

**Report for an Evaluation of two  
UNFPA Lao PDR Programmes:  
Community Based Distribution (CBD) and  
Individuals, Families, and Communities (IFC)**

Final

15 January 2014

## Disclaimer Statement

This evaluation report was prepared by a team of consultants: Sam Clark, Evaluation Team Leader, and Niramongh Chanlivong, National Evaluation Associate. The report was produced under the guidance and supervision of the Evaluation Manager, Mr. Thomas Lammar, United Nations Population Fund (UNFPA), Lao People's Democratic Republic (PDR), with review and oversight from the UNFPA Lao PDR Evaluation Reference Group. The content, analysis and recommendations of this report do not necessarily reflect the views of the UNFPA, its Executive Committee or member states.

## Acknowledgments

The authors would like to express their sincere thanks to the numerous representatives and staff from the Lao PDR Ministry of Health (MoH), the Maternal and Child Health Centre (MCHC), the Centre for Information and Education on Health (CIEH) and related institutions at the National, Provincial and District level, the UN collaborating agencies, as well as Non-Government Organizations (NGOs), implementing agencies and donor agencies for providing time, resources and materials to permit the development and implementation of this evaluation. The collaboration and support of the Savannakhet provincial health office, especially the Provincial CBD/IFC Programme Coordinator, was deeply appreciated.

We appreciate the participation of members of the Evaluation Reference Group, especially those who took time to attend the inception and out-briefing and provided comments. We are particularly grateful to the UNFPA Lao PDR staff members (including senior staff who have since left) who, despite their many other pressing commitments, were so responsive to our requests on short notice. We would also acknowledge the highly professional and good humoured assistance provided by the UNFPA Lao PDR driver, as well as the local language translator who interpreted for us in Savannakhet.

We would also like to acknowledge the many other Lao PDR stakeholders and client/beneficiaries, including the men and women in rural villages of the three Savannakhet Districts of Vilabouly, Sepone, and Nong, who collaborated with this evaluation despite their many other obligations.

In addition, the authors are grateful for the collegiality shown by international experts in the IFC Programme process who shared extremely useful materials for the design and implementation of the IFC related component of the evaluation.

It is the team's hope that this evaluation and the results and recommendations presented in this report will help in achieving desired results in the remaining implementation of the 5<sup>th</sup> UNFPA Country Program and subsequent UNFPA Lao PDR programmes.



## Executive Summary

**Overview:** UNFPA Laos has been implementing family planning (FP) activities with and for communities within the framework of its 5th Country Programme (CP5) from 2012 through 2015. This report presents the results from an evaluation of two interlinked components of the CP5:

1) Community-Based Distribution (CBD) of contraceptives and other reproductive health commodities and 2) the application of the WHO framework for community mobilisation working with Individuals, Families and Communities (IFC) to improve maternal and new-born health. The current combined estimated overall budget for these two programmes, including overhead and capacity building activities, was \$1.4 million for 2012 through 2014.

**Objectives and scope:** This evaluation has been commissioned by UNFPA Lao PDR in collaboration with the main implementing partners within the Lao PDR Ministry of Health (MoH). The key implementing partners for CBD and IFC programming include the Ministry of Health at the National, Provincial (e.g. the Savannakhet Provincial Health Department and other Provinces) and District Level, the Department of Hygiene and Health Promotion (DHHP), the Mother and Child Health Centre (MCHC), Centre of Information and Education for Health (CIEH) and the Lao Woman's Union (LWU). The purpose of the evaluation is to assess the progress these two programme components have made toward the achievement of their defined outputs, to identify lessons learned, and to develop recommendations to inform UNFPA's future programming in the areas of CBD and IFC. The intended audience and users of the evaluation are the UNFPA management in the Country Office, UNFPA staff working on CBD and IFC, government counterparts in Lao PDR, and other development partners.

**The overall objectives of the Evaluation** are: (i) To provide an independent assessment of UNFPA's contribution to the progress made through the CBD and IFC programme towards the expected Output 2 set forth in the results framework of the country programme; (ii) Enhanced accountability of the Laos Country Office, as well as UNFPA as a whole, for the relevance and performance of its CBD and IFC programme components, and (iii) A broadened evidence-base, documented lessons learned, as well as a set of actionable recommendations, based on credible findings, to be used for organisational learning and the design of future UNFPA programming. While this evaluation is limited to the UNFPA CP5 components for IFC and CBD, it is informed by the larger context of the CP5 programme's other activities as well as the activities of other development partners, such as the WHO and UNICEF. The evaluation covers a 34-month implementation period, from January 2012 to October 2014.

### **The two programmes.**

**Community-based distribution (CBD)** is a strategy that relies on trained non-professional members/or retired health workers of the community to provide health services directly to other members of the community. In the case of FP, these services provide information and modern temporary contraceptive methods, including pills and condoms. Under CP5 (2012-2015), CBDs have been supported in 4 UNFPA Lao PDR target provinces: Savannakhet (South/Central), and Phongsali, LuangNamtha and Oudomxai in Northern Laos. CBDs provide FP services to communities, each of them being responsible for 3 to 6 target villages. The villages have been selected based on their distant location from village health centres. Prior to being deployed, the CBDs received a 5-day training course. After the initial training, the CBDs received a 3-day refresher training. Currently, there are 62 UNFPA-supported CBDs travelling monthly to villages in the target provinces, and covering more than of 280 communities/villages, with an estimated 5,098 active FP clients. The main focus of the CBD evaluation is in

Savannakhet province, where there are 31 CBDs who visit an estimated 2,700 FP clients in 137 Villages. UNFPA covers the CBDs' travel costs and allowances. The CBDs are now managed by the MoH with CBDs reporting to the District Health Offices (DHOs). CBDs report every 1 to 3 months, and at the same occasion replenish their stocks of contraceptives, Vitamin A, Iron, and other items.

**Individuals, Families and Communities (IFC)** The IFC approach, developed by WHO, can be seen as a process of enabling people and groups to increase control over, and to improve, their health and quality of life. The aim of working at the IFC level is to contribute to the empowerment of women, families and communities to improve and increase their control over maternal and new-born health, as well as to increase the access and utilization of quality health services, particularly skilled birth attendance. Interventions at the IFC level are meant to foster supportive environments for healthier mothers, new-borns, families and communities. Interventions are organized into four priority areas:

1. Developing capacities to stay healthy and respond to obstetric and neonatal emergencies.
2. Increasing awareness of the rights, needs and potential problems related to MNCH.
3. Strengthening links for social support between communities and the health care system.
4. Improving quality of care and health services, and of their interactions with IFCs.

UNFPA Lao PDR initiated its IFC component in 2009, under its 4th Country Programme. It has been adapted in CP5 for implementation in four districts in Savannakhet Province. Its interventions aim at empowering village community structures through community involvement, by identifying needs of the population through participatory workshops. Once needs are identified, they are addressed through Village Health Committees (VHCs) who organize health education and health promotion activities to raise awareness and promote access to services and establishment of Emergency Birth Preparedness Plans (EBPPs). The Participatory Community Assessment (PCA) is the critical first stage of the IFC process. The results from the PCAs have informed the design and implementation of interventions in collaboration with Village Health Committees. Under the CP5 programme, a total of 74 IFC training events have been held since 2012 for VHCs and VHV on EBPP, trainings for VHCs and village health volunteers (VHVs) on Maternal Neonatal Child Health (MNCH) and trainings on the counselling needs of adolescents. As of 2013, there have been at least 1,009 trainees, more than a quarter of those trained (272) were women. MNCH training for VHCs has achieved a coverage for almost two-thirds of target villages.

**Evaluation Approach:** The evaluation terms of reference follows the UNFPA Evaluation Handbook (UNFPA 2013) and employs six main criteria: relevance, effectiveness, efficiency, sustainability, value added as well as gender. The evaluation is guided by a simplified logic model that presents the relationships between the CBD and IFC sub-activities within each of four main activities that contribute to an overall output to ensure that individuals, families and communities in priority areas have access to an integrated package of services for MNCH.

**Methodology:** The evaluation was conducted by a two-person team (international team leader, national evaluation associate) in two phases: development of a design report in October 2014, and the evaluation mission in Lao PDR in November 2014 for three weeks. The evaluation is based on non-random samples of respondents with qualitative data collection methods. All interviews followed informed consent procedures as required by the UN ethics guidelines for evaluators. The collection of evaluation data was implemented using four main methods: 1) Desk review 2) Site visits to targeted areas in three districts in the province of Savannakhet 3) Semi-structured group and individual interviews with stakeholders and 4) Focus Group and Semi-structured individual and group interviews with programme client/beneficiaries. As needed, all

interviews were done in Lao or in local language with translation. This included the assistance of a highly competent translator, who is from a local ethnic group and is fluent in related dialects. Analysis is based on a synthesis and triangulation of information obtained from the above-mentioned evaluation activities. Limitations of the evaluation include its inherently non-representative, qualitative nature due to the small, non-random sample sizes and low response rates for certain interview categories. All interviews were conducted without UNFPA agency or implementing partner staff present. The evaluation is based on a total of 45 interviews and five FGDs; this was below the target of 70 completed interviews. The use of group interviews provided an opportunity to expand the number of respondents: the forty-five individual and group interviews were conducted with a total of 88 respondents. An additional 30 respondents participated in the five focus group discussions (FGDs), four with women client/beneficiaries and one with men. There was a minimum of 22 respondents per district and a reasonable balance in the total number of respondents on the basis of gender. Out of 118 respondents, there were 62 women and 56 men.

**CBD Conclusions - Overall:** UNFPA Lao PDR support for CBD programmes remains a valid strategy for remote areas without access to Health Centres (HCs). UNFPA supported CBDs clearly provide access to FP for women in remote rural hard-to-reach areas. **Relevance:** The use of locally hired CBDs ensures culturally appropriate interactions. There is evidence of an increasing demand for FP (especially injectables) and MNCH services. Non-cultural barriers to FP and MNCH services (distance, time and cost loom large based on the qualitative data) justify further support for CBD programmes. The current information education and communication (IEC) materials may be insufficient and additional materials and training should be developed, especially to help CBDs to effectively counsel both women and their husbands regarding the side effects and benefits of contraception. **Effectiveness:** Despite some challenges and constraints, CBDs are contributing to use of FP among women in remote villages. District level data show substantial increases in contraceptive prevalence. Assumptions about CBD work patterns may not be valid. Examples of inaccurate assumptions relate to the number work days per month, number of households visited in each village, frequency of use of IEC materials, data collection, and capacity for effective FP counselling. The impact of training may be undermined by lack of translation into local ethnic languages. There is often a close working relationship between CBDs and VHCs, for example in order to have access to households (HHs) in villages where the CBD is not resident. This relationship does not seem to be adequately considered in the design of both CBD and IFC outreach activities. There are missed opportunities for CBD to reach out to husbands of women who wish to use FP. Given that CBDs may not be visiting all households in their assigned villages and are mainly visiting current users, CBDs may be able to collaborate with VHCs to establish regular monthly village meetings to encourage non-users to come forward. While it is acknowledged that CBDs are intentionally selected to work in villages that are remote from HCs, there was little evidence of ongoing collaboration or linkage between the CBDs and HCs. CBDs appear to be willing to carry non-FP supplies in a manner consistent with an expanded CBD strategy, called CBD Plus. The MCHC may be interested in adapting and this expanded approach and other senior MoH stakeholders may be supportive. **Sustainability:** Active CBD clients, mainly women using oral contraception, are highly vulnerable to interruption of contraceptive supplies. To avoid unwanted pregnancies, a transition/exit planning is essential before abruptly ending UNFPA support for CBDs. **Efficiency:** UNFPA disbursement of funds for the CBD programme has not been efficient and may have been disruptive and undermined CBD morale due to delays in payment. CBDs may only be visiting the households of current users. This suggests that the CBD programme is not efficient and warrants follow-up.

**Value Added:** While UNFPA has clearly been a lead player for CBD programmes, other agencies, such as CARE, JICA and WB (CBD Plus) have shown interest in the past; some of these agencies might consider support in the future.

**IFC Conclusions – Overall:** Despite an initial lack of IFC expertise, UNFPA Lao PDR was the primary agency to commit itself to implementing the Strategic Objective 3 (Mobilize IFC for MNCH) of the MoH MNCH Policy Framework. **Relevance:** The IFC Programme is highly relevant to the needs of the vulnerable populations and SO 3, but it faces two important challenges: 1) the current Lao cultural context, which tends to be hierarchical and male dominated within certain ethnic groups, and 2) the MoH's tradition of a centralized management style. The IFC programme has developed relevant materials for the target population, including a recently developed manual for VHCs and VHVs. **Effectiveness:** It is plausible that the UNFPA Lao PDR-supported IFC programme has contributed to improvements in MNCH, especially ANC visits, FP and HC deliveries. Based on admittedly limited qualitative data and based on the quantitative data, which also has limitations, the MNCH indicators in Savannakhet appear to be improving despite problems of attribution. Empowerment among women to control their own access and use of MNCH services was not very pronounced. There were instances where villagers were hesitant to request more services. There was little evidence of any significant changes in perinatal service demand and behaviour. **Functionality of VHCs according to Terms of References (TORs):** There was a consistent reporting of VHCs organizing village dissemination meetings shortly after trainings. However, none of the VHC respondents had any knowledge of a TOR or could provide examples of IFC IEC materials. **Emergency Birth Preparedness Plans (EBPPs):** While there was some reporting of awareness about EBPPs among VHC respondents, there was little evidence of much impact based on qualitative data from FGDs. Some districts report relatively large numbers (> 500) emergency transport events in the past year, but these were not limited to obstetric emergencies. **Sustainability:** The IFC training level of effort is quite substantial with significant coverage of district villages. This capacity building for VHCs has potential for significant long- term impact with continued donor support. The IFC Participatory Community Assessment (PCA) process is very unlikely to be sustainable without streamlining. Although capacity has been developed and the IFC concepts have been taken on, for example by CIEH and UNFPA, it seems likely that any future IFC activity will require additional UNFPA support. The IFC training of VHCs and VHVs is an efficient approach to reach villagers to support access and use of MNCH services. This is with the caveat that the quality of the training needs to be monitored more closely. The IFC program could be replicated in other districts, so long as the PCA can be streamlined to reduce cost and time and kept within the context of local District administration.

**CBD Recommendations. Overall:** UNFPA Lao PDR should continue to support CBD programmes with the understanding that current problems (stock outs, delay in payments, lack of training, lack of supportive supervision field visits, and insufficient HH visits) need to be addressed. The CBD Plus model appears to be promising and should be considered in remote areas not served by HC Outreach programme, with the reservation that this should only be considered if and when current CBD programme problems have been resolved.

**Effectiveness:** As recommended by WHO and other internationally recognized RH authorities, CBDs with a suitable background should be trained to provide injectable contraception. An explicit CBD TOR should be developed in consultation with CBDs so that it reflects realistic performance standards. CBDs should be trained based on this revised TOR. The finding that CBDs are only visiting current users for re-supply needs to be further explored and confirmed. Efforts are needed to increase CBD interaction with non-users (both men and women), promote

the introduction of long-term family planning methods (IUD and Implants) and improve CBD knowledge and understanding for effective counselling for these long-term methods. Regular annual refresher training (in minority languages as needed in all Provinces) is needed for CBD counselling skills, especially to address women's and men's concerns for contraceptive side effects. More culturally-specific training is urgently needed to reduce these cultural barriers.

**Sustainability:** If CBD activities were not to be funded anymore, UNFPA should develop an “exit strategy” for the CBD programme that ensures a gradual phase out, with a minimum of three-month advance notice that allows women sufficient time to find credible alternate sources of FP. While it is acknowledged that CBD programme is not currently sustainable, in the short-term UNFPA should advocate for Government of Laos (GoL) and other donor agencies to fund CBD programmes until such time as FP services are available in remote areas as part of a national integrated MNCH service package. In the longer term, UNFPA should, along with other partners, support efforts to integrate FP in remote areas within a GoL MNCH integrated service package.

