergy between other UNFPA interventions and MHTF efforts to address EmONC and support integrated SRHR and MNH services Views and experience of health authorities and partner institutions regarding UNFPA leadership on core principles of equity in access, quality of care, accountability, and on principles related to human rights and gender equality. 	
Observations	Sources of evidence
<p>Zambia programme decision related to mapping EmONC national network with GIS technology</p> <ul style="list-style-type: none"> UNFPA Zambia declined to use MHTF funds to support GIS technology to map the EmONC network of facilities. Instead, it works with the provincial health offices as they know the facilities and the people. Not all facilities manage deliveries; some offer SRH services, but not maternity services. 	Interview, UNFPA Zambia national staff. August 2021.
<p>EmONC functionality assessments</p> <ul style="list-style-type: none"> EmONC is considered one of the areas that has been identified as key to ensuring that UNFPA is able to deliver on one of the transformational results – zero maternal deaths. The resources that come from MHTF, enable us to assess facilities to look at the readiness of facilities to provide EmONC. With the assessments, MHTF funds are used to obtain equipment needed. 	Interview, UNFPA Zambia staff. August 2021.
<p>EmONC functionality assessment</p> <ul style="list-style-type: none"> UNFPA supported an assessment of EmONC functionality that identified various gaps, such as the lack of equipment and skills among health workers to perform all signal functions. 	UNFPA, Zambia. 2019 Annual Report. 2020.
<ul style="list-style-type: none"> “To increase the number of health facilities providing quality Emergency Obstetric and Neonatal Care (EmONC) services according to international standards, 162 health facilities in Central, Western, and Luapula Provinces were assessed for EmONC functionality including the status of other RMNCAH&N services to inform programme improvement. Key gaps noted in the provision of EmONC services include non- availability of skilled staff, incomplete emergency management kits for eclampsia and post-partum haemorrhage (PPH) as well as inadequate knowledge and skills among health facility staff to perform selected EmONC procedures such as MVA, cervical tear repair and use of anti-shock garments. To address these gaps, the capacity of 37 health workers to provide quality EmONC and other SRH services was enhanced through training, an additional 28 qualified as mentors in EmONC, and 64 nurses qualified as midwives. In addition, assorted RH equipment for targeted facilities were procured. Further, in order to respond to MPDSR reports that show that more than 85% of maternal deaths occur in health facilities, especially hospitals (CEmONC facilities), support was provided for the establishment a triage system and high dependence units in 10 districts of Central and Western province to improve the care of women with complications related to pregnancy and childbirth.” 	UNFPA, Zambia. 2019 Annual Report. 2020. pp.1-2
<ul style="list-style-type: none"> “An EmONC functionality assessment was undertaken in Central, Luapula and Western Provinces to ascertain the availability of equipment, infrastructure and medical/surgical supplies. In addition, an evaluation of the level of competencies for all the members of staff trained/mentored in EmONC was conducted to facilitate provision onsite technical support and make recommendation for better service provision. 	UNFPA, Zambia. MHTF Annual Report, 2020. Undated.

Assumption 2.1: MHTF efforts at global, regional, and national level in evidence-based advocacy, policy dialogue, coordination, and knowledge management lead to national plans for a well-functioning national network of EmONC facilities with the capacity to provide quality SRHR services and maternal and newborn care, including EmONC	
<ul style="list-style-type: none"> Key gaps noted in the provision of EmONC services include non-availability of skilled staff, incomplete emergency management kits for eclampsia and PPH, as well as inadequate knowledge and skills among health facility staff to perform selected EmONC procedures such as MVA, cervical tear repair and use of anti-shock garments. It was also observed that most facilities lacked EmONC equipment such as MVA Kits, suturing equipment and supplies. To address these identified challenges, UNFPA will in 2021 distribute the already procured MVA equipment under Access Project and build capacity of health care providers in provision of BEmONC services such as CAC provision, Neonatal resuscitation, and provision of essential medicines such as Magnesium sulphate for eclampsia. (p.3) 	
<ul style="list-style-type: none"> UNFPA supported the development of the emergency obstetric and neonatal care (EmONC) report, which influenced strategic EmONC interventions articulated in the National Health Strategic Plan 2017-2021. UNFPA also supported capacity development of health-care providers on effective planning, delivery and monitoring of high-quality (EmONC) services, including post-abortion care. (p. 26) The number of health providers trained (including nurses, midwives, doctors, and clinical officers) in the focal districts exceeded the target by mid-2019 (at 91 per cent, or over 900 of 1000 staff). (p. 27) 	UNFPA. UNFPA 8 th Country Programme Evaluation: Zambia 2016 – mid-2019. 2019.
<p>National Respectful Maternal Care Guidelines</p> <ul style="list-style-type: none"> UNFPA supported the MAZ to organize and conduct, in collaboration with the MoH, a five-day workshop to develop Respectful Maternity Care (RMC) Guidelines. “Zambia is the first country to develop RMC guidelines as most countries have developed advocacy toolkits and training guides.” Participants were from the MoH, the Women and Newborn Hospital – University Teaching Hospital, Ministry of Defence, General Nursing Council of Zambia, Jhpiego, USAID/JSI Deliver, the MAZ National Executive Board, educators from midwifery colleges and senior midwives from Southern, Western, Eastern and Central Provinces. 	Midwives Association of Zambia. Development of National Respectful Maternity Care Guidelines Report. 2019.
Assumption 2.2: MHTF inputs at national and sub-national level regarding the use of QI processes, tools and data collection are consistent with improved monitoring and quality of SRHR services and maternal and newborn care, including EmONC	
Indicators	
<ul style="list-style-type: none"> Examples of MHTF efforts to strengthen QI processes, tools, and data collection at national and sub-national level Views of health officers at national and sub-national level in geographies supported by UNFPA, which confirm implementation of QI monitoring on a regular basis and the utilisation of findings to support improvements in services Examples of how QI efforts incorporate MHTF core principles, human rights and gender equality within supervision and mentorship Views of health officials, including facility managers, providers, and community members regarding how SRHR and MNH services, including EmONC services, are monitored to ensure quality Availability of plans to sustain (institutionalize) UNFPA-supported QI processes within national performance and supervision systems 	
Observations	Sources of Evidence
<p>MoH perspectives on challenges in MNH and EmONC services</p> <ul style="list-style-type: none"> There are many things that are contributing to poor maternal outcomes. The most pressing issue regarding maternal health is that the improved indicators do not lead to better outcomes. For example, we look at particular indicators, such as coverage 	Interview, MoH national staff. Lusaka, Zambia. August 2021.

Assumption 2.2: MHTF inputs at national and sub-national level regarding the use of QI processes, tools and data collection are consistent with improved monitoring and quality of SRHR services and maternal and newborn care, including EmONC	
<p>indicators i.e., ANC, things have improved remarkably over a relatively short period of time, more than other indicators. But outcomes remain poor. “Even though we are seeing these women, the service is not up to its best to detect problems as a woman progresses in service delivery. Quality of services is a big problem. ANC first visit = 90 % coverage. Even if they come once, it is up to us to pick up the problem that this woman has, and it is not being done.”</p> <ul style="list-style-type: none"> • When a woman comes for ANC or for whatever service, delivery, PNC anything related to MH, it looks like we lack certain standards of procedures or protocols that should be followed. It is assumed that when someone undergoes training, the provider will do everything they need to do. Protocols or SOPs are not there, the provider is going to provide the service the way they have understood it, and they might have missed something extremely important that might endanger the life of the women. • Commodities are also a gap; when the HW will write a prescription or advice the client to get the medicine. Commodities such as those to check syphilis and the like. At some point, these problems are still with us. Things related to commodities to treat hypertension, blood. Sometimes they find them, sometimes they do not. Those are the bit issues that are affecting our health service delivery. • “Demand is also an issue related to health-seeking behaviours in our culture; those beliefs may not necessarily be true. BCC a very big role if there is a belief that undermines health seeking behaviour, such as delivery in home” 	
<ul style="list-style-type: none"> • A systems approach is very important in the operation of any programme is the health care system, especially to improve services. The systems that require strengthening are the emergency responses system, communication and transport system, the supply chain system. The public health system also needs strengthening, as health starts in the community. “At an individual level, if certain things can be prevented in the community, then that also reduces the disease burden within the health care system. This is why I said we have certain systems such as SMAGs who are the link between the community and the health care system at the lower level in terms of primary healthcare.” • However, the public health system is not very strong because, in some areas, the SMAGs are not very active while in others, they do not even exist; partly because there are few incentives. As a result, the health care system is negatively affected. Community leaders play a very big role in the health of the mothers within the communities where they live. 	<p>Interview, MoH service provider. Lusaka, Zambia. August 2021.</p>
<ul style="list-style-type: none"> • UNFPA has provided training for EmONC services for MoH facility staff. They have also trained tutors in the midwifery school to incorporate EmONC in their teaching. In this way, as the midwives graduate, they will have had EmONC skills. UNFPA has also provided equipment to address issues of EmONC and funds for supervision and mentorship. This enables staff to reach the facilities to supervise and mentor staff in those facilities. • There are challenges to the delivery of quality health services in maternal health. There is need for infrastructure to ensure delivery of services is not disrupted; logistics for materials deliver quality health services (vaccines, preventive drugs, ITNs, stationery such as data collection, registers, tally sheets, etc.), human resources (skills, knowledge); and information to community members for creating demand for services. • <i>“There is also a need for mechanisms for feedback including informing us our deficiencies in providing services.”</i> 	<p>Interview, MoH staff. Western Province, Zambia. August 2021.</p>
<ul style="list-style-type: none"> • UNFPA is the only organization that has been strengthening EmONC services in Solwezi District. They conducted abridged trainings in EmONC in which 22 nurses were trained. They have been conducting quarterly mentorships in the health facilities. “In our rural setup, some of our facilities are manned by nurses and not by midwives. Therefore, UNFPA support has been helpful. They 	<p>Interview, MoH staff, Solwezi District, North-</p>

Assumption 2.2: MHTF inputs at national and sub-national level regarding the use of QI processes, tools and data collection are consistent with improved monitoring and quality of SRHR services and maternal and newborn care, including EmONC	
<p>have really been there to strengthen. One hundred and three (103) nurses have been mentored in EmONC issues. What I am saying is that it does not consist of a full package of EmONC training but at least we've had training for 5 to 7 days where nurses or midwives are equipped with things that enable them to handle cases in a rural setup to avoid maternal death.”</p> <ul style="list-style-type: none"> • “Solwezi District has trainers of trainers in EmONC, and staff were trained by them. This is the team that has been empowered through the Provincial Health Office to go round in all of the districts to strengthen EmONC activities. We as Solwezi District are one of the beneficiaries and this is why I said 103 nurses and midwives have been mentored in EmONC.” • EmONC training takes almost 21 days, and it is very long training; in “abridged” training, students go into the basic issues that would help the nurse handle emergencies. The abridged course is a maximum of 7 days instead of 21 days. • “Much as they have been supporting mentorship in EmONC and long-term family planning, we ask them not to stop because only few have been trained and mentored compared to the needs of the district. We would wish for them to continue to help us with capacity building in the long term family planning. We would want them to continue. Regarding CBVs, they only touched one area in Solwezi where they trained Community Based Distributors. We would appreciate it if they could help us to scale up to other places as well.” • “In North-Western Province, even when we have benefited in various ways, Solwezi district is not part of their selected districts. They have their own districts that they support; they have Mfumbwe, Zambezi and Chavuma. These are the districts that they support although they stretch further to help us too.” • Solwezi has a higher number of maternal mortalities than Mfumbwe (which has seen major decreases). This could be because Solwezi is a general hospital that receives referrals from all the districts within North-Western Province. Also, there is an unavailability of adequate EmONC equipment. “We have been empowered with knowledge and skills, but it is difficult to utilise them when you do not have the appropriate equipment to use.” 	<p>Western Province, Zambia. September 2021.</p>
<p>Revision of EmONC Training Package UNFPA, with UNICEF (with support from EU), WHO, CHAI, CIRDZ and others, joined efforts to support the update of the EmONC Training Package in 2016. This version updated the original training package developed in 2007 and revised in 2009. This version includes a two-week course, with week one devoted to theory and demonstration and week two for skills acquisition and practicum in a clinical site, followed by four weeks of self-directed learning at the trainee’s work site and a structured five-year mentorship programme, 4-6 weeks later. Other updates included the non-pneumatic shock garment for shock management, uterine balloon tamponade (UBT) for postpartum haemorrhage, guide and checklist for administration of magnesium sulphate, Elimination of mother-to-child transmission (EMTCT), Option B+, management of HIV exposed infants and Post Exposure Prophylaxis.</p>	<p>MoH, Zambia. EmONC Trainer’s Guide (Draft). 2016.</p>

Assumption 2.2: MHTF inputs at national and sub-national level regarding the use of QI processes, tools and data collection are consistent with improved monitoring and quality of SRHR services and maternal and newborn care, including EmONC	
<p>Training of service providers in EmONC (abridged course)</p> <ul style="list-style-type: none"> • UNFPA supported the North-Western Provincial Health Office to conduct an abridged EmONC training course for 13 health care providers from facilities which had challenges in managing pregnant women who presented with complicated conditions. North-Western Province has been facing challenges with reducing maternal deaths for past five years; most common deaths were from postpartum haemorrhage and eclampsia. Although intended for 13 providers, a total of 86 health care providers from Kalumbila, Solwezi and Mufumbwe Districts benefitted from the activity. Findings include: <ul style="list-style-type: none"> ○ Majority of sites visited had the full range of recommended protocols for labour ward and antenatal clinics. ○ In nearly all facilities, infection prevention strategies were evident. ○ Rapid response mechanisms were in place to respond to emergencies, i.e., use of social media platforms (i.e., WhatsApp, call alerts for incoming referrals). ○ Evidence observed of well-coordinated team effort in most facilities despite not having adequate numbers of staff. ○ Despite country-wide shortage of magnesium sulphate and blood supply, most sites had a consistent supply of key commodities for service provision. ○ Majority of providers used partographs. ○ Although protocols and posters existed, providers were ignorant of content. 	<p>Sasa, D. and Muna, L. Report on EmONC Mentorship conducted in Kalumbila, Mufumbwe and Solwezi Districts, North-Western Province. 2020.</p>
<ul style="list-style-type: none"> • “Initially the programme was meant for three districts but in the past two to three years, we’ve seen how they’ve spread out their support to other districts by identifying health care providers and training them in EmONC. We do not restrict the training to the three initial districts, but we go round to all the other districts in the province; identifying the participants.” 	<p>Interview, MoH staff, North-Western Province, Zambia. September 2021.</p>

Assumption 2.2: MHTF inputs at national and sub-national level regarding the use of QI processes, tools and data collection are consistent with improved monitoring and quality of SRHR services and maternal and newborn care, including EmONC	
<p>MoH EmONC training</p> <ul style="list-style-type: none"> • “Provision of Emergency Obstetric and Neonatal Care (EmONC) is one of the many interventions that the MoH has put in place to reduce deaths of women and their newborns from obstetric and neonatal complications. In order to achieve the goal of having less than 100 maternal deaths per 100,000 live births by 2021, the MoH through the Provincial Health Office has partnered with UNFPA in Solwezi to train midwives in basic EmONC. Fourteen (14) nurses, of which 12 were from Solwezi district, 1 from Mufumbwe district and 1 from Kabompo district were recruited for the training which was conducted from 18th to 27th November 2019. The mix of participants included Registered Nurses, Certified Midwives, Enrolled Nurse and Enrolled Midwives from different health facilities. Majority of these facilities were selected either because there were challenges in managing pregnant women identified in those facilities or due to their uniqueness with respect to distance to the next level hence requiring staff with additional skills to manage complicated cases.” p.1 • The goals of the course were to: <ul style="list-style-type: none"> ○ Train participants to become skilled birth attendants. ○ To equip participants with skills to resuscitate neonates ○ To equip participants with basic checklists to ensure timely referral of complex cases to next level of care. ○ Other objectives were to foster teamwork and ensure good communications. ○ PAC and family planning was included in the EmONC training. 	<p>MoH, Zambia. Report: EmONC Training, Solwezi General Hospital, North-Western Province. 2019.</p>
<ul style="list-style-type: none"> • UNFPA supported a lot of in-service trainings for staff within the district, including for EmONC. These trainings have been conducted throughout the whole province. There is also short term and long term family planning trainings; qualified Enrolled Nurses have been trained as midwives. At community level, UNFPA has also trained SMAGs (Safe Motherhood Action Groups). UNFPA has contributed to the training of human resources by sponsoring staff for training. This included general nurses (not just midwives) who upon completion of training are posted to health facilities and “not at hospitals.” This contributes to the high number of qualified staff running health facilities. While the facilities are run by qualified staff, only a few facilities are run by midwives; “We still have a challenge when it comes to midwives because they are very few.” • Regarding capacity-building, following training if a facility requires mentorship, a person with skills is engaged to go and mentor staff at that facility so that the knowledge that the person acquired during training “trickles down to the grass roots.” For example, staff received a 3-week training course in EmONC some time ago, and in January, mentorship was conducted under the sponsorship of UNFPA. The district called 10 staff from several facilities and arranged for a doctor and some tutors to mentor and train them. • As much as UNFPA has helped equipping staff with knowledge and skills, this has not been consistent and there are gaps. “It would be good to look at the number of facilities in a district to consider how many midwives a district need. We have unqualified midwives in facilities, and this puts stress on the few that are trained. There should also be continued support for EmONC equipment such as vacuum aspirators. The abrupt phasing out of UNFPA support, I think is not good.” 	<p>Interview, MoH staff. Mufumbwe District, Zambia. September 2021.</p>
<p>UNFPA support of mentorship and supervision to support quality of care</p> <ul style="list-style-type: none"> • Mentorship was conducted at Mushili RHC, Fwaka RHC and Kasanka Zonal facility by a team from Luapula Province and two mentors from Samfya District. The focus areas were: Helping Babies Breathe (HBB) and Helping Mothers Survive (HMS) following postpartum haemorrhage. These gaps had been identified from prior quarterly supervisory visits. The mentors identified gaps and 	<p>Kanswata, M and Chabi, CA. Report on Mentorship: MoH, Luapula Province, Zambia. 2019.</p>

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<p>supported actions to address them, e.g., supporting the in-charge to implement logistics to ensure that the PPH box is available (Mushili), supported infection prevention/daily cleaning of labour and postnatal room (Fwaka), and supporting management of PPH skills by a new RN deployed at the facility (Kasanka Zonal Facility).</p>	
<ul style="list-style-type: none"> • “MHTF has been catalytic for supporting mentorship programmes/supportive supervision programmes as well as provinces for support for integrated SRH. Quarterly MPDSR meetings are conducted for all the districts. Whenever there is a maternal death provinces support surveillance and teams that do reviews. Now we want to start the confidential inquiry. MHTF is supporting 2021.” • The programme supports mentorship for midwives in a number of areas, including FP, LARCs and also in the issue of leadership to encourage them to take a leadership role, since most are facility managers. There are trained mentors in EmONC, in FP and also at provincial level, i.e., the Nursing Officer. Once a quarter UNFPA supports them to mentor midwives who have identified and experienced maternal deaths. 	<p>Interview, UNFPA Zambia national staff. August 2021.</p>
<ul style="list-style-type: none"> • “EmONC functionality mentorship and monitoring visits continue to be conducted in UNFPA-supported provinces (North-Western, Luapula, and Western Provinces). Some of the identified gaps include lack of basic equipment and demand generation for timely maternity care. Plans to train SMAGs and procure equipment have been included in 2020 AWP for possible funding from MHTF and Core Funds. 25 midwives trained in HBB, and HMS by the Midwives Association were mentored in Luapula Province.” (p.2) 	<p>UNFPA, Zambia. MHTF 2019 End of Year Annual Report. Undated.</p>
<ul style="list-style-type: none"> • UNFPA supported interventions aligned with the MoH goal of reducing maternal deaths and to achieve universal access to RMNCAH in Zambia. Mentorship was supported for 219 healthcare professionals from Western, North-Western and Luapula Provinces to increase the number of health facilities that offer BEmONC services, including CAC, neonatal resuscitation and provision of essential medicines. Thirty (30) midwives were mentored in the provision of CAC. Provision of signal functions remain a challenge in most EmONC facilities; Constant unavailability of blood products was identified as the main challenge in CEmONC facilities. 	<p>UNFPA, Zambia. MHTF Annual Report, 2020. Undated.</p>
<p>Example of mentorship in province not supported by UNFPA</p> <ul style="list-style-type: none"> • JHPIEGO had a five-year project for integrated maternal, newborn and child health and family planning which came to an end in December 2020. It provided assistance at community-level and at facility-level. The lead partner was the Church Health Association of Zambia (CHAZ) with JHPIEGO as the sub (for facility inputs). CHAZ took care of community (SMAGs) who work with the women in the community, find the pregnant women and refer to health facility for early ANC booking danger signs in pregnancy and PNC follow-up. For those that were living in hard to reach areas, they ensured that they lodged at maternity homes. They also did some village banking to sustain efforts. At facility level, JHPIEGO built capacity for providers in EmONC and did mentorship and formed mentorship group teams in the district and supported them to conduct mentorship. Also did refocus the efforts of mentorship to zonal hubs. Zambia has zoned their health facilities and we provided the models for simulations to assist in training and mentorship in various skills at zonal facilities for existing mentors at facilities. Provided mentorship to all other facilities. Also assisted in training in LARCs. On the community side, CHAZ trained CBDs for injectable. During EmONC, we trained providers in various skills (helping babies breathe, care for every baby, manual removal of the placenta, PPH management, management of pre-eclampsia. Strengthening referrals and use of the uterine ??? and the pneumatic shock garment. Project 	<p>Interview, INGO national staff. Lusaka, Zambia. August 2021.</p>

Assumption 2.2: MHTF inputs at national and sub-national level regarding the use of QI processes, tools and data collection are consistent with improved monitoring and quality of SRHR services and maternal and newborn care, including EmONC	
<p>operated in 5 provinces: Luapula in selected districts (5 districts), Southern (5), Eastern (certain number, but because they created new districts), Lusaka (1 district, Muganwa).</p> <ul style="list-style-type: none"> UNFPA also worked in Luapula District. “They worked on those thematic areas, except not sure about midwifery. They have been supporting the MAZ (I am a member) to do some activities and conferences.” 	
<p>Introduction of Safe Delivery App</p> <ul style="list-style-type: none"> UNFPA collaborated with the Maternity Foundation to support the MoH to introduce the Safe Delivery Application, an app that can be downloaded on any smart phone and used offline by midwives and doctors to support knowledge on the management of pregnancy-related complications. Twenty-five midwives and doctors were trained in its use with the intention to roll-out in 2020. 	UNFPA, Zambia. 2019 Annual report. 2020.

Assumption 2.3: UNFPA inputs at national and sub-national level to address gaps in capacity of skilled birth attendants in EmONC facilities results in improved quality of integrated SRHR services and maternal and newborn care, including EmONC	
<p>Indicators</p> <ul style="list-style-type: none"> Demonstrable improvements in health care provider capacity (as defined by the COM-B¹⁸ model of behaviour change) in the MHTF-supported facilities to deliver quality integrated SRHR services and MNH care in accordance with service standards and guidelines Trends in the proportion of functioning BEmONC and EmONC facilities within the national network Views of implementing partners (national health officials, NGOs, CSOs, community leaders and individuals) regarding effectiveness of capacity development efforts by UNFPA and how it has improved the performance of skilled birth attendants Alignment of UNFPA capacity development inputs with MHTF core principles (Equity in access, quality of care and accountability; plus, principles of human rights and gender equality). 	
Observations	Sources of evidence
<ul style="list-style-type: none"> Obstetric care from a health professional during delivery is recognized as a critical element in managing complications that may arise during childbirth and reducing maternal and neonatal mortality. Women who deliver at home are usually more likely to do so without assistance from a trained provider, whereas women who deliver at a health facility are more likely to be assisted by a trained health professional. In the 5 years preceding the survey, 80% of births were delivered by a skilled provider. Among the births assisted at delivery, 71% were delivered by a nurse/midwife, whereas 9% were delivered by a relative/friend and 8% by a doctor The percentage of births with skilled assistance during delivery declined from 50% in 1992 to 42% in 2001-02. Thereafter, the percentage has increased steadily, from 47% in 2007 to 80% in 2018. (p. 135) By province, the percentage of births delivered by a skilled provider range from 70% in Northern to 91% in Copperbelt and Lusaka. Women in Luapula and North-Western are more likely to be assisted by a traditional birth attendant (18% and 17%, respectively) than women in other provinces. (p. 136) 	Zambia Statistics Agency, MoH Zambia, and ICF. Zambia Demographic and Health Survey 2018. 2019.

¹⁸ The COM-B model of behaviour change (Mayne 2016) will be used to assess provider capacity based on three necessary conditions: 1) capability (necessary knowledge, skills, and attitudes to deliver quality care), 2) opportunity (having the necessary infrastructure, equipment, supplies and tools to deliver quality care), and 3) motivation (internal cognitive and emotional processes related to willingness and perceived personal benefit of providing good quality of services).