**Efficiency:** UNFPA Lao PDR should adapt existing Population Services International (PSI) Interpersonal Communication (IPC) or similar cost effectiveness models to the CBD programme in order to better assess comparative District and Provincial performance, especially to identify new clients. Also consider collaboration with PSI IPC management for sharing and/or adaptation of IPC systems for monitoring for more rigorous and regular supportive supervision of CBDs. Fund capacity building to enhance the Provincial and District level M&E data collection and reporting, especially for capacity building to improve village level denominators for CBD indicators.

**Gender:** Given the cultural barriers to access and use of MNCH services, future CBD training should have a gender component. Strengthen CBD refresher training to include gender awareness for CBDs with the goal of improved counselling skills for working with husbands and young men in support of women's needs for access and use of MNCH service, especially to address husband and wife opposition to FP based on concerns for side effects.

**UNFPA Future programming:** Strengthen UNFPA Lao PDR budget and project management procedures to avoid unexpected gaps in disbursements. Support capacity building for provincial and District level counterparts for project management and reporting.

**IFC Recommendations. Overall:** UNFPA Lao PDR should consider continued capacity building for VHCs and VHVs (for EBPPs, Husband support for pregnant women, and empowerment to insist on free quality services) in the four Savannakhet Districts, building on the CIEH work (like the VHC/VHV manual) and informed by the District-level PCA report findings.

**Relevance:** Where feasible, trainings should be done in local minority languages. VHC training impact may have been limited by lack of comprehension among Ethnic language speakers.

**Effectiveness:** Establish clear, measurable criteria for determining if VHCs and EBPPs are functional in all target villages. Support the implementation of six-month supportive supervisory visits for VHCs and monitor VHC and EBPP functionality. Develop local language (for example, Bru in Savannakhet; Khamu, Hmong in Northern provinces) radio segments for encouragement of ethnic audiences on access and use of MNCH services.

**Sustainability:** Coordinate VHC capacity building with other ongoing Province and District programmes, including Skilled Birth Attendants (SBA), when and where applicable, the UNICEF-supported Integrated HC Outreach Programmes, and CBD activities.

**Future UNFPA Programing:** UNFPA Lao PDR should consolidate its capacity for IFC activities by working with and/or through NGOs to conduct future community IFC MNCH PCAs and IFC MNCH related empowerment activities in Districts. The UNFPA Lao PDR supported



IFC PCA process needs to be shortened and simplified to permit a more efficient and rapid community consultation at the District level. UNFPA Lao should not attempt future IFC PCAs without a) revising the process to be more efficient, as mentioned above, and b) continuing to use external international consultants. UNFPA Lao PDR needs to develop a clear time-bound advocacy plan to end unauthorized charges for MNCH services at the District and Sub district Level, preferably in collaboration with other UN sister agencies, such as the WHO and UNICEF, by end of 2015.

## Abbreviations

<b>ANC</b>	Antenatal Care
<b>ASRH</b>	Adolescent Sexual and Reproductive Health
<b>AWP</b>	Annual Work Plan
<b>CBD</b>	Community Based Distributor or Community Based Distribution
<b>CHW</b>	Community Health Worker
<b>CIEH</b>	Centre for Information and Education on Health
<b>CM</b>	Community/Peer Motivators
<b>CMW</b>	Community Midwife
<b>CO</b>	Country Office
<b>CP</b>	Country Programme
<b>CP5</b>	5 <sup>th</sup> Country Program
<b>CPR</b>	Contraceptive Prevalence Rate
<b>C-section</b>	Caesarean section
<b>DH</b>	District Hospital
<b>DHHP</b>	Department of Hygiene and Health Promotion
<b>DHO</b>	District Health Office
<b>Dist.</b>	District
<b>DSA</b>	Daily Subsistence Allowance
<b>EBPP</b>	Emergency Birth Preparedness Plan
<b>EMOC</b>	Emergency Obstetric Care
<b>EMONC</b>	Emergency Obstetric and New-born Care
<b>ERG</b>	Evaluation Reference Group
<b>FACE</b>	Funding Authorization and Certificate of Expenditure
<b>FGD</b>	Focus Group Discussion
<b>FP</b>	Family Planning
<b>FPRH</b>	Family Planning and Reproductive Health
<b>GDP</b>	Gross Domestic Product
<b>GMT</b>	Greenwich Mean Time
<b>GoL</b>	Government of Laos
<b>HC</b>	Health Centre
<b>HH</b>	Household
<b>HIV</b>	Human Immunodeficiency Virus
<b>HMIS</b>	Health Management Information System
<b>ICPD</b>	International Conference on Population and Development
<b>IDA</b>	International Development Association
<b>IEC</b>	Information Education and Communication
<b>IFC</b>	Individuals, Families and Communities
<b>INGO</b>	International Non-Governmental Organizations
<b>IPC</b>	Interpersonal Communication
<b>IUD</b>	Intra-uterine Device
<b>JICA</b>	Japan International Cooperation Agency
<b>Lao PDR</b>	Lao People's Democratic Republic
<b>LDC</b>	Least Developed Countries
<b>LMIS</b>	Logistics Management Information System
<b>LNT</b>	Luangnamtha
<b>LSIS</b>	Lao Social Indicator Survey
<b>MDG</b>	Millennium Development Goals
<b>MICS</b>	Multi-Indicator Cluster Study (Survey)

<b>MMR</b>	Maternal Mortality Ratio
<b>MNCH</b>	Maternal, Neonatal and Child Health
<b>MCHC</b>	Maternal and Child Health Centre
<b>MoH</b>	Ministry of Health
<b>M&amp;E</b>	Monitoring and Evaluation
<b>NGOs</b>	Non-Governmental Organisations
<b>OC</b>	Oral Contraceptive
<b>ODA</b>	Official Development Assistance
<b>ODX</b>	Oudomxay
<b>PCA</b>	Participatory Community Assessment
<b>PEER</b>	The PEER study
<b>PNC</b>	Postnatal Care
<b>PSI</b>	Population Services International
<b>PSL</b>	Phongsaly
<b>RH</b>	Reproductive Health
<b>SBA</b>	Skilled Birth Attendant
<b>SO3</b>	Strategic Objective 3
<b>SRH</b>	Sexual Reproductive Health
<b>STIs</b>	Sexually Transmitted Infections
<b>SVK</b>	Savannakheth
<b>TPT</b>	Thapangthong district
<b>TOR</b>	Terms of reference
<b>UN</b>	United Nations
<b>UNEG</b>	United Nations Evaluation Group
<b>UNICEF</b>	United Nations Children's Fund
<b>UNDAF</b>	UN Development Assistance Framework
<b>UNJP</b>	United Nations Joint Programme
<b>UNFPA</b>	United Nations Population Fund
<b>USD</b>	United States Dollar
<b>VHC</b>	Village Health Committee
<b>VHV</b>	Village Health Volunteer
<b>VHW</b>	Village Health Worker
<b>VL</b>	Village Leader
<b>WB</b>	World Bank
<b>WFP</b>	World Food Programme
<b>WHO</b>	World Health Organization
<b>WRA</b>	Women of Reproductive Age

## Table of Contents

Disclaimer Statement .....	ii
Acknowledgments .....	ii
Executive Summary .....	iv
Abbreviations .....	x
List of Tables .....	xiii
List of Figures .....	xiii
List of Attachments .....	xiii
Section 1. Introduction .....	1
Section 1.1 Purpose and objectives of the CBD / IFC Evaluation .....	1
Section 1.2 Scope of the Evaluation .....	1
Section 1.3 Methodology and process .....	1
Section 1.4 Limitations and risks .....	4
Section 2. Country context .....	5
Section 2.1 Development challenges and national CBD/IFC-related strategies .....	5
Section 2.2 The role of external assistance in the area of maternal health .....	7
Section 3. UNFPA response and CBD/IFC strategies .....	8
Section 3.1 Context for the UNFPA Lao PDR Supported CBD and IFC strategies .....	8
Section 3.2 Brief description of the CBD strategy, goals and achievements .....	11
Section 3.3 Brief description of the IFC component Strategy, Goals and Achievements .....	13
Section 3.4 Rationale for UNFPA CP5 focus on CBD and IFC in Savannakhet Province .....	14
Section 3.5 Financial Structure and Resource Allocation for CBD and IFC programmes .....	15
Section 4. CBD Findings for Six Evaluation Criteria .....	16
Section 4.1 Relevance .....	16
Section 4.2 Effectiveness .....	18
Section 4.3 Sustainability .....	23
Section 4.4 Efficiency .....	24
Section 4.5 Value Added .....	26
Section 4.6 Gender .....	26
Section 5. IFC Findings for Six Evaluation Criteria .....	26
Section 5.1 Relevance .....	26
Section 5.2 Effectiveness .....	29
Section 5.3 Sustainability .....	36
Section 5.4 Efficiency .....	38
Section 5.5 Value Added .....	39
Section 5.6 Gender .....	39
Section 6. Conclusions .....	40

Section 6.1 CBD Conclusions .....	40
Section 6.1.1 Strategic Level.....	40
Section 6.1.2 Programmatic Level .....	40
Section 6.2 IFC Conclusions .....	44
Section 6.2.1 Strategic Level.....	44
Section 6.2.2 Programmatic Level .....	44
Section 6.2.3. Transferable lessons learned.....	45
Section 7. Recommendations .....	46
Section 7.1 CBD Recommendations.....	46
Section 7.1.1 Recommendations for UNFPA’s component on communities.....	46
Section 7.1.2 Recommendations for future UNFPA programming.....	50
Section 7.2 IFC Recommendations .....	50
Section 7.2.1 Recommendations for UNFPA’s component on communities.....	50
Section 7.2.2 Recommendations for future UNFPA programming.....	52

## List of Tables

- Table 1: Number of Interviews and Respondents by Types, City and District and by Gender  
Table 2: UNFPA-Supported CBDs and Active Family Planning Clients in Four Provinces  
Table 3: UNFPA Lao PDR Budget for IFC, CBD and Other Activities for 2012 through 2014  
Table 4: IFC Trainings in Savannakhet Province by District and Year

## List of Figures

- Figure 1. Total ODA for Lao PDR RH Care from 2000 to 2011 in US\$  
Figure 2. Total ODA for Lao PDR RH Care in 2011 by Source in US\$  
Figure 3. Simplified Logic Model for Laos IFC/CBD Programmes  
Figure 4. Annual UNFPA Lao PDR Budget for IFC, CBD and Other activities 2012-2013  
Figure 5. Estimated number of Active UNFPA-Supported CBD Clients, December 2014  
Figure 6. Trends in Contraceptive Prevalence in four Savannakhet Districts 2010-2013  
Figure 7. Cover from IFC Manual on MCH Care for VHC and VHVs  
Figure 8. Participatory Community Assessment (PCA) Process  
Figure 9. IFC Villages Covered and Number of Trainings in Savannakhet Province by Year  
Figure 10. Selected MNCH and IFC Indicators for Four Districts in Savannakhet Province

## List of Attachments

- Attachment 1: TOR  
Attachment 2: List of persons and institutions met/interviewed  
Attachment 3: List of documents consulted.  
Attachment 4: Evaluation Matrix  
Attachment 5: Site Visit Schedule  
Attachment 6: Data Collection Instruments  
Attachment 7: Key PCA Findings from Four Savannakhet Districts  
Attachment 8: Evaluation Questions

## Section 1. Introduction

### Section 1.1 Purpose and objectives of the CBD / IFC Evaluation

UNFPA Lao PDR has been implementing family planning activities with and for communities within the framework of its 5th Country Programme (CP5). The CP5 includes a focus on two interlinked components: 1) Community-Based Distribution (CBD) of contraceptives and other reproductive health commodities and 2) the application of the WHO framework for community mobilisation working with Individuals, Families and Communities (IFC) to improve maternal and new-born health. The purpose of the evaluation is to assess the progress these two programme components have made toward the achievement of their defined outputs, to identify lessons learned, and to develop recommendations to inform UNFPA's future programming in the areas of CBD and IFC.

The overall objectives of the Evaluation are:

- (i) To provide an independent assessment of UNFPA's contribution to the progress made through the CBD and IFC programme towards the expected Output 2 set forth in the results framework of the country programme;
- (ii) Enhanced accountability of the UNFPA Lao PDR Country Office, as well as UNFPA as a whole, for the relevance and performance of its CBD and IFC programme components, and
- (iii) A broadened evidence-base, documented lessons learned, as well as a set of actionable recommendations, based on credible findings, to be used for organisational learning and the design of future UNFPA programming.

The intended audience and users of the evaluation are the UNFPA management in the Country Office, UNFPA staff working on CBD and IFC, government counterparts in Lao PDR, and other development partners.

### Section 1.2 Scope of the Evaluation

While this evaluation is limited to the UNFPA CP5 components for CBD and IFC, it is informed by the larger context of the CP5 programme's other activities as well as the activities of other development partners, such as the WHO and UNICEF. The evaluation covers a 34-month implementation period, from January 2012 to October 2014.

### Section 1.3 Methodology and process

**Evaluation Criteria:** This evaluation is designed to review the CBD and IFC programmes based on a defined set of evaluation criteria: relevance, effectiveness, efficiency and sustainability, as well as value added and gender.

**Evaluation Questions and Evaluation Matrix:** As outlined in the evaluation TOR, a set of questions have been recommended for each of the above evaluation criteria (See Table 3 in Design Report for an Evaluation of the UNFPA Lao PDR CBD and IFC Programmes Draft 0.2 31 October 2014). With few exceptions, the original questions from the evaluation TOR have been retained in their original wording (See Attachment 8 for final wording of evaluation questions). As required by the terms of reference, a detailed evaluation matrix has

been prepared which explains which data sources and methods were to be used to address each of these questions. See Attachment 4.

**Focus of the Evaluation:** The evaluation covers the entire CP5 period (January 2012 to date) and is focused on the CBD and IFC programme activities within the framework outlined in the simplified logic model presented below in Figure 3. The evaluation is focused on the specific activities outlined in the Annual Work Plans (AWPs) for 2012, 2013 and 2014 for the CBD and IFC programmes.

## **Methods for data collection and analysis**

**Overview:** The collection of evaluation data was carried out through a variety of techniques: direct observation, informal and semi-structured interviews and focus groups. The analysis builds on triangulating information obtained from various stakeholders' views as well as with secondary data and documentation reviewed by the evaluation team.

The evaluation follows the principles of the UN Evaluation Group's norms and standards (in particular with regard to independence, objectiveness, impartiality and inclusiveness) and is guided by the UN ethics guidelines for evaluators in accordance with the UNEG's Ethical Guidelines for Evaluation.

The evaluation is based on the following key activities<sup>1</sup>:

- a) Desk review of documents and financial and other pertinent programme data.
- b) Site visits to UNFPA programme areas in three Districts of Savannakhet Province.
- c) Semi-structured Interviews with stakeholders (including national counterparts, implementing partners and development partners).
- d) Focus Group Discussions with male and female clients of the CBD and IFC programmes.

**Stakeholder Involvement:** This design report was reviewed by the Evaluation Reference Group, which consists of key stakeholders for the CBD and IFC programme, including appropriate National level ministries, civil society organizations, NGOs, donor community as well as a key implementing agencies. Their comments were incorporated into the approaches taken in the final draft of the design report, including the design of the site visit schedule and persons to be interviewed.

**Site visit Schedule:** Visits were made to implementation partners at the National, Provincial and District level, selecting sites chosen on the basis of consultation with stakeholders. Attention was given to achieving a balanced review of project activity and client/beneficiaries for both the CBD and IFC programmes. See the attached site visit schedule in Attachment 5 and stakeholder listing in Attachment 2.