Assumption 2.3: UNFPA inputs at national and sub-national level to address gaps in capacity of skilled birth attendants in EmONC facilities results in improved quality of integrated SRHR services and maternal and newborn care, including EmONC	
<ul style="list-style-type: none"> • “Following the EmONC training, the staff are knowledgeable about the management of maternal and neonatal complications. They are able to identify clients with maternal conditions. Those that are reversible such as anaemia in pregnancy, are easily dealt with during antenatal care and also during labour. A woman in labour is monitored using a pantograph and one that is trained is able to recognise if at all there is a problem. Consequently, timely intervention is put in place. Before the training, we used to have a lot of referrals because people were not knowledgeable and did not have the knowledge and skill to manage such conditions. Following UNFPA training, there has been better management of maternal conditions, and this has resulted in less referrals. Staff are now equipped with the knowledge and skill to manage certain maternal procedures including vacuum extraction and vacuum aspiration. If you take current maternal mortality rates and compare them with the time before UNFPA support, I think there is a drastic decline of the number of deaths in our district.” • All 23 facilities in the district now have qualified staff. “So they (UNFPA) really have played a major role in terms of human resources in our district.” • “We’ve seen an impact on maternal death rates. I think the rates are going down because most of the staff have been equipped with knowledge and skills so that they are able to handle cases, identify complications and take action regarding women during delivery, post-delivery or antenatal. I think that is a significant role that UNFPA has played. They have also increased the number of qualified personnel in terms of midwifery care, and this has contributed to the drastic reduction of maternal and neonatal mortality rates as compared to the past when they was no training of such kind.” 	<p>Interview, MoH staff. Mufumbwe District, Zambia. September 2021.</p>
<ul style="list-style-type: none"> • UNFPA is supporting EmONC by supporting midwifery skills. There has been quite palpable impact in my view as no other organization is working on midwifery. • UNFPA is the only organization that is directly supporting the MoH at the level of human resources in focus provinces, i.e., supporting the government to train and place personnel. This kind of approach – they are in the places where systems are weaker, you identify locals, send them to school and then contract with them to stay. 	<p>Interview, UN agency staff, Lusaka. August 2021.</p>
<ul style="list-style-type: none"> • UNFPA has been key to the development of a number such guidelines to ensure that quality of care is improved. The EmONC trainings conducted with support from UNFPA are helping in ensuring that quality of care is provided to women. Monitoring is also conducted periodically with support from UNFPA. “We actually get down to the facilities to see what is prevailing in there. We have developed assessment tools, use to assess the health care providers thereby ensuring that quality health care services are being provided out there.” 	<p>Interview, MoH national staff. Lusaka. August 2021.</p>

Area of Investigation 3: Maternal and perinatal death surveillance and response

Evaluation Question 3: To what extent has the MHTF contributed to firmly establish the main components of the MPDSR programme (guidelines and tools, mandatory notification, costed national plan); to support its implementation at national scale; and to increase the notifications of maternal deaths and strengthen the quality of maternal death reviews and implementation of the “response” component?

Sub-questions:

- a) How, where and to what extent has the MHTF contributed to the establishment and scale-up of MPDSR?
- b) To what extent has MHTF support contributed to sustained or increased quality and credibility of MPDSR as evidenced by increased notification of maternal deaths among other features?
- c) Where and how has MHTF contributed to service and systems improvements because of MPDSR findings?

Evaluation Criteria	<i>Relevance, effectiveness, sustainability</i>
Rationale	<p>MPDSR efforts intensified globally following the publication of technical guidance by WHO in 2013. By 2015, over 76 countries adopted policies for the systematic review of maternal deaths, and 41 and 56 countries have adopted policies for review of stillbirths and neonatal deaths, respectively. Since then, WHO and UNFPA have monitored progress in MPDSR implementation. They noted substantial gaps between adopting national MPDSR policies, setting up national and subnational review committees and monitoring other aspects of implementation. Quality of reviews varies within and between countries. MPDSR methodology requires comprehensive investigation of causes, circumstances, and preventability of each maternal death identified and a no-blame atmosphere is essential to pinpoint and make policy and operational changes that would improve quality of care. UNFPA supports countries to develop MPDSR with tracking indicators that are clear and measurable, and methods for analyses that best assess quality of death reviews and can track the impact of death reviews on health service quality. Strengthening MPDSRs is supported by the MHTF as a vital mechanism to build sustainable systems strengthening for better MNH and is linked to the EmONC response.</p>

Assumption 3.1: MHTF technical support to the establishment and national scale-up of MPDSR in its partner countries is evidence based and comprehensive

Indicators

- Alignment between global and regional evidence-based guidance and national strategies for establishing and operating a MPDSR process.
- Examples of UNFPA advocacy and policy dialogue in support of national plans designed to strengthen and scale up MPDSR.
- Strengthened coordination and capacity including increasing number of timely, complete death audits
- MHTF workplans include application of lessons learned (knowledge management) to improve quality and support scale-up of MPDSR within countries and to new countries.
- Number of MPDSR components that are implemented (out of 4)
- Examples of investment by health authorities and partner institutions at global, national, and sub-national level with a focus on the relevance, effectiveness, and sustainability of MPDSR process and relevant follow up.
- Health authorities and partner institutions regard MHTF leadership on core principles of equity in access, quality of care, accountability, and on principles related to human rights and gender equality as a critical underpinning of the MPDSR approach.

Observations	Sources of Evidence

Assumption 3.1: MHTF technical support to the establishment and national scale-up of MPDSR in its partner countries is evidence based and comprehensive	
<ul style="list-style-type: none"> • “In 2018 Zambia reported 674 maternal deaths (MMR: 183 deaths per 100,000 live births). The primary causes of maternal deaths were obstetric haemorrhage and indirect causes. Obstetric haemorrhage was the most common cause of death among women ages 30-49 and women who had experienced more than one pregnancy, while indirect causes attributed to the most deaths among pregnant women ages 10-29 and first-time pregnant women. Despite committing to improve maternal health by endorsing the United Nations SDGs, Zambia is behind in achieving the third SDG of a maternal mortality ratio of less than 70 maternal deaths per 100,000 live births. To actualize this goal, Zambia must continue comprehensive surveillance of maternal deaths as well as increase access to family planning services, quality antenatal care services, skilled birth attendants, and emergency obstetric care.” (p. 12) • “Upon reporting of a maternal death in Zambia, an investigation is launched within 24 hours to determine the cause of death. Currently, the MoH coordinates the MPDSR database. Maternal deaths are also electronically documented using the District Health Information System 2 (DHIS2) and the national Health Management Information System as well as captured on a weekly basis in the Integrated Disease Surveillance and Response (IDSR) reports. In addition to the electronic reporting systems, maternal deaths are reported in a paper-based format and sent to the MoH on a weekly basis. Discrepancies in the multiple surveillance databases make it difficult to ascertain the true number of maternal deaths and require a platform on which data from all surveillance systems can be collected and collated. Zambia has already begun enhancing its surveillance efforts. The introduction of Event Based Surveillance is leading to higher reporting of community based maternal deaths. However, electronic integration of national maternal death data is required to provide a comprehensive view of maternal mortality in Zambia.” (pp. 15-16) 	<p>Gianett B, Musakanya KE, Ngomah Moraes A, Chizuni C, Groeneveld C, Kapina M, Hamoonga R, Mazaba ML, Mukonka V. Maternal mortality trends and correlates in Zambia. Health Press Zambia Bull. 3(4&5), pp. 12-16. 2019.</p>
<p>Development of MPDSR Plan, Strategy and Guidelines</p> <ul style="list-style-type: none"> • UNFPA Zambia supported the MoH to develop an MPDSR plan aligned to international standards. The plan includes targeted interventions aimed at addressing critical gaps that cause or contribute to preventable maternal deaths. • UNFPA provided support to strengthen capacity of a team of 30 technical staff from all provinces with representatives from the MoH and development partners, including the national MPDSR Committee appointed by the Minister of Health, to provide oversight to the MPDSR system through the following processes: <ul style="list-style-type: none"> ○ Review of maternal deaths ○ Identification of factors contributing to the death ○ Develop of response plans to prevent recurrence • UNFPA also supported the ZAGO to draft a position paper of strategic interventions to implement to address maternal mortality. 	<p>UNFPA, Zambia. 2019 Annual Report – Zambia. 2020.</p>
<ul style="list-style-type: none"> • “In the continued efforts to strengthen the national MPDSR system and end preventable maternal mortality, the country office supported the ministry of Health to develop a national MPDSR plan. The plan outlines targeted interventions aimed at addressing critical gaps that cause or contribute to preventable maternal deaths. The plan augments the national response to the declaration in May 2019 by the Republican President of maternal and perinatal deaths as a Public Health emergency. • The CO also provided technical and financial support to the ZAGO to develop a position paper of strategic interventions that the country needs to implement to address maternal mortality – this was done during the annual scientific and general meeting held in March 2019. 	<p>UNFPA, Zambia. MHTF 2019 End-of-year Report. Undated.</p>

Assumption 3.1: MHTF technical support to the establishment and national scale-up of MPDSR in its partner countries is evidence based and comprehensive	
<ul style="list-style-type: none"> The MoH was supported to commence revision of Maternal death surveillance and response (MDSR) guidelines to incorporate the perinatal component. The process will be completed in 2020. 	
<ul style="list-style-type: none"> Over the past two years, there has been growing interest by World Health Organisation (WHO) member states to include 'Perinatal' component in MDSR and strengthen perinatal reviews. However, the perinatal guidelines have not been outlined despite having many perinatal deaths (Early NND, FSBs and MSBs). Early this year, the Neonatal Health team started working on the PDSR guidelines to guide the perinatal reviews. These guidelines will be merged to have one comprehensive MPDSR document for reference during reviews. 	MoH Zambia, Report on meeting to review of MPDSR guidelines and tools. December 2019.
<ul style="list-style-type: none"> "In an effort to strengthen the national Maternal Perinatal Death Surveillance and Response (MPDSR) system and end preventable maternal deaths, the CO supported the MoH at national level to review the MDSR guidelines and tools and incorporate the perinatal component as well as align the document to international standards. 	UNFPA, Zambia. MHTF Annual Report, 2020. Undated.
<ul style="list-style-type: none"> UNFPA supported capacity development of healthcare providers on effective planning, delivery and monitoring of high-quality (EmONC) services, including post-abortion care. UNFPA also strengthened maternal death surveillance and response in line with international standards and guidelines and supported its institutionalization in 2016. "This appears to function well, enabling tracking of the benefits of early antenatal care and follow up, and of facility-based deliveries. In 2017 the MDSR was modified to include perinatal deaths, reporting tools were revised, and UNFPA supported extensive multi-sectoral provincial and district level meetings on the underlying causes of maternal deaths. Weekly facility reporting to the office of the MoH is reported to have ensured that documentation is taken seriously." 	UNFPA. UNFPA 8 th Country Programme Evaluation: Zambia 2016 – mid-2019. 2019. p.38
<ul style="list-style-type: none"> UNFPA has made a huge push on MPDSR – making sure that this is being mainstreamed. There has been a big change where we are now doing on a weekly basis regular reviews and surveillance meetings. This is being done with support from all of the other RMNCAH&N partners. There is more attention to the weekly bulletin published where maternal deaths are reported on. This is an area that everyone has acknowledged – putting the information out and showing the numbers – acknowledging that this is a problem. The contribution of UNFPA has been very, very critical. They are the ones that have backstopped the MoH on this issue. A systemic approach, held together by UNFPA, bringing other partners, assuring the committees are in place. 	Interview, UN Agency staff, Lusaka. August 2021
<ul style="list-style-type: none"> UNFPA has strengthened capacity in MPDSR. Last year, the CO supported the review of national guidelines in collaboration with a consortium of UN agencies helping with the process, i.e., WHO, UNICEF and World Bank. Earlier this year, the draft was validated, and it is awaiting the printing, dissemination and roll-out. There is a plan with the MoH on how to implement the rollout. Representatives are selected from the 10 provinces to do their own dissemination, e.g., PHOs will disseminate to districts and then down to health facilities. When there are windows of opportunity, the MHTF will co-fund and support the provinces to roll-out. 	Interview, UNFPA Zambia staff. August 2021.
<p>Capacity building in MPDSR processes</p> <ul style="list-style-type: none"> In addition to this, the CO built capacity of a team of 35 technical staff from MoH and development partners, including members of the national MPDSR committee appointed by the Minister of Health, in the conduct of quality MPDSR processes and providing oversight to the national MPDSR system. The CO supported the conduct of MPDSR processes in all supported provincial to review maternal deaths, identify factors contributing to the death and development response plans to prevent recurrence. Some UNFPA supported districts have made 	UNFPA, Zambia. MHTF 2019 End-of-year Report. Undated.

Assumption 3.1: MHTF technical support to the establishment and national scale-up of MPDSR in its partner countries is evidence based and comprehensive	
gains in reducing maternal deaths through initiatives of early identification of at-Risk pregnancies, follow up and accommodating the pregnant women at facilities to facilitate timely interventions.” (pp. 1-2)	
<ul style="list-style-type: none"> • The CO supported MPDSR processes in all supported provinces that resulted in reviews of maternal deaths, identification of factors contributing to the deaths and development of response plans to prevent recurrence. As a result of the response plans some of the supported districts have made gains by implementing initiatives such as early identification of at-risk pregnancies, follow up and accommodation of pregnant women at health facilities, to facilitate timely management of labour and its complications. The CO continued to support the implementation of the MPDSR Plan developed in 2019 to ensure that maternal and perinatal deaths are part of the multi-sectoral approach to addressing preventable maternal and perinatal Deaths. The plan outlines targeted interventions aimed at addressing critical gaps that cause or contribute to preventable maternal deaths. The plan also augments the national response to the declaration made by the President in May 2019 on maternal and perinatal deaths as a public health emergency. This has resulted in strengthening the National MPDSR committee appointed by the Minister of Health, to conduct quality MPDSR processes and provide oversight to the national MPDSR system.” 	UNFPA, Zambia. MHTF Annual Report, 2020. Undated. p.4
<ul style="list-style-type: none"> • MHTF supported MPDSR, a central piece of programme management at provincial level. UNFPA also provides support at national level to clean up data and inform planning. “The beauty of the way MPDSR is structured, we support the national level as well as the Provincial level in the three provinces.” Basically, a national level committee that has been appointed to review maternal deaths. At MoH level they do this on a weekly level. Former President made maternal mortality a national priority. For every death that occurs, the facilities are supposed to immediately report. Facility notifies DHO, notifies PHO then PH Director at MoH. Then the countdown begins for receipt of a detailed report. Committees are instituted at all levels to look at preventable causes are addressed. The institutionalization of MPDSR is at different levels; staff turnover affect this. “We have noticed some gaps and are trying to work on that: at facility level, whenever a death is being reviewed there is fear. Do not get the depth and detail.” Confidential inquiries into maternal deaths; anonymous teams. The Zambia CO recently reached out to the EASRO since they have been doing them for a long time – want TA to train MoH and ZAGO to probably help with running these confidential. 	Interview, UNFPA Zambia national staff. August 2021
<ul style="list-style-type: none"> • UNFPA has contributed to the institutionalization of maternal death surveillance and response in the country. They have provided support in terms of capacity building for the health care providers and also meetings to ensure a review of figures (statistics). “This is why we are able to say where we are as a country in terms of maternal mortalities. They have also supported the services (survey) that we conduct every five years to see where we are as a country in terms of outcome indicators.” • They have been working to institutionalize MPDSR across the country. “In 2016; we still had a number of districts that did not understand maternal death surveillance and response. So through UNFPA, we are able to bring the provinces together and capacity build them to ensure that they understand what MPDSR meant. UNFPA has also supported the reports that we generate because just collecting figures is not enough; you also need to look at the numbers that we are generating and be able to analyse them to find out where the gaps are so that they can be addressed.” • UNFPA has been supporting the MPDSR meetings as well. National meetings are held every year supported by UNFPA. “They’ve also gone down to the district particularly in the four provinces where they provide support; these are Luapula, Western, North-Western as well as Central provinces. We have ensured that MPDSR has been institutionalised and there is an understanding of what it is.” 	Interview, MoH Zambia national staff. August 2021.

Assumption 3.1: MHTF technical support to the establishment and national scale-up of MPDSR in its partner countries is evidence based and comprehensive	
<ul style="list-style-type: none"> • The major result or output is the institutionalization of MPDSR at all level, the facility, the district, the province and national. This has been spearheaded by UNFPA. Initially, districts were not having meetings and when a death occurred, whether a maternal death or prenatal, districts did not sit to review those deaths and the underlining causes of those deaths. Because of UNFPA, those meetings are being held. “Currently I can boast that we have technical meetings every week. Every Friday we have national meetings via zoom despite the COVID-19 situation and all the districts that had deaths are discussed. The provinces are on board just as the technical personnel as well as policy makers at national level.” • “After we have gathered that information, the analysis that we do is able to tell us where the gaps are. Depending on the findings; if, for example, the gap is on provider skills regarding in managing postpartum haemorrhage cases, then UNFPA will actually provide funding so that we can actually go and provide technical in that area. Support will be given to that facility where the gaps were found. Similarly, if the gap is to do with supplies and commodities, UNFPA has come on board to actually provide supplies. I can cite an example where we had run out of oxytocin, drugs for prevention and management of postpartum haemorrhage. We reached out to UNFPA who were able to procure those supplies. Thus, we are able to respond to the findings to come up with key interventions to address the problem.” • At facility level, review of maternal and perinatal deaths is done immediately the death occurs. A death is supposed to be reported to the district within 24 hours. The district will report to the province and the province will report to the national level. Within 24 hours, the national level will know there was a death in a particular facility. “Once notification is made, a date is set within one week to sit and review the deaths. So within one week they are actually able to sit as a team and review that death to come up with the factors that could have contributed to that death. When we have our meetings on Friday, the facilities as well as the districts and provinces are able to report what they have done so far. Because it does not help just reporting numbers, we ask them to give us information on what they have done to address the gaps that were identified when they were doing those reviews. Thus reports are given every Friday to learn what the districts as well as the facilities have done to address the identified gaps. Reporting and implementation of activities is done consistently.” 	
<ul style="list-style-type: none"> • “We’ve seen a lot of improvement in what the MPDSR should be. The gaps I see – we need to keep pushing people. Whenever there is a mortality, people in that facility should be interested in reviewing the death – they should be able to sit and say how this happened, how to prevent. As a MoH, we have taken certain steps that we should not leave to facilities to review alone. They should share with the rest of country in an organized way. As we move forward, we look at outcomes of new-borns and learn more about general management of mother.” • Mortality reviews have been conducted for over a year now. Since we have started, the number of deaths/week have decreased. “We had more than 20 mortalities each week, but for quite some months, we have not had a figure above 20. Some have recorded below 10. Though even from the management, when we discuss with provinces, there has been a certain level of change.” 	Interview, MoH Zambia national staff. August 2021.
<ul style="list-style-type: none"> • UNFPA has assisted in strengthening the review of maternal and prenatal deaths. “Behind every maternal or prenatal death, there is a lesson to learn in terms of what we could have done better so that we do not lose another life in a similar manner.” UNFPA has sponsored quarterly maternal and prenatal death reviews. Staff sit to review every maternal and prenatal death. The review is done immediately and as a province, reviews are conducted to discuss those maternal and prenatal deaths. • As a result, the situation in the province has improved. “At one time in 2019, we had 69 deaths and last year, we recorded 44 maternal deaths and currently, this year in August, we have recorded 24 deaths. If we continue to improve, we can see maternal deaths continue to reduce. We may record 40 or 39 by the end of this year.” 	Interview, MoH staff, Western Province. August 2021.

Assumption 3.1: MHTF technical support to the establishment and national scale-up of MPDSR in its partner countries is evidence based and comprehensive	
<p>Areas to strengthen</p> <ul style="list-style-type: none"> Progress has been made in establishing national guidelines and a system for conducting weekly reporting. One missing area is to strengthen the area of confidential inquiries around maternal deaths and to produce regular reports. In the region there are a couple of countries where there are annual reports to review and analyse deaths over past three years. “These reports attract discussion about changes. Something we need to do in Zambia.” The work on MPDSR has been evolving over time – started off with a lot of advocacy and sensitization. In many countries, once you report a maternal death that occurred within a health facility, who is responsible, blame. Inquiries to improve the quality of care – but it has not fully developed until now. Now there are district reviews that take place, there are updated guidelines that now include the perinatal component. “This year, the MoH has requested TA from UNFPA to strengthening the area of confidential inquiries which should help move towards the biannual reports. At national level, would be important to have a committee, quasi-independent with researchers, academics, ministry, to put together the report.” 	<p>Interview, UNFPA Zambia national staff. August 2021</p>
Assumption 3.2: MHTF support has addressed the need for sustained or increased quality or credibility of maternal and perinatal death audit as evidenced by increased notification of maternal, perinatal and neonatal deaths in national and sub-national systems and increased implementation of responses	
<p>Indicators:</p> <ul style="list-style-type: none"> Quantifiable increase in the notification of deaths to health facilities, districts, and other authorities In target areas, increasing or continuing number and frequency of MPDSR events and hearings with multi-stakeholder participation Examples of policies and processes to support improved quality and comprehensiveness of death audits at national and at sub-national levels Examples of UNFPA efforts to strengthen QI processes, tools and data collection at national and sub-national level linked to MPDSR National and sub-national health and district supervisory officers in areas supported by UNFPA implement MPDSR monitoring on a regular basis and utilize findings to support improvements in services Views of health officials, including facility managers, providers, and community members regarding credibility of MPDSR processes. 	
Observations	Sources of evidence
<p>Regional support for MPDSR</p> <ul style="list-style-type: none"> In 2020, the East and Southern Africa joint UN team organized a series of virtual trainings for interested countries to support the strengthening of MPDSR systems, supported by the 2Gether4SRH Sweden emergency grant for continuing essential SRHR services during COVID-19. This is a six-month activity that entails 2 weekly virtual trainings to strengthen capacity to 1) identify and report all maternal and perinatal deaths, 2) correctly assign and code maternal and perinatal deaths, and 3) analyse maternal and perinatal death data. Inception meeting was held on 30 November 2020 and included MPDSR focal points from WHO, UNICEF, UNFPA and MoH for the first phase countries. 	<p>UNFPA, ESARO. Strengthening the availability, quality and reporting of maternal and perinatal death and cause-of-death data in national health information systems through enhancing the performance and quality of existing MPDSR systems in first phase ESA Countries (draft), 2020.</p>

Assumption 3.2: MHTF support has addressed the need for sustained or increased quality or credibility of maternal and perinatal death audit as evidenced by increased notification of maternal, perinatal and neonatal deaths in national and sub-national systems and increased implementation of responses	
<p>MPDSR results</p> <ul style="list-style-type: none"> • “The CO provided technical support to MoH MPDSR processes including participation in weekly review of maternal and perinatal deaths, identification of factors contributing to the deaths. This has resulted in other provinces reducing maternal deaths. For example, Western Province reported 69 maternal deaths in 2019 and have reported 44 in 2020. In 2021 UNFPA will support the national and subnational level to develop annual MPDSR reports. The country is now ready for another step in MPDSR to start conducting Confidential Enquiries into Maternal Deaths (CEMD). Consultations are being made particularly with South Africa on how to start this process which will be supported by UNFPA in 2021. The CO has continued to provide technical support for national MPDSR team to participate in virtual MPDSR regional meetings for capacity development and sharing best practices. 	<p>UNFPA, Zambia. MHTF Annual Report, 2020. Undated. p.5</p>
<ul style="list-style-type: none"> • MPDSR follow up is being done, with a number of the follow-ups supported. “I remember at one point we had gaps in Serenje [district], which was reporting a number of maternal deaths. A team was tasked to visit the district and identified the gaps that could have contributed to the maternal deaths. We were subsequently able to give them action points for the district to implement. Later, we went back to assess the extent to which those action points had been implemented. Sometimes, in the absence of physical visits to the facility, monitoring is done through other means such as a phone call, email or zoom; especially now that there's COVID-19.” 	<p>Interview, MoH national staff, Lusaka. August 2021.</p>
<ul style="list-style-type: none"> • Facilities are required to report every week (Monday) on whether any mortality occurred or any other condition worth noting. Not just mortalities are reviewed, but also successes regarding overcoming mortalities. • “Timely reporting is being done such as for maternal deaths. That is a hundred per cent guarantee. The only challenge that we face is communication and this is because of distance; the furthest facility is about 450 kilometres. Sometimes, network is a bit of a challenge, and this affects MPDSR reporting. Consequently, you may find that the report arrives a bit late, but we do try to make sure that we get the reports. Where network is not very reliable, we try to communicate, even by texting, to find out what is happening in the health facility. If there is need to follow up, we do that.” • Following the review or audit, recommendations are made for the hospital, the district and for the community. If the recommendation is for the community, the community volunteers are engaged. The district is also informed about the recommendation to ensure that similar problems do not occur in the future. • “This has been helped by UNFPA support, but it is also the result of the general requirement by the Ministry.” 	<p>Interview, MoH staff, Mufumbwe District, Zambia. September 2021.</p>
<ul style="list-style-type: none"> • MPDSR cannot be disassociated from issues to do with capacity building for EmONC for instance because EmONC covers both maternal and perinatal issues. UNFPA was the first organisation to train the community in MPDSR; they trained at community level, they trained people at district level, they trained people at provincial level and right now the past five years they have been supporting Multisectoral Maternal Perinatal Death Surveillance Response meetings. • “UNFPA has been the pioneer of that activity and therefore when we have that support, we would ask other partners if they really want, like to know how big the budget, they will like we want to support. UNFPA would bear 75% and the other partners 25% so that we have adequate representation of the different stakeholders across the province. Of course in the past, we even had the districts initially when they came from the Provincial Multisectoral Meeting; they would have their own support from UNFPA for the MPDSR meetings and then they would be able to track the recommendations and follow through.” 	<p>Interview, MoH staff, North-Western Province, Zambia. September 2021</p>

Assumption 3.2: MHTF support has addressed the need for sustained or increased quality or credibility of maternal and perinatal death audit as evidenced by increased notification of maternal, perinatal and neonatal deaths in national and sub-national systems and increased implementation of responses

- **UNFPA has helped to sensitize and bring up to speed in terms of what is expected in terms of identifying the causes of perinatal deaths and addressing the causes of maternal death.** The province has been able to reduce the number of maternal deaths recorded over time. “The power behind multisectoral and surveillance meetings that we had and also the awakening because of the consistence in the actual meetings, it causes us to be alert to do certain thing right and also to be able to look out on maternal deaths and strengthen the mentorship to bring out the skill of the health providers and the other stakeholders to realise their contribution towards the reduction of maternal death, I think that’s the reason MPDSR has been strong over the years with the help from UNFPA.”
- **Engaging with traditional leaders has also been an important aspect of the multisectoral approach promoted by UNFPA.** “We have seen traditional leaders taking it upon themselves to even come up with some documents which they have put forth, i.e., the Child Protection By-Law which are in the Chiefdoms, from the issues which are rising in the chiefdoms. We have seen penalties (sanctions) which have been put in place in those chiefdoms if maybe somebody delays in taking the health services.”
- **“The multisectoral MPDSR had kind of alerted everybody to rise to the challenge that they do their part in terms of maternal health, anything to do with anything that will do with occurrence of maternal death each of the different stakeholders have taken their role and they want to ensure that they do their job so that we end up with the positive outcome for the maternal health issues.... for instance, the Ministry of Community Development were now talking about women empowerment because we realise that sometimes what may cause a woman not to come is not having resources for them to come and say now I have this challenge if my husband does not have resources with the little money I have saved I will be able to move from my home and be able to seek the next facility to seek the service. So now they are looking at taking up into looking at the village banking issues right there at the community level so that women can have resources where they can be able to be empowered and make decisions, to have their own resources and able to buy food or prepare for a referral or something like that so this is the value that I think UNFPA has brought to the different stakeholders in family planning and adolescent reproductive health and improve or bear the outcome in the life of a woman and a girl child.”**

Area of Investigation 4: Obstetric fistula and other obstetric morbidities

Evaluation Question 4: To what extent has the MHTF contributed to the capacity of governments to develop, implement and monitor costed and time-bound national strategies for ending fistula cases that are founded on: prevention; access to quality treatment of fistula cases and other obstetric morbidities; and social reintegration of obstetric fistula survivors?