**Desk review and synthesis based on programme analysis matrices:** The desk review addressed both the IFC and the CBD programmes with an assessment of the specific activities

---

<sup>1</sup>There was an explicit expectation in the Design Report to conduct a) Training follow-up interviews with trainees in UNFPA supported training events and b) Semi-Structured Interviews with Clients/beneficiaries of the CBD and IFC programmes. Due to time and resource constraints it was not feasible to conduct the training follow up and client/beneficiary interviews. In lieu of training follow-up interviews, a sampling frame was developed for all CBD and IFC training events in Savannakhet District and a sub-set of training events was selected for assessment of: i. training resource materials, ii. Pre- and post-test results and iii. Signed participant lists. Results of the review of these materials are included in this report (See Footnote 40). In addition to 5 FGD discussions with client/beneficiaries (24 women and 6 men), an informal group interview was conducted with 5 beneficiaries at the village level (3 women and 2 men).

for each programme. The desk review was based on the above-mentioned Evaluation criteria for the CBD and IFC programmes: (Relevance, Effectiveness, Efficiency, Sustainability, Added value and Gender). The desk review was guided by a set of criteria analysis matrices that cover the key activities for each programme.

**Stakeholder Interviews with semi-structured questionnaire based on the Evaluation TOR criteria:** The interviews were conducted with a consistent set of precautions for informed consent and confidentiality at the National, Provincial and District level. See attached semi-structured interview guides in Attachment 6 and the site visit planning calendar in Attachment 5. As needed, all interviews were done in local language with translation. This included the use of a highly competent translator, a local resident of Vilabouly District, who is from a local ethnic group and is fluent in Bru and related dialects. This local translator's assistance was absolutely essential for all FGDs as well as client beneficiary interviews. As outlined below in the section on the development of the sampling frame, a purposive selection was made of key informants at the National, Provincial and District level and below, with an attempt to achieve an appropriate balance for CBD and IFC respondents (See Table 1 below). In addition, key informants were selected from donor agencies and UN agencies.

**Focus Group Discussions (FGDs):** were conducted with client/beneficiaries of activities conducted by the CBD and IFC programmes. The target was to complete five FGDs, each with six respondents, two in Vilabouly, two in Sepone and one in Nong Districts. The intent was to obtain three FGDs for women and two for men, with a reasonable representative mix between the CBD and IFC programmes. (See Table 1 below). Five FGDs were completed with six respondents each. Due to logistical issues all but one of the five FGDs were with women. These FGDs assessed client knowledge of and satisfaction with the services available from CBD and IFC programmes. The FGD guide was modelled after prior work to evaluate IFC programmes<sup>2</sup>. See the draft FGD guide in Attachment 6.

**Selection of the sample of stakeholders:** Efforts were made to ensure that a wide range of stakeholders were consulted during the evaluation, with a good balance for the CBD and IFC programmes at the National, Provincial, District level and village level. In view of the importance to focus on villages that are serviced by the CBD programme, a total of 8 remote villages were selected based on the criteria of being at least 5 kilometres from the nearest health facility. Due to field constraints, especially rain and unusually difficult mud conditions in Nong, it was not feasible to visit remote villages in all three Districts. The sample of stakeholders, while small, purposive and non-random, provides a reasonable range of information and perceptions among the implementing partners and programme beneficiaries (See the site visit Planning Schedule in Attachment 5 and Stakeholder listing in Attachment 2).

---

<sup>2</sup> The CBD/IFC FGD Guide for this evaluation was adapted in part on a draft IFC FGD instrument kindly shared by Ms. J. Perkins in November 2014.



**Table 1: Number of Interviews and Respondents by Types, City and District and by Gender**

Row	Interviews Planned and Conducted by Location	City	City	District	District	District	
No		Vientiane	Svkt City	Vilabuly	Sepone	Nong	Total
1	Total Interviews Planned	16	8	14	16	16	70
2	Total Interviews Conducted	20	4	7	8	6	45
3	Number of Interview Respondents by Type and Location						
4	IFC/CBD Stakeholders (Donors, MoHC, CIEH, Dist. Teams, VHC, VHV, HC Staff)	21	8	13	17	13	72
5	CBD Worker Respondents	1	0	4	3	3	11
6	CBD/IFC Client Respondents (excludes FGDs)	0	0	0	5	0	5
7	Total Respondents Achieved (Interviews only)	22	8	17	25	16	88
8	Total FGDs Planned - Female	NA	NA	1	1	1	3
9	Total FGDs Planned - Male	NA	NA	1	1	0	2
10	Total Number FGD Participants Planned (6 in each FGD)	NA	NA	12	12	6	30
11	Total FGDs Conducted - Female	NA	NA	2	1	1	4
12	Total FGDs Conducted - Male	NA	NA	0	1	0	1
13	Total Number FGD Participants Achieved (6 in each FGD)	NA	NA	12	12	6	30
14	Total Respondents Achieved (Interviews and FGDs combined)	22	8	29	37	22	118
	<b>Respondents by Gender</b>						
		Female	Male	Total			
	IFC/CBD Stakeholders (Donors, MoHC, CIEH, Dist. Teams, VHC, VHV, HC Staff)	33	39	72			
	CBD Workers	2	9	11			
	CBD/IFC Client beneficiaries (Including FGD participants)	27	8	35			
	<b>Total Respondents</b>	<b>62</b>	<b>56</b>	<b>118</b>			

As anticipated in the Design Report, despite concerted efforts it was not feasible to complete the planned number of interviews. As shown above in Table 1, this evaluation is based on a total of 45 interviews and five FGDs. The use of group interviews provided an opportunity to expand the number of respondents. As shown above in rows 1 through 7 in Table 1, forty-five individual and group interviews were conducted with a total of 88 respondents; this was below the target of 70 completed interviews. As shown in Row 13 in Table 1, an additional 30 respondents participated in the five FGDs. There were a total of 118 respondents in all. Row 14 in Table 1 shows the distribution of respondents by city and district, with a minimum of 22 respondents per district. Overall, as shown on the bottom of Table 1, there was a reasonable balance in the total number of respondents on the basis of gender, with a total of 62 women and 56 men respondents. The CBDs are predominantly men, and a special effort was made to interview two women CBDs.

#### Section 1.4 Limitations and risks

**Limitations and possible biases of the approach:** There are several important limitations in the implementation of the evaluation. The evaluation is inherently qualitative in nature due to the small, non-random sample sizes. The samples were selected on a non-random, purposive basis and therefore cannot be considered representative of the target populations of stakeholders and client/beneficiaries. Due to limited time and resources, it was not feasible to collect representative samples. Due to the relatively short three-week time frame permitted to field the evaluation, the response rates for certain interview categories were lower than expected. In particular, it was not possible to set up and conduct training follow-up interviews or client exit interviews. It was not possible to collect sufficiently large numbers of respondents to meet minimum requirements to be statistically representative on a random basis, especially due to long distances to reach remote villages. Resources only permitted the

hiring of one translator fluent in local languages and the team was not able to split up in the remote districts. Due to lack of time, there were no visits to the three Northern Provinces where UNFPA Lao PDR has programme activities.

In addition, there are possible biases in the selection of respondents due the absence of detailed maps for the three Districts. The lack of maps required a pragmatic selection of locations with assistance from local district level programme staff. The three districts visited were chosen because of their geographic location, as they are located close to each other. To the extent feasible, to avoid the possibility of bias from the presence of UNFPA staff, all interviews were conducted by the evaluation team in private without any UNFPA agency staff present<sup>3</sup>.

## Section 2. Country context

As of 2013, Lao PDR had a population estimated at 6.8 million, which is projected to grow to 8.3 million by 2025, and 10.6 million by 2050. As a landlocked country, it has been categorised among the ‘Least Developed Countries’ (LDC) worldwide. Geographic conditions pose difficulties in the development of social infrastructure, transport and communication links and trade. This is compounded by a highly dispersed and low density population. Since 1975, Lao PDR’s national development policies have been introduced gradually and the New Economic Mechanism has introduced reforms aimed at the gradual transformation from a centrally planned economy to a more market oriented one. As outlined in the MDG Progress Report for Lao PDR 2013, since 2006, Lao PDR has sustained strong economic growth at 7 percent, due in part to foreign investment and development of the country’s natural resources. With a youthful population age distribution and gradually reduced patterns of fertility, there will be a growing share of the working age population with a potentially beneficial reduction in the dependency ratio. As Lao PDR makes the transition from LDC status<sup>4</sup>, there will be a need to go beyond growth in Gross Domestic Product (GDP) to eliminate disparities, not just in income but in health status.

### Section 2.1 Development challenges and national CBD/IFC-related strategies

Lao PDR has made substantial progress in key MNCH indicators since 1990: under five mortality has dropped from 163 to 72 per 1,000 live births, the maternal mortality ratio (MMR) has dropped from 1100 to 220 per 100,000 live births<sup>5</sup>. Since 2000, the proportion of women with one or more antenatal care visits doubled from 27% to 54%, and skilled attendance at birth has doubled from 19% in 2006 to 42% in 2011-12<sup>6</sup>.

---

<sup>3</sup> The evaluation team had the final say in the selection of sites visited. The team was not told which villages they could visit and which ones they should not visit. The evaluation team met with the local district CBD/IFC coordinators in all three districts visited. The district coordinators and their colleagues helped the team to assess the feasibility of traveling to villages that were selected by the evaluation team. The team was assisted by a representative of the Provincial MoH Department, who was very helpful in providing brief introductions for the team at local offices when conducting District level interviews. These introductions included an emphasis on the need for candid, open and honest responses. The introductions were not perceived to be a source of bias for the actual interviews. The provincial representative was not present during any of the actual interviews.

<sup>4</sup> Least Developed Countries are nations identified as such by the United Nations Economic and Social Council through its Committee for Development Policy and includes countries with “a low per capita income”, “a low level of human assets” and “a high degree of economic vulnerability”. The figures for this criteria are reviewed every three years. Laos is listed under this category. However, when looking at the country income groups as classified by the World Bank classification, Laos is among the lower middle income country groups.

<sup>5</sup> NB: The GoL currently refers to the UN MMR estimates from 2012/2013, which is 220 for the MMR in Laos. See [http://www.who.int/gho/maternal\\_health/countries/laos.pdf](http://www.who.int/gho/maternal_health/countries/laos.pdf)

<sup>6</sup> UNICEF. 2014 Laos MNC Survival Countdown to 2015 report for Laos.

Despite these favourable trends, the need for continued improvement is clear. Lao PDR's MMR remains far too high, in part due to the fact that national availability of emergency obstetric care services is less than half of the recommended minimum (46%) and the total and rural C-section rates are below the minimum target of 5% (4% national, 2% rural, 10% urban)<sup>7</sup>. As demonstrated by the 2011-2012 LSIS, Lao PDR is still characterised by a weak health system and limited access to health services with large disparities between the poor and the wealthy, the urban and rural populations, particularly poor people from ethnic groups who live in remote rural areas. For example, the percentage of women making four or more visits for ANC increases sharply with increasing wealth and education level. Only one in ten women from the poorest households, and those with no education received ANC four or more times compared to as many as eight in ten women in the richest quintile and women with at least upper secondary education. Similarly, seventy-one per cent of women in urban areas received four or more ANC visits, compared with only twenty-seven per cent of women in rural areas (Lao Social Indicator Survey (LSIS) 2011-2012).

While the use of modern methods contraceptive methods has increased from 28 per cent in 2000 to 42 per cent of 2011-12, an estimated 12 per cent of births are reported as either mistimed (five per cent), or not intended (seven per cent) (LSIS 2011-12). The contraceptive prevalence rate is approximately 50% for all methods and needs to be increased to meet the current unmet need for family planning (20%) women to be able to space and limit their births. Unmet need for family planning is highest among women with no education (26%), with an indirect relationship between unmet need for family planning and wealth quintile, with the exception of the richest wealth quintile. Unmet need for family planning is highest among women from households in Hmong-Mien villages (31%), and lowest in Lao-Tai headed households (18%). In 2011/2012, the Nation's total fertility rate of 3.2 (3.6 rural, 2.2 urban) ranged from 2.3 in Vientiane to 6.4 in Huaphan province (LSIS 2011-2012).

In response to these challenges, Lao PDR has identified CBD and IFC programmes as priority strategies within the context of various national maternal and child health and family planning policy frameworks. The most important of these frameworks is the 2009-2015 Framework for the Integrated Package of Maternal, Neonatal and Child Health (MNCH) Services<sup>8</sup>. This document explicitly identifies IFC as a viable strategy in Strategic Objective 3: Mobilizing IFC for MNCH. For example, "Community participation techniques, when truly participatory in nature, allow individuals, families and communities (IFC) more ownership in not only identifying priorities in MNCH, but also finding local solutions and contributing to planning and monitoring of services to ensure services do meet their needs and expectations." In particular, see Strategy 1: Create a supportive environment for the involvement of individuals, families and communities in MNCH and Strategy 2: Develop Community Participation mechanisms for better MNCH Expected Result 3.2.1. Through sensitization, capacity building and greater integration into existing health promotion efforts, IFCs will be enabled to participate effectively in improving MNCH.

---

<sup>7</sup> UNICEF. 2014 Countdown report for MNC Survival, page 123.

<sup>8</sup> See: MoH. Lao PDR. Strategy and Planning Framework for the Integrated Package of Maternal, Neonatal and Child Health Services 2009-2015: Taking Urgent and Concrete Action for Maternal, Neonatal and Child Mortality Reduction in Lao PDR 10 May 2009. In addition to being a signatory to the 1994 ICPD, the Lao PDR has endorsed a National Birth Spacing Policy (1995) that declares that contraceptive methods and services "will be provided free to everyone who needs it, irrespective of marital and social status and residence" as well as the National Reproductive Health Policy (2005) whereby the Government pledges "to improve the availability and sustainability of, and access to quality family planning services to all couples and individuals of reproductive age"

The 2009-2015 MNCH Framework also explicitly cites the role of community based distribution (CBD) for family planning as having been successfully piloted in three southern provinces (which was done with support from UNFPA) and includes CBD as a component activity within Strategic Objective 3. CBDs are explicitly referenced as an activity within Expected Result 3.2.2 Provision of interventions and medications for mothers and children in hard to reach areas, as “Expansion of FP provision by CBDs to northern and central provinces.”

In addition to the 2009-2015 MNCH Framework, the CBD initiative is closely aligned with the Family Planning Action Plan for 2014-15, which reflects a strong GoL commitment to increased access to family planning services (National Family Planning Action Plan for 2014 & 2015 and beyond, Nguyen-Toan Tran, MoH, October 2013).

**Section 2.2 The role of external assistance in the area of maternal health**

As shown in Figure 1, since 2000, an estimated US\$23.9 million dollars in Official Development Assistance (ODA) have been contributed for reproductive health care in Lao PDR. UNFPA has been a substantial contributor, as have Belgium, Japan, and WHO. For example, as shown in Figure 2, in 2011, UNFPA was the second largest contributor of ODA reported funds for Reproductive Health, second to the World Bank’s, International Development Association (IDA).

**Figure 1. Total ODA for Lao PDR RH Care from 2000 to 2011 in US\$**

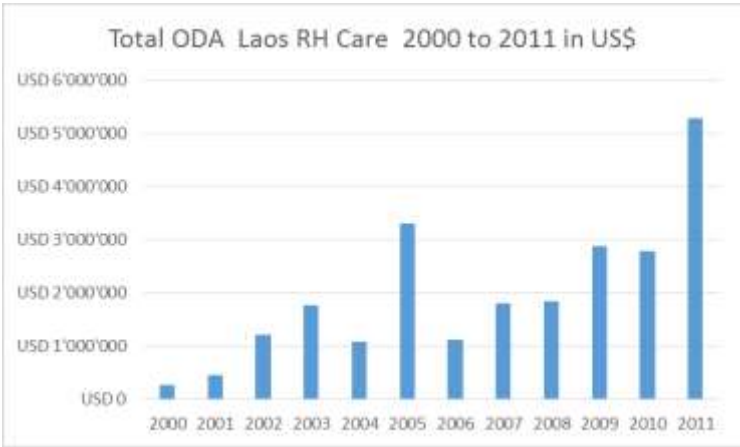


Figure data extracted on 29 Oct 2014 20:31 UTC (GMT) from OECD.Stat

**Figure 2. Total ODA for Lao PDR RH Care in 2011 by Source in US\$**

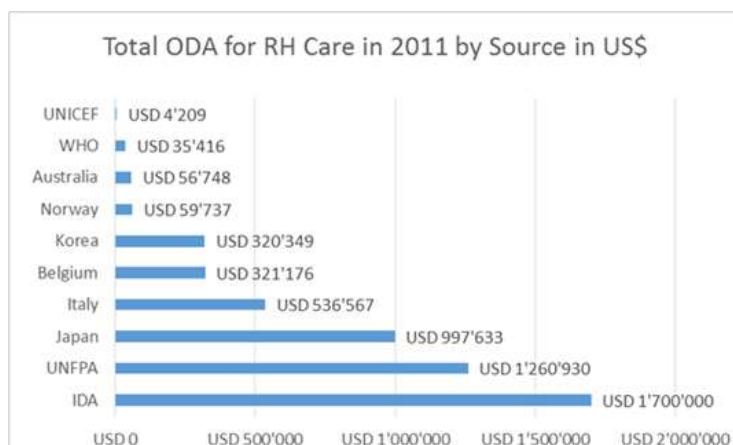


Figure data extracted on 29 Oct 2014 20:31 UTC (GMT) from OECD.Stat

## Section 3. UNFPA response and CBD/IFC strategies

### Section 3.1 Context for the UNFPA Lao PDR Supported CBD and IFC strategies

UNFPA Lao PDR CP5 strategies for CBD and IFC are founded on and work within four overlapping policy and programme documents. In addition to the above mentioned MoH 2009-2015 MNCH Framework, UNFPA supported CBD and IFC programme activities are articulated within Output 2 of the 2011 UNFPA CP5 Draft Country Programme Document, and within the 2011 United Nations Joint Programme (UNJP) Document for UNICEF, UNFPA and WHO (See Strategic Objective 2, which explicitly refers to CBD; and Strategic Objective 3, which explicitly refers to IFC). The fourth policy context is UNFPA's working relationship with UN sister agencies within the UN Development Assistance Framework (UNDAF) where the CBD and IFC activities are tracked as part of the UNDAF OUTPUT 4.5. Individuals, families and communities in priority areas have access to an integrated package of services on maternal, neonatal and child health (UNFPA, UNICEF, WHO) as well as the UNDAF monitoring and evaluation framework (See the UNFPA Lao CP Framework Annual Target, 2012-2015 Annex 5 as updated May 2014).

The goal of 'Increasing demand for and uptake of public health services, before, during, after pregnancy and for childbirth and childhood care' is part of the National Strategy and Planning Framework for the Integrated Package of Maternal and New-born Child Health (MNCH) services. UNFPA supports the government in Lao PDR to reach targets related to this goal, including through its support to CBD and IFC, aimed at ensuring that individuals, families and communities in priority areas have access to an integrated package of services on maternal, neonatal and child health (Output 2).

This intervention strategy is expected to contribute to UNDAF Outcome 4, which is that “by 2015, people in the Lao PDR will benefit from equitable, promotive, preventive, curative and rehabilitative health services.” The CP5 Output 2 gives priority to selected remote and vulnerable populations by

- (a) expanding the scope and coverage of community-based family planning services,
- (b) training health-care providers,
- (c) empowering and mobilizing communities, including through data collection,
- (d) developing integrated information, education and communication materials, and
- (e) supporting partnerships for resource mobilization, joint planning and the implementation of district and provincial health plans for the integrated package of maternal, neonatal and child health services.

### **Simplified Logic Model for the Lao CP5 CBD and IFC Programmes**

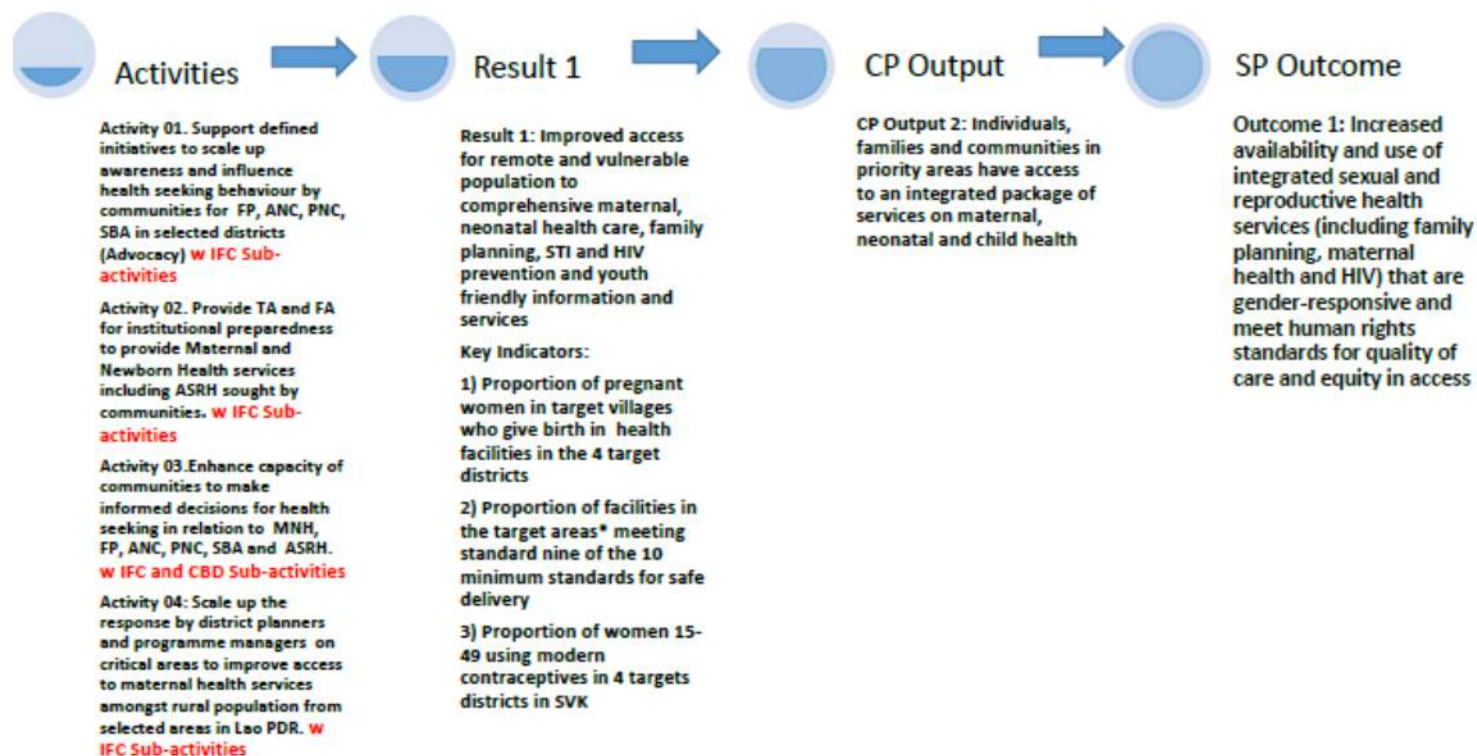
As part of the design of this evaluation, a simplified logic model was developed that presents the relationships between the CBD and IFC sub-activities within each of four main activities that contribute to achievement of Output 2. As shown below on the left-hand side of Figure 3, CBD and IFC activities (shown in red text as sub-activities) contribute to four main activity headings that contribute to the achievement of Result 1, which in turn contributes to the achievement of Output 2. Output 2 contributes to the overall Strategic Programme Outcome 1, which in turn contributes to the UNDAF Outcome 4 and the National MNCH Strategic Goal.

The details for the sub-activities, the heart of the CBD and IFC work supported by UNFPA, are presented in the UNFPA Annual Work plans (AWPs) for 2012, 2013 and 2014. These work plans specify the work that is carried out by UNFPA staff and by the key implementing partners for CBD and IFC programming. These implementing partners include the Ministry of Health at the National, Provincial (e.g. the Savannakhet Provincial Health Department) and District Level, the Department of Hygiene and Health Promotion (DHHP), the Mother and Child Health Centre (MCHC), Centre of Information and Education for Health (CIEH) and the Lao Woman’s Union (LWU)

**Figure 3. Simplified Logic Model for Laos CBD IFC Programmes**

**National MNCH Strategy Goal:** ‘Increasing demand for and uptake of public health services, before, during, after pregnancy and for childbirth and childhood care’

**UNDAF Outcome 4:** By 2015, the people in the Lao People’s Democratic Republic benefit from equitable, promotive, curative and rehabilitative health services



## Section 3.2 Brief description of the CBD strategy, goals and achievements

**The CBD Component:** Community-based distribution (CBD) is a strategy that relies on trained non-professional members/or retired health workers of the community to provide health services directly to other members of the community. In the case of family planning, these services provide information and modern temporary contraceptive methods, including pills and condoms. CBD of contraceptives can be used to supplement other government and private family planning (FP) services to make FP more widely available, especially for hard to reach areas. It involves providing FP services in community settings, basing these services on the needs and resources of the community. CBD can be an important addition or alternative to clinic-based services. It is usually less costly than clinic services, easier for many people to be reached, and available in a wider range of settings. In that sense, this approach represents a way of improving access to FP services in remote communities. Furthermore, because the community is directly involved, the services are more likely to be accepted.

UNFPA's CBD programme has been shared as a good practice after the first two years of its implementation. A first evaluation, in 2011, highlighted its major contribution to an increasing CPR in target areas. Under CP5 (2012-2015), CBDs have been supported in 4 UN target provinces: Savannakhet (South/Central), and Phongsaly, LuangNamtha and Oudomxai in Northern Laos. CBDs provide FP services to communities, each of them being responsible for 3 to 6 target villages. The villages have been selected based on their distant location from village health centres (HCs).

Prior to being deployed, the CBDs receive a 5-day training course. The training course covered family planning, modern contraceptives, maternal and child health, prevention and treatment of common diseases, communication/counselling with clients, expectations, reporting and a pre-test for the trainees. After the initial training, the CBDs receive a 3-day refresher training every 2 years, including discussions on challenges faced in the field.

CBDs are supposed to work for 16-20 days per month<sup>9</sup> to provide information and family planning services, as well as primary health care services to mothers and children in the selected villages. Their tasks also include working with, and providing counselling to men, unmarried youth and adolescents. They try to target people who are at risk of unwanted pregnancy and STIs including HIV/AIDS, travelling within target villages distributing contraceptive pills, condoms, injectable contraceptives<sup>10</sup>, iron, and vitamin A.

---

<sup>9</sup>See Training Manual for Trainers of Community Health Workers in Remote Areas, MoH Department of Hygiene and Health Promotion, MCHC. Published with support from the European Union. 2011. Although this implies that the CBD works full time, the CBDs are only provided an allowance for lunch for 6 days/month, the days they are supposed to travel outside of their villages, plus DSA for two nights to go to the district health centre (once every three months) to submit their reports and get additional supplies of contraceptives. The CBDs are allowed to be reimbursed for transportation cost to the District Health Office (DHO) based on bills showing actual cost. The CBDs are not paid for transport cost for their work in the villages. The quarterly remuneration comes out to a minimum quarterly payment of 850,000 kip per quarter (the equivalent of USD \$104) plus transport costs to the DHO.

<sup>10</sup> In this report, "Injectable contraceptives" are referred to as, "injectables." They refer to a progestin-only hormonal injectable contraceptive that is administered every three months.



As shown below in Table 2, there are currently 62 UNFPA-supported CBDs travelling monthly to villages in the target provinces, covering a total of 282 communities/villages, with an estimated 15,317 women of reproductive age (WRA). Thirty-one of these CBDs work in the main target province of Savannakhet, to address the needs of 7,482 WRA in 137 villages.

**Table 2: UNFPA-Supported CBDs and Active Family Planning Clients in Four Provinces**

	Province/District	No CBDs	No Villages	No Active Clients	Est. Contraceptive Prevalence <sup>11</sup> in Villages	Est. No WRA
Province	Savannakhet					
District	Vilabouly	8	30	954	49.6%	1924
District	Sepone	7	35	435	41.5%	1047
District	Nong	10	48	853	38.3%	2225
District	TPTN	6	24	458	20.0%	2286
	<b>Total</b>	<b>31</b>	<b>137</b>	<b>2700</b>	<b>36.1%</b>	<b>7482</b>
Province	PSL					
District	PSL	2	13	166	26.3%	632
District	Bounneua	2	12	172	29.6%	582
	<b>Total</b>	<b>4</b>	<b>25</b>	<b>338</b>	<b>27.8%</b>	<b>1214</b>
Province	ODX					
District	Beng	1	4	169	44.2%	382
District	Hoon	5	22	476	43.7%	1090
District	Pakbeng	3	15	353	23.5%	1505
District	Nga	4	18	452	29.9%	1512
District	Xay	4	18			
	<b>Total</b>	<b>17</b>	<b>77</b>	<b>1450</b>	<b>32.3%</b>	<b>4489</b>
Province	LNT					
District	Long	3	17	252	31.8%	793
District	Namtha	2	9	143	36.4%	393
District	Sing	2	6	87	17.6%	494
District	Nalae	3	11	128	28.3%	452
	<b>Total</b>	<b>10</b>	<b>43</b>	<b>610</b>	<b>28.6%</b>	<b>2132</b>
	<b>Grand Total</b>	<b>62</b>	<b>282</b>	<b>5098</b>	<b>33.3%</b>	<b>15317</b>

NB: Data are for Quarter 3, 2014 except ODX Province, which are for Quarter 2, 2014.

UNFPA covers the CBDs' travel costs and allowances. The management of CBDs has been taken over by the government with CBDs reporting to HCs or the District Health Office (DHO). CBDs

<sup>11</sup> The estimated contraceptive prevalence for CBD villages is based on numbers of women of reproductive age in each village as reported in the CBD M&E system. These counts of WRA have not been validated and appear to have been generated by different methods and individuals at the village level. Therefore the estimates of contraceptive prevalence based on CBD data may not be accurate and do not correspond to other estimates of contraceptive prevalence provided by the MoH for the District and Province.

report every 1 to 3 months, and at the same occasion replenish their stocks of contraceptive pills, Vitamin A, Iron, and other items. They further cooperate with the government health system, encouraging pregnant women to consider safer deliveries at facilities with skilled birth attendants present. When HC or district staff come to provide health check-ups for mothers, new-borns, and children, the CBDs help to gather community members to obtain these check-ups.

Monitoring and follow-up among CBDs and clients in communities is done on a 3-monthly basis by MCH staff from the District Health Office, provincial officials and/or the Maternal and Child Health Centre (MCHC), with technical assistance from UNFPA. CBDs seem to be generally satisfied with their functions. Lunch allowance of about US\$5 per day is provided for 6 days per month<sup>12</sup>. There is limited turnover among CBDs, those having resigned doing so because of their age, or declaring that they have moved to other villages.

### Section 3.3 Brief description of the IFC component Strategy, Goals and Achievements

**The IFC Component:** At community level, UNFPA works with Individuals, Families and Communities (IFC). The IFC approach is considered to be the critical link in ensuring continuum of care throughout the perinatal period<sup>13</sup>. It is recognized that the availability of quality services will not produce the desired health outcomes where there is no possibility to make healthy decisions and to act on them. The aim of working at the IFC level is to contribute to the empowerment of women, families and communities to improve and increase their control over maternal and new-born health, as well as to increase the access and utilization of quality health services, particularly skilled birth attendance. Interventions at the IFC level are meant to foster the supportive environments for survival but also for healthier mothers, new-borns, families and communities. The IFC approach, developed by WHO, can be seen as a process of enabling people and groups to increase control over, and to improve, their health and quality of life. Empowerment, in this context, is defined as a process through which women, men, families and communities gain control over maternal and new-born health and related potential problems.