Sub-questions:

- To what extent has MHTF/ UNFPA contributed to the government capacity to develop, implement and monitor costed and time-bound national strategies for ending fistula?
- To what extent has MHTF/UNFPA contributed to building government capacity at national and sub-national levels equally across prevention, access to quality treatment and social reintegration of survivors?
- To what extent has MHTF been an effective platform for the global Campaign to End Fistula?

Evaluation criteria	<i>Relevance, effectiveness, efficiency</i>
Rationale	<p>Obstetric fistula is caused by prolonged obstructed labour and is an extreme consequence of poor access to basic emergency maternal health care. Once fistula occurs, surgical repair is the only option. Surgical skills needed draw across disciplines (gynaecology, urology, general and plastic surgery, in some cases also gynaecology). Recovery time is protracted and not certain. Post recovery, women and girls may not be able to return home and, in most cases, may need a range of social protection support. Obstetric fistula is thus a complex development problem that has multiple dimensions. MHTF aims to support countries to take steps to prevent and respond to fistula and similar conditions to reduce maternal emergencies, save the lives of newborns, and improve quality and availability of care. Fistula incidence reflects proximity and use of emergency obstetric care (EmONC) and referral capacity making prevention part of a comprehensive maternal health strategy. Post fistula repair depends, to some extent, on identifying sufferers and connecting them with services. Post fistula recovery depends on a multi-sectoral approach to well-being, employment and skills, social reintegration and other factors. As fistula is still poorly understood and sufferers are hidden, data needs to be treated carefully as increasing numbers could be a sign of improved service response rather than increasing incidence. Although it has its own fistula aims, the MHTF also hosts the global Campaign to End Fistula which works with a mandate from the UN Secretary General & UN Member States to end fistula in 55 countries. The Campaign is largely merged with the MHTF goals on fistula but reaches beyond the scope of the MHTF and brings its own funds to bear.</p>

Assumption 4.1: MHTF and UNFPA, including through leadership of the Campaign to End Fistula, support is consistent with strengthened government leadership and capacity at national and sub-national levels to develop, implement and monitor costed and time-bound national strategies for preventing and treating fistula

Indicators

- Development of costed time-bound national and sub-national strategies that set out meaningful prevention, treatment and recovery objectives and strategies.
- Examples of implementation of plans and progress rolling out plans to sub-national and community levels
- Fistula indicators incorporated into the health management information system at national and sub-national levels
- Monitoring arrangements in place for fistula strategies across the three dimensions (prevention, treatment, recovery)
- Examples of policy dialogue and development between national and sub-national health authorities especially around linking to EmONC networks
- Examples of engagement with communities around fistula prevention and management, for example, maternal emergency transportation plans
- Trends in the identification fistula cases
- Examples of investments in preventing, treating and supporting recovery from fistula

Assumption 4.1: MHTF and UNFPA, including through leadership of the Campaign to End Fistula, support is consistent with strengthened government leadership and capacity at national and sub-national levels to develop, implement and monitor costed and time-bound national strategies for preventing and treating fistula													
<ul style="list-style-type: none"> Establishment and operation of programmes for staff training to implement strategies (surgery and nursing and community health workers). Number of fistula repairs undertaken National and local systems incorporate multisectoral engagement to address fistula, for example with nutrition, social protection, employment, and training sectors 													
Observations	Sources of evidence												
<p>Fistula “roadmap” and operational plan to end fistula:</p> <ul style="list-style-type: none"> Through the roadmap, new resources have been invested to recruit and train surgeons, midwives, SMAGs, and other health workers to identify, mobilize and carry out fistula repairs. The Fistula Foundation has joined the campaign to end fistula together with the MoH and UNFPA to identify, mobilize and support treatment for patients with fistula. 	Kasunda, G. Obstetric Fistula in Zambia. Undated.												
<ul style="list-style-type: none"> Through UNFPA technical and financial support, the Draft Operational Plan to End Obstetric Fistula was developed. The plan provides strategic focus on fistula management (prevention, identification, repair, and re-integration) and institutionalization. 	UNFPA, Zambia. 2019 Annual Report. 2020												
<ul style="list-style-type: none"> Over the last decade fistula has received increased attention in national and international agenda. New resources have been invested to improve medical care, train surgeons and health workers and fund units to carry out fistula repair. Education campaigns have alerted more women, families, and communities to the importance of medical care during pregnancy and childbirth as well as the specialized surgery available to help them. MoH with support from United Nations Population Fund (UNFPA) held a three (3) days meeting to finalise the fistula operational plan for the country. The main objective was to finalise the fistula operational plan to guide the implementation of fistula activities in Zambia. UNFPA supported the MoH to conduct a three-day meeting to finalize the fistula operational plan for the country, the objective of which is to guide the implementation of fistula activities in Zambia. The meeting drew participants from health facilities where fistula repairs are currently being done in facilities and camps. The plan is based on a blended model that integrates the UNFPA and EngenderHealth models (summarized in the table below and is aligned with the WHO three-pronged approach. It was resolved that the model would be called, The “Zambia End Fistula Model.” <table border="1" data-bbox="352 1122 1501 1260"> <thead> <tr> <th>Area</th> <th>UNFPA Model</th> <th>EngenderHealth Model</th> </tr> </thead> <tbody> <tr> <td>Focus</td> <td>Identify, treatment and integration</td> <td>Outlines level of care</td> </tr> <tr> <td>Target</td> <td>Excludes multiparous women</td> <td>Includes multiparous women</td> </tr> <tr> <td>Approach</td> <td>Includes other sectors</td> <td>Inclined to MoH systems</td> </tr> </tbody> </table>	Area	UNFPA Model	EngenderHealth Model	Focus	Identify, treatment and integration	Outlines level of care	Target	Excludes multiparous women	Includes multiparous women	Approach	Includes other sectors	Inclined to MoH systems	MoH, Zambia. Activity/Trip Report: Finalization of the Fistula Operational Plan Report. 2019
Area	UNFPA Model	EngenderHealth Model											
Focus	Identify, treatment and integration	Outlines level of care											
Target	Excludes multiparous women	Includes multiparous women											
Approach	Includes other sectors	Inclined to MoH systems											
<ul style="list-style-type: none"> A road map to end fistula is under development by GRZ, UNFPA and the Fistula Foundation. The latter has been active in Zambia since 2017 and contributes significantly to identification and repairs. Current linkages between UNFPA and the Foundation do not appear strong, it is to be hoped that through the road map effective collaboration in support of the MoH will be clarified, maximizing the comparative advantage of each partner. The ideal will be to have a highly trained fistula surgeon in each province to bring the services nearer to clients. 	UNFPA. UNFPA 8 th Country Programme Evaluation: Zambia 2016 – mid-2019. 2019. p.28												

Assumption 4.1: MHTF and UNFPA, including through leadership of the Campaign to End Fistula, support is consistent with strengthened government leadership and capacity at national and sub-national levels to develop, implement and monitor costed and time-bound national strategies for preventing and treating fistula	
<p>High-level advocacy via international conference attendance</p> <ul style="list-style-type: none"> • UNFPA and the Fistula Foundation sponsored a Zambian delegation to attend the 7th International Conference of Obstetric Fistula Surgeons in Nepal in 2018. This conference supported the UN call to end Fistula within a generation and provided an opportunity for the global community dedicated to fistula prevention and care to share experiences and best practices in scientific oral and poster presentations and workshops. • Conference recommendations on the way forward included: <ul style="list-style-type: none"> ○ Continued efforts by national governments and development partners to work together to improve the availability, accessibility and quality of maternal health services. ○ Efforts to address the growing numbers of iatrogenic fistula through high quality training for surgeons and medical officers. ○ Promotion for the rational use of C-sections and access to those women who need it in a timely manner. ○ Global, regional, national and local level strategies and action plans with clear milestones to ensure prevention and care of fistula. 	<p>UNFPA Zambia. Mission Report: International Conference of the Society of Obstetric Fistula Surgeons (ISOFS), Nepal. 2018</p>
<p>MoH perspectives on fistula</p> <ul style="list-style-type: none"> • Fistula is an area that UNFPA has played a role for some time, until the Fistula Foundation joined in. It was approached from a public health point of view alone. “We’ve done fistula treatment without mainly paying a lot of attention to community and health worker engagement regarding the prevention of fistula.” It might look that you are mopping but you have an open tap. If we could have close linkages between activities we have been undertaking on repair with prevention, we will be winning both ways.” • Efforts to treat are needed, and with increased support and collaboration with UNFPA and Fistula Foundation, there has been more routine fistula service delivery. Fistula should not occur if there is good communication with providers and communities. There is a need to increase the number of people and sites for repair and marry this with prevention strategies. • Re changes in fistula landscape, there has been discussion that is we are having from people speaking about fistula (iatrogenic vs obstructed labour). More research is needed. The question should be food for thought and moving forward, there is a need for more information. “The C-section rate was very low in this country and now coverage has gone up, but quality has not kept pace. Lots of poor techniques for C-sections. For us, to answer that question with confidence, it needs data.” 	<p>Interview, MoH national staff. Lusaka, Zambia. August 2021</p>
<ul style="list-style-type: none"> • Only UNFPA and Fistula Foundation are supporting Fistula programmes at the moment. Prior to engagement of the Fistula Foundation came in, “UNFPA supported sensitization and they made a very big impact because they highlighted a lot of issues concerning Fistula. UNFPA also has a different way of how they finance the Ministry as they channel those resources to the Ministry through the Ministry of Finance. UNFPA actively participates in the planning that the Ministry makes. I think that is unique.” • The strategic plan is not yet completed. Fistula Foundation and UNFPA played a big role, particularly UNFPA because they initiated and supported the start of the strategic plan. “We had meetings with them, they made contributions on the document itself and also brought a number of key players together through their support to have this programme done.” Later on, Fistula Foundation joined the effort, and they supported the consultant who was to collect the information and put the documents together. 	<p>Interview, MoH service provider. Lusaka, Zambia. August 2021.</p>

Assumption 4.1: MHTF and UNFPA, including through leadership of the Campaign to End Fistula, support is consistent with strengthened government leadership and capacity at national and sub-national levels to develop, implement and monitor costed and time-bound national strategies for preventing and treating fistula	
<ul style="list-style-type: none"> In terms of high-level leadership, the Permanent Secretary has keen interest in fistula. “When we have Safe Motherhood Week, UNFPA usually supports the treatment within that week for fistula care. And they also support the Permanent Secretary, including for the first lady to actually attend and grace the occasion.” 	
<ul style="list-style-type: none"> “Fistula is a rare condition in Mufumbwe and I think there are very few cases. In November, a party came to sensitize on fistula, and I think we had one woman who was found to have a problem and we encouraged them to send her to the hospital so that the issue can be evaluated. But I think it is a rare condition here although some with such problems may exist. We are however sensitizing so that women with such cases are identified and evaluated. Once they have been identified, a fistula camp is set for them to go for repair.” 	Interview, MoH staff, Mufumbwe District, North-Western Province, Zambia. September 2021.
<ul style="list-style-type: none"> UNFPA is the only organization working on fistula in Solwezi district, “perhaps for the whole of North-Western Province.” This has included supporting CBVs to sensitize communities on fistula, identify fistula cases in the community, organize fistula camps at Solwezi General Hospital. “Specifically, in Solwezi District, we had about 14 cases that were identified and UNFPA even provided transport to go and pick them up as well as providing food for them while in the Hospital and ensuring that these clients were taken back to their various places. They have really done a lot although we still need more of that because out of the 14, we still have 3 with a bit more complicated fistula. These need more attention or surgeries.” 	Interview, MoH staff, Solwezi District, North-Western Province, Zambia. September 2021.
<p>Future items for fistula agenda</p> <ul style="list-style-type: none"> On the top of the agenda is Iatrogenic Fistula. There is no data on iatrogenic fistula; info is anecdotal. “Going forward, there is a need to establish that health workers are on the lookout for this problem happening.” There is a department created with the Department of Clinical Care which includes a cadre national coordinator – one is on Ob/Gyn to coordinate with specialists (senior residents) in provinces to ensure skills are polished through mentorship. “My hope that this team of experts is supported with travel to carry out the mentorship. Training of specialists – MHTF may not put resources to train specialists, but resources have been used to influence the policy direction.” 	Interview, UNFPA Zambia national staff. August 2021.
<ul style="list-style-type: none"> Opportunity also exists for the prevention of fistula because health care staff that are trained in EmONC can contribute to preventing fistula. These health care personnel can prevent delay that may lead to fistula. It is also important for the leadership to become actively involved because the problem of fistula is not isolated; it is occurring within the health care system which has its own leadership at different levels. “We need more surgeons to treat fistula and more midwives in the rural areas who can manage maternal health more effectively by preventing obstructed labor that leads to fistula and thereby prevent fistula. If we had to have a robust programme, I would advocate for a more robust programme for the prevention of fistula just as much as we treat fistula that has not been prevented.” 	Interview, MoH service provider. Lusaka, Zambia. August 2021.
See Assumption 4.3 for inputs related to International Day to End Obstetric Fistula activities (to increase awareness and commitment to fistula at national and sub-national levels)	
Assumption 4.2: MHTF and UNFPA, including through leadership of the Campaign to End Fistula, have engaged with national leadership, to enhance ownership and accountability in ways that build <u>health systems, and community capacity</u> at national and sub-national levels across prevention, access to quality rehabilitation and social reintegration of survivors	
Indicators	

Assumption 4.2: MHTF and UNFPA, including through leadership of the Campaign to End Fistula, have engaged with national leadership, to enhance ownership and accountability in ways that build health systems, and community capacity at national and sub-national levels across prevention, access to quality rehabilitation and social reintegration of survivors	
<ul style="list-style-type: none"> • Increase in reported progress in all stages of fistula prevention, diagnosis, repair and recovery • Guidance available to health workers including midwives (prevention, diagnosis), surgeons (repair) and community health workers (prevention and recovery) • Policies and programmes in place to support rehabilitation of fistula survivors • Trends in number of fistula survivors who benefit from rehabilitation and reintegration programme and support. • Examples and of Community engagement and advocacy regarding the causes and consequences of fistula • Examples of changing community and health worker attitudes towards fistula sufferers and survivors • Documented multisectoral approaches which include life skills, nutrition, and social protection especially in the recovery phase • Examples of concrete integration of fistula strategies into EmONC and maternal health plans and approaches. 	
Observations	Sources of evidence
<p>UNFPA support for fistula repair services (camps)</p> <ul style="list-style-type: none"> • Education campaigns supported by partners have alerted more women, families, and communities to the importance of obstetric care as well as the specialized surgery available to help them. Currently, six hospitals offer routine fistula treatment; nine fistula surgeons have the skills to offer repair as compared to a decade ago with only two hospitals and two surgeons. More than 300 patients undergo fistula repair annually, most through outreach camps. Camps contribute to having more fistula survivors access treatment while serving to mentor other doctors to strengthen surgical skills. The MoH plan is to institutionalize fistula treatment at all provincial hospitals. 	Kasunda, G. Obstetric Fistula in Zambia. Undated.
<ul style="list-style-type: none"> • In collaboration with the Fistula Foundation, UNFPA supported 185 fistula repair surgeries. 	UNFPA, Zambia. 2019 Annual Report. 2020
<ul style="list-style-type: none"> • UNFPA and other partners have supported Luapula Province for the past nine years to provide fistula operations via camps. The 2020 camp was sponsored by UNFPA at Manza General Hospital; 24 clients were mobilized from districts both within and outside the province, including Luwinyi, Serenje, Kitwe, Cilubi, Kawambwa, Samfya, Chitambo and Nchelenge. Clients were mobilized one week prior to the camp by community-based volunteers collaborating with the facility. 	Mwanza, M. Report on Fistula Surgery, Manza General Hospital, Luapula Province. 2020
<ul style="list-style-type: none"> • UNFPA supported a fistula surgical camp at Mansa General Hospital in collaboration with the Fistula Foundation. Thirty-five clients (35) clients were mobilized from 12 different districts in Zambia, drawing most from Cheingwi District. Two visiting surgeons from Kusaka and Mpika were invited to provide technical and supportive supervision to the local team. Two off-duty nurses were mobilized to assist as there was an inadequate number of staff working during the camp. • The camp was reported to be a success and well-coordinated; theatre staff worked well with no challenges and the visiting doctors interacted and worked well with the local team. Few challenges were encountered. A total of 35 clients came to the camp and 29 underwent surgery, with the last patient discharged after 2.5 weeks. 	Mulembwe, Daniel Mutale. Report on Fistula Surgery, Mansa General Hospital, Luapula Province. 2019.
<ul style="list-style-type: none"> • Two hundred and twenty (220) women with obstetric fistula were repaired in 2018 with UNFPA support. 	UNFPA Zambia. Annual Report-2018-2019. 2019.
<ul style="list-style-type: none"> • 101 women with obstetric fistula underwent successful surgical repair, thus restoring their dignity. 	UNFPA Zambia. Annual Report 2020

Assumption 4.2: MHTF and UNFPA, including through leadership of the Campaign to End Fistula, have engaged with national leadership, to enhance ownership and accountability in ways that build <u>health systems, and community capacity</u> at national and sub-national levels across prevention, access to quality rehabilitation and social reintegration of survivors	
<ul style="list-style-type: none"> • Through the Global Campaign to End Fistula, UNFPA provides support to the Government of the Republic of Zambia towards Fistula prevention, treatment and social reintegration programmes. Since 2005, UNFPA's support has translated into nearly 5,000 life-transforming surgeries across the country. • In keeping with the 2030 Agenda for Sustainable Development, UNFPA and partners such as the Fistula Foundation also continue to draw the attention of policymakers, communities and individuals, to key actions and investments required to end the needless suffering caused by Obstetric Fistula, including among adolescent girls. This includes key actions to end child marriage and adolescent pregnancies. • As the COVID-19 pandemic rages on, UNFPA continues to support the prevention of Obstetric Fistula through the delivery of essential sexual and reproductive health services, including midwifery services and emergency obstetric and newborn care, which is key towards Fistula prevention. (p. 12) 	
<ul style="list-style-type: none"> • The results framework for the 8th Country Programme (2016-2020) regarding the Number of fistula repair surgeries conducted in supported provinces: Baseline: 1,786; Target: 3,800 • Of the target of 3,800 fistula repairs by 2020, 2,575 had been undertaken with UNFPA support by mid-2019 (as compared to the baseline of 1,786 undertaken in the previous CP). Up until mid-2019, the results were on track with expectations. The numbers had dropped off in the first half of 2019 compared with earlier years, however, further fistula camps are still planned. • UNFPA has contributed by training obstetricians in fistula repair, supporting fistula repair camps, and raising community awareness about fistula through community volunteers such as SMAGs. While the camps provide an important service, they are not sustainable. A more sustainable approach has been training obstetricians at provincial level to undertake fistula repair and supporting a ward at Mansa General Hospital that has intakes every six weeks of maximum 16 fistula patients who stay for two weeks and have access to counselling and support, including for SRH, as well as medical fistula repair. Being in a group for two weeks also promotes bonding and confidence building and was greatly appreciated by the group of 11 women present on the field visit. All had been living with fistula for several years. (p.28) • The aim of the 8CP was to institutionalize routine fistula case identification, treatment, and linkages to social reintegration programmes, in line with international standards. UNFPA has undertaken advocacy, capacity development, knowledge generation and service provision in relation to fistula. Since 2017 the international Fistula Foundation has also been operating nationally in Zambia, with its CO in Mansa, Luapula, and it is now contributing significantly to fistula identification and repair throughout the country. The Foundation accompanies women to treatment facilities, paying for transport and other costs, and operates a telephone hotline. The ideal will be to have a highly trained fistula surgeon in each province to bring the services nearer to clients. (p.41) • UNFPA has contributed by training obstetricians in fistula repair, supporting fistula repair camps, and raising community awareness about fistula through community volunteers such as SMAGs. While the camps provide an important service, they are not sustainable. A more sustainable approach has been training obstetricians at provincial level to undertake fistula repair and supporting a ward at Mansa General Hospital that has intakes every six weeks of maximum 16 fistula patients who stay for two weeks and have access to counselling and support, including for SRH, as well as medical fistula repair. (p.42) 	<p>UNFPA. UNFPA 8th Country Programme Evaluation: Zambia 2016 – mid-2019. 2019.</p>

Assumption 4.2: MHTF and UNFPA, including through leadership of the Campaign to End Fistula, have engaged with national leadership, to enhance ownership and accountability in ways that build health systems, and community capacity at national and sub-national levels across prevention, access to quality rehabilitation and social reintegration of survivors	
<ul style="list-style-type: none"> • During camps, UNFPA supports the treatment, the feeding of fistula patients, and the provision of the necessary equipment and supplies, which may not be in the system. “I would love it if they can provide more support except that they have limited funding. Three or four treatment camps are held within a year and before they used to support more than that, but I think because of limited funding, they are supporting less of those treatment camps. In terms of reintegration and rehabilitation, I think this is why we still have the big challenge in terms of not having a very well organized system that rehabilitates or reintegrates patients with fistula. I think we have not done much in terms of the rehabilitation of those patients; particularly those patients who cannot have successful treatment of the fistula.” 	Interview, MoH Service provider. Lusaka, Zambia. August 2021.
<ul style="list-style-type: none"> • “For UNFPA, Fistula remains top on the agenda – strengthening EmONC so that fistula does not happen in the first place. We prioritize identification of clients and being able to support the camps on where they are being done.” 	Interview, UNFPA Zambia national staff. August 2021.
<p>Fistula Prevention</p> <ul style="list-style-type: none"> • UNFPA has been effective in fistula prevention and care because of the way the programme has been done. UNFPA did a good job in sensitizing communities so that women who have been secluded for as long as 15 to 30 years have come out to access services. One such woman said, “I did not believe that I could even socialize with people.” 	Interview, MoH Zambia national staff. August 2021.
<ul style="list-style-type: none"> • “Solving the problem of fistula is twofold, preventing fistula and repairing fistula. By sharpening the skills of midwives so that they can be able to tell when a delivery could lead to fistula and therefore, they can prevent fistula during delivery; for instance, by recognizing quickly that the baby’s position is such that it may lead to complications and consequently cause fistula. The midwives can make quick decisions to deliver the baby as quickly as possible or to consult experts at the next level facilities. • We have recorded some successes in some cases, where the midwife conducts a complicated birth through instructions from a specialist by phone. If necessary, the midwife can make a decision to transfer the patient to the next level facility. If the fistula has already occurred, we bring these women to a health facility where they can be worked and then they can be integrated back into their communities.” 	Interview, MoH staff. Western Province, Zambia. August 2021.
<ul style="list-style-type: none"> • Although the UNFPA focus was initially on identification and treatment, the CO has also contributed to fistula prevention through increased attendance for antenatal care and for facility based delivery. 	UNFPA. UNFPA 8 th Country Programme Evaluation: Zambia 2016 – mid-2019. 2019. p.28
<p>Increasing community awareness about fistula</p> <ul style="list-style-type: none"> • “Sensitization is actually done in the communities, in the rural communities. Women are sensitized, right from the time of antenatal care that they need to deliver from a health facility. Usually, prolonged or obstructed labour leads to fistula. If they are left out on their own to deliver and not seek care on time, such is what leads to fistula. Most of the places have mothers’ shelters where those who stay far from the clinic or in hard to reach places where transport is difficult to find; can for even a month or so. Mothers are able to get to the nearest health facility where they can safely deliver. If not, it can lead to fistula.” 	Interview, MoH staff. North-Western Province, Zambia. September 2021.
<ul style="list-style-type: none"> • In Zambia, only 3 in 10 women age 15-49 (31%) have heard of the symptoms of obstetric fistula. Less than 1% of women reported that they have ever experienced symptoms of fistula. 	Zambia Statistics Agency, MoH Zambia, and ICF.