Interventions are organized into four priority areas:

1. Developing capacities to stay healthy, make healthy decisions and respond to obstetric and neonatal emergencies
2. Increasing awareness of the rights, needs and potential problems related to maternal and new-born health
3. Strengthening linkages for social support between women, men, families and communities and with the health care system
4. Improving quality of care and health services, and of their interactions with Individuals, Families and Communities.

---

<sup>12</sup> According to UNFPA Lao PDR, this 6 days of lunch allowance plus DSA for two nights for quarterly meetings at the DHO (with transport to DHO reimbursed based on showing bills) is the only compensation the CBDs receive. They do not get additional funds for motorbike fuel or other costs such as boat fare during the rainy season.

<sup>13</sup> Pertaining to the period immediately before and after birth. According to the WHO, the perinatal period commences at 22 completed weeks (154 days) of gestation and ends seven completed days after birth.

The above aims should be achieved through strategies of education, community action for health, partnerships, institutional strengthening and local advocacy, to be implemented largely in the settings of household, community and health services. Special attention is to be given to the different interventions that address the status of women, in particular within the family, as health outcomes are largely determined by decisions made within the households

In Lao PDR, UNFPA initiated its IFC component in 2009, under its 4th Country Programme. It has been adapted in CP5, based on lessons learned from the WHO methodology for community mobilisation, and the recommendations of an external evaluation. Its interventions aim at empowering village community structures through community involvement, by identifying needs of the population through participatory workshops. Once needs are identified, they are addressed through Village Health Committees (VHCs) and Community/Peer Motivators (CM) who organize health education and health promotion activities to raise awareness, encourage positive health behaviour and promote access to services. Emergency Birth Preparedness Plans (EBPPs) are to be established in every target village, including village emergency funds<sup>14</sup>, which provide pregnant women the opportunity to seek transportation to health facilities and access skilled birth attendants. Furthermore, service providers in health facilities in target areas are trained to provide user-friendly reproductive health services and are encouraged to organize open-door days at health facilities. Monthly meetings are organized between village and district levels. IFC interventions supported by UNFPA are exclusively implemented in the target province of Savannakhet. The expected outcome is that the communities will develop their capacities and support mothers, pregnant women and other community members to take responsibility for their own health.

### Section 3.4 Rationale for UNFPA CP5 focus on CBD and IFC in Savannakhet Province

There is an urgent need to address key gaps in MNCH within the four target districts in Savannakhet. At baseline, none of the health facilities in the four districts were adequately equipped to provide Emergency Obstetric Care (EMOC) services at their respective level of service provision, less than 40% had accredited skilled birth attendants and none met at least 7 of the ten standards for safe delivery<sup>15</sup>. Based on the results from initial UNFPA supported CBD and IFC programme activity in other provinces during the UNFPA CP4, it is plausible that the CBD and IFC interventions could help address these and other gaps in the four Districts. As demonstrated below in Sections 4 and 5, significant progress has been made on most of these indicators as of the time of this evaluation.

---

<sup>14</sup> The use of emergency funds was part of the CBD strategy in the UNFPA Lao PDR 4<sup>th</sup> Country Programme, but was not included in the CP5.

<sup>15</sup> These baseline indicators are taken from UNFPA Lao CP Framework Annual Targets, 2012-2015 Annex 5 May 2014 Update. The initial indicator for standards for safe delivery included all ten of the minimum requirements.

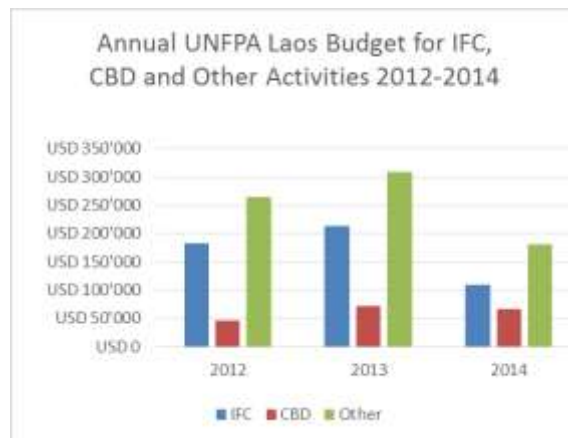
### Section 3.5 Financial Structure and Resource Allocation for CBD and IFC programmes

As shown in the financial summary in Table 3 and Figure 4 below, overall, the CBD and IFC related activities represent roughly one-half of the past and current planned Output 2 expenditures for the first three years of the CP5 programme. Total expenditures for Output 2 come to US\$1.4 million. The category for “Other”, includes the budget for CIEH, MCHC and DHHP capacity building and other activities that are implemented at the central level, such as IEC materials production, radio and TV, media campaigns, and for M&E and coordination. The allocation of which programme activities belong in the CBD and IFC or Other categories is somewhat difficult to determine. While reasonable, in some cases the allocations are by necessity somewhat subjective. Attention was given to assessing the efficiency of the IFC and the CBD programme based on these overall costs and summary measures of concrete activities implemented.

**Table 3: UNFPA Lao PDR Budget for IFC, CBD and Other Activities for 2012 through 2014**

Activity	2012	% of total	2013	% of total	2014	% of total	Total	% of total
IFC	USD 182,800	37%	USD 213,900	36%	USD 110,000	31%	USD 506,700	35%
CBD	USD 46,860	10%	USD 71,700	12%	USD 66,420	19%	USD 184,980	13%
OTHER	USD 263,589	53%	USD 309,254	52%	USD 180,200	51%	USD 753,043	52%
Total	USD 493,249	100%	USD 594,854	100%	USD 356,620	100%	USD 1,444,723	100%

**Figure 4. Annual UNFPA Lao PDR Budget for IFC, CBD and Other activities 2012-2013**



## Section 4. CBD Findings for Six Evaluation Criteria

### Section 4.1 Relevance

The CBD programme is highly relevant. As evidenced by stakeholder interviews at the national, provincial and district level, it is clear that UNFPA support for the CBD programme is closely adapted to the needs of vulnerable populations. Despite concerns about sustainability, especially as raised by some respondents at the national level, virtually all respondents felt the CBD programme was relevant and appropriate. Vulnerable groups, especially poor married women of reproductive age who live beyond the reach of HCs in remote rural areas, face important time and cost barriers to access family planning methods and counselling, especially during the raining season. For example, a few women mentioned that, before the CBD programme started, they had to walk a half-day to the HC just to get the pills or injectables. Despite limitations in the design and implementation of the CBD programme, on balance, the CBDs help vulnerable women gain regular, monthly, access to FP methods at no cost. For many, both the cost and time required to reach a HC is too great, especially for those who cannot afford injectable contraceptives. The CBD programme has demonstrated a capacity to “increase physical accessibility and cultural acceptability for FP services in remote and difficult to reach communities.” (UNFPA Presentation. 2010). Until there are alternative approaches to reach remote areas in these districts, such as comprehensive quarterly Health Centre (HC) outreach programmes that consistently reach the most remote villages, the CBD programme will remain highly relevant.

The CBD programme has benefited from cumulative experience over more than eight years and is grounded on experience with the needs of hard to reach populations in Lao PDR. There have been a series of assessments and reports that demonstrate the CBD approach is responsive of the target populations<sup>16</sup>. The needs of the target population, especially among low-income rural women have been well established with quantitative data, such as the recent MICS (LSIS 2012). UNFPA through its support for the MICS, has clearly established that there are severe lack of equity in access to FP and Reproductive Health (FPRH) and the CBD programme has potential to reduce this inequity.

As designed, the CBD programme is highly appropriate to address the needs of vulnerable populations, but in practice it is occasionally falling short, especially for consistent access to FP MCH IEC and services for women with unmet need for family planning. For example, based on qualitative data, which are anecdotal, some low income women from remote areas who wanted to use contraceptives reported that CBDs did not visit their households. It appeared that CBDs were not seeking new clients, but mainly stopping to visit the homes of current users. CBDs explained

---

<sup>16</sup>UNFPA. The MoH/MCHC and UNFPA Outreach Family Planning Initiatives in the three Southern Provinces. May 2008. UNFPA. Report on the Lessons Learned from the Outreach FP Worker [CBD Worker & DRF/VHV] Strategy Workshop in Thalath. December 2010. UNFPA. The MCHC/MoH-UNFPA Outreach Family Planning Service Delivery Strategy In Saravane, Sekong, Attapeu, Savannakhet, Oudomxay, Luang Namtha, Houa Phan, and Xieng Khouang (April 2006-December 2010). Presentation. 2010. Seetharam, KS et al. Assessment of development results supported by UNFPA CP4 for Lao PDR: Report and recommendations. April 2011.

that they had identified the households interested in using family planning during initial community meetings organized by the VLs of their assigned villages. The CBDs did not see any need to visit households of non-users. One CBD, who was also a VL, explained that he felt FP should be voluntary and that going to households of non-users might be seen as coercive.

The CBD IEC materials observed were of good quality and relevant to the needs of rural low-literate vulnerable women. For example, the IEC cards appear to be well designed and appropriate. But the CBDs interviewed reported needing additional materials, especially to help them to better explain combined OC pills, and address women's concerns about side effects. Given the low-literacy of the target populations, there is a need for additional photos and clear images to help support the messages. Some CBDs admitted that they do not use the IEC materials very often, except once or twice during their initial village consultations. These initial meetings, usually done in collaboration with the Village Leaders (VLs), allowed the CBDs to recruit new acceptors without having to visit all households in the village. CBDs appeared to need some type of visual job aids to help them address women and their husbands concerns about side effects<sup>17</sup>. They frankly acknowledged they need more training to improve their ability to inform, counsel and advocate for FP<sup>18</sup>.

The CBD programme, as designed, fits well with the needs and expectations of vulnerable populations and is the only currently available strategy to provide access in some remote areas. However, the actual implementation of the CBD programme often fails to meet the needs and expectations of vulnerable remote populations. For example, women reported that they prefer combined OCs but had to use single-hormone minipills due to persistent stock-outs. Other women stated they would prefer to use injectables but could not get them from the CBD programme and they could not reach the HC or afford to pay for injectables at the HC. Some women reported being overlooked by their local CBD. The CBD did not visit their households. He only stopped at the households of current users. These women wanted the CBD to visit them, not just the current users. These women wanted the CBD to do outreach to include their husbands, who were often opposed to FP out of concern for potential side effects that might affect their wives. Women wanted to know more about their options and choices for family planning and the CBDs did not seem adequately trained to address this need.

Based on the qualitative data from client interviews and FGDs, there was clear evidence of demand for FP as a general concept and demand for FP services among the respondents (both women and men in FGDs). Among some of the very poor respondents, there was a clear statement that more children means more poverty. Apart from concerns about potential side effects, there were no objections to FP. The respondents reported a need for post-partum family

---

<sup>17</sup> For an example of a job aid with content concerning side effects, see the checklist on page 28 of the WHO supported, "A Guide to Family Planning for Community Health Workers and their Clients" available at [https://www.fphandbook.org/sites/default/files/guidetofp\\_eng\\_2012\\_0.pdf](https://www.fphandbook.org/sites/default/files/guidetofp_eng_2012_0.pdf)

See also, <http://www.fhi360.org/resource/service-delivery-tools-and-job-aids-family-planning-providers>

<sup>18</sup> They actually forgot what they learned given the fact that the refresher training takes place two years after the initial training. It would help to have a yearly refresher training to provide the opportunity for the CBDs to meet and share experience among themselves and get updates from the district health team.

planning services, preferably delivered respectfully in their own language, for free and close to their villages. Among some women respondents there were reports of unintended pregnancies due to stock outs, which was associated with a strong plea for an uninterrupted supply of contraception: “No more stock outs please.” The women respondents frequently requested reassurance and information on side effects, not just for themselves but for their husbands, who otherwise would oppose their wives’ use of family planning.

## Section 4.2 Effectiveness

**Overall Effectiveness of the CBD Programme:** Based on the qualitative data and the quantitative data on CBD service statistics and District contraceptive prevalence rate (CPR) data, CBDs are making a substantial contribution to the use of FP among vulnerable women in remote villages. Data from the Savannakhet Provincial Health Department show a steady increase in contraceptive prevalence (See Figure 6 below). This contribution is being made despite serious problems, such as stock-outs of combined OCs, inadequate training, chronic delays in payments to CBDs, and inability of most CBDs to provide injectable contraception.

**Access to an integrated package of MNCH Services.** Based on the qualitative interviews, the CBDs provide access to FP, but the evaluation team found little evidence that the CBD programme provides access to an integrated package of MNCH services. Except for their initial introductory meeting with the villages, when they reported giving their full presentation using a flip chart that covers integrated services for MNCH, the CBDs interviewed only reported promoting FP with an occasional encouragement of ANC and safe delivery. On occasions, the CBDs reported distribution of iron tablets or vitamins, but this was only twice in a year at most. The MCHC has had a long-term interest in the development of a CBD Plus (CBD+) integrated service package, but so far this approach has not been implemented with the exception of a relatively brief World Bank-supported effort (less than two years in three southern provinces)<sup>19</sup>.

Based on the available quantitative data, the CBD programme is contributing to access to FP, but does not play a major role in uptake of other components of an integrated MNCH package. For example, the CBD M&E data show that the CBDs focus exclusively on FP and do not record any distribution of non-family planning items.

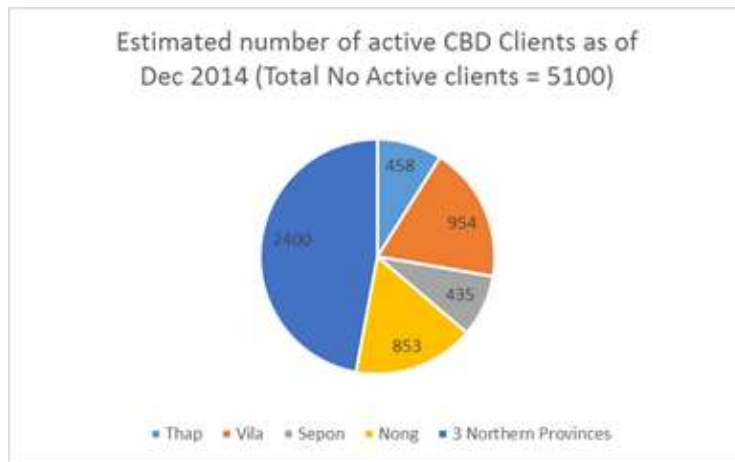
As shown below in Figure 5, the CBD programme, based data provided by UNFPA and the Savannakhet Province MCHC, currently has over 5,000 active FP clients, slightly over half from Savannakhet Province, the remainder from three northern provinces of LNT, ODX and PSL.

---

<sup>19</sup>The current training of trainer (TOT) manual for the CBD program was based on the WB supported program for CBD Plus. As a result there are report forms for non-FP CBD services, some of which were shown us by the CBDs, but these forms are not routinely completed. The CBDs reported that they do not use them. One of the monthly reporting forms for CBD FP services includes columns for Vit A, Iron Tablets. See CBD TOT Training Manual, Annex18 MCH services. Also see CBD+, Past experience and future direction, MoH DHHP, 9 November 2011. ; CBD+ Delivery of MNCH Outreach package of serviced in underserved communities, 2010.