<p>Assumption 4.2: MHTF and UNFPA, including through leadership of the Campaign to End Fistula, have engaged with national leadership, to enhance ownership and accountability in ways that build <u>health systems, and community capacity</u> at national and sub-national levels across prevention, access to quality rehabilitation and social reintegration of survivors</p>	
	Zambia Demographic and Health Survey 2018. 2019.
<ul style="list-style-type: none"> • Fistula Foundation has worked with partners in Zambia to provide fistula surgery since 2012. • In 2017, with support from Johnson & Johnson, a new countrywide treatment network is being established to build Zambia’s long-term capacity for fistula care. • Since the network’s launch, it has achieved tremendous results: <ul style="list-style-type: none"> ○ 1,228 fistula surgeries provided at seven hospitals ○ 3 surgeons and 46 nurses trained in fistula management ○ 688 community health volunteers trained ○ 57 midwives trained on fistula identification and prevention efforts ○ 2,165 local leaders sensitized on fistula ○ 8,683 outreach visits carried out in 32 districts ○ Over 735,000 people reached through radio programmes and advertisements. 	<p>Fistula Foundation, Zambia. Accessed from: https://fistulafoundation.org/country/zambia/ on 15 Nov 2021.</p>
<p>Shifting from camps to routine services on demand</p> <ul style="list-style-type: none"> • Most of the repairs are done through camps. For the future, the aim is to institutionalize fistula repair in UNFPA supported provinces and nationally by looking at how to build capacity in surgeons so that they can do fistula on demand. “Institutionalization is happening with a couple of surgeons, deliberately – whilst proficient surgeons are learning on the job – registrars in training, attached to surgeons. As we speak, we have put in our plan, we propose to train two surgeons to train with proficient surgeons in Kenya. We are looking at this as a long-term solution. The issue we may have to grapple with – the usual problem of movement/attrition of staff. The surgeons-in-training would stay to carry on with these works.” 	<p>Interview, UNFPA Zambia national staff. August 2021.</p>
<ul style="list-style-type: none"> • The policy is in place to support the institutionalization of the treatment of fistula by obstetricians; however, when it comes to implementation, it is a challenge to focus on training of postgraduate and graduate students in Obstetrics. “Institutionalization of fistula treatment requires that you have specialists who are able to operate in all these provincial positions, but we do not have this yet.” • “We have an opportunity in the sense that all the provinces have at least one obstetrician and this is an opportunity for realizing the policy on the institutionalization of fistula treatment in Zambia.” 	<p>Interview, MoH service provider. Lusaka, Zambia. August 2021.</p>
<p>Tracking/follow-up of fistula clients</p> <ul style="list-style-type: none"> • The purpose of this mission was to check on the well-being of fistula survivors operated on in 2019 and to introduce and use SMAGs in the tracking and identification of fistula clients. • The tracking incorporated the use of 15 SMAGs; training included: <ul style="list-style-type: none"> ○ What is obstetric fistula, how it is caused, signs and symptoms ○ Complications of fistula ○ SMAGs role in prevention of fistula through encouragement of institutional deliveries, identification of fistula clients in communities, and referral of fistula clients to health facilities 	<p>MoH, Zambia, Western Provincial Health Office. Report on tracking of fistula survivors. 2019.</p>

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<ul style="list-style-type: none"> • A total of 12 clients were tracked from 5 districts (Kalabo, Mongu, Shangombo, Senanga and Kaoma). All clients had shown signs of healing well. • Lessons learned: <ul style="list-style-type: none"> ○ Involvement of SMAGs increased community participation in case identification and referral of clients ○ Reviewing clients in their own homes by health workers resulted in confidence in the facility and the care received. 	
<ul style="list-style-type: none"> • UNFPA supported a tracking exercise in 2020 to follow-up fistula clients in Mongu, Shagongo, Shesheke, Mulobezi, and Senanga Districts in order to: <ul style="list-style-type: none"> ○ Establish the outcome of the repairs and rebook those who had an unsuccessful repair ○ Identify new clients and book them for repairs. • Lessons learned: <ul style="list-style-type: none"> ○ Involvement of SMAGs in the tracking provided them with a greater understanding of fistula ○ Visiting clients helped to identify new cases in the community and book them for repair. ○ Tracking of clients through their families and phones facilitated their identification. 	Mayatola, Cathrine. Report on tracking Fistula Survivors, Western Province. 2020
<ul style="list-style-type: none"> • A follow up of post-operative fistula survivor clients was done in Chiengi and Nchelenge districts in November 2018 and a total of 35 clients (out of a target of 40) were tracked and interviewed. • The follow-up was facilitated by the involvement of the District Health Directors from the districts visited and the community health volunteers. • Recommendations from the exercise include: <ul style="list-style-type: none"> ○ Need to link post-operative fistula clients with nearby health facilities for continuous care ○ Clients need to receive information on where to access health services following surgery ○ Continue to increase community awareness for general public to explain the cause of fistula to promote acceptance in the community and families. ○ Link clients to traditional and civic leaders to facilitate Social Cash Transfers, given that majority are single, divorced and financially poor. 	Mulembwe, Daniel Mutale. Fistula Tracking Report, MoH, Luapula Province. 2018.
<p>Reintegration</p> <ul style="list-style-type: none"> • With regard to reintegration, the plan is to explore an avenue to collaborate with other ministries to address reintegration and social impact. The route to take is partnership with line ministries that have the capacity to help with re-integration. Ministry of Community Development and Social Welfare – has a unit that looks at social cash transfers. It begins with an assessment of vulnerable members of the community who can be helped with cash so that they can be stabilized. Social Welfare Officers in the district – it will help identify fistula clients/survivor and then support them to start-up businesses in the community. These women are vulnerable because they lost their marriages because of fistula. 	Interview, UNFPA Zambia national staff. August 2021.
<p>Fistula client perspectives</p> <ul style="list-style-type: none"> • A 26-year old fistula survivor (married) lived with fistula since 2010 following a C-section and the birth of a healthy baby when she was 15 years old. At Solwezi General Hospital. She leaked urine following the operation but said nothing about it until an ANC visit 	Interview, fistula survivor, Solwezi. September 2021

Assumption 4.2: MHTF and UNFPA, including through leadership of the Campaign to End Fistula, have engaged with national leadership, to enhance ownership and accountability in ways that build <u>health systems, and community capacity</u> at national and sub-national levels across prevention, access to quality rehabilitation and social reintegration of survivors	
<p>during her second pregnancy in 2012. She was sent to Monze for repair, but it was not successful. In 2017 she returned to Solwezi General Hospital for a second repair, but this was not successful either. Despite this, she felt well taken care of and was provided with support.</p> <ul style="list-style-type: none"> • “In the year 2018, the madam (nurse) phoned me to ask me if my problem had been repaired. I told her that it had not been completely repaired and I still had a little more fistula. She told me that I should prepare myself because the surgeon would be coming in November. When that time came, I went to the clinic from where I was picked and taken to Solwezi General Hospital. There, we stayed for fourteen days and together with others who had fistula, we were repaired. We were also looked after very well and were provided with everything. We were then discharged from hospital and told to have sex with our respective husbands for three weeks. Subsequently, my fistula was completely repaired, and I did not have the problem anymore. It took three operations to finally repair my fistula because the problem was very big. I really thank everyone that contributed to curing my problem. I am encouraging all those who have doubts that they should be strong and have belief that one day, they too will be okay.” • When asked about discrimination or stigma, the woman responded, “It was only in the home where I was staying where I was discriminated against. I was given my own plate to use and was told that I should not use the plates that everyone else used in the household because I would make them dirty. I also had my own plate, and I prepared my own food and ate alone; separate from the rest of the family.” 	
Assumption 4.3: MHTF is an effective platform to host the <u>Global Campaign to End Fistula</u>, enabling harmonisation of strategies, activities, advocacy and financing to deliver results on fistula more efficiently than either approach would alone	
Indicators <ul style="list-style-type: none"> • Examples of increased political commitment, national leadership and ownership and financial mobilization linked to campaign activities (i.e., International Day to End Fistula, 23 May) • Examples of improved knowledge sharing and collaboration among global campaign partners 	
Observations	Sources of evidence
<p>Increasing awareness through Campaign to End Fistula</p> <ul style="list-style-type: none"> • UNFPA Zambia developed a concept note for the Zambia News and Information Service (ZANIS) to increase awareness of fistula in Zambia. It highlighted the efforts of UNFPA and its partners to launch the Campaign to End Obstetric Fistula, now present in 50 countries and with 80 organizations collaborating at global level and hundreds more at national and local levels. • Key points made in the note include: <ul style="list-style-type: none"> ○ Zambia joined the campaign in 2003, but much remains to be done given the lack of access to EmONC services and referrals. ○ Only 5 out of 38 hospitals repair fistula on a routine basis for fewer than 200 patients a year. ○ UNFPA and partners have supported treatment of 1,786 fistula survivors since 2005 at static facilities and fistula camps. This year (unknown), five camps were conducted at St Fancis Mission Hospital, Chilonga Mission Hospital, Mansa General Hospital, St, Paul Mission Hospital, and Solwezi General Hospital for a total 163 fistula survivors. In addition, 38 fistula survivors have been repaired via routine services at Monze Mission Hospital and UTH. 	UNFPA, Zambia. Concept Note: Management of Obstetric Fistula in Zambia (prepared for Zambia news and Information Services.) Undated.

Assumption 4.3: MHTF is an effective platform to host the <u>Global Campaign to End Fistula</u>, enabling harmonisation of strategies, activities, advocacy and financing to deliver results on fistula more efficiently than either approach would alone	
<ul style="list-style-type: none"> ○ Data is not easily available, but it is estimated that there are “tens of thousands of fistula cases in Zambia and that over 2,000 fistula patients await surgery every year.” (p.1) 	
<p>International Day to End Obstetric Fistula</p> <ul style="list-style-type: none"> ● UNFPA Zambia supported the national commemoration of the International Day to Eliminate Obstetric Fistula and Safe Motherhood week in May 2019 to continue raising community awareness on the need for skilled deliveries to prevent obstetric fistula as well as for the available of fistula repair services in Luapula Province. In collaboration with Fistula Foundation who supplemented efforts through support for community awareness programmes, training of SMAGs, and tracking fistula survivors, 30 fistula survivors were tracked and 29 had repair surgery. 	UNFPA Zambia. MHTF2019 End of Year Annual Report. Undated.
<ul style="list-style-type: none"> ● The theme of the 2019 National Commemoration of Safe Motherhood Week held in May was “Universal Access to Sexual and Reproductive Health Services: Leaving No One Behind.” It was held in Mkushi District in Central Province at the Chibefwe Urban Clinic. The First Lady was a guest of honor and gave a speech on Donations of baby packs (from WHO) and dignity packs (from UNFPA) were distributed. ● Safe Motherhood Week was an opportunity to coordinate a range of activities, including: <ul style="list-style-type: none"> ○ Social mobilization through radio programmes on GBV, cervical and breast cancer, pregnancy complications and fistula, nutrition, adolescent SRH, voluntary male circumcision, newborn baby care and obstetric fistula. The radio programmes reached over 200,000 people. ○ Anti-GBV sensitization meetings in areas with high incidence of GBV according to police reports (Musofu, Itala and Kangili). These were led by two Victim Support Unit police officers and one health worker and covered such topics as causes and effects of GBV, the role of the community, early child marriage, children’s rights. A total of 2,1451 persons attended these sessions. ○ Training for Chiefs in safe motherhood. Five chiefs and 15 Chilolos and head men were also trained. ○ Training of SMAGs (n=20) on the importance of early antenatal booking and facility delivery. ○ Health service delivery, including family planning, breast and cervical cancer screening, HIV testing and a blood drive. ● Surgical operations done during Safe Motherhood Week: obstetric fistula repairs (n=13), tugal ligations from Mkushi and Luano Districts at the Mkushi District Hospital. 	Chisi, Mercy Mulwanda. Activity Report: National Safe Motherhood Week Commemoration, Chibefwe Urban Clinic, Mkushi District. 2019.
<ul style="list-style-type: none"> ● UNFPA staff consider the International Days of Fistula during Safe Motherhood Week to be a good way to raise visibility of fistula. However, they note that there is not a good way to track the outcomes related to this goal and whether it is worth the investment. “What are the outcomes we want to see from these days? An increase in the national budget? A shift in attitudes? An increase in the number of fistula clients? Cost-effectiveness is hard to determine.” It is not seen as costing a lot of money; however, the level of effort is high and there is an expectation that we follow the global lead from headquarters. 	Interview, UNFPA Zambia staff, Lusaka, August 2021.
<ul style="list-style-type: none"> ● “We would love to see increased activities in advocacy, including on special days as International Day to Commemorate Fistula.” UNFPA supports some advocacy activities through the media and through the organization itself. However, this year advocacy activities were reduced as a result of COVID-19, apart from a few programmes on TV and radio. UNFPA has also supported advocacy activities in the three provinces: Luapula, North-Western and Western and their respective communities through the sensitization of people on fistula. This is tied to when there is a fistula treatment camp. 	Interview, MoH service provider. Lusaka, Zambia. August 2021.

Assumption 4.3: MHTF is an effective platform to host the Global Campaign to End Fistula, enabling harmonisation of strategies, activities, advocacy and financing to deliver results on fistula more efficiently than either approach would alone

- **Advocacy is also done through the Safe Motherhood Technical Working Group**, which is chaired by the MoH and which UNFPA is part of. Fistula is one of the issues that are discussed during these meetings.

Area of Investigation 5: Integrated SRHR

Evaluation Question 5: To what extent has the MHTF contributed to strengthened integration between maternal health and sexual and reproductive health (with a focus on family planning, post-partum family planning, post-abortion care and safe abortion care (where legal); cervical cancer prevention; preventing mother-to-child transmission of HIV (PMTCT), and SGBV to achieve quality service delivery, to increase client satisfaction and to stimulate greater public demand for SRHR services?

- How and to what extent has UNFPA advocacy for strengthened integration between maternal health and SRHR resulted in adoption within various strategies and initiatives at global, regional and national level?
- To what extent have UNFPA-supported models and approaches for linking MNH and SRHR been implemented at national level within health service delivery settings (supply) and behaviour change and communication efforts (demand)?
- To what extent has UNFPA supported integrated programming and synergies within MHTF (across the four core technical areas) and with other UNFPA technical areas (UNFPA Supplies, SRHR, Gender, Youth, etc.)?

Evaluation Criteria	<i>Relevance, effectiveness, efficiency, coordination</i>
Rationale	In order to support women and adolescent girls across their lifespan, there needs to be in place a continuum care from sexual and reproductive health through to pregnancy and the postnatal period and wellness across all stages. Women and newborns are at the highest risk of death and morbidity during labour, childbirth and in the first week after birth. The MHTF aims to support countries to address the “three delays” in accessing quality maternity care and improving the post-partum or post-abortion period. The MHTF supports countries to strengthen access to and the quality of antenatal care, with special attention to adolescent girls and youths. The antenatal care package includes essential sexual and reproductive health information and services, such as for the prevention of unsafe abortion, access to safe abortion (where legal) and the prevention of mother-to-child transmission of HIV.

Assumption 5.1: UNFPA is active in advocacy for the full integration of SRHR and MNH into health systems, national strategies including UHC and other platforms and for initiatives that strengthen linkages between MNH and SRHR within global, regional, and national strategies and plans

Indicators

- MNH services integrated into PHC and UHC protocols, approaches, Global Financing Facility (GFF) investment cases and SDG3 GAP process, where applicable
- Examples of MHTF leadership for ensuring global and regional attention to MNH-SRHR integration within global initiatives, (such the Global Strategy for Women’s Children’s and Adolescents’ Health, the ICPD 25 Nairobi business, and the SDG 3GAP process)
- GFF investment cases (where applicable) include a full complement of SRHR and MNH services.
- Activities in countries linked to the Global Action Plan initiative

Assumption 5.1: UNFPA is active in advocacy for the full integration of SRHR and MNH into health systems, national strategies including UHC and other platforms and for initiatives that strengthen linkages between MNH and SRHR within global, regional, and national strategies and plans	
<ul style="list-style-type: none"> National health sector strategies and plans incorporate linkages and integration of MNH and SRHR, including post-partum contraception, postabortion care, safe abortion care (where legal), cervical cancer prevention, PMTCT) Views of partners and stakeholders on the role of UNFPA leadership on progress toward integration with global, regional, and national strategies and plans. 	
Observations	Sources of evidence
<p>Government of Zambia emphasizes integrated approach to RMNCAH&N</p> <ul style="list-style-type: none"> The RMNCAH&N roadmap has been developed to accelerate actions to help meet the targets of the National Health Strategic Plan 2017-2021, which calls for a focus on the provision of a continuum of care with particular emphasis placed on the strengthening of health systems and services using the primary health care approach. The road map also supports the achievement of the Sustainable Development Goals. It identifies key challenges with respect to achieving the targets set forth within, namely: <ul style="list-style-type: none"> Inequities in the distribution of services between urban and rural areas, Low ratio of skilled providers in relation to population Inadequate service delivery infrastructure Weaknesses in the RMNCAH&N supply chain Inadequate community involvement for RMNCAH&N activities Weak quality assurance systems. 	MoH, Zambia. Reproductive, Maternal, Neonatal, Child, Adolescent Health and Nutrition Roadmap, 2018-2021. 2019.
<ul style="list-style-type: none"> UNFPA supported the revision of the National Guidelines for SRHR, HIV and SGBV Service Integration developed in 2013 to take into account the SADC SRHR strategy. Further, a Training Manual for Service Providers in SRHR, HIV and SGBV service integration was developed as part of efforts to scale up quality integration of services. The manual will enable service providers understand the importance and implementation process of the SRHR/HIV/SGBV service integration guidelines at health facility and community service delivery points. With UNFPA support to MoH, a Comprehensive Package of Adolescent Health Services and Standards for health care providers was developed. This package is pivotal in standardizing the provision of quality adolescent friendly health services in the country. 	UNFPA Zambia. 2019 Annual Report. 2020
<p>Alignment of Midwifery Curriculum to integration approach</p> <ul style="list-style-type: none"> “Through UNFPA technical and financial contribution to MoH, the midwifery curriculum was revised in order to be aligned to international standards and incorporate emerging issues such as GBV, adolescent health and people living with disabilities, aimed at improving the quality of midwifery training and provision of quality Sexual Reproductive Health (SRH) services. In addition, Respectful Maternity Care Guidelines were adapted to foster quality of care during pregnancy and childbirth. Further, within the context of advancing equity and leaving no one behind, a disability inclusion module for pre-and in- service training of health care providers was developed, and selected information, education and communication materials developed in Braille to facilitate provision of SRH information to persons with visual impairment. UNFPA supported the revision of the National Guidelines for SRHR, HIV and SGBV Service Integration developed in 2013 to take into account the SADC SRHR strategy. Further, a Training Manual for Service Providers in SRHR, HIV and SGBV service integration was developed as part of efforts to scale up quality integration of services. The manual will enable service providers understand 	UNFPA Zambia. 2019 Annual Report. 2020.

Assumption 5.1: UNFPA is active in advocacy for the full integration of SRHR and MNH into health systems, national strategies including UHC and other platforms and for initiatives that strengthen linkages between MNH and SRHR within global, regional, and national strategies and plans	
<p>the importance and implementation process of the SRHR/HIV/SGBV service integration guidelines at health facility and community service delivery points.</p> <ul style="list-style-type: none"> • With UNFPA support to MoH, a Comprehensive Package of Adolescent Health Services and Standards for health care providers was developed. This package is pivotal in standardizing the provision of quality adolescent friendly health services in the country. • In addition, capacity of 345 health care workers to provide adolescent friendly integrated SRH/HIV/GBV services was enhanced. As result, about 85, 726 young people accessed adolescent and youth friendly integrated SRH services in 161 public health facilities. This was augmented by trained peer educators and counsellors who established adolescent friendly spaces and undertook community outreach services such as condom distribution and provided referral services.” (p.2) 	
<p>Integration as strategy to leverage resources/create linkages:</p> <ul style="list-style-type: none"> • Integration has allowed the Zambia CO to leverage resources from many programmes – “enables us to stop thinking about clients are a programme (family planning, MNH, HIV). Promotes client-centred perspectives in service delivery.” • UNFPA is very involved in PFPF as well as PAC where one of the key elements emphasized is being able to provide counselling for women who come through both PAC and CAC. UNFPA just started a collaboration with Global Fund to look at ways to champion integration. “For example, when we look at maternal health component, one of the key areas is teenage pregnancy. When you look at HIV – the highest level of incidence is happening in youth (19-24). When you look at both sides of the coin, we have a common denominator being adversely affected. If we are to develop message and programmes in young adults. Age bands that access a lot of abortion care – dealing with the same team. Currently have funding from DFID, specifically family planning and ASRH. Some of the key activities – integration of FP and CAC. Resources that come from UK and resources from Swedes (Together for SRHR) and also have a programme that is running through the regional office – ACCESS Project (CAC). Key things that resonate in all these programmes is integration.” 	Interview, UNFPA Zambia national staff. August 2021.
<p>UNFPA CO perspectives on integration</p> <ul style="list-style-type: none"> • “Integration is a key programme component for UNFPA, guided by our three transformative results. We have managed to plan for all our programmes in an integrated manner. Even when you are working on FP you will find components of MHTF. Because we know that these things are integrated. Early and child marriage and GBV, contribute to fistula. If you address these norms you are trying to address fistula. Everything is just so integrated in terms of advancing the ICPD agenda. We see the 4 components are supporting the transformative results.” 	Interview, UNFPA Zambia national staff. August 2021.
<ul style="list-style-type: none"> • Implementing integrated SRH service delivery is often through a “patchwork” of resources. It is a challenge to coordinate the funds and timing of resources. “We will use the MHTF to train a midwife who is going to work in the CAC room, and the ACCESS project will procure the MVA kits. You have trained the midwife, but you do not get the kits from ACCESS. Resource envelope is a challenge to coordinate all the inputs.” 	Interview, UNFPA Zambia national staff. August 2021.
<ul style="list-style-type: none"> • “When we talk about integration, the way services are structured, there is integration.” We had instances where there was a supermarket model, women walk in that clinic should be able to get all the services. ANC, HIV screening, FP. But the model does not work because of staff shortages. Facilities segment services – Monday is for FP, Tuesday for Child health, etc. In principle it is there, MoH wants to see. But depends on locations.” 	Interview, UNFPA Zambia national staff. August 2021.