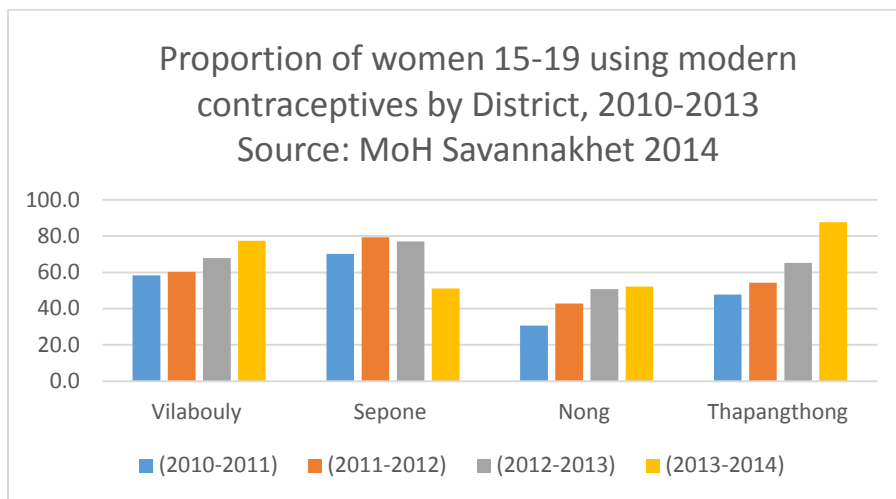
As shown below in Figure 6 there has been a trend toward increased contraceptive prevalence rate (CPR) as well as other MCH-related indicators (Shown below in Figure 10 in Section 5) in the four districts of Savannakhet Province where the CBD programme is active. The increase in CPR is due in part to the CBD programme, but it is not likely that the CBDs have contributed to the trends in the other indicators.

**Figure 5. Estimated number of Active UNFPA-Supported CBD Clients, December 2014**



Source: UNFPA Lao PDR and MoH Savannakhet Province December 2014

**Figure 6. Trends in Contraceptive Prevalence in four Savannakhet Districts 2010-2013**



**Changes in health seeking behaviours.** In FGDs and interviews, many but not all respondents reported an increase over the past two to three years in the use of ANC visits, increased awareness of the need for, if not actual use of HC delivery and increased interest in and use of FP. There appears to be very strong and increasing interest in injectable contraception (as reported both among women and among CBDs). The CBDs reported an increase interest in FP in general. For example, when asked if there was a change in the use of family planning in the past



few years, the majority of CBDs reported that more couples were choosing to adopt family planning. Apart from one CBD, no respondents reported decreasing interest in FP<sup>20</sup>. Many respondents cited the increase in interest in FP over a period of three years<sup>21</sup>, but some of the CBDs interviewed had only begun working in the last two years. There was little or no indication of support for condom use (which was derided by male respondents, including some CBDs). Condom use remained at best anecdotal, only recorded rarely in the CBD registers. Based on a review of the CBDs' monthly reports, there were very few active condom users. As mentioned above, based on the quantitative data, it appears that there have been increases in FP as well as other MNCH indicators. But there are clear problems in attribution of an impact on MNCH behaviours other than FP for the CBD programme. For example, there are other interventions that have a more direct influence on MNCH behaviours, such as the introduction of women providers at HCs, the IFC trainings for VHCs, and HC outreach activities.

Demand for FP Services and commodities. The CBDs reported having created demand by holding village meetings to promote FP, and identifying new clients. Those clients who are satisfied with their method, have created a supportive environment for FP. Those clients who are dissatisfied, especially women who were required to use single-hormone minipills due to a stock-out of combined OCs, may have undermined demand. Demand for OCs has increased where villagers accept OCs. Despite the reported strong demand for injectables, most CBDs cannot provide injections and this is an area where the CBD programme may not have had as much impact as it could<sup>22</sup>. According to two CBDs, if they could be trained and certified to do injectables, the demand for injectables is so strong that they could potentially double the use of contraception in their villages. CBDs frequently reported that they encourage women to consider injectables and to go to the HC to get this method. All but one of the CBDs reported that they would like to provide injectables themselves.

**Cultural sensitivity of CBD workers to clients in target areas.** Women reported that they were more comfortable talking with women than with men, but they were still willing to talk with male CBDs. The women also stressed that it was important to have a male CBD to talk to their husbands, in order to get their husbands support for their use of FP. Based on interviews with senior national, provincial and district staff as well as interviews with CBDs, most CBDs were from the local village or sub-district and were fluent in local languages<sup>23</sup>. The overall impression was that they were behaving in a culturally sensitive way. For example, depending on the specific village, they observe cultural requirements to schedule appointments while the husband is present or always visit houses in the presence of a VHC member (Village Health Volunteer (VHV) or

---

<sup>20</sup> A CBD reported that in one of his villages all of the women had stopped using OCs. There were initially eight OC users who gradually stopped using OCs for reasons he could not explain. Perhaps it was due to intended pregnancies, or issues shared by word of mouth, such as side effects, but he could not explain it.

<sup>21</sup> CBDs began work in SVK in 2011 with support from the World Bank program. In 2012 UNFPA continued to support operational costs and trained more CBDs.

<sup>22</sup> It should be noted here that medical legal regulations do not permit non health providers to give injections. Only retired health workers who are working as CBDs are allowed to provide injectables.

<sup>23</sup> Many of the CBDs were also VLs, VHVs and Party Leaders. Given their influence in the community, this is a possible concern as far as potential for coercion. It is also a potential concern with respect to conflict of interest, time available to do CBD activities, and confidentiality.

Village Leader (VL)). However, as mentioned above, the CBDs were not proactive to seek new clients, especially by working with husbands to make the case for FP<sup>24</sup>. The CBDs appeared to relate well with VHC members and we did not observe any tensions between the two cadres. There were occasional concerns raised by DHO staff that the fact that the CBDs were getting remuneration and the VHVs did not, was a potential source of friction.

**Access to SRH services for vulnerable groups.** While there is evidence of an increase in access to FP, and potentially other MNCH services due to CBDs, there was also clear evidence of major barriers to access for vulnerable groups<sup>25</sup>. These barriers included cost of transport and charges at clinics. Women who reported a strong demand for FP also reported hesitating to go to the nearest HC because they feared being charged for services. Stock-outs were an important barrier as was the lack of training in counselling, injectable training and certification for CBDs.

There are challenging cultural barriers as husbands are often acting as gatekeepers for FP and MNCH services. For example, there were female respondents who were not using FP and wanted to learn more about FP. These women noted that the CBD did not visit their houses because they were not current users. In a different FGD in another village, women respondents cited their husbands' opposition to FP because of fear of side effects, especially illness that would reduce the women's ability of work in the fields or at home. The husbands were quoted by some women as saying "If you take the pills and you get sick I will not take care of you." When asked what they recommended, they strongly recommended that the CBDs counsel their husbands to overcome these concerns.

**Continued validity of CBD approach.** Until there is an alternative, such as more HCs, or more long-acting FP methods for remote populations, such as implants or injectables, or an alternate cadre to provide services, the CBD remains appropriate and is no less valid a strategy than it was eight years ago. Apart from sustainability issues, there was support for the CBD strategy at all levels.

**CBD Skill levels.** With few exceptions, the CBDs have limited skills and education and need more training and supervision on FP methods and counselling. The CBDs themselves report needing more training and some said they did not have the counselling skills for helping dealing side effects. The CBDs reported that they need refresher training on basic family planning concepts and counselling skills for side effects. They said that they have forgotten much of what they learned and cannot speak with confidence on many of the issues related to SRH. For some CBDs, Lao is not their first language and they may have difficulty retaining concepts when

---

<sup>24</sup>There were some concerns from respondents at the national level as to whether having male CBDs can be appropriate for female clients. This proved to not be a problem given the very high number of OCs users. Male CBDs could play an important role in convincing the husbands to understand the side effects of the OCs and injectables and subsequently allow their wives to use FP methods.

<sup>25</sup>During a FGD with poor and illiterate women living in a village where a CBD worker lived, the women were asked why they could not get FP from him. The CBD had told them that he could not support FP services in his own village because it was too close to the Health Centre that serves his village. These women were not willing to go to the HC because they knew that they would be charged for FP services. This means that while these women reported a strong demand for FP services, it is not likely to be met due to arbitrary programme management issues.

trained in Lao<sup>26</sup>. The monthly to quarterly CBD visits for reporting and resupply are a good opportunity for in-service training, but we did not see any evidence of this<sup>27</sup>. Apart from one CBD who was fearful of giving injections, all CBDs expressed interest in training to provide injections<sup>28</sup>.

**Opportunities and Barriers to CBD effectiveness.** Based on a review of the CBD job description and interviews with CBDs, it appears that the current assumptions about CBD work patterns may not be valid. For example:

- 1) Number work days per month: The CBDs reported working between 6 to 8 days versus an expectation of working 10-20 days in remote villages.
- 2) Number of households visited in each village: Rather than visit all households in each visits, the CBDs interviewed reported that they only visited current users for the purpose of resupplying them.
- 3) Use of IEC materials: The CBDs reported that they rarely needed to use their IEC materials since they primarily were resupplying existing clients. CBDs nonetheless expressed interest in updated materials, especially to help address concerns about side effects. They prefer IEC materials with more photos and drawings than text.
- 4) Data collection: Despite earlier expectations that CBDs would be involved in collection of village demographic data<sup>29</sup>, the CBD interviewed had little or no knowledge of basic village population parameters and did not seem able or interested in knowing how to calculate a CPR for their villages. This is due in part to the fact that these calculations are made by the District Health Office staff at monthly meetings.
- 6) Knowledge of FP counselling: Overall, the CBDs were not confident in their knowledge of SRH and were unable able to respond to client concerns regarding side effects.

The above issues need to be addressed in order to increase the effectiveness of the CBD programme. In addition, it was clear that some CBDs were not fully fluent in Lao. Future training of CBDs should employ competent translation into local ethnic language (Bru) or use fluent Bru-speaking Trainers. There appears to be a lack of coordination between CBDs and HCs and HC Outreach programmes. The CBDs work closely with VHCs in order to have access to households (HHs) but, in part because the CBDs work in more remote villages, the CBDs have little interaction with the staff of the sub-district HCs. There are missed opportunities to reach out to husbands of women who wish to use FP. In lieu of visiting all HHs, CBDs should arrange for regular village meetings to encourage non-user couples with unmet need for FP to agree to HH visits with CBDs.

**CBD Monitoring and Evaluation.** There were gaps in the data collection process that are a threat to the quality of CBD reporting. As noted above, despite repeated probing at the Provincial, District and Village level, it was not possible to get a clear understanding on the

---

<sup>26</sup>During a phone interview with a CBD in Luangnamtha, he clearly did not understand Lao. He was from another ethnic group than Mankong/Tri, who are mainly in the South. Training in the Northern provinces should also consider appropriate translator for Northern ethnic groups.

<sup>27</sup>This recommendation was made by Dr. Sengsay earlier this year in a monitoring report based on a field visit to Savannakhet.

<sup>28</sup>In Nong District, all CBDs are deemed competent to do injectables but only three of the ten sub-district CBDs have completed training to provide injectable contraception. The District level staff report that the limiting step is a lack of funding for training the CBDs. Funding this training would have potential to increase access to FP in remote districts where demand for injectables may be high.

<sup>29</sup>“...all CBD Workers undertake either a baseline or annual FP-Demographic & Vital Events Registration Survey immediately after completing their basic FP training session, or as part of an annual data collection exercise.” From Stanley Zankel. The MoH/MCHC’s & UNFPA’s Outreach Family Planning Initiatives in the 3 Southern Provinces. May 2008.

methodology for determining the number of eligible women of reproductive age at the village level. CBDs had not been involved in any routine data collection concerning the residents in the households within their villages. Most CBDs interviewed did not know how many women of reproductive age were in their villages. Those that had an estimate usually could not explain how it was collected; they simply reported that they obtained these data from the VL or VHCs. There were important discrepancies in the way the CBDs completed their data forms. In one district, women who were using injectables were reported as active CBD clients, even though the CBD did not provide this method. This may be causing a problem if double counting between CBD service data and the HCs. These issues need to be addressed in a systematic way through regular supervisory visits.

**MNCH Package.** Most CBDs were willing to carry non-FP supplies, such as iron tablets or vitamins, in a manner consistent with the CBD Plus approach. Senior staff at the MCHC are interested in adapting this approach and other senior MoH stakeholders appear to be supportive. The CBD+ approach might provide an incentive for CBDs to visit all households in their villages at regular intervals, not just the households with current users of FP. This might increase the number of new FP clients by giving the CBDs greater access to non-using households that have an unmet need for FP and wish to adopt FP.

### Section 4.3 Sustainability

**Overall Sustainability.** The current CBD programme (in particular in Savannakhet) depends on UNFPA financial support in the short term. CBD clients in remote areas are highly vulnerable to interruption of contraceptive supplies, receiving just one month-supply of contraceptives per month. In view of this vulnerability, transition exit planning is essential before an abrupt ending of UNFPA support for CBDs. At least three-month notice is required before a UNFPA cessation of funding in order to permit adequate arrangements to reduce the likelihood of unwanted pregnancies and potentially life threatening complications. Senior stakeholders at the national and province level have requested GoL to consider funding the CBD programme, but it is uncertain if this funding will be provided. Given the current de facto policy of HCs charging for SRH services, it might be plausible for CBDs to use a sliding scale fee-for-service approach, especially if they were able to provide injections for long-term hormonal methods.

**Sustainability of the CBD intervention.** There is no cost-free approach. Even if CBDs were willing to work for free, there are significant costs for petrol, motorbike maintenance, supervisory and training costs. Based on interviews with respondents at National, provincial and district level, there is little prospect for CBDs to continue providing their services without remuneration. The current level of payment to CBDs (approximately \$30 per month or 240,000 Kip) is quite low, and barely covers the cost for petrol for motorbike transport, or for boat fares during the rainy seasons. CBDs are willing to work for up to three months at a time without payment, but after that may stop working (two CBDs indicated they intended to stop work if they were not paid by the end of November, a delay of four months).

**Extent of CBD programme capacity building.** There has been major level of capacity established at the national, provincial and district level to train, supervise and monitor the CBD programme. This capacity should be taken into consideration as a major contributor toward sustainability. While much of this capacity was developed before the CP5, much has been developed during the CP5. Discontinuing the CBD programme involves serious opportunity costs for the lost UNFPA investment in this capacity development. While there is room for improvement for more rigorous and frequent supportive supervision of CBDs and to develop more precise and efficient routine M&E systems, UNFPA should consider building on the progress made so far. If GoL funding was secured for CBD remuneration, there would be enduring benefits from the UNFPA supported capacity that has been achieved for supervision, training and monitoring<sup>30</sup>.

**Potential for enduring benefits.** While the CBD program is not currently sustainable without external donor support, CBD interventions are likely to have some persistent long-term positive effects. These long-term benefits include an increased knowledge and demand for FP services as well as increased health seeking behaviour among residents in remote communities. A case could also be made for some enduring benefits from CBD dissemination of information on ANC and other MCH issues. But the actual flow of concrete benefits would be very limited without continued CBD visits. Apart from the above mentioned increased knowledge and demand, there would be an immediate increase in unmet need among more than 5,000 women who depend on CBDs for their resupply. There would be a huge financial loss for these 5,000 women who would now have to pay for transport, or walk and have to pay for HC supplied FP services.

**Vulnerability of current CBD benefits to being discontinued.** Couples in remote areas are dependent on monthly resupply for FP methods and would be very vulnerable without a carefully planned transition phase to ensure alternate sources of FP supplies. Based on respondent accounts of the experience with the end of UNFPA support for CBD programmes in other provinces, CBDs have not been absorbed into province programmes and clients have been abruptly left without contraceptives at risk of unwanted pregnancies.

**Extent of CBD partnerships through coordination and national ownership.** Based on interviews at national, provincial and district level there is strong collegial and professional commitment to and support for the CBD programme. The National MCH programme staff has a strong sense of ownership and commitment to FP services for vulnerable populations. The issue of GoL payment for the costs of CBDs is an entirely different issue. There was little evidence of any concrete GoL support for the costs of CBDs.