Assumption 5.1: UNFPA is active in advocacy for the full integration of SRHR and MNH into health systems, national strategies including UHC and other platforms and for initiatives that strengthen linkages between MNH and SRHR within global, regional, and national strategies and plans	
<ul style="list-style-type: none"> • There are several different actors supporting RMNCAH&N services in North-Western Province, including UNFPA, UNICEF, the Global Fund, USAID (Global Health Supply Chain, Procurement and Management project), AIDS FREE, Marie Stopes (family planning in hard-to-reach areas), IPAS (CAC), Discover Health (family planning, cervical cancer screening, PMTCT). • UNFPA support has been for EmONC, fistula camps, supply chain management (Electronic LMS), training of community-based distributors for family planning, training and mentorship in long-acting reversible contraception, and “complete training for IRH” (Integrated Reproductive Health). • UNFPA is one of the partners that provides financial resources directly to the provincial account which increases the percentage of the provincial budget devoted to RMNCAH&N services from 10% to 25%. This enables the province to support 100% of the districts in the province. 	<p>Interview, MoH staff, North-Western Province, Zambia. September 2021</p>
<ul style="list-style-type: none"> • At sub-national level, in the 8CP UNFPA has supported selected districts in seven provinces out of 1070 to strengthen SRH systems and services. This includes: on-going support for integrated and strengthened SRH, HIV and GBV services, and for adolescent friendly health services in three provinces (Luapula, North-Western and Western), where UNFPA has sub-offices; joint DfID/UN support for Central and Western Provinces as part of GRZ health systems strengthening (HSS) through a joint UN RMNCAH&N programme; a UNFPA-UNICEF joint programme to end child marriage in Eastern Province; and a GRZ, EU, UN joint Millennium Development Goals Initiative (MDGi) in the Copperbelt and Lusaka Province. (p. 15)- • The SRH focus of UNFPA is fully aligned and responsive to the priority needs of GRZ, building on commitments and support from previous CPs and new policies and guidelines in the 8CP. These include UNFPA technical and/or financial contributions to the National Health Strategic Plan 2017-2021, National HIV and AIDS Strategic Framework 2017-2021, the Road Map for HIV Prevention 2017-2021 and its indicator and target framework, and National Guidelines for Sexual and Reproductive Health, HIV and GBV Services Integration 2015 among many others. (p.21) • UNFPA has built human capacity and resources for integrated facilities in the selected districts within North-Western Province, Luapula and Western Province, with staff trained for SRHR and HIV, adolescent friendly services, and counselling for survivors of GBV (predominantly intimate partner violence, IPV). UNFPA has also strengthened capacity among health providers for a gender focus and to address gender based violence. Adolescent SRH services include setting aside specific sessions for adolescents and establishing adolescent corners. Health provider awareness and support for people with disabilities in accessing SRH services has also been raised, although this needs further development. • The model integrated sites provide antenatal care and facility based delivery, basic EmONC services, comprehensive family planning, HIV counselling and testing, and antiretrovirals for pre-exposure prophylaxis and treatment. However, the quality and upkeep of facilities, the responsibility of government, is poor (site observation) and not conducive to the optimal provision of integrated service provision. <ul style="list-style-type: none"> ○ At one site post-natal mothers were being discharged only six hours after delivery if no complications were apparent (key informant group interview), on the grounds that there were not enough beds to keep them longer. ○ In one hospital, the condition of the antenatal ward was so poor that the women had to be moved elsewhere (site observation and key informant interviews). Privacy is also sometimes compromised by the lack of space, not just regarding beds but also with regards HIV testing and counselling. The extent to which clients need to queue separately to address different SRH needs appears to vary between sites (key informant interviews and observation). 	<p>UNFPA. UNFPA 8th Country Programme Evaluation: Zambia 2016 – mid-2019. 2019.</p>

Assumption 5.1: UNFPA is active in advocacy for the full integration of SRHR and MNH into health systems, national strategies including UHC and other platforms and for initiatives that strengthen linkages between MNH and SRHR within global, regional, and national strategies and plans	
<ul style="list-style-type: none"> • Building on the Linkages Project and the joint GBV programme, a three-year joint regional programme “2gether for SRH” commenced in 2018. Under this programme, UNFPA is further developing comprehensive integrated SRHR/HIV/SGBV services in conjunction with the MoH and other stakeholders. The support from UNFPA included the development of guidelines on effective linkage, oversight and management, and GRZ is reported to have started mentoring service providers on using the guidelines to assure integrated services at all levels of care from health posts, rural and urban clinics, to district and provincial hospitals. (p.29) 	
Assumption 5.2: Evidence-based models and approaches to support programming for integrated MNH and SRHR service delivery promoted by UNFPA are adopted and implemented by national authorities for both supply of and demand for services	
Indicators	
<ul style="list-style-type: none"> • National health authorities confirm adoption/adaptation of evidence-based models and approaches for integration of MNH and SRHR, including but not limited to PFPF, PAC, safe abortion services – (where legal), PMTCT • Operational guidelines for health services staff include protocols for integration of MNH and SRHR information, services and referrals • Reported results from UNFPA-supported programmatic interventions to pilot, adapt, or scale-up integration models and approaches (PFPF, PAC, PMTCT, etc.) • Reported results from efforts to expand antenatal care package for essential SRHR information and services for adolescent girls and youth • Reported experiences and views of selected national health authorities and implementing partners on progress and challenges related to integration of MNH and SRHR. 	
Observations	Sources of evidence
<p>UNFPA support for quality SRHR/HIV/SGBV services (non-MHTF-funded)</p> <ul style="list-style-type: none"> • Four UN agencies (UNAIDS, UNFPA, UNICEF and WHO) are supporting the MoH to strengthen in the integration and scale-up of quality, integrated SRHR/HIV/SGBV services, with a focus on adolescent girls, young people and key populations. The goal is to reduce unintended pregnancies, STIS, new HIV infections, maternal and neonatal mortality and SGBV. Other partners supporting activities in Central Province include JSI, Marie Stopes, and others. • UNFPA supported the MoH to monitor integration of SRHR/HIV/SGBV services in the Central Province within mentorship activities. The objectives of this review were to 1) assess the level of knowledge with regard to integration, identify knowledge gaps in service provision; and 30 provide mentorship in areas that need improvement. Sites visited included Kabwe and Kapiri Mposhi Districts. It was found that integration of services exists, although SGBV services remain a challenge. • Recommendations from this review included: <ul style="list-style-type: none"> ○ Strengthen Provincial Health Office to support integration and coordination of activities ○ Conduct more facility orientations/clinical meetings ○ Develop indicators for GBV to capture data at all levels of service ○ Train more staff in CAC ○ Ensure availability of FP commodities. 	<p>Mushukulumbwe, S. Activity/Trip Report: TSS on SGBV Services in Central Province. 2020.</p>
<ul style="list-style-type: none"> • UNFPA, UNAIDS, UNICEF and WHO provided technical leadership and financial support for the development and pre-testing of a training manual for service providers in SRHR, HIV, SGBV services integration. The target group is health care providers at health facility level and community volunteers such as mentor mothers, SMAGS, TB supporters, adherence supporters, SGBV agents, legal support personnel and policy makers and managers. 	<p>Government of the Republic of Zambia. SRHR, HIV and SGBV Service Integration</p>

Assumption 5.2: Evidence-based models and approaches to support programming for integrated MNH and SRHR service delivery promoted by UNFPA are adopted and implemented by national authorities for both supply of and demand for services	
<ul style="list-style-type: none"> • “The manual is a collection of adapted/adopted information from the Zambia National Guidelines for SRHR/HIV/SGBV Service Integration, Adolescent Job Aid: A handy Desk Reference Tool for Primary Level Health Worker, WHO 2010, WHO orientation programme on Adolescent Health for Health Care Providers: Facilitator Guided and the Open University, Adolescent and Youth Reproductive Health, the National Gender training manual for Zambia and several other documents as referenced. The manual provides the facilitators and participants an opportunity to engage in in-depth discussions and reflections around SRHR/HIV/SGBV service integration information and take steps to practice integration skills at community, health facility and policy level. (p.4) • The overall purpose of the training is to enable service providers understand the importance and implementation process of the SRHR/HIV/SGBV services integration guidelines at health facility and community service delivery points.” (p. 4) • The manual includes four modules with corresponding sessions: <ul style="list-style-type: none"> ○ Module 1: Introductory and Guiding Principles ○ Module 2: Background information ○ Module 3: Integration of SRHR, HIV and SGBV Services at different service points ○ Module 4: Monitoring and Evaluation 	Training Manual for Health Care Providers. 2019.
<ul style="list-style-type: none"> • Although cervical cancer screening was initiated in 2006 and the HPV vaccine was piloted in 2013 in Zambia, cervical cancer remains the leading cancer in the country. Cervical cancer prevention clinics are operational in all provinces. In 2019 UNFPA supported the MoH to hold a ten-day, facility-based training of trainers for cervical cancer and treatment at Chawama, Kanyama and Chelstone clinics in Lusaka. • The main objective was to increase knowledge and skills of participants to increase capacity to screen and treat cancer patients, as well as to train others. 	Chizuni, Caren. Activity/Trip Report: Facility-Based Training of Trainers in Cervical Cancer Screening. 2019.
<p>UNFPA leadership and support for PFPF:</p> <ul style="list-style-type: none"> • MHTF does not fund PFPF per se; however, we promote it. It is a very good entry point for the next MHTF programme. “If the MHTF can supplement with FP would be very happy as it would be supporting the capacity of the same MW. It is the MW who does those things. Would be very helpful. Building capacity in the same MW. Ensure that she can do all the things FP, MPDSR, EmONC – part of an integrated approach.” 	Interview, UNFPA Zambia staff. August 2021.
<ul style="list-style-type: none"> • “We want UNFPA to take PFPF to the next the level: They are involved in training of midwives, and they are the ones that tend to deliveries, ANC sessions, etc. They are the same that attend to these women that are bringing babies to vaccinations. They can build capacity in that area and be sure that they are providing these services; implement and monitor to bring Zambia on the map to say that we did this. To mainstream PFPF, UNFPA is key.” • Clinton Health Access Initiative has trained providers on LARCs, on PFPF. All members of the FP technical WG promote PFPF with the MoH as the lead. PFPF is a priority – one of the requirements for FP2030 commitment. Zambia is currently developing the FP2030 country commitment. “FP2030 has indicated they would like to see Zambia to focus on PFPF. Big opportunity to coming up as Zambia is going through the process for submission.” 	Interview, International NGO staff, Lusaka, Zambia. August 2021
MoH perspectives on integration	Interview, MoH Zambia national staff. August 2021.

Assumption 5.2: Evidence-based models and approaches to support programming for integrated MNH and SRHR service delivery promoted by UNFPA are adopted and implemented by national authorities for both supply of and demand for services	
<ul style="list-style-type: none"> • “Our trainings are also integrated. This means that during ANC, a woman should be aware of family planning and her intentions before delivery or even before she gets pregnant. There is sensitisation of communities on the importance of family planning which should start way back before a woman comes to the health facility. In North-Western province we have a “champion” (traditional chief) supported by UNFPA who has supported maternal health and family planning [in the chiefdom], sensitising people on the importance of family planning and importance of seeking early antenatal care. We have seen that people have confidence in their traditional leaders; their champion, who is their traditional leader; their chief. And during trainings we integrate family planning so that it should be discussed at any point of maternal or reproductive health.” 	
<ul style="list-style-type: none"> • UNFPA supports integration of FP through access to commodities. “They have made sure that there are at least 5 methods of family planning in every facility. They have ensured that family planning services are of high quality. They have also helped to train community based distributors (CBDs). Women do not have to walk long distances to access family planning services. UNFPA helped us to recruit retired midwives to ensure that we have enough personnel to address the problem of shortage of midwives. Up to last month we had 23 retired midwives who were recruited.” 	Interview, MoH staff. Western Province, Zambia. August 2021.
<p>NGO perspectives on integration</p> <ul style="list-style-type: none"> • JHPIEGO has done a lot of work on integration of family planning and maternal health, e.g., revised the FP register to include PFP. These days, all advocate for integrated services. Within MoH there is a task force looking at integration of FP into HIV. There was a meeting yesterday, brought about because of the ECHO results, to work towards increasing women’s access to other services, including FP. “What we are working on – whichever entry point a woman is seeking services, they should integrate FP or HIV or other services. Not sure about UNFPA leadership. They are a member of the Safe Motherhood technical working group, and UNFPA is also represented on the FP technical working group. They are key on supply chain. The other issues they discuss on the safe motherhood. The Task force is part of the HIV and family planning technical working groups (TWGs). These two are integrated, so that as we plan our activities, we should also plan for integration.” 	Interview, International NGO staff. Lusaka, Zambia. August 2021.
<p>Partner perspectives on UNFPA leadership on integration</p> <ul style="list-style-type: none"> • UNFPA has done its homework and helped to define a package of support for a joint programme. “UNFPA makes sure donors understood – adolescent health and SRHR, issues of respected maternity care. They defined a package, if you want us to intervene (central and Western province, this is the package. UNICEF came with a complimentary package with child health. They were convincing and we see their influence. There was enough strategic thinking so that the donors listened and saw a logical approach to linking everything together to advance maternal health. Unfortunately, UK discontinued funding for this kind of comprehensive programming.” 	Interview, Multilateral organization national staff. August 2021.
<p>Non-MHTF funded project on integrated SRH and MNH services.</p> <ul style="list-style-type: none"> • Under this project, UNFPA has contracted MSZ (Marie Stopes-Zambia) to conduct trainings in adolescent friendly SRH service delivery, trainings in safe abortion delivery, trainings in comprehensive and cost abortion care, including oral abortion family planning, and tubal ligation under local anaesthesia. Other activities include strengthening of the health system quantification for commodities, commodity management, data collection and data management and trying out some key innovations. 	Interview, National NGO staff. Zambia. August

Assumption 5.2: Evidence-based models and approaches to support programming for integrated MNH and SRHR service delivery promoted by UNFPA are adopted and implemented by national authorities for both supply of and demand for services	
<ul style="list-style-type: none"> • “We are an implementing partner in this partnership. UNFPA funds us to carry out key activities set out in the broader pragmatic document to help meet their broader maternal and newborn health targets. In areas where core focuses intersect, we are able to produce key activities and once approved by UNFPA, we are then responsible for the actual implementation.” • One of the key components of the partnership is innovation. The idea being tried out is the use of video cards to help improve information dissemination among CBDs. You know that CBDs are a key component of both information and service in the communities, not only are they responsible for trying to create demand for services on contraceptives, they are also responsible for delivery of some of those services. • “It’s very rare that a funding partner allows innovation because most projects are very quantity result-oriented. What is unique about this project is that we have been allowed to experiment with new innovations regardless of the results. They have allowed us to take a risk so that we see whether this can be the future of SRH in Zambia. I think that takes a lot of courage on the part of the donor, or on the part of our partnership with UNFPA.” 	
<p>Activities on integration: Midwifery Curriculum, capacity building</p> <ul style="list-style-type: none"> • “Through UNFPA technical and financial contribution to MoH, the midwifery curriculum was revised in order to be aligned to international standards and incorporate emerging issues such as GBV, adolescent health and people living with disabilities, aimed at improving the quality of midwifery training and provision of quality SRH services. • In addition, Respectful Maternity Care Guidelines were adapted to foster quality of care during pregnancy and childbirth. Further, within the context of advancing equity and leaving no one behind, a disability inclusion module for pre-and in- service training of health care providers was developed, and selected IEC materials developed in Braille to facilitate provision of SRH information to persons with visual impairment. • In addition, capacity of 345 health care workers to provide adolescent friendly integrated SRH/HIV/GBV services was enhanced. As result, about 85,726 young people accessed adolescent and youth friendly integrated SRH services in 161 public health facilities. This was augmented by trained peer educators and counsellors who established adolescent friendly spaces and undertook community outreach services such as condom distribution and provided referral services.” 	UNFPA Zambia. 2019 Annual Report. 2020, p.2
<p>Integration as strategy to leverage resources/create linkages:</p> <ul style="list-style-type: none"> • Integration has allowed the Zambia CO to leverage resources from many programmes – “enables us to stop thinking about clients are a programme (family planning, MNH, HIV). Promotes client-centred perspectives in service delivery.” • UNFPA is very involved in PFPF as well as PAC where one of the key elements emphasized is being able to provide counselling for women who come through both PAC and CAC. UNFPA just started a collaboration with Global Fund to look at ways to champion integration. “For example, when we look at maternal health component, one of the key areas is teenage pregnancy. When you look at HIV – the highest level of incidence is happening in youth (19-24). When you look at both sides of the coin, we have a common denominator being adversely affected. If we are to develop message and programmes in young adults. Age bands that access a lot of abortion care – dealing with the same team. Currently have funding from DFID, specifically family planning and ASRH. Some of the key activities – integration of family planning and CAC. Resources that come from UK and resources from Swedes (Together for SRHR) and also have a programme that is running through the RO – ACCESS Project (CAC). Key things that resonate in all these programmes is integration.” 	Interview, UNFPA Zambia national staff. August 2021

Assumption 5.2: Evidence-based models and approaches to support programming for integrated MNH and SRHR service delivery promoted by UNFPA are adopted and implemented by national authorities for both supply of and demand for services	
<p>Challenge Implementing integrated SRH service delivery is often through a “patchwork” of resources. It is a challenge to coordinate the funds and timing of resources. “We will use the MHTF to train a midwife who is going to work in the CAC room, and the ACCESS project will procure the MVA kits. You have trained the midwife, but you do not get the kits from ACCESS. Resource envelope is a challenge to coordinate all the inputs.”</p>	Interview, UNFPA Zambia national staff. August 2021
<p>“When we talk about integration, the way services are structured, there is integration.” We had instances where there was a supermarket model, women walk in that clinic should be able to get all the services. ANC, HIV screening, family planning. But the model does not work because of staff shortages. Facilities segment services – Monday is for family planning, Tuesday for Child health, etc. In principle it is there, MoH wants to see. But depends on locations.”</p>	Interview, UNFPA Zambia national staff. August 2021
<p>MHTF does not fund PFP per se; however, we promote it. It is a very good entry point for the next MHTF programme. “If the MHTF can supplement with family planning would be very happy as it would be supporting the capacity of the same midwife. It is the midwife who does those things. Would be very helpful. Building capacity in the same midwife. Ensure that she can do all the things family planning, MPDSR, EmONC – part of an integrated approach.”</p>	Interview, UNFPA Zambia staff. August 2021
Assumption 5.3: The MHTF was an effective programme to shape the overall strategic direction of UNFPA in relation to the integration of SRHR and MNH and has acted as a catalyst within UNFPA to build commitment to SRHR – MNH integration as a vital strategy	
<p>Indicators</p> <ul style="list-style-type: none"> • Evolution over time of coordination mechanisms within MHTF for ensuring linkages in programming and outcomes across the four technical areas, i.e., fistula, EmONC, midwifery and MPDSR • Structure and operation of coordination mechanisms at global, regional, and country level within UNFPA for ensuring linkages between MHTF and other areas of work, i.e., SRHR/the Supplies Partnership, SGBV/ gender, adolescents, and youth etc. 	
Observations	Sources of evidence
<ul style="list-style-type: none"> • The CO wanted to introduce the First Time Young Mothers Model for preventing teenage pregnancy; however, the MoH was not keen at that time to have a standalone programme. It felt that young mothers were adequately taken care of by existing programmes. 	Interview, UNFPA Zambia staff. August 2021.
<ul style="list-style-type: none"> • UNFPA Zambia used to receive UNFPA Supplies funds for supporting family planning-specific activities, training, and commodities. The same midwives supported by MHTF supported family planning trainings, as midwives at health centres are conducting ANC, deliveries, and FP. “Integration is a transformational goal for UNFPA. Prevention of maternal deaths comes in with the use of family planning. We integrate family planning in maternal health component. Used to have funds as but it is not seen as a one stream. We do not use the MHTF funds for family planning, but the funds are given to the provider/who does it all.” 	Interview, UNFPA Zambia staff. August 2021.

Area of Investigation 6: Equitable and accountable access	
Evaluation Question 6: To what extent has the MHTF contributed to strengthening the availability and quality of health service delivery and health information system to meet the diverse and differentiated needs of the women, newborns, and adolescent girls including in the lowest wealth quintiles, living in hard-to-reach areas, facing discrimination (based on identity, ethnicity, and/or faith) and/or living with disabilities?	
Sub-questions:	
<p>a) To what extent has UNFPA been effective in promoting and supporting national strategies and programmes, which consider the diverse and differentiated needs of women, newborns, and adolescent girls, including the most vulnerable and disadvantaged?</p> <p>b) To what extent have national governments responded positively to UNFPA advocacy and technical support by allocating resources, altering policies, and implementing programmes that strengthen the supply and demand sides of care, ensure equitable and accountable access to quality MNH and SRHR services and that meet the needs of and empower women and adolescent girls?</p> <p>c) Have UNFPA-supported programmes have been effective in increasing the availability and utilization of MNH and SRHR services to women, adolescents, and newborns, including the most vulnerable and disadvantaged?</p>	
Evaluation Criteria	<i>Relevance, effectiveness, sustainability</i>
Rationale	Globally, maternal mortality is the second largest cause of deaths among adolescent girls aged 15 to 19. Of all births globally each year, around 16 million (11 per cent) are among girls in this age range; about 2 million are among girls under the age of 15 ¹⁹ . Stigma, discrimination, judgmental treatment, lack of confidentiality, and inability to physically access services are important barriers to care for adolescent girls. The MHTF supports countries to improve access among adolescent girls to broader sexual and reproductive health services. Further, poor women in rural and urban areas and minority women have less access to quality maternal health care than wealthier women in urban areas. The MHTF supports their equitable access to MNH care and broader SRHR.
Assumption 6.1: UNFPA promotes and supports national strategies and programmes which consider the diverse and differentiated needs of women, newborns and adolescent girls, including the most vulnerable and disadvantaged	
Indicators	
<ul style="list-style-type: none"> National strategies and plans support programmes and approaches that promote, assess, and address the differentiated needs of women, newborns and adolescent girls, including the most vulnerable and disadvantaged National official statements regarding the protection of the rights of women and girls and “leaving no one behind” 	
Observations	Sources of Evidence
Disability inclusion	UNFPA, Zambia. 2019 Annual Report. 2020
<ul style="list-style-type: none"> “Close collaboration with the Zambia Library for Persons with Visual Impairment led to effective mainstreaming of disability into the country programme. Going forward the CO will leverage and maximise on this to advance availability of and access to relevant SRH communication material to persons with visual impairment.” (p. 3) 	
<ul style="list-style-type: none"> UNFPA provided technical and financial support to the MoH to finalize and disseminate its first RMNCAH&N Communications and Advocacy Strategy geared to increase coverage and utilization of RMNCAH&N services. 	UNFPA, Zambia. 2018 Annual Report. 2019.

¹⁹ UNFPA (2017). Maternal and Newborn Health Thematic Fund – phase III Business Plan, p. 18

Assumption 6.1: UNFPA promotes and supports national strategies and programmes which consider the diverse and differentiated needs of women, newborns and adolescent girls, including the most vulnerable and disadvantaged	
<ul style="list-style-type: none"> • A disability inclusion module for pre-and in-service training of healthcare providers was developed. Selected information, education and communication materials were developed in Braille to facilitate provision of SRH information to persons with visual impairment. 	UNFPA, Zambia. 2019 Annual Report. 2020.
<p>Addressing teen pregnancy and early marriage</p> <ul style="list-style-type: none"> • UNFPA developed two concept notes designed to address issues related to teen pregnancy and child marriage: <ul style="list-style-type: none"> ○ UNFPA Zambia and Restless Development: Research to gather evidence on the phenomenon of child marriage, teenage pregnancies and SGBV looking at the causality links between teenage pregnancies, early marriage and socio-cultural norms; decision-making pathways leading to teenage pregnancies and child marriage; bottlenecks to preventing teenage pregnancies and child marriage, especially in relation to SGBV. ○ UNFPA Zambia proposed a multi-sector approach to increase access to and retention in education; strengthen the health system’s capacity to reach out to adolescents for sexual and reproductive health services; regulate through formal and customary legal systems the age of marriage; utilize community-based counselling to identify and respond to vulnerabilities and risks; and strengthen formal and informal community support structures to challenge social norms. It would support the implementation of the national strategy to end child marriage through a joined up multi-sectoral approach in 15 districts. The funds would provide specific support to strengthening the quality of services provided and the linkages between the sectors in tackling multiple deprivations facing vulnerable children and their families which lead to child marriage. • [The status of these concept notes is unknown.] 	<p>UNFPA Zambia and Restless Development. Concept Note: Teenage pregnancy and child marriage research in Zambia – Decision-making pathways and influence of GBV on ASRH outcomes. December 2019.</p> <p>UNFPA Zambia. Our Future, Our Choice: Transforming the lives of adolescents in Zambia. Draft Concept Note. September 2020.</p>
<ul style="list-style-type: none"> • “The data on teenage pregnancy is not good; it has remained the same at 28-29%. And we know that these young girls who are getting pregnant are more likely to develop complications, they are more likely to drop out of school. It’s a ripple situation that comes out from teenage pregnancy.” 	Interview, MoH Zambia national staff/ August 2021.
<ul style="list-style-type: none"> • UNFPA has supported adolescent sexual reproductive health issues and helped to scale up. They laid a foundation for other organisations that are coming in now, to work in already existing spaces. “UNFPA laid the foundation through the training of this huge number of skilled health care providers. That was a gain for the district. Even the recent project that is still running under Population Council to do with CSE (Comprehensive Sexuality Education) and Linkages; the funding comes from them (UNFPA). We have gained when it comes to adolescent sexual reproductive health because we have scaled up. In relation to maternal and sexual and reproductive health, there has been capacity building among our own peer educators and health care providers. They (UNFPA) have sharpened our knowledge and skills through mentorship regarding Long Term Family Planning. They engaged Ministry of Education to try and reduce the number of teen pregnancies in our district; they trained the teachers and the nurses. They also helped us to open those spaces so that adolescents in schools are taught and can be able to access Sexual Reproductive Health Services in our facilities.” 	Interview, MoH staff, Solwezi District, North-Western Province, Zambia. September 2021.
<ul style="list-style-type: none"> • UNFPA has established youth friendly corners (spaces) in three districts. UNFPA has also engaged Indaba Chief, i.e., involvement of Chiefs in maternal health services where the chiefs have also been empowered. UNFPA has helped to go beyond MoH to Ministry of Education. “We have seen the collaboration which UNFPA has brought, when you look at these other partners, they are only in the MoH most of them, I think maybe 95 % are just in the MoH but when you look at UNFPA, we have gone into 	Interview, MoH staff, North-Western Province, Zambia. September 2021.

Assumption 6.1: UNFPA promotes and supports national strategies and programmes which consider the diverse and differentiated needs of women, newborns and adolescent girls, including the most vulnerable and disadvantaged	
Ministry of Chief and Traditional Affairs which has been aligned somewhere where we have seen working with the structure at the community level. That's what we call Traditional Governance Structure."	
<ul style="list-style-type: none"> • "The multisectoral MPDSR had kind of alerted everybody to rise to the challenge that they do their part in terms of maternal health, anything to do with anything that will do with occurrence of maternal death each of the different stakeholders have taken their role and they want to ensure that they do their job so that we end up with the positive outcome for the maternal health issues.... for instance the Ministry of Community Development were now talking about women empowerment because we realise that sometimes what may cause a woman not to come is not having resources for them to come and say now I have this challenge if my husband does not have resources with the little money I have saved I will be able to move from my home and be able to seek the next facility to seek the service. So now they are looking at taking up into looking at the village banking issues right there at the community level so that women can have resources where they can be able to be empowered and make decisions, to have their own resources and able to buy food or prepare for a referral or something like that so this is the value that I think UNFPA has brought to the different stakeholders in family planning and adolescent reproductive health and improve or bear the outcome in the life of a woman and a girl child." 	Interview, MoH staff, North-Western Province, Zambia. September 2021.
<ul style="list-style-type: none"> • Expected output areas include integrated SRH, HIV and GBV services, supply chain management, adolescent and youth skills and capabilities for a total of USD 284,955. • The budget includes USD 90,000 (ZZT05) and USD 25,500 (ZZT06) 	UNFPA Zambia. Provincial Integrated RMNCAH&N Programme Workplan, Luapula Province, 2018
<ul style="list-style-type: none"> • Expected output areas include integrated SRH, HIV and GBV services, supply chain management, and adolescent and youth skills and capabilities for a total of USD 291, 528. • The budget includes USD 35,998 (ZZT06) and USD 8,000 (ZZT05) 	UNFPA Zambia. Provincial Integrated RMNCAH&N in Western Province revised workplan, 2020.
<p>Advocacy for fistula geared to increasing political and financial commitment</p> <ul style="list-style-type: none"> • "Obstetric fistula is a form of gender-based human rights violation. It is a manifestation of deep socio-economic inequalities and inadequate reproductive health systems. Despite its reality and debilitation, obstetric fistula has remained a "hidden" condition, mainly because it affects some of the most marginalized members of the population. Therefore, it has limited visibility in decision-making processes at all levels of the system." 	Kasunda, G. Obstetric Fistula in Zambia. Undated. p.3
<p>IDM supports messages about LNOB</p> <ul style="list-style-type: none"> • The theme of the 2019 National Commemoration of Safe Motherhood Week held in May was "Universal Access to Sexual and Reproductive Health Services: Leaving No One Behind." 	Chisi, Mercy Mulwanda. Activity Report: National Safe Motherhood Week Commemoration, Chibefwe Urban Clinic, Mkushi District. 2019
<p>Focus on marginalized populations</p> <ul style="list-style-type: none"> • One of the unique things that I have noticed with UNFPA is that they really focus on PHC. When you look for example at the family planning services that they support. They also go into communities and look at some of the marginalized populations and these are patients for example who have fistula. 	Interview, MoH service provider. Lusaka, Zambia. August 2021.

Assumption 6.2: UNFPA advocacy and technical support to national authorities focuses on the need to increase allocation of resources, adopt favourable policies, and strengthen accountability mechanisms to ensure equitable access to quality MNH and SRHR services that meet the needs of and empower women and adolescent girls, including the most vulnerable and disadvantaged	
Indicators	
<ul style="list-style-type: none"> • Changes over time in national strategies and plans that reflect increased attention to the differentiated needs of women, newborns and adolescents, including in the four technical MHTF focal areas • Shifts and increases in financial allocations and expenditures to address needs of women, newborns and adolescents, including the vulnerable and disadvantaged • Use of disaggregated data by health information systems to track equity in access to MNH and SRHR services, in particular EmONC and fistula care • Views of national, district and community stakeholders regarding equitable access to MNH and SRHR services for women, newborns and adolescent girls, including the most vulnerable and disadvantaged • Examples and results from UNFPA-supported programmes to strengthen supply and demand sides of MNH and SRHR care and empower women and adolescent girls. 	
Observations	Sources of Evidence
<ul style="list-style-type: none"> • Coverage of at least one ANC visit was high (97%), but the proportion with four or more visits was lower (64%) and is lower than in previous years. • The gap has narrowed between urban and rural women for ANC visits (four or more) • NHSP targets (2018) for deliveries and postnatal care have either been achieved or nearly reached. • 79% of women delivered under a skilled birth attendant in 2018. Socioeconomic inequities have been reduced. (p. 10) 	MoH Zambia. Mid-term review of the National Health Strategic Plan 2017-2021. 2020.
<ul style="list-style-type: none"> • UNFPA assisted the district to conduct the first district TWG to address adolescent needs. • UNFPA supported training of 20 peer educators; “For a space [assume this is an adolescent-friendly space or corner], to work well, you need to presence of a peer educator.” 	Interview, MoH staff, Solwezi District, North-Western Province, Zambia. September 2021.
<ul style="list-style-type: none"> • A key challenge in improving integrated ASRH services is the constrained fiscal space from government to sustain and also monitor quality SRH services overall (as noted in 4.2.2), with inadequate funding for health despite the commitment of the MoH to strengthen primary health care, including for adolescents and youth and greater attention to youth. (p. 34) • A lesson learned was the importance of taking a synergistic approach to addressing the SRH needs of adolescent girls, addressing child marriage together with integrated service provision for SRHR, HIV, GBV, CSE, adolescent friendly services, youth empowerment and asset building and leadership, as well as addressing an enabling environment at all levels. Programmes addressed above thus include a focus on ending child marriage as indicated, rather than child marriage being approached in isolation. (p. 37) • Addressing the integrated SRH needs and rights of the most vulnerable, including people with disabilities, marginalized women and girls and their partners, women with fistula and others, is evidence of a human rights perspective. Likewise, UNFPA selected provinces and districts with poor SRHR indicators as the priority for interventions, indicating the intention to reach those most in need. “Specific rights-based language is not generally apparent in the documents reviewed, for instance in terms of rights holders, duty bearers and gatekeepers, and it might be useful for the CO specifically to adopt this framework. Nonetheless, the entire orientation of the UNFPA CP supports the realisation of rights to SRH including for safe motherhood, family planning, HIV prevention, for adolescents, around GBV and for the empowerment of women.” (p. 39) 	UNFPA. UNFPA 8 th Country Programme Evaluation: Zambia 2016 – mid-2019. 2019.

<p>Assumption 6.2: UNFPA advocacy and technical support to national authorities focuses on the need to increase allocation of resources, adopt favourable policies, and strengthen accountability mechanisms to ensure equitable access to quality MNH and SRHR services that meet the needs of and empower women and adolescent girls, including the most vulnerable and disadvantaged</p>	
<ul style="list-style-type: none"> • UNFPA has begun to focus on people with disabilities in a variety of ways, although this is a focal area that the CO acknowledges is lagging behind and wishes to strengthen in the next country programme. A key area of strategic support by UNFPA is changing attitudes to disability in the communities and among health staff. Traditionally, disability has been seen as a curse caused by witchcraft or wrongdoing, and the birth of a child with a disability brought shame on the family. (p. 39) • UNFPA support for the identification of and treatment for women with obstetric fistula, as addressed above, can also be viewed as a positive response to a pernicious form of disability that had been largely neglected in the past. • The adolescent health strategy to which UNFPA contributed financially and technically includes a focus on adolescents with special needs but acknowledges that little is known about the numbers of male or female adolescents with different disabilities, and a great deal more is needed to ensure their realization of all human rights including access to SRH information and services. (p. 40) 	
<p>Disability inclusion</p> <ul style="list-style-type: none"> • “Close collaboration with the Zambia Library for Persons with Visual Impairment led to effective mainstreaming of disability into the country programme. Going forward the CO will leverage and maximise on this to advance availability of and access to relevant SRH communication material to persons with visual impairment.” 	UNFPA, Zambia. 2019 Annual Report. 2020, p.3
<ul style="list-style-type: none"> • UNFPA provided technical and financial support to the MoH to finalize and disseminate its first Reproductive, maternal, New-born, Child, Adolescent Health and Nutrition (RMNCAH&N) Communications and Advocacy Strategy geared to increase coverage and utilization of RMNCAH&N services. 	UNFPA, Zambia. 2018 Annual Report. 2019
<ul style="list-style-type: none"> • A disability inclusion module for pre-and in-service training of healthcare providers was developed. Selected IEC materials were developed in Braille to facilitate provision of SRH information to persons with visual impairment. 	UNFPA, Zambia. 2019 Annual Report. 2020
<p>Addressing teen pregnancy and early marriage:</p> <ul style="list-style-type: none"> • UNFPA developed two concept notes designed to address issues related to teen pregnancy and child marriage: <ul style="list-style-type: none"> ○ UNFPA Zambia and Restless Development: Research to gather evidence on the phenomenon of child marriage, teenage pregnancies and SGBV looking at the causality links between teenage pregnancies, early marriage and socio-cultural norms; decision-making pathways leading to teenage pregnancies and child marriage; bottlenecks to preventing teenage pregnancies and child marriage, especially in relation to SGBV. ○ UNFPA Zambia proposed a multi-sector approach to increase access to and retention in education; strengthen the health system’s capacity to reach out to adolescents for sexual and reproductive health services; regulate through formal and customary legal systems the age of marriage; utilize community-based counselling to identify and respond to vulnerabilities and risks; and strengthen formal and informal community support structures to challenge social norms. It would support the implementation of the national strategy to end child marriage through a joined up multi-sectoral approach in 15 districts. The funds would provide specific support to strengthening the quality of services provided and the linkages between the sectors in tackling multiple deprivations facing vulnerable children and their families which lead to child marriage. • The status of these concept notes is unknown. 	<p>UNFPA Zambia and Restless Development. Concept Note: Teenage pregnancy and child marriage research in Zambia – Decision-making pathways and influence of gender-based violence on ASRH outcomes. December 2019.</p> <p>UNFPA Zambia. Our Future, Our Choice: Transforming the lives of adolescents in Zambia. Draft Concept Note. September 2020.</p>

Assumption 6.2: UNFPA advocacy and technical support to national authorities focuses on the need to increase allocation of resources, adopt favourable policies, and strengthen accountability mechanisms to ensure equitable access to quality MNH and SRHR services that meet the needs of and empower women and adolescent girls, including the most vulnerable and disadvantaged	
<ul style="list-style-type: none"> • “The data on teenage pregnancy is not good; it has remained the same at 28-29 percent. And we know that these young girls who are getting pregnant are more likely to develop complications, they are more likely to drop out of school. It is a ripple situation that comes out from teenage pregnancy.” 	Interview, MoH Zambia national staff/ August 2021
Assumption 6.3: UNFPA MHTF inputs are directed toward increased availability and utilization of MNH and SRHR services to women, adolescents and newborns, including the most vulnerable and disadvantaged	
Indicator	
<ul style="list-style-type: none"> • Trends in data on MNH and SRHR service utilization, disaggregated by age, ethnicity, wealth, geography, and other available indicators²⁰ 	
Observations	Sources of evidence
MHTF resources directed to underserved provinces	
<ul style="list-style-type: none"> • UNFPA has directed its resources to three provinces (Luapula, Western and North-Western) where there were few healthcare providers offering services. Health facilities were unmanned by unqualified staff. UNFPA embarked on the training of midwives and nurses, as they are key for MNH service provision. 	Interview, Multilateral organization national staff. August 2021.
<ul style="list-style-type: none"> • UNFPA supports activities in the Western, Central and North-Western provinces. “And these have places that are hard to reach, so they've made a very good attempt at least to reach those areas in an attempt to have equity. For example, Western province is an area that is mostly desert-like. It is sandy, it is very, very difficult to reach. They have trained midwives who have been posted in those facilities where women have not been able to have access these health services.” 	Interview, MoH Zambia national staff. August 2021.
<ul style="list-style-type: none"> • UNFPA is now the only organization that is directly supporting at the level of human resources, in their focus provinces, supporting the government to do midwifery training and placements. The approach is to work in the places where the systems are weaker, and identify local girls, send them to school and then contract with them to stay. In the Western Province, UNFPA has its “foot on the ground.” It is a very poor, rural province. 	Interview, Multilateral organization national staff. August 2021.
<ul style="list-style-type: none"> • Initially, MHTF supported three districts within North-Western Province. “We noted that if we really needed to have an impact, on changing the performance of the RMNCAH&N indicators, the three districts had minimal contribution to change in the maternal health indicator. So during the annual planning meetings we would advocate our problem from the point of view of the province, and this we have been doing for the past three years, and we were able to get this leverage to extend the activity. The districts that we were focusing on were Mfumbwe, Chavuma and Zambezi, if you look at the proportion of their population for these districts in the province, the highest population district in the province is Mwinilunga, we have Solwezi, we’ve got Kalumbila, the we’ve got Kasempa, all those districts that had a bigger chunk of contributing to the Provincial Performance were left out this why we engaged UNFPA.” 	Interview, MoH staff, North-Western Province, Zambia. September 2021.
Humanitarian response (non-MHTF funded)	
<ul style="list-style-type: none"> • UNFPA worked to ensure women, adolescent girls and young people in refugee settlements in Nchelenge had access to quality health care, in line with the UNFPA “Safe Birth Even Here” campaign and as part of the UN Zambia joint response to the DRC emergency situation funded by the UN Central Emergency Response Fund (CERF). 	UNFPA Zambia. 2018 Annual Report. 2019.

²⁰ Given the COVID-19 pandemic, it is unlikely that data will be available for 2020; however, anecdotal information may be useful here to capture the implications of COVID-19 for maternal care.

Assumption 6.3: UNFPA MHTF inputs are directed toward increased availability and utilization of MNH and SRHR services to women, adolescents and newborns, including the most vulnerable and disadvantaged	
<ul style="list-style-type: none"> Nchelenge District (Luapula Province) hosted over 13,600 refugees who fled the DRC. “Over 70% of the refugee population is comprised of women, including 50% women of reproductive age. Among these over 400 were pregnant and faced increased risks of complications due to limited access and uptake of quality services.” (p.22) 	
<ul style="list-style-type: none"> In Nchelenge District, Luapula Province, UNFPA has contributed effectively to the national contingency plan and the design and delivery of the Minimum Initial Service Package, and to the implementation of interventions supported by the joint UN Central Emergency Relief Fund. The contributions of UNFPA were highly valued by the GRZ and partners, with the CO reaching 99 per cent of its intended beneficiaries regarding integrated SRHR/HIV and GBV services. UNFPA by 2018 had: provided financial and technical support for emergency obstetric and neonatal care (EmONC) equipment and deployed five midwives; trained 30 SMAG members, 22 personnel in GBV prevention and response, and 17 peer educators among young people to raise awareness and increase demand for antenatal services and for family planning. By mid-2019, reports indicated reduced home deliveries and an increase in FP uptake, particularly of injectables, although the team was unable to verify or quantify this finding. UNFPA also supported the equipping of the health facility in the resettlement area. 	UNFPA. UNFPA 8 th Country Programme Evaluation: Zambia 2016 – mid-2019. 2019. p.30

Area of Investigation 7: Catalytic role	
Evaluation Question 7: To what extent has the MHTF fulfilled its catalytic role enabling UNFPA to ‘punch above its weight’ in support of MNH outcomes and integration with SRHR?	
<p>Sub-questions:</p> <p>a) To what extent has UNFPA used the MHTF as a vehicle to play a broker role for the promotion of MNH and wellbeing in high MMR countries, improving coordination and partnerships, leveraging more funding from both international and national sources, and providing effective strategic direction, technical assistance, and capacity building through country-driven interventions?</p> <p>b) To what extent has the MHTF leverages a range of discernible, tangible, and practical results, including political commitments and policy support and financial commitments and investments</p> <p>c) To what extent has global and regional technical support from UNFPA supported country teams and national health authorities through strengthening reliable data and information collected through monitoring and review, stimulating knowledge sharing approaches, and identifying, scaling-up or replicating innovation and good practices within and between countries?</p>	
Evaluation criteria	<i>Relevance, efficiency, coordination</i>
Rationale	<p>Catalytic is defined as an agent that provokes or speeds significant action. In this evaluation, catalytic actions are those that are assessed to provoke or accelerate relevant change or progress. A catalytic role is therefore one that identifies, promotes and advances those actions. There is an implied counterfactual which is that without the catalytic investment, significant change would not have occurred or would have occurred only very slowly. Given its wide scope, its relatively low resource envelope, its commitment to sustainability, equity, human rights and gender equality, the MHTF gains more traction and achieves better results if it concentrates its effort on catalytic investments and actions, playing a broker role within UNFPA and with external partners, and sparking political, programmatic and financing commitment beyond its own investments. Catalytic support includes using the UNFPA mandate to good effect, focusing on its role to strengthen partnerships, coordination, strategy and capacity building, and extending innovation through knowledge management strategies including the identification of best practices.</p>
Assumption 7.1: The MHTF is an effective vehicle to <u>play a broker role both internally within UNFPA and externally with programme countries and other partners</u> at global, regional, and national levels for the promotion of MNH in high MMR countries through its comparative advantage to coordinate, build partnerships, leverage funding	
<p>Indicators</p> <ul style="list-style-type: none"> • MHTF engagement in or support to strategy, policy and planning development especially involving other partners and players to forge partnerships and negotiate coordinated approaches and strategies including the allocation of roles and responsibilities • Examples of UNFPA convening partners to assist with the development of costed maternal health approaches and strategies including national plans • Examples of UNFPA leadership or coordinated working with other country level partners to provide effective strategic direction, technical assistance, and capacity building through country-driven interventions • Examples of MHTF support to UNFPA intervention to bring partners together around plans, ideas, proposals, strategies in ways they otherwise would not have and to allocate additional resources, focus, effort to these 	

Assumption 7.1: The MHTF is an effective vehicle to play a broker role both internally within UNFPA and externally with programme countries and other partners at global, regional, and national levels for the promotion of MNH in high MMR countries through its comparative advantage to coordinate, build partnerships, leverage funding	
<ul style="list-style-type: none"> • Specific examples of how MHTF at global level or through support to UNFPA CO efforts at country level helped negotiate the involvement of new partners, increased resources, better approaches, or innovations to support/ fund MNH at any level (global, regional or country) • Clear definition of the role and approach of UNFPA to working with SDG3 GAP agencies at country level especially on MNR related activities and plans. 	
Observations	Sources of evidence
Leveraging partnerships <ul style="list-style-type: none"> • UNFPA and other partners supported the dissemination of the preliminary Zambia Demographic and Health Survey (ZDHS) results. There have been significant improvements in key national indicators: <ul style="list-style-type: none"> ○ MMR was reduced from 387 to 278 per 100,000 births ○ Percentage of births attended by skilled personnel increased from 64% to 84% ○ Unmet need for family planning was reduced from 21% to 20% and the use of modern methods increased from 45% to 48% ○ Teenage pregnancy remains an issue and increased from 28.5% to 29.2%. 	UNFPA Zambia. 2019 Annual Report. 2020.
UNFPA CO perspectives on MHTF as catalytic mechanism: <ul style="list-style-type: none"> • “It is important for us to direct the little funding we have to strategic investment areas and use evidence to inform these decisions.” Once the MHTF supports these areas, UNFPA works to leverage other investments from government or other partners through the generation of evidence and to support advocacy. UNFPA plays its convening role for planning and budgeting through the national planning process. The government is initiating a process for the next national strategic plan and there is the opportunity to support the process by advocating for high-impact interventions. • For example, with EmONC, UNFPA can support national or targeted EmONC assessments to identify areas of need or for scalability. “Once something is in the strategic plan, then significant progress follows.” 	Interview with UNFPA Zambia, Lusaka. August 2021
<ul style="list-style-type: none"> • “MHTF provides a platform for interaction that enables sharing experiences through the existing platforms to share progress. The other thing I have come to understand is that MHTF provides “catalytic” funds, becomes important for us to prioritize and be strategic. What is it that we can do to take the lead and have others participate. Through those processes and understanding of catalytic funding – forges partnerships and bring others to the table. Fistula is the best example. Now the Fistula Foundation is also taking the lead and bring resources to the table and support camps and mentorship. Room for all of us – not encroaching in our space, but additive. This has been helpful to be strategic to the General Nursing Council and MAZ – they have tentacles with all the other partners – catalytic fund – helps us support the MoH to support stronger partnerships.” 	Interview, UNFPA Zambia national staff. August 2021
<ul style="list-style-type: none"> • Regarding serving as a champion that plays a catalytic function, one challenge is that there are strong coordination mechanisms at the national level (TWG), but these are not so strong at the sub-national level. MHTF has been supporting MPDSR to ensure that the committees should be as strong as the national level. There is a need to strengthen coordination mechanisms at lower levels to better understand problems and inform interventions. 	Interview, UNFPA Zambia national staff. August 2021
<ul style="list-style-type: none"> • During Phase III, MHTF funding has been reducing gradually. The reductions have not been felt as much because we have built capacity in regulation and education and have in place the national midwifery strategic plans and curriculum. These activities have reached a sustainable level so that they do not solely depend on UNFPA support. Resources have been mobilized from other programmes. When funding was reduced, other partners were identified (CHAI, JHPIEGO), as they also had funding for 	Interview, UNFPA Zambia national staff. August 2021

Assumption 7.1: The MHTF is an effective vehicle to play a broker role both internally within UNFPA and externally with programme countries and other partners at global, regional, and national levels for the promotion of MNH in high MMR countries through its comparative advantage to coordinate, build partnerships, leverage funding	
<p>midwifery. “Instead of just doing in silos, we pooled resources together. All three partners are able to put in something. Stretch little funding as much as possible.”</p> <ul style="list-style-type: none"> • “Most impact has been felt in supporting the nurses who want to become MWs. Used to be able to support 50-60 in a go. Cake was cut to support only 10.” 	
<ul style="list-style-type: none"> • To a great extent, the MHTF was very influential in the 4 areas. That is the totality of maternal health. Started it some years ago (decade) and we recorded major milestones – this assisted us in developing the joint programme; our work in MW and EmONC is very instrumental. MHTF funding is meant to be catalytic; it has led to resource mobilization because of the foundation set by this catalytic funding. “It is management – we normally do annual planning, very participatory around the 4 resources and how they are allocated. What we notice that the funding is released in tranches, comes in very late. What we do at country level, we advance with core resources, to avoid any gaps.” 	<p>Interview, UNFPA Zambia national staff. August 2021</p>
<p>MoH perspectives on UNFPA role in Zambia</p> <ul style="list-style-type: none"> • UNFPA has been consistent. While it supports three provinces, the MoH will include similar approaches in the provinces that UNFPA is not supporting. “We do incorporate others just to increase on numbers and also to make use of available resources that have been given to us.” 	<p>Interview, MoH Zambia national staff. August 2021.</p>
<p>Other partner perspectives on UNFPA role in Zambia</p> <ul style="list-style-type: none"> • To a large extent, they are strong in FP and Supplies – important in Zambia. In the areas of MHTF, on fistula they are probably the only agency that has been pushing the government to ensure that these unfortunate occurrences are addressed. As far as I can see, no one would be raising the issue of fistula. Over time, you noticed that the conversation now includes fistula. • Re EmONC, “in my view, UNFPA is making a quick palpable impact in EmONC through its support for building midwifery skills. No other organization is working on midwifery. • UNFPA also made a “huge push” on MPDSR, making sure that this is being mainstreamed. There has been a huge change as a result of weekly meetings, regular reviews and surveillance meetings. It is widely acknowledged that putting out the information and showing the numbers results in greater understanding of the problems. The contribution of UNFPA has been “very, very critical. They are the ones that have backstopped the MoH on this issue.” It is a systemic approach, held together by UNFPA, bringing other partners, and assuring the committees are in place. • Regarding UNFPA as catalytic: “I can say that if you convince the MoH that there is a problem in a particular area of maternal health, i.e., fistula, and you see the government itself raising the issue. Very big win. Whichever institution has shifted the mindset through advocacy with MoH and other partners.” 	<p>Interview, Multilateral organization national staff. August 2021.</p>
Assumption 7.2: The MHTF leverages a range of discernible, tangible, and practical results, including political commitments and policy support, and financial commitments and investments	
<p>Indicators</p> <ul style="list-style-type: none"> • Documented and reported progress on policy processes and political commitment in partner countries • Examples of increased financial commitment from other donor partners for SRHR-MNH efforts in partner countries linked to MHTF advocacy and investments • Examples of trends in financial commitments in countries to MNH 	