## Section 4.4 Efficiency

---

<sup>30</sup> UNFPA has supported the cost for supervision (according to UNFPA respondents) but when asked, few CBDs had seen district supervisors even once or twice during the past two years. A woman CBD who was recruited nearly two years ago, did not have any supervisory visits from the district staff. It may be difficult for the district staff to supervise CBDs, but if the HC staff were trained and involved, it would be much easier for them to be in contact and support the CBDs.

While overall the UNFPA Lao PDR Country Office (CO) has managed the CBD programme in a highly professional manner, there have been challenges in disbursement of funds for the CBD programme related to reporting requirements. In particular, despite the fact that this is the 5<sup>th</sup> country programme implemented in Laos, the CO was not able to get implementing partners to meet deadlines for reporting on programme activities. This is a very common challenge faced by all donors, both international NGOs and the UN agencies, and has resulted chronic delays in UNFPA disbursements, with CBDs being paid an average of 3 months late. These problems in UNFPA fund disbursement for CBD programme are disruptive to the CBD programme and may have undermined CBD productivity.

With the caution that the sample of respondents is very small, based on the interviews with 11 CBDs, the CBDs tend to only visit current users of family planning for the purpose of re-supply. This approach is very inefficient as it reduces the opportunity for generating new users of family planning by reducing CBD interaction with non-users (both men and women). If CBDs are not expected to visit all households in their assigned villages it greatly reduces the potential for increasing contraceptive prevalence and for reaching women with non-family planning services, such as iron tablets or vitamin A.

There is a considerable literature on Community Based Distribution of Family Planning (for example see: <https://www.k4health.org/toolkits/communitybasedfp>). Methods have been developed to assess the cost effectiveness of CBD programmes and to compare them to other strategies for promoting access family planning. According to a DFID-supported article on community based distribution<sup>31</sup>,

“Research indicates that the cost per unit of output for CBD programmes is consistently lower than for clinic-based service delivery approaches throughout Asia and Latin America. As with most programme approaches, CBD incurs high initial costs, but cost-effectiveness improves with time.”

Rigorous methods are available for the calculation of CBD programme costs per client visit and for new clients. For example, a study of the costs of a large, well-established CBD programme in 1999 found that each client visit cost US\$6.00<sup>32</sup>. Using a very crude simplistic approach that cannot be considered as rigorous or valid, the UNFPA supported CBD programme cost per CBD visit may be as low as from US\$1.17 to US\$2.43 per CBD visit<sup>33</sup>. Population Services International (PSI) has developed a strategy for family planning promotion, the Interpersonal Communication (IPC) Programme that has been implemented in multiple countries, including Laos<sup>34</sup>. Based on an interview with a PSI staff member at PSI Laos, as part of PSI IPC

---

<sup>31</sup>See. Neil Price. Service Sustainability Strategies in Sexual and Reproductive Health: Community Based Distribution. accessed 7 Dec 2014 at <https://www.k4health.org/sites/default/files/service%20sustainability%20strategies.pdf>

<sup>32</sup>See B. Janowitz et al. An Assessment of the Zimbabwe National Family Planning Council's Community Based Distribution Programme. 2001.

<sup>33</sup>Calculated by dividing the estimated total annual program costs for 2013 in Table 3: on page 15 (\$71,700) by the total estimated UNFPA supported CBD client visits per year (5,100 active clients as shown in Figure 5 on page 20, at 12 visits per year=5,100x12=61,200 visits per year). (\$71,700/61,200 CBD visits)=\$1.17 per visit. If a pro-rated proportion (25%) of the “other” costs from the Output 2 budget are included in the estimated total annual cost for 2013, the cost is \$2.43 ((\$71,700+77313)/61,200 CBD visits)=\$2.43 per visit), although it might decrease over time, once the programme is well established.

<sup>34</sup>See PSI. IPC TOOLKIT: A compilation of examples, lessons learned and best practices in IPC programs. 2011. R. Hess et al. Cost effectiveness comparison between Convenience and Mapped Interpersonal Communication (IPC) Models in India and Nigeria. Abstract. International FP Conference. Addis Ababa. November 2013.

Programme approach PSI has developed a validated cost model that may be applicable to the UNFPA supported CBD programme.

#### Section 4.5 Value Added

Based on stakeholder interviews and document review, UNFPA Lao PDR has clearly been the lead supporter to the GoL MoH for CBD programmes in Laos for the past decade and this can be considered one of UNFPA Lao PDR's areas of comparative advantage. It is unlikely that CBD programmes would have been launched within Laos without UNFPA support, but other agencies, such as CARE, JICA and World Bank (CBD Plus) have shown interest in CBD programmes in the past and CARE is currently implementing a CBD programme in a Northern province. It is plausible that these agencies might consider supporting and/or collaborating with the implementation of CBD programmes in the future. UNFPA has been the lead organization in supporting the Lao Government in RH and remains committed to continued support for RH in the future.

#### Section 4.6 Gender

In as much as the CBD programme is designed to increase access to SRH services to vulnerable populations, especially women, it can be considered to be advancing gender equality. However, based on a review the 2011 CBD Training of Trainer Manual, no attention has been given gender issues (Training Manual for Trainers of Community Health Workers in Remote Areas, MoH Department of Hygiene and Health Promotion, MCHC. Published with support from the European Union. 2011). This lack of a gender focus is a major gap in the CBD training materials and future CBD training should cover gender issues. This is vital if CBDs are to be expected to counsel husbands to support their wives when they wish to use family planning methods. The CBD programme should be considered “gender accommodating”, since it does not challenge existing status quo in gender relations. It is neither gender exploitive nor gender transformative. The CBD programme usually hires male CBD workers because gender roles permit men to travel overnight to other villages. Older women are sometimes chosen to be CBDs, they are respected for their experience and they have support from sons or husbands for transport. Younger women are not likely to be selected to be CBDs due to the cultural barriers of gender roles; the young women have to care for their children, prepare meals and work in the fields and therefore cannot leave their home villages.

### Section 5. IFC Findings for Six Evaluation Criteria

#### Section 5.1 Relevance

**Adaptation to the needs of vulnerable populations.** Based on document review and interviews with senior informants at the national and provincial level, the IFC process is well adapted to the needs of vulnerable populations. By design, the IFC process uses a participatory community consultation approach, the PCA, to identify the needs of the population. The training of facilitators for the PCA approach places a strong emphasis on using an inclusive interpersonal approach to generate open dialog among various subgroups in the community. As implemented, all four districts received a rich variety of input from local group discussions (six distinct groups from within each district) for inclusion into their PCA implementation plans.

There are important cautions related to the relevance of the IFC as implemented in Savannakhet Province. While the PCA process is designed to reflect the needs of local vulnerable populations, it should be stressed that the actual implementation of the IFC on the ground, largely through village institutions such as the VHCs, may not actually reach the most vulnerable groups at the margins of village society. The IFC fundamentally challenges many aspects the current Lao cultural context, which tends to be hierarchical and male dominated within certain ethnic groups in Savannakhet. In addition, as discussed below, the overall IFC process was hampered by the constraints of the highly centralized MoH management style, which elevated final decisions on the activities to be implemented from the district level to the provincial level; this no doubt reduced emphasis on local district priorities.

**Analysis of the on-going needs of the target population.** The IFC process was based on a thorough analysis on the needs of vulnerable populations. It was included within the UNFPA Lao PDR CP5 based on prior IFC work supported by UNFPA in three southern provinces under the UNFPA Lao PDR CP4. It was informed by in-depth qualitative research such as the PEER study and the RH3 evaluation (UNFPA, MoH. Reproductive Health at the Margins, Results from PEER Studies in Southern Laos. May 2008; UNFPA. RH3 Final Evaluation- Report. 2011).

**Appropriateness of IFC to meet the needs of the target population.** While there have been some problems with the implementation of the programme, such as the centralized nature of the MoH administration of the IFC process and budgetary constraints, on balance, the IFC programme activities are highly appropriate to meet the needs of the target population. The majority of the activities within the IFC work plans fit well with the needs identified by the PCA process, such as working with VHCs to develop EBPPs and encourage greater use of ANC and respond to the needs of adolescents.

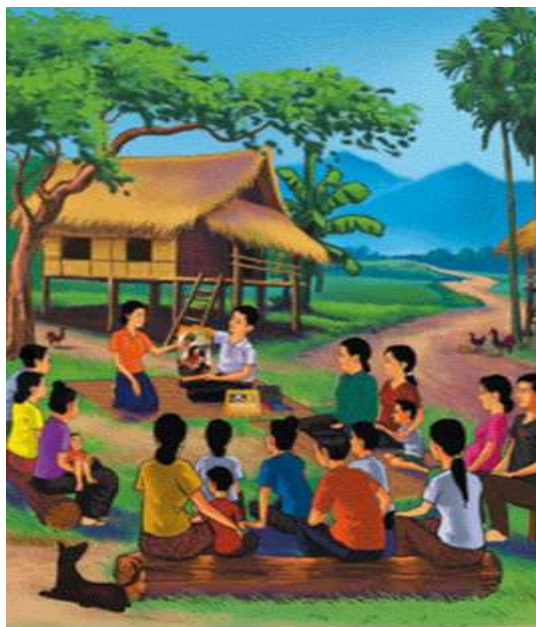
**Relevance of IEC materials.** The IFC IEC and advocacy materials are of high quality with a strong emphasis on visual culturally appropriate content suitable for low-literate or illiterate populations. While these materials were not evident during site visits to VHCs, the evaluation team were able to review the materials at the national and district level. They included posters and a well-designed flip chart that were suitable for rural remote areas, such posters encouraging husband support for the woman in pregnancy as well as emergency birth preparedness. While the materials were reported to have been pre-tested, there was no external assessment of their efficacy, although an external consultant advised the process of IEC materials development. The evaluation team was not able to confirm if there were pre-tests of materials for non-Lao speaking audiences. There were no attempts to do pre- and post-tests of the TV and radio IEC spots, which were primarily, if not entirely, in Lao. Based on short-term assessment of responses to a radio call in show, it was concluded that the TV and radio spots were not effective. Based on comments



from some non-Lao speaking respondents, a greater use of local language (Bru) radio hours might be better suited for remote rural populations.

At the time of the evaluation the CIEH had just completed a high quality VHC manual tailored to priority IFC activities (See Figure 7 for the cover page of this VHC manual). The VHC manual emphasizes images in a comic book format that is suitable for low literacy and illiterate audiences. If properly disseminated with adequate training, it may be effective in guiding VHCs and VHVs toward implementation of IFC activities. It must be emphasized that many, at times most, of the vulnerable populations in rural remote areas of Savannakhet are not able to read and have a limited understanding of Lao.

**Figure 7. Cover from IFC Manual on MCH Care for VHC and VHVs.**



There were difficulties in the logistics for the distribution of IFC IEC materials. The initial set of materials were distributed all at one time, leading to an accumulation of materials at District offices. This was reported to have initially caused an over stock with difficulties in storage resulting in damaged and lost IEC materials. This was later followed by a complete stock out of IEC materials, undermining the effectiveness of the IEC efforts.

**Care preferences of the communities, women and youth.** The IFC process, through the six group discussions in each of the four districts as part of the PCAs, has developed a rich in-depth documentation of the MNCH related priorities, concerns and needs of village level stakeholders. A matrix summarizing some of the key findings from the four district PCAs is shown in Attachment 7. The IFC process is clearly addressing many of the care preferences identified by the PCAs. These include women's concerns for husband support, concerns on costs for health

services<sup>35</sup>, and the need for more midwives, emergency transport and better quality health services. The results from the PCAs, as well as the qualitative assessments as part of this evaluation, clearly identify major cultural barriers to access and use of MNCH services. The remedies for these cultural barriers may need to be developed by the local populations themselves, in terms that only they can understand<sup>36</sup>. The IFC Manual on MCH Care for VHC and VHVs is an excellent response to the concerns identified by the PCAs. For example, it models men asking how to take care of their wives during pregnancy, men caring for wives and organizing emergency transport when needed.

## Section 5.2 Effectiveness

**Overview on IFC implementation.** The Participatory Community Assessment (PCA) is the critical first stage of the IFC process. As shown in Figure 8 below, the PCA process entails four steps, starting with a district situation analysis, followed by group discussions, an institutional prioritization and planning meeting, and a final report. The overall process of PCA for the four districts in Savannakhet covered about one year and was supported by international consultants who were extremely knowledgeable and experienced concerning the IFC process<sup>37</sup>. The preparations for the PCA process in Savannakhet began with training for key Savannakhet staff (provincial and district level staff) in August 2012. This training was implemented with support of national CIEH and DHHP staff with experience with the prior CP4 IFC activities in three provinces. The training was followed by the fielding of six group discussions conducted in Sepone District<sup>38</sup>.

The initial institutional meeting to prioritize the PCA findings for Sepone, took place in October 2012 with technical support from an international consultant. This meeting included participants from national level (CIEH, UNFPA), provincial level MoH staff and CIEH, as well as district level staff from all four districts, giving district level staffs a better understanding of the process. It was the model for the subsequent PCAs conducted in the remaining three districts. The institutional prioritization and planning meetings for the remaining three districts took place nine

---

<sup>35</sup> Respondents repeatedly cited the barrier of the cost of care at HCs or if they were to request a home visit. While ANC visits were free, respondents reported being charged for visits for FP. One woman reported that her two-month old baby had diarrhoea and she did not dare go to the HC because she had no money. The baby died. One respondent in a remote area reported being charged one million KIP for transport and medicine for a home visit for a problematic home birth. Respondents from two different villages reported that births at a HC usually entail a cash payment of between 200,000 to 300,000 KIP, plus the traditional gift of one hand woven skirt, one bottle of alcohol and one chicken. These findings are confirmed by the results from the PCA reports for all four districts in Savannakhet (See DHHP, CIEH, MCHC and UNFPA. Final Report on the Participatory Community Assessment (PCA) Sepone District, Savannakhet Province. Undated. In English and Lao. 2012. DHHP, CIEH, MCHC and UNFPA. Final Report on the Participatory Community Assessment (PCA) Nong District, Savannakhet Province. Undated. In Lao only. 2013. DHHP, CIEH, MCHC and UNFPA. Final Report on the Participatory Community Assessment (PCA) TPTH District, Savannakhet Province. Undated. In Lao only. 2013. DHHP, CIEH, MCHC and UNFPA. Final Report on the Participatory Community Assessment (PCA) Vilabouly District, Savannakhet Province. Undated. In Lao only. 2013.).

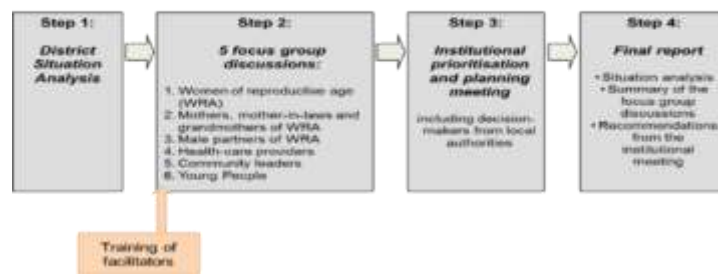
<sup>36</sup> For example, expecting a woman from a remote village culture to lie down in a bed at a health center that has previously been used by other pregnant women may be quite unreasonable given her culture's concepts of the pollution associated with child bearing.

<sup>37</sup> The technical assistance for the UNFPA Lao PDR supported IFC process was extremely well documented in a series of consultant reports that were kindly provided by Ms. Isabelle Cazottes. Her collegiality in sharing of these reports is gratefully acknowledged. See Trip Reports - Consultancy to support the training and implementation of the Participatory Community Assessment (PCA) in Maternal, New-born and Child Health in Bolikhamxay and Khammouanne Provinces, Laos – Isabelle Cazottes - November 2010 and February 2011 and Trip Report - Consultancy to support the Institutional Prioritization and Planning Meeting of the Participatory Community Assessment (PCA) in Maternal, New-born and Child Health in Sepone District, Savannakhet Province, Lao PDR October 4 to October 16, 2012 Report prepared by: Isabelle Cazottes.