Assumption 7.2: The MHTF leverages a range of <u>discernible, tangible, and practical results</u>, including political commitments and policy support, and financial commitments and investments	
<ul style="list-style-type: none"> • Examples of UNFPA technical or programmatic support to country teams and national and sub-national health authorities that were taken forward by other partners • Assessed technical quality of UNFPA assistance as reported by health authorities and partners • Relevance of UNFPA technical assistance as reported by health authorities, practitioners and implementing partners • Examples of UNFPA engagement in capacity building, which is sustained, relevant and meaningful in monitoring, research, review and knowledge management • Examples of UNFPA at country level building momentum and supporting tangible policy and programming changes. 	
Observations	Sources of evidence
<p>Reported progress on policy and political commitments in Zambia</p> <ul style="list-style-type: none"> • In 2018, UNFPA in Zambia continued to support sub-national level programmes aimed at improving EmONC, midwifery services, as well as prevention and repair of obstetric fistula, among other crucial needs to ensure “no woman dies giving life”. Specific actions included the following: <ul style="list-style-type: none"> ○ Through technical and financial support from UNFPA, the MoH finalized and disseminated its first RMNCAH&N Communications and Advocacy Strategy. This strategy is a key milestone for the country as it seeks to increase coverage as well as utilization of RMNCAH&N services. ○ UNFPA supported the development and dissemination of the National Human Resources for Health Strategic Plan (2018 - 2024), which details key approaches for addressing human resource for health challenges in the country (including skilled birth attendants), as well as the critical role of community health workers towards improving availability of services. ○ UNFPA supported the development of Nursing and Midwifery Protocols, whose implementation is expected to facilitate improved quality of care in health facilities across the country, towards reducing maternal mortality and morbidity. (p.11) • “As one of the 46 countries supported by the global “UNFPA Supplies”, UNFPA in Zambia sustained its collaborations with the Government of Zambia in operationalizing the National Family Planning Scale-Up Plan (2013- 2020), which aims to increase the national contraceptive prevalence rate from 33% to 58% by the year 2020. Specific actions by UNFPA and the Government of Zambia included the following: <ul style="list-style-type: none"> ○ Development of a short to medium term concept note for increased domestic financing for family planning commodities ○ UNFPA’s procurement of an estimated 50% of targeted commodities for the public sector, among others. ○ Government’s budgetary allocation to family planning commodities was increased by 50%; from an average of USD 1million in the preceding four years to USD 1.6million in 2018.” (p.7) 	<p>UNFPA Zambia. 2018 Annual Report. 2019.</p>
<ul style="list-style-type: none"> • Results reported for 2018 include: <ul style="list-style-type: none"> ○ 1,000 maternal deaths averted due to contraceptive use ○ 80 midwives trained in skilled birth attendance; 177 health care providers acquired skills and knowledge in EmONC ○ 220 women with obstetric fistula repaired ○ 203 health facilities improved capacities to provide EmONC services 	<p>UNFPA Zambia. 2018 Annual Report. 2019.</p>

Assumption 7.2: The MHTF leverages a range of <u>discernible, tangible, and practical results</u> , including political commitments and policy support, and financial commitments and investments																						
<ul style="list-style-type: none"> In 2020, the Q2 monitoring report included “not reported” as the status for the following milestones: 	<table border="1"> <thead> <tr> <th>Milestone</th> <th>Q2 Target</th> </tr> </thead> <tbody> <tr> <td>Number of nurses enrolled in midwifery training with UNFPA support</td> <td>10</td> </tr> <tr> <td>Number of health care providers with capacity to conduct quality MPDSR processes in UNFPA supported provinces</td> <td>20</td> </tr> <tr> <td>Number of obstetric fistula survivors repaired and followed up for post-operative care</td> <td>40</td> </tr> <tr> <td>Number of health care providers with knowledge and skills in the management of SGBV</td> <td>85</td> </tr> <tr> <td>Number of health care providers with capacity to provide adolescent friendly integrated SRH/HIV/GBV services</td> <td>85</td> </tr> <tr> <td>Number of health care providers with knowledge and skills to provide quality Comprehensive Abortion Care services</td> <td>25</td> </tr> <tr> <td>Number of health care providers oriented on Respectful Maternity Care guidelines</td> <td>30</td> </tr> <tr> <td>Number of public health facilities providing adolescent-friendly integrated SRH services in UNFPA supported districts</td> <td>20</td> </tr> <tr> <td>Number of adolescents and young people reached with SRH information and services</td> <td>120,000</td> </tr> </tbody> </table>	Milestone	Q2 Target	Number of nurses enrolled in midwifery training with UNFPA support	10	Number of health care providers with capacity to conduct quality MPDSR processes in UNFPA supported provinces	20	Number of obstetric fistula survivors repaired and followed up for post-operative care	40	Number of health care providers with knowledge and skills in the management of SGBV	85	Number of health care providers with capacity to provide adolescent friendly integrated SRH/HIV/GBV services	85	Number of health care providers with knowledge and skills to provide quality Comprehensive Abortion Care services	25	Number of health care providers oriented on Respectful Maternity Care guidelines	30	Number of public health facilities providing adolescent-friendly integrated SRH services in UNFPA supported districts	20	Number of adolescents and young people reached with SRH information and services	120,000	UNFPA Zambia. 2020 Q2 Monitoring – Zambia. 2020.
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<ul style="list-style-type: none"> UNFPA is very supportive to MoH in terms of policy. It supports us to review and update policies; they need to be reviewed and updated every five years. UNFPA supported the review and revision of the FP Costed Implementation Plan which expired last year and helped come up with a new plan for the next five years. UNFPA supported it through a consultancy with very short notice. “One of the biggest policy areas we need to work on is RH policy (which had been delayed because of COVID-19). UNFPA has been very supportive – have not yet started, but they are ready to support it. We did the terms of reference. Now elections are over, we can start running with that.” 	Interview, MoH Zambia national staff. August 2021.																					
<p>Reported challenges in achieving results through UNFPA assistance:</p> <ul style="list-style-type: none"> The GRZ faced a “severely constrained fiscal space” which affected its ability to sustain the financing of key social services, including the SRH programme. “This led to supported provinces receiving less than 30 per cent of expected annual grants from government, making it difficult to achieve desired results in SRH and sustain initial investment from development partners. For example, limited funding to fistula management compromised investments into mobilization, follow-up, and social re-integration of fistula clients. In addition, despite the recognized shortage of skilled human resource, the identified gaps could not be addressed due to lack of authority to recruit additional critical workers such as midwives and doctors. During the year, there was high 	UNFPA Zambia. 2019 Annual Report. 2020.																					

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<p>government reliance on limited resources from development partners to support routine health system processes such as performance review meetings.” (p. 3)</p> <ul style="list-style-type: none"> • Several changes were made at Ministerial, Permanent Secretary and Director levels in most line Ministries and provinces where the CO operates which resulted in some implementation delays. • “The changes to implementing partners’ funding modalities from direct cash transfer to direct payment, specific to a particular restricted funding grant, and the change in strategic focus of the DFID supported RMNCAH&N programme resulted in limited and delayed investment in expanding the number of health facilities providing quality EmONC services. This could not be addressed within the year under consideration, and interventions will in 2020 be scaled up to broader geographical coverage focusing on family planning and adolescent health. (p.3) 	
<p>UNFPA CO perspectives on results from catalytic programming</p> <ul style="list-style-type: none"> • “MHTF has been very beneficial and has gone a long way; catalytic. The provinces have benefitted. Provinces can only hold a MPDSR meeting because of MHTF. When government has been constrained, the funding has been very useful. Right now, the institutions that support midwifery training still feel the effect of the resources that have been available. But what can investments in policy do if there are no resources for training, capacity and equipment?” 	Interview, UNFPA Zambia staff. August 2021.
<ul style="list-style-type: none"> • “Although the funds are limited/catalytic, we are constrained by the many priorities. The areas of focus remain critical in Zambia. If the funding was increased, it would make a great impact. Flexibility would be good, but do not want to spread ourselves too thin. We cannot even adequately fund one area in full. Would like the flexibility to direct perhaps to one or two areas, if relevant in country. The funding is very important to us and to other countries – advocate for it to be increased. Would not like to see the funding concentrated to fewer countries, as it would mean that funding might get cut from places that really need it.” 	Interview, UNFPA Zambia staff. August 2021.
<ul style="list-style-type: none"> • “MHTF has been very, very helpful. Without Dfid we will be limping. Core resources will be very difficult to locate funding for maternal health. Family planning is very key – family planning commodities are critical, and this will take priority. Really depending on the MHTF and core funds to support this programme.” 	Interview, UNFPA Zambia staff. August 2021.
<ul style="list-style-type: none"> • “It is important for us to direct the little funding we have to strategic investment areas; use the evidence we have to use the funds.” One example involves supporting evidence through national or targeted EmONC assessments to identify areas of need or for scalability. • Another area that is important is supporting advocacy and convening – playing a convening role for planning, budgeting “That area requires better guidance and some work to more strategically support national planning processes. The government is initiating a process for the next national health strategic plan. There is the opportunity for us to support the national planning process, we know the unit cost of interventions for high-impact interventions. Once that appears in the strategic plan, then we can see significant progress in the EmONC.” 	Interview, UNFPA Zambia staff. August 2021.
Assumption 7.3: Global and regional technical support from UNFPA fostered, identified, and scaled-up innovation and good practices within and between countries	
Indicators	
<ul style="list-style-type: none"> • Documented and reported progress by UNFPA in developing and implementing a knowledge sharing strategy and approach that was systematically disseminated at global and regional levels 	

Assumption 7.3: Global and regional technical support from UNFPA fostered, identified, and scaled-up innovation and good practices within and between countries	
<ul style="list-style-type: none"> • Examples of regional level knowledge sharing, identification of innovations and good practices • Examples of UNFPA approaches to gathering evidence about best practices and developing ideas and strategies to take these to new countries or settings • Examples of UNFPA support to better monitoring and review and to more knowledge sharing among country teams and national and sub-national health authorities • Reported timeliness of UNFPA technical assistance • Assessed technical quality of UNFPA assistance as reported by health authorities and partners • Relevance of UNFPA technical assistance as reported by health authorities, practitioners and implementing partners • Examples of UNFPA engagement in capacity building, which is sustained, relevant and meaningful in monitoring, research, review, and knowledge management • Examples of UNFPA at global and regional level building momentum and supporting sustained roll out of innovation or best practices • Examples of knowledge development, management, and communication especially around good practices in the MHTF programme. 	
Observations	Sources of Evidence
<p>UNFPA perspectives on use of evidence for programming</p> <ul style="list-style-type: none"> • As a result of evidence and research conducted, including assessments, the programme has evolved over time to implement more targeted interventions. “Once you do the assessment, you have better evidence. We actually assisted in HSS and contributed to improved quality of care through capacity-building for health service providers. Also assisted in promotion of how child marriage and early pregnancies lead to fistula. We integrate service strengthening with the community component. For example, fistula: we have noticed from our own research that fistula was occurring among young mothers/adolescent girls because of delays in getting appropriate care and decisions to seek care which resulted in prolonged labor. We noticed this happening because of child marriage/early marriage. This message was integrated during our commemoration during fistula day, bring community leaders/members to create awareness around dangers of child marriage and for ordinary mothers to inform re mothers’ shelters; assist to monitor mothers/SMAGs. 	<p>Interview, UNFPA Zambia staff. August 2021.</p>
<p>Collaboration with Maternity Foundation to pilot Safe Delivery App</p> <ul style="list-style-type: none"> • UNFPA collaborated with the Maternity Foundation to support the MoH to introduce the Safe Delivery App that can be loaded on any smartphone and used offline. The app is designed to increase skills to manage pregnancy-related complications. Twenty-five (25) midwives and doctors acquired knowledge and skills as trainer on the use of the Safe Delivery App to support the roll-out across the country. • UNFPA reported that effective collaboration with the Maternity Foundation, the Zambia Library for Persons with Visual Impairment and the Fistula Foundation led to achievement of results that could not have been achieved alone. 	<p>UNFPA Zambia. 2019 Annual Report. 2020.</p>
<ul style="list-style-type: none"> • The Safe Delivery App was developed by the Maternity Foundation as a free application for use by midwives and other skilled health personnel to provide direct access to evidence-based and up-to-date clinical guidelines for BEmONC services. The app contains easy-to-understand animated instruction videos, action cards and drug lists and can serve as a training tool in both pre- and in-service training as well as an on-the-job reference tool for health workers, trainers, and supervisors. There are training exercises/modules in the following topics: infection prevention, post-abortion care, hypertension, normal labor and birth, active management of third stage labor, prolonged labor, postpartum haemorrhage, manual removal of placenta, maternal sepsis, neonatal resuscitation, newborn management, and low birth weight. 	<p>The Maternity Foundation. Accessed from: https://www.maternity.dk/safe-delivery-app/.</p>

Area of Investigation 8: MHTF governance and management	
Evaluation Question 8: To what extent have the MHTF management mechanisms and internal coordination processes contributed to the overall performance of the programme? Specifically, how have these facilitated: (i) resource mobilization for the MHTF; (ii) the breaking of silos among UNFPA programmes; (iii) the integration of MNH within country programmes; and (iv) effective oversight and guidance by the MHTF Advisory Committee?	
Sub-questions: <ol style="list-style-type: none"> a) To what extent has the MHTF management mechanisms and internal coordination processes contributed to the overall performance of the programme including through influencing the overall strategic directions and efforts of UNFPA in MNH and broader SRHR more broadly? b) To what extent have MHTF management mechanisms and internal coordination processes benefitted from effective oversight and guidance by the MHTF Advisory Committee and contributed to MHTF resource mobilization? c) To what extent have MHTF management mechanisms and internal coordination processes contributed to breaking silos among UNFPA programmes at global and national levels including strengthening integration of MNH within country programmes? 	
Evaluation Criteria	<i>Effectiveness, efficiency, coordination</i>
Rationale	<p>The MHTF is one of several thematic funds in UNFPA. Focused on maternal health, it is also one of the few global maternal health funds (others include the GFF) but is distinguished in part by its specific focus on four technical areas (midwifery, EmONC, MPDSR and fistula) in 32 countries. Resources are generally declining as global MNH is less prioritised in the SDGs. Coordination, management, leadership, and efficiency are critical to ensure the aims of the fund are met and maximum impact from available resources is realised.</p>
Assumption 8.1: MHTF management mechanisms and internal processes within the MHTF and with other UNFPA departments <u>fostered effective and efficient coordination of programmes and prioritization of financial and human resources to deliver</u>	
Indicators <ul style="list-style-type: none"> • MHTF programme guidance which incorporates required adjustments/improvements in SRHR policies and programmes communicated to other branches • MHTF staff/secretariat participation in forums and meetings at global, regional and CO to develop broader SRHR policies and to integrate services • MHTF results frameworks and programme reports incorporate linkages to SRHR policies and programmes • UNFPA staff in other branches engaged in SRHR report MHTF input and influence on policies and programmes • Minutes and report of intra-UNFPA coordinating bodies note cross influence of MHTF and SRHR on policies and programmes • Examples of mechanisms to support coordination, strategic direction, forward momentum, and overall performance at global, regional, and country levels • MHTF investments and activities contributed to strengthening coordination with other UNFPA thematic programmes • COs approached thematic areas holistically, in line with countries' own systems (integration at the country level) • Examples of efforts to integrate across the sexual, reproductive, maternal, newborn, child, and adolescent health agenda at global, regional, and country level • MHTF support enabled increasingly effective performance of the programme, breaking down barriers to programmatic silos and supporting increased efficiency • Examples of the MHTF role and activities in relation to regional knowledge and management approaches. 	
Observations	Sources of evidence
<ul style="list-style-type: none"> • See Area of Investigation 6 for information on examples on integration across sexual, reproductive, maternal, newborn, child, and adolescent health agenda. 	

Assumption 8.1: MHTF management mechanisms and internal processes within the MHTF and with other UNFPA departments fostered effective and efficient coordination of programmes and prioritization of financial and human resources to deliver	
<p>MHTF implementation challenges:</p> <ul style="list-style-type: none"> • Delay in release of MHTF funds led to delays in implementing some of the supported activities such as finalization of the Operational Plan to End Obstetric Fistula. • Due to the delayed release of the revised Global MPDSR Guidelines, the country did not revise the existing national guidelines as these need to be aligned to the global guidelines.” (p.2-3) 	UNFPA Zambia. 2019 Annual Report. 2020.
<ul style="list-style-type: none"> • Late remittance of MHTF resources was identified as an issue. “I know that it is not their fault for timely remittance of funds so that we can implement funding. The needs of the country are more than the funding received. We are only given USD 300K/year for all these components. Funds are always not enough. We are grateful that we have it as catalytic in all areas. I hope the programme can continue and expanded to other components (integration).” 	Interview, UNFPA Zambia national staff. August 2021.
<p>Strategic decision-making under MHTF</p> <ul style="list-style-type: none"> • Regarding strategic decisions: COs are encouraged to choose among the four technical areas where there is the greatest need. Funds are limited and meant to be catalytic; however, it is sometimes difficult to address an issue in a resource poor setting. In the case of fistula, the need is great, but it requires a lot of investment for training specialist doctors to repair fistula and many of the fistula clients are vulnerable, extremely poor and not linked to existing social security systems (i.e., social cash transfers). “More guidance is needed within UNPFA on how best to innovate and extend the MHTF scope of work around fistula, especially when it comes to linkages with social protection areas.” • When it comes to midwifery, it is possible to reduce work in this area because the needs are huge and there is not the capacity to support every nurse-midwife who wants to go to school. “The priority should be to support the strategic areas at the national level and strengthen the linkages between the National Midwife Association and the MoH.” • One of the areas that requires strengthening is the culture of data collection and use of data in policy and programme implementation. “What I have noticed is that there is the push to collecting the data at service delivery point, make use of it and make the decisions. Very little analysis and reflection. There is a need to strengthen routine data collection, analysis and reporting. Hopefully MPDSR can be used as a process for this; for every woman that dies, there are many others. We need to begin to use the data at the service delivery point level. Could help with iatrogenic fistula if this were recorded systematically.” 	Interview. UNFPA Zambia staff, Lusaka. August 2021.
<ul style="list-style-type: none"> • MHTF is an extremely important stream of funding for maternal Health in Zambia, given high maternal mortality. One of the key indicators is significantly high MMR. “This fund is extremely relevant for Zambia, even though there has been a decrease. But we also have high neonatal mortality. Neonatal mortality has been increasing for past 5-6 years. With HR for Health, component for MWs is a big issue. There is high proportion of SBAs and high proportion of women who deliver in health facilities, quality of care is not good. Competencies and skills of MWs are not up to speed. The issue of having competent MWs and MW training is critical. There are significant challenges in EmONC – absence of appropriate equipment, staff not having appropriate skills, challenges with infection control, absence of drugs and supplies. Areas that require significant investment.” 	Interview. UNFPA Zambia staff, Lusaka. August 2021.
<ul style="list-style-type: none"> • The MHTF mechanism does not allow for a lot of flexibility to do work outside of the four technical areas. “I suggest going forward, the fund is more flexible to allow countries to decide the areas of investment as long as they contribute to MH. For example, lots of work on social determinants on maternal health. Lot of work that could be done on that. When one looks critically at these four areas, many of the challenges are within the health facility. Important that we look at areas that are not 	Interview. UNFPA Zambia national staff. August 2021.

Assumption 8.1: MHTF management mechanisms and internal processes within the MHTF and with other UNFPA departments fostered effective and efficient coordination of programmes and prioritization of financial and human resources to deliver	
<p>within the health sector. That thinking might help to broaden our approach to reducing. Reason: combination of donors’ preferences and also an issue of capacity. We do not always have staff with expertise/broad mindset to look at social issues: If we are to root cause analysis for maternal death, there are so many factors we could identify. The usual default is to look at the issues of the MoH because we work with the MoH we have an agreement with them year end and year out, they are always our partner. Many of our officers do not have sufficient warm bodies to work across the sectors. We may never be able to change some of the outcomes if we do not take a holistic.”</p>	
<ul style="list-style-type: none"> • To advance the ICFP agenda, UNFPA cannot work alone. UNFPA partners with UNICEF on joint programmes on MNCAH and each takes an area of focus that complements the other. The joint programme (DfiD) just ended, but the agreement is going on in separate areas in two provinces (Western and Central), although resources are not adequate. This makes partnership all the more important. “We maintained the agreement health system strengthening in RMNCAH; the programme itself was redesigned for UNFPA to focus on ADH and FP, with UNICEF focused on nutrition under the same agreement up to September this year with a no-cost extension.” 	Interview, UNFPA Zambia staff. August 2021.
<ul style="list-style-type: none"> • In general, UNFPA provides both financial and technical support, but “it has been dwindling, especially for technical support from outside the country when we do not have the competency locally.” The focus has not been as technical as in the past. Also, recently, the MoH has not played as active a role in the identification and evaluation of consultants. There used to be better coordination with UNFPA in this area. “In some cases, this appears to slip our fingers. Maybe we can make a better effort. When we just find a consultant is on board, we think we could have done better.” 	Interview, MoH Zambia national staff. August 2021.
<p>UNFPA CO perspectives on integration across four technical areas of MHTF</p> <ul style="list-style-type: none"> • “When you tackle maternal health, it is not just fistula, EmONC also comes in. When you look at your transformative results, a number of things come in. Maternal deaths MPDSR and training the provincial teams on MPDSR so that we reduce the mistakes being made and tackle the things that are preventing delays – transportation. Train the safe motherhood action groups SMAGS to ensure the community is able to demand SRH services, safe delivery and the babies that are safe. Preventing unnecessary abortions.” 	Interview, UNFPA Zambia national staff. August 2021.
<ul style="list-style-type: none"> • “For us, EmONC/MPDSR/MW/Fistula are integrated in Zambia. We cannot remove one – they all contribute to maternal well-being. <ul style="list-style-type: none"> ○ EmONC supports health care providers that are key to preventing maternal deaths. ○ Supporting midwifery curricula, when we see gaps, we come in to support so that the curriculum in line with ICM and adapted to the cultural situation in Zambia. We also support the midwives’ association, as they need an enabling environment and trainings. so that they have a voice and continuous training and education. We support their scientific conferences, research so that they can improve. ○ We support MPDSR; the midwives are the ones that come in contact with the women. They are the ones that feel bad when the woman dies in their care. We need midwives that are skilled in timely referrals and care. Midwives are encouraged as part of the MPDSR team. ○ When it comes to fistula, why did this woman end up with a fistula – usually because of prolonged and obstructed labor. The ANC should educate clients about the need for facility/hospital delivery, set aside emergency funds to book transport. They go early to facility maternity homes until they have skilled delivery. So we need to continue to educate them – even at the 	Interview. UNFPA Zambia national staff. August 2021.

Assumption 8.1: MHTF management mechanisms and internal processes within the MHTF and with other UNFPA departments fostered effective and efficient coordination of programmes and prioritization of financial and human resources to deliver	
<p>hospital. Dedicated people. Once this woman is prepared. Community should be able to refer a woman who is leaking urine for further treatment.”</p> <ul style="list-style-type: none"> • “For these 4 technical focus areas, we see them as interrelated. It is OK for silos to exist in the headquarters. We do not know much about the silos; we report to a number of people when we write ONE report, and we just copy them. We do not see much of the silos in that respect. We implement the activities, send one report and copy all.” 	
<p>Technical support from regional office and headquarters</p> <ul style="list-style-type: none"> • At the ESARO, there is only one member who works on maternal health. The MHTF work does not get regular reviews or systematic reviews on an annual or mid-year basis, likely due to capacity. “The team is not well coordinated at headquarters, MW advisor, fistula, MPDSR and EmONC – we do not get that coherence.” MHTF would benefit mid-year reviews with every country or within the region or focus countries coming together to discuss sharing, look at experiences. Some COs have innovations, and it would be helpful to share across implementation countries. • “We need to see how we can transition out of the fund. There is not a clear exit strategy.” 	Interview, UNFPA Zambia national staff. August 2021.
<p>Implementing partner perspectives</p> <ul style="list-style-type: none"> • One suggestion for improvement would be a longer implementation period. “First and foremost, the implementation period is not long enough, and it is a challenge to be able to being able to adequately implement activities, obtain information from the ground and improve on those activities.” The situation has been compounded by the challenges of COVID-19; it would have been good to have the opportunity of an extension. • A second suggestion is to ensure that partners fully understand the objectives and all the components of the project. “Better understanding at an early stage would have enabled us to redesign our implementation plan in a way that would have enabled more effective implementation. For example, the component on persons with disability was only added this year.” 	Interview, NGO staff, Zambia. August 2021.
<p>Coordination processes</p> <ul style="list-style-type: none"> • The Provincial Coordinator for Maternal Health is in contact with the national level; most of the programmes that are planned for by MoH are “trickled down” from national to province level. Coordination is mostly done at the provincial level. UNFPA provides funds for maternal and child health programmes in the province. 	Interview, MoH staff. North-Western Province, Zambia. September 2021.

Assumption 8.2: The MHTF management mechanisms and internal coordination processes benefitted from effective oversight and guidance by the MHTF Advisory Committee and UNFPA leadership, and contributed to MHTF resource mobilization	
<p>Indicators</p> <ul style="list-style-type: none"> • Advisory Committee role is clearly identified through terms of reference and performance standard • Meetings and other engagement enabled the Advisory Committee to meet its terms of reference • Materials distributed in the form of briefing and information sharing were sufficient to ensure the Advisory Committee could provide strategic guidance and oversight • Guidance of the Advisory Committee was considered and incorporated into the MHTF approach and roll-out efforts • Trends in resources mobilized and constraints identified • Advisory Committee contributed to resource mobilisation strategy 	

Assumption 8.2: The MHTF management mechanisms and internal coordination processes benefitted from <u>effective oversight and guidance by the MHTF Advisory Committee and UNFPA leadership</u>, and contributed to MHTF <u>resource mobilization</u>	
<ul style="list-style-type: none"> • Examples of resource mobilisation efforts and results • Examples of inter-relatedness of funding modalities within MHTF and between MHTF and other funding streams in UNFPA including core funds. 	
Observations	Sources of evidence
<ul style="list-style-type: none"> • n/a – no evidence about role/guidance of advisory committee at country level 	

Area of Investigation 9: COVID-19	
Evaluation Question 9: To what extent has the MHTF been able to respond to emerging and evolving needs of national health authorities and other stakeholders at national and sub-national level due to the COVID-19 pandemic?	
Sub-questions:	
<p>a) To what extent have MHTF programmes pursued a flexible and adaptive approach to generate evidence on the availability of SRH services amidst the pandemic to ensure access to a continuum of comprehensive life-saving maternal and sexual and reproductive health services as part of the COVID-19 response and recovery efforts?</p> <p>b) To what extent did the MHTF reallocation of funds and reprogramming help maintain the continuity of SRMNH services, in particular maternity services; ensure the protection of healthcare workers (in particular obstetricians, midwives and anaesthesiologists); and strengthen the SRMNH coordination mechanisms in response to COVID-19 at national and sub-national levels?</p>	
Evaluation criteria	<i>Relevance, efficiency, coordination, sustainability</i>
Rationale	In 2020, the COVID-19 pandemic spread to every country in the world leading to a range of complex and far-reaching health, socio-economic and other impacts. COVID-19 affected the health system and equitable access to MNH and SRHR services in detrimental ways. UNFPA working alongside other partners adopted a flexible approach to ensure continuation of access to RMNCAH services. The reprogramming and reallocation of funds, combined with mobilisation of additional resources for the emergency response, was aimed at mitigating the negative effects of COVID-19 on the ability of the health system to deliver quality MNH and SRHR services and to ensure continuous access to those services. MHTF partner countries pivoted their health system capacity to prevent, identify, treat and manage COVID-19 cases. UNFPA, including the MHTF, like other United Nations agencies and global partners, took steps to support countries to respond quickly and effectively to COVID-19 while ensuring the continuity in the provision of essential services.

Assumption 9.1: MHTF programmes pursued a flexible and adaptive approach to generate evidence on the availability of SRHR serviced amidst the pandemic and to ensure continued access to a continuum of essential life-saving sexual, reproductive and maternal health services as part of the COVID-19 response and recovery efforts
Indicators
<ul style="list-style-type: none"> • Number of MHTF funded assessments conducted on continuity of essential and lifesaving RMNCAH services amidst COVID-19 pandemic • Documented and reported adjustments in MHTF programmes in terms of scope, timing, and targeted outcomes in light of the pandemic at global and country levels

<p>Assumption 9.1: MHTF programmes pursued a flexible and adaptive approach to generate evidence on the availability of SRHR serviced amidst the pandemic and to ensure continued access to a continuum of essential life-saving sexual, reproductive and maternal health services as part of the COVID-19 response and recovery efforts</p>	
<ul style="list-style-type: none"> • Examples of joint work by thematic teams within MHTF and across UNFPA to prioritise and address the COVID-19 related needs of partner countries • Examples of how MHTF processes, activities and goals continued to be delivered even during the COVID-19 response where that was possible • Examples of policies and programme adjustments related to practical changes and reorganisation of processes or systems • Participation by UNFPA and the MHTF in studies and reviews to assess the impact of COVID-19 on women and adolescents and identify critical needs for support to them as the COVID-19 pandemic unfolded • Incorporation of the response to COVID-19 impacts into annual MHTF plans and budgets. 	
<p>Observations</p>	<p>Sources of evidence</p>
<p>Development of guidance for essential public health services during COVID-19:</p> <ul style="list-style-type: none"> • UNFPA, WHO, UNICEF, PEPFAR, USAID, and Stop TB supported the MoH, Directorate of Public Health in the development of these guidelines. • The guidelines called for a strategic shifts or principles for Provincial and District Health Officers as Health Facility in-Charges: <ul style="list-style-type: none"> ○ “Identification of context-relevant essential services ○ Optimization of service delivery settings and platforms ○ Establishment of effective patient flow (screening, triage, and targeted referral) at all levels ○ Rapid re-distribution of health workforce capacity, including by re-assignment and task sharing ○ Identification of mechanisms to maintain adequate essential medications, equipment and supplies ○ Health worker well-being and joy in the workplace ○ Infection prevention and control of COVID-19 in the areas of service provision and beyond” (p.7). • The following priorities were highlighted in order to prevent communicable disease, avert maternal and child morbidity and mortality, prevent acute exacerbation of chronic conditions (such as HIV and TB) and manage emergency conditions: <ul style="list-style-type: none"> ○ Promotion of good practices in hygiene, nutrition and health-seeking behaviours ○ Prevention for communicable diseases, including vaccination ○ Reproductive and child health, including family planning, care during pregnancy, childbirth, postnatal and infant care. ○ Other categories: diagnosis and provision of medications and supplies for on-going treatment of chronic diseases, including mental health; continuity of critical inpatient services; auxiliary services, such as basic diagnostic imaging, laboratory services and blood bank services. • The guidance included chapters on infection prevention and control of COVID-19 in service provision, and monitoring and supervision needs, as well as those relevant for the difference areas of public health, i.e., SRH, child health, nutrition, adolescent health, non-communicable diseases during COVID-19, essential mental health services amidst COVID-19, malaria, HIV, TB, neglected topical diseases and community health. • The guidance also includes specific guidance for SRHR. An example of selected guidance follows: <ul style="list-style-type: none"> ○ “The population’s sexual and reproductive health needs continue even under the time of a pandemic. Pregnancies planned or unplanned and hence obstetric emergencies will continue. There is likelihood of increase in pregnancies due to challenges in accessing contraception. This may result from; women and girls not wanting to risk COVID-19 infection through visiting the 	<p>MoH, Zambia. General Guidance: Provision of Essential Public Health Services During the COVID-19 Pandemic. May 2020.</p>

Assumption 9.1: MHTF programmes pursued a flexible and adaptive approach to generate evidence on the availability of SRHR serviced amidst the pandemic and to ensure continued access to a continuum of essential life-saving sexual, reproductive and maternal health services as part of the COVID-19 response and recovery efforts

health facility; lack of health care providers at health facilities due work overload and absenteeism occasioned by infection among health care providers; stock-outs of contraception and abortion commodities and other commodities in general. **The COVID-19 pandemic can increase sexual violence and subsequently unintended pregnancies. Sexual violence is a form of gender-based violence, and primarily occur between intimate partners. Thus, women need access to comprehensive sexual and reproductive health care and information. This includes family planning, ANC, care during childbirth, postnatal care (PNC), contraception, safe abortion care services, prevention, testing and treatment of HIV as well as STIs, detection and treatment of GBV.** Women’s choices and rights to sexual and reproductive health care should be respected irrespective of COVID-19 status.” (p.12)

Development of guidance for essential RMNCAH services during COVID-19

- The MoH issued **guidelines for the provision of RMNCAH&N services during the COVID-19 pandemic, intended for use by healthcare care providers providing services to women of reproductive age including adolescent, pregnant and lactating mothers, the newborn as well as children under the age of five.** It is not meant to replace existing guidance or provider judgment, but rather to strengthen clinical management of these patients, and ensure continuity of essential service package for women and children. **The technical guidance was prepared with support from ZAGO. With contributions from the Zambia Paediatric Association, Midwifery Association of Zambia, Medical Women Association of Zambia and cooperating partners** for their input
- Examples of selected guidance includes the following:
 - **“Routine Maternal and Newborn Care services:** In order to reduce maternal and newborn morbidity and mortality, there is an ongoing routine maternal and new-born care services that the systems adhere to. **For the response of COVID-19, the routine services will be continued with clear guidance for reduction of the spread of the virus.** Pregnant women will continue to visit the health facilities except in the case of a lock down. During these visits, there will be adherence to standard procedures by the client and the services providers.
 - **Functional triage:** At the level of the health facility where other members of the population are seeking care, a triage service should be in place. **Pregnant women and new-borns should be prioritized.**
 - **Quality isolation services:** For the COVID-19 health response, isolation services will be provided for affected cases. **Pregnant women and new-borns should receive isolation services** that provides quality maternal care services for maximum outcome. Each patient should have a separate room with attached bathroom and doors closed at all times. The facility should ensure appropriate and consistent use of PPE by all people entering the patient’s room.
 - **Precautionary Observation Centre (POC):** **A designated space with at least two MNH service providers should be available at every POC for pregnant woman and women with newborn.** Pregnant women, mothers and new-borns should immediately be taken to the designated room, suitable for the majority of their stay at POCs. All precautionary IPC measures should be taken, and care should be provided according to their specific needs.
 - **Treatment Centre:** Every treatment centre should have a **designated space and at least four (4) MNH service providers like nurse, midwife etc. Pregnant women, mothers and newborn, should be provided with necessary support and IPC care during their stay.** Care should also be taken during the provision of drugs as to reduce risk of miscarriage or other adverse outcome.

MoH, Zambia. Guidelines for the Provision of RMNCAH&N Services for COVID-19 Containment in Zambia. November 2020.

Assumption 9.1: MHTF programmes pursued a flexible and adaptive approach to generate evidence on the availability of SRHR serviced amidst the pandemic and to ensure continued access to a continuum of essential life-saving sexual, reproductive and maternal health services as part of the COVID-19 response and recovery efforts	
<ul style="list-style-type: none"> ○ IPC: Infection prevention control measures should be included in all service provision package for pregnant women and new-borns. PPE should cover the clothing and skin and should completely protect mucous membranes when caring for pregnant women and new-born with suspected or confirmed COVID-19. Individuals unable or unwilling to adhere to infection control and PPE use procedures should not provide care for patients with COVID-19.” (pp. 11-13) ○ “Home visits may be preferable, provided the woman and everyone in her household is well. Maternity staff attending homes should be mindful of exposure to COVID-19 in a home visit and should adhere to strict infection control procedures when entering and leaving homes. It has been shown that the coronavirus can survive on surfaces for up to 17 days. Maternity staff should be provided with appropriate personal protection equipment as per public health guidelines when providing care for women with suspected infection or when entering homes where other members of the household have symptoms.” (p. 16) 	
<p>Collaboration to ensure essential services during COVID-19</p> <ul style="list-style-type: none"> ● UNFPA, UNICEF and others supported government to have a strategic approach on how things should be done to ensure that essential services are continued, while taking into account the safety measures for clients, communities and providers. These guidelines did help the GOZ maintain a fairly high level of health services. The government has documented that COVID-19 had an impact, i.e., a 10-15% reduction in clients accessing services. Indicators will see a dip. ● The monitoring of the effects of COVID-19 is on-going between Government and partners. A huge meeting planning meeting is envisioned for the coming year. The MoH has reviewed the past three years, and there has been a big variation between 2019 and 2020. Since then, we the trend has been more positive, and the system has adjusted. “We know that COVID-19 is around, and now we know how to provide services.” Periodically, WHO conducts a “desktop survey” on what has been happening with health services. It is done by the UN jointly, but WHO is producing this.” [Note: The WHO informant did not respond to any requests for an interview, despite many tries.] 	Interview, multilateral organization national staff. August 2021.
<ul style="list-style-type: none"> ● There is a study underway to determine impact of COVID-19 on service delivery and on maternal deaths themselves (with WHO). Some of the maternal deaths were among women infected by COVID-19. It is not clear how to classify these deaths. “Initially, WHO did not include COVID-19 mothers as maternal deaths. But people argued, if they have malaria, it is a maternal death; why not COVID-19? Whichever women dies while pregnancy, we need to review to determine whether a COVID-19 or a MH death. Need more clarification by WHO. From the data, we just observed that a number of services decreased during pandemic lockdowns and access by communities was affected.” 	Interview, MoH Zambia national staff. August 2021.
<ul style="list-style-type: none"> ● Zambia saw its first confirmed COVID-19 case in late March 2020 and the number of cases has continued to increase exponentially across the country with more cases reported in the capital Lusaka. The COVID-19 pandemic has posed major challenges for programme implementation. The public health guidelines issued by the government to prevent the spread of the virus which included restrictions on internal travel and physical meetings contributed to delayed programme implementation. UNFPA played a major role in supporting government efforts to mitigate the impact of COVID-19, by supporting interventions focused on ensuring the continuation of maternal health services. UNFPA supported the MoH to develop COVID-19 guidelines and protocols for continuity of essential SRH/HIV/GBV services during the pandemic. In addition, funds were reprogrammed to support the launch of the midwifery strategy and procurement of PPE and Infection Prevention and Control supplies that were distributed to 	UNFPA Zambia. MHTF 2020 Annual Report. 2020.

Assumption 9.1: MHTF programmes pursued a flexible and adaptive approach to generate evidence on the availability of SRHR serviced amidst the pandemic and to ensure continued access to a continuum of essential life-saving sexual, reproductive and maternal health services as part of the COVID-19 response and recovery efforts	
support improved risk management in provision of services in the four UNFPA supported provinces. The government confirmed the second wave of COVID-19 and isolation of a new variant in December 2020. (p.3)	

Assumption 9.2: MHTF reallocation of funds and reprogramming helped maintain the continuity of lifesaving SRMNH services, particularly maternity services/units	
Indicators:	
<ul style="list-style-type: none"> National and subnational data DHIS2/HIMS indicate continuation of SRMNH services, in particular in maternity units Reported (quantitative and qualitative) effectiveness of UNFPA support to procurement, distribution and use of PPE by health care providers (in particular obstetricians, midwives and anaesthetists) to protect them against COVID-19 infections Examples of UNFPA support to SRMNH coordination mechanisms at national and sub-national level which has helped to prevent overlap/duplication and enhance complementarity and synergies with other SRMNAH programmes and actors 	
Observations	Sources of evidence
UNFPA CO reallocation of MHTG and other resources: <ul style="list-style-type: none"> At national level, UNFPA reallocated funding to support the needs that arose; for example, at national level, this helped to support O2 requirements at one of the big hospitals as well as the procurement of PPE and infection prevention materials. The CO reallocated from other fund codes in addition to MHTF. The CO also supported the urgent need to reorient providers to infection prevention and control for COVID-19 mitigation measures. With regard to maternal health, PPEs were in short supply (goggles, face shields, coveralls) as was disinfectant. There was the need to educate support staff/cleaning staff, reorient patients and attitudes. “In more rural areas, there has been fear to come to facilities, coupled with existing in delays in seeking care, lack of transport. Talking to one of the nursing officers in Western province – we need more community engagement/awareness and messages with regard to COVID-19. It would be good to do some form of survey re COVID-19 to learn what is keeping the women from seeking care. What are the issues for health care providers? What are the fears? They are the ones more on the ground, supervising and seeing what on the ground.” 	Interview, UNFPA Zambia staff. August 2021.
<ul style="list-style-type: none"> UNFPA empowered the Provincial Health Office and the DHO to sensitize facilities, including communities and community-based volunteers, on issues regarding infection prevention in line with COVID-19, “the five golden rules of COVID-19.” In labour wards, this included how to handle pregnant women, how to deal with patients who are infected with COVID-19. On a quarterly basis, UNFPA also helped by supplying a few commodities to some facilities. “They went further when we had issues of COVID-19 in Solwezi District and came on board to sensitize our facility staff on issues of how to handle reproductive health activities during COVID-19 in order that we do not have re-infections and so on. A lot has been done by them.” 	Interview, MoH staff, Solwezi District, North-Western Province, Zambia. September 2021.
<ul style="list-style-type: none"> UNFPA engaged with a consultant to study the impact of COVID-19 on SRH and MNH services in Zambia in late 2020, the results of which were not available at the time of the evaluation. The purpose of the study is to provide evidence to understand the impact of COVID-19 on RMNCAH and inform the redesign of key strategies in subsequent and on-going response plans. 	Jacobs, C., Impact of the COVID-19 pandemic on Sexual, Reproductive, Maternal, Newborn, Child

Assumption 9.2: MHTF reallocation of funds and reprogramming helped maintain the continuity of lifesaving SRMNH services, particularly maternity services/units	
<ul style="list-style-type: none"> • The following questions will be answered in this study: <ul style="list-style-type: none"> ○ What are the trends for coverage of selected essential RMNCAH services between 2018 and 2020? ○ Which RMNCAH services have been most affected regarding coverage in relation to the COVID-19 pandemic ○ What aspects of the health system have been affected the most? ○ How did the health system respond to ensure the continuation of essential health services such as sexual and reproductive health services? ○ What mitigating factors were put in place to ensure continuation of essential RMNCAH+N health services? ○ What is the attitude, perceptions and experiences of populations towards access to RMNCAH services in the selected COVID-19 epi areas of Zambia ○ What are the barriers and facilitators to provision of essential RMNCAH health services by frontline health care workers in relation COVID-19 pandemic. 	<p>and Adolescent Health (RMNCAH) services and the health system in Zambia: Inception report, 2020</p>
<ul style="list-style-type: none"> • In Zambia, for instance, an increase in fertility rates, especially among adolescent girls, is projected based on preliminary data from health facilities. This is as a result of low use of services such as family planning and adolescent sexual and reproductive health, for fear of contracting COVID-19 in health facilities. • Zambia is currently experiencing a third wave of the pandemic. With schools remaining closed to reduce the spread of the virus, adolescent girls are more vulnerable to pregnancy and child marriage, which could in turn contribute to an increase in the country’s already high fertility rates. A notable increase in maternal deaths during peak infection periods has been recorded by the government, which is worrying. The pandemic has also exacerbated gender inequities and gender-based violence. Under lockdowns, incidences of violence have increased. 	<p>UNFPA Zambia, News: How COVID-19 has increased fertility, adolescent pregnancy and maternal deaths in East and Southern African countries. 11 July 2021. Accessed from: https://zambia.unfpa.org/en/news/how-covid-19-has-increased-fertility-adolescent-pregnancy-and-maternal-deaths-east-and-southern on 15 Nov 2021.</p>

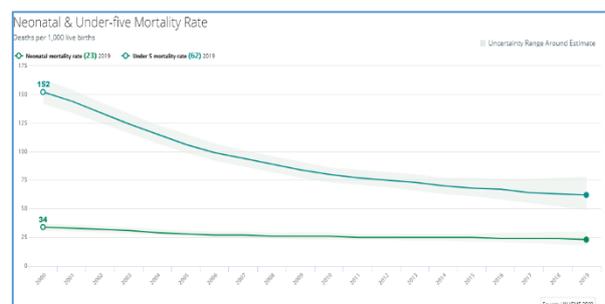
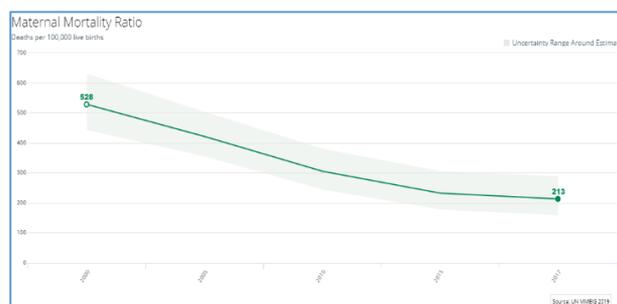
ANNEX 2: PERSONS INTERVIEWED IN ZAMBIA

Name	Organization	Position
Dr Angel Mwiche	Ministry of Health, Lusaka	Deputy Director, Public Health
Caren Chizuni	Ministry of Health, Lusaka	Chief Safe Motherhood Officer
Daphen Shamambo	Ministry of Health, Lusaka	Chief Nursing Officer (Training)
Ruth Bwepe	Ministry of Health, Lusaka	Family Planning Programme Officer
Toddy Sinkamba	General Nursing and Midwifery Council of Zambia, Lusaka	Director, Education and Training
Dr Goshon Kasanda	Ministry of Health, Lusaka	Fistula surgeon
Gift Malunga	UNFPA Zambia, Lusaka	Country Representative
Leonard Kamugisha	UNFPA Zambia, Lusaka	Assistant Country Representative
Dr Wezi Kaonga	UNFPA Zambia, Lusaka	Programme Specialist, SRH
Elizabeth Kalunga	UNFPA Zambia, Lusaka	Programme Coordinator
Jenipher Mijere	UNFPA Zambia, Lusaka	Fistula Analyst
Dr Rodgers Mwale	UNICEF, Lusaka	Health Specialist
Sarah Ngoma	Midwifery Association of Zambia, Lusaka	President
James Mdala	Marie Stopes Zambia, Lusaka	Programme Officer
Jully Chilambwe	JHPIEGO, Lusaka	Health Advisor, MNCH
Alice Chembe	Planned Parenthood of Zambia, Lusaka	Programme Officer
Betty Kunda	Catholic Relief Services	MNH Technical Advisor
Miriam Mwiinga	Young Women's Christian Association (YWCA)	Programme Officer
Rosemary Mwanza	Lewanika Midwifery School, Mongu, Western Province	Principal Tutor
Danny Mulembwe	Ministry of Health, Luapula Province	Principal Nursing Officer
Catherin Matyola	Ministry of Health, Western Province	Principle Nursing Officer

ANNEX 3: ZAMBIA COUNTRY DATA PROFILE

General and health financing profile					
Indicator	Value	Source	Indicator	Value	Source
Total Population: estimated size of population at mid-year, in millions, 2021	18.9	(1)	Life expectancy at birth in years, 2021 (male/female)	61/68	(1)
GNI per capita, Atlas method (current USD) 2019	1,430	(3)	Current health expenditure as per cent of GDP, 2018	5%	(2)
Primary Health Care expenditure as per cent of current health expenditure, 2018	79%	(2)	Domestic general government health expenditure (% of current health expenditure/% of general government expenditure, 2018)	39.08%/7.04%	(3)
Out-of-pocket expenditure (% of current health expenditure) 2018	9.98%	(3)	External health expenditure (% of current health expenditure)	44.56%	(3)

Health and population profile		
Indicator and Definition:	Indicator value	Source
Total fertility rate: Number of children born per woman in her lifetime.	4.4	(1)
Average annual rate of population change: Average exponential rate of growth over one year based on a medium variant projection (2015-2020)	2.9	(1)
Maternal mortality ratio, 2017: Number of maternal deaths per 100,000 live births	213	(4)
Neonatal mortality rate (deaths in babies in the first month of life per 1000 live births) 2019	23	(3)
Births attended by skilled health personnel, 2015: Percentage of births attended by skilled health personnel (doctor, nurse or midwife)	80	(5a)
Contraceptive prevalence rate, modern method (CPR): Percentage of (all) women aged 15-49 who are currently using any modern method of contraception	37	(1)
Unmet need for family planning: Percentage of (all) women aged 15-29 who want to stop or delay childbearing but are not using a method of contraception	15	(1)
Adolescent birth rate, 2020: Number of births per 1,000 adolescent girls aged 15-19	135	(1)
Child marriage by age 18, 2019: Proportion of women aged 20-24 years who were married or in a union before age 18	29	(5b)



(1) United Nations Population Division <https://www.unfpa.org/data/world-population-dashboard> (2) World Health Organization Global Health Expenditure database <https://apps.who.int/nha/database/ViewData/Indicators/en>; (3) World Bank Data Bank: <https://databank.worldbank.org/home> accessed on 28 June 2021; (4) UN Interagency group for maternal mortality estimation <https://www.who.int/data/gho/indicator-metadata-registry/imr-details/26> (5) UNICEF (a) <https://data.unicef.org/topic/maternal-health/delivery-care/> (b) <https://data.unicef.org/resources/dataset/child-marriage/> (6) Source of graphics: <https://profiles.countdown2030.org/#/ds/UGA>

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