<sup>38</sup> The six groups were: women of reproductive age, husbands of women of reproductive age, mothers or mothers in law of women of reproductive age, community leaders, and young people aged 12 to 24 and health care providers (I. Cazottes – December 2012).

months later with support from UNFPA Lao PDR and CIEH, but without any support from an international consultant. The three district-level prioritization meetings were done in quick succession in three two-day meetings over a two-week period from 15 through 23 July 2013. This was a very rapid pace to conduct these three meetings, and may have resulted in inadequate follow-up, especially without the assistance of the international consultant. The reports from these meetings are not dated but they appear to have been completed at the National level by CIEH in September 2013.

Figure 8. Participatory Community Assessment (PCA) Process



Source: Annex 1, I. Cazottes, Dec 2012.

Based on a detailed review of the four District level PCA final reports (only one of which was in English) and based on interviews at the National, Province and district level interviews, on balance the PCA process in all 4 districts was a genuine community assessment exercise. There are similarities among the four PCA reports, with some evidence of a “cut and paste” approach with each successive document, but the details from the group discussions were different in each district. The PCA reports reveal common issues to be addressed at the district and provincial level. The TPT PCA report was a bit more derivative of the other three district reports, but it appeared to be nonetheless based on district level discussions. See Attachment 7 for a summary of the four PCA findings.

The PCA process was a useful exercise for CIEH and the province but it is not clear how the districts benefited. Based on qualitative interviews, the response from the district level staff who participated in the PCA process was somewhat muted. The lack of enthusiasm at the district reflected the reality that the PCA process was ultimately “extractive” and resulted in a Province-wide implementation plan that was not under the district level administrative and budgetary control<sup>39</sup>. A sense of local ownership of the PCA process was not evident. Senior MoH staff among the three districts visited noted that, out of more than 10 specific priority activities they had recommended, only two or three were ultimately approved and funded. Despite the process

<sup>39</sup>Based on prior IFC programme experience in the CP4, the UNFPA Lao PDR CO wanted to encourage more district-level ownership of the IFC PCA process and opted not to hold a Savannakhet Province-wide institutional prioritization and planning meeting in the CP5. Despite this change in approach, the districts still do not seem to be driving the IFC process.

of local consultation with group discussions, their expectations for local implementation were not met.

**Level of Effort for IFC Training.** In order to interpret the findings of this evaluation, there is a need to appreciate the level of effort implementing the main IFC programme activities in the four Savannakhet Districts. As shown in Table 4 and Figure 9 below, under the CP5 programme a total of 74 IFC training events have been held since 2012. This includes 29 trainings for VHCs and VHVs on EBPP, and 36 trainings for VHCs and VHVs on MNCH and 9 trainings with District health staff on the counselling needs of adolescents. Since 2013 there have been at least 1,009 training participants, more than a quarter of which (272) were women (data not shown; available on request). The available data do not permit an unduplicated count of the number of persons trained or the number of villages reached, but there were 20 or more trainings each year, reaching more than six villages during each training (There are a combined total of 275 villages within the four Districts and each year the districts expand to new villages, so far achieving a coverage of 63 per cent (185/275) of villages for MNCH training for VHC/VHVs). For the past three years each of the four districts have participated in more than 5 training events each year. Most of these trainings involved a pre- and post-test (results of these pre-and post-tests were not available at the time of the evaluation was conducted)<sup>40</sup>.

---

<sup>40</sup> Based on a review of the documents related to the IFC and EBPP trainings, below are some key findings: IFC training: The training was conducted for two days and the trainee's signed lists correspond to the information provided by Provincial Program Coordinator (Dr. Keo). The training materials were taken from the "Training materials for the VHCs" from 2009 for the 3 southern provinces (Saravan, Sekong and Attopeu) with the Logo from Health Unlimited and supported by UNFPA. The training time table indicated there was a session on gender (Definition of gender, difference between sex and gender, the role of male and female gender in the society and that there should be mutual respect between men and women. Men should respect their wife's opinion and her decisions in family planning methods used, when to have sex with her husband, when and how many children she should have; husbands to help their wives with house work.) A separate pre- and post-test form was provided. There was no summary of pre and post-test results and the evaluation team could not verify whether the pre and post-tests were done for each training. EBPP training: Only the signed lists of participants were received and nothing else. There were few discrepancies noted regarding the number of training days. In the training data table provided by the Program Coordinator it says 2 day training however the trainee's signed list showed only one day of training. The DHO and HC staff signed 3 days. Conclusion of the findings: It took quite some time for the program staff to provide training materials requested by the evaluation team. It was not possible to measure the quality of the training based on the materials provided as there were no data on the pre- and post-test of the training. There were a few discrepancies in the training on the EBPP as stated above. UNFPA did not have in hand all the training related materials when requested by the evaluation team. UNFPA should pay more attention to the quality of the trainings and make sure that the training related materials and the reports on the training are provided by the government counterparts to UNFPA.

Table 4: IFC Trainings in Savannakhet Province by District and Year

	Sepone (14 S-Ds, 13 HCs)			Vilabouly (13 S-Ds, 8 HCs)			Thapangthi (8 S-Ds, 7 HCs)			Nong (9 S-Ds, 8 HCs)			Totals
	2012	2013	2014	2012	2013	2014	2012	2013	2014	2012	2013	2014	2012-2014
No Villages (VHC/VHV) trained on MNCH	15	20	10	17	28	10	15	15	10	15	20	10	185
Number of Trainings	3	4	2	3	4	2	3	4	2	3	4	2	36
No Villages w VHC meetings on EBPP	10	25	10	17	28	10	10	15	15	10	15	10	175
Number of Trainings/meetings	2	3	2	2	3	2	2	3	3	2	3	2	29
No Villages w VHCs meetings on Youth	0	0	10	0	0	11	0	0	32	0	0	9	62
Number of Trainings/meetings	0	0	2	0	0	2	0	0	3	0	0	2	9
Total Villages covered	25	45	30	34	56	31	25	30	57	25	35	29	422
Total No of Trainings/Meetings	5	7	6	5	7	6	5	7	8	5	7	6	74

Source: UNFPA Lao PDR and CIEH 2014

Figure 9. IFC Villages Covered and Number of Trainings in Savannakhet Province by Year



Source: UNFPA Lao PDR and CIEH 2014

**Access to an integrated package of MNCH services.** Both qualitative and quantitative data suggest that the IFC programme may have improved access to a range of MNCH services. While there are problems in attribution given that other interventions have been underway in the districts (such as the hiring of Skilled Birth Attendants, and work of the CBDs), based on the somewhat limited qualitative data from interviews and FGDs with both men and women, there may have been some improvement in past three years on some pertinent indicators. For HC births and ANC for example, women reported that people go more frequently due to a greater awareness of the risks of pregnancy, interest in obtaining reassurance and, in some cases, because of the presence female HC staff. Men are reported to be accompanying women more for ANC and for HC births. Based interactions with VHCs and health authorities there was some evidence of support for EBPP, ANC, delivery at HCs, exclusive breast feeding, and the need for SBAs present at home delivery. There were no reports of increased post-partum care for new-borns. Senior stakeholders mentioned that prior to the IFC program the village authorities could name only vaccination as an MNCH activity and that now, when they talk to them about MNCH, they name ANC, safe delivery at HC, exclusive breast feeding, nutrition, and family planning. This was validated and confirmed by the evaluation team's interviews.

Based on the available quantitative data for the four districts, despite concerns for the quality of the data and possible reporting bias, there appears to be an overall upward trend on multiple key MNCH indicators: Contraceptive prevalence, First ANC visits, Fourth ANC Visits, Birth in a HC with a SBA and Post Natal Care (See the graphs shown below in Figure 10 for trends for the four years 2010-2013). As with the qualitative data, there are problems of attribution, given that other interventions have been ongoing. But it is plausible that the IFC activities may have contributed to a wider range of MNCH services.

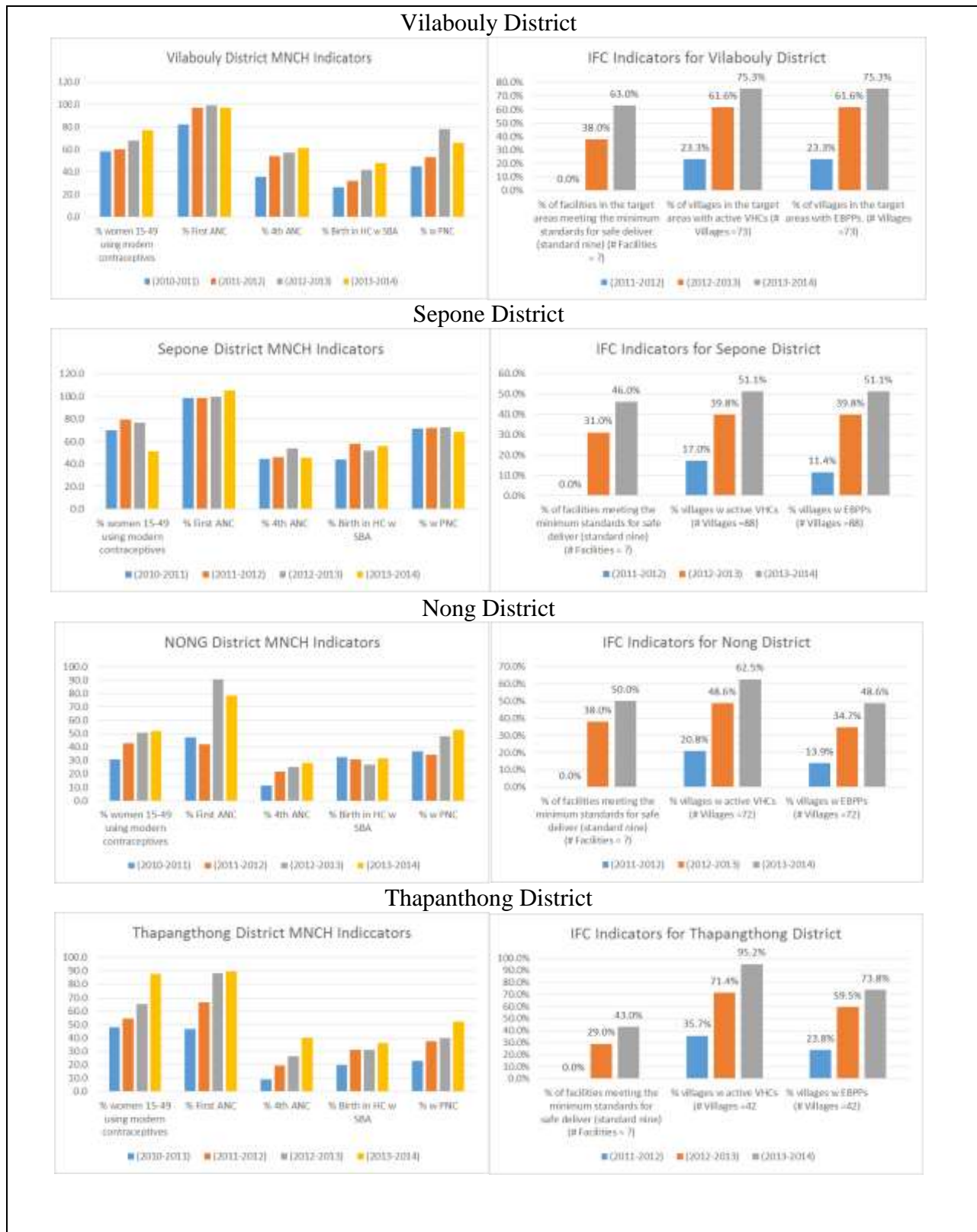
#### **Cultural Barriers to Safe Birth**

Traditional Mangkong beliefs hold that child birth cannot take place at home, as the birth process would pollute the home and anger household spirits. During a FGD with 6 women in a remote village, 4 of the 6 women reported that their last child was born at some distance outside of their house on the ground with only a piece of skirt underneath them. In another village, a rude hut on the outskirts of the village has been allocated for child birth. The Village leader, who is also the VHV, supports the idea of a birthing hut, and would support constructing a more adequate hut on the outskirts of the village.



Birthing Hut in Nong District 2014.

Figure 10. Selected MNCH and IFC Indicators for Four Districts in Savannakhet Province



**Changes in health seeking behaviour regarding pregnancy and FP.** As mentioned above, based on both qualitative and quantitative data there seems to have been an increase in ANC visits as well as an increase in FP and demand for injectable contraception. It is difficult to attribute these changes to the IFC programme as they may be partially the result of the CBD programme, HC outreach, the SBA initiative as well as the work of other NGOs in the target districts. Interviews with health centre staff suggested that the VHCs have been encouraging the local population to use the HCs, especially for ANC. While respondents complained about being charged for HC births and FP services, the fact that respondents reported that HCs did not charge for ANC visits may also be a factor supporting an increase in ANC visits. Charges for services, or even the perception that there will be charges, are a considerable barrier. The villagers and village authorities gave compelling testimony about expensive fees at HCs and district hospitals. This issue should be addressed (or even audited) by the government.

**Demand for FP services and commodities.** In the context of the IFC programme, VHC respondents reported learning about FP during trainings and including FP information in village dissemination meetings in the weeks following their trainings. This is with the caution that the number of VHC respondents is small, and their recall concerning the content of their trainings was fairly general and imprecise.

**Increased utilization of district and provincial health facilities.** The trend for an increase in visits cannot be attributed solely to the IFC programme activities. It seems probable that there is some synergy between the IFC activities, especially the training of VHCs, and the CBDs, who report close collaboration with members of VHCs, such as the VHV and Village Leaders.

**Changes in perinatal service demand and behaviour.** As shown in Figure 10 above, the quantitative data for the four districts all show an increase in PNC visits. But based on the qualitative findings, there was little or no evidence of greater use of perinatal services. Despite frequent probing, VHCs did not mention any changes in perinatal services. Women respondents stressed that they were under pressure from their husbands and mothers in law to resume work very soon after child bearing and could not afford to take time off for visits to HCs, unless it was a dire emergency. They frequently used the expression, “If you do not work you do not eat”. They could not justify the cost of the petrol to go to the HCs. The demands of working in the fields, husking rice and gathering firewood are relentless. Women reported that, they put aside extra fire wood in the last months of pregnancy. This buys them some time for a little extra rest just before and after giving birth.

**Functionality of VHCs according to their TORs.** Based on the qualitative interviews, VHC respondents consistently claimed that they held at least one or two dissemination meetings for their villages soon after any training. Some even reported dividing their village into four sub-groups of households to repeat the same dissemination message four times. But the VHC respondents were vague about the nature of the trainings they received (stating that trainings were fairly common and they were not able to recall specifics). They freely admitted that they would forget about the content of the trainings related to MNCH after a few months<sup>41</sup>. The dissemination meetings tended to be done only once or twice. This was not surprising as they did

---

<sup>41</sup>This could be due partly to language used in the trainings for the ethnic VHCs, who would prefer that the trainings be conducted in their local language. This was confirmed by the use of the Bru translator help during the interviews. The VHCs and villagers understood more and gave more information in their own language.



not report receiving any follow up visits from health centre staff or district IFC staff. Despite frequent probing, none of the VHC staff were aware of having any type of TOR or accountability to HCs. Based on the quantitative data from UNFPA Lao PDR and CIEH there has been a steady increase in the proportion of targeted villages with active VHCs. As of this year, more than half of all villages are reported to have functional VHCs (ranging from 51% in Sepone to over 90% in Thapangthong). This reporting has important limitations as there are currently no standard criteria for what constitutes a functional VHC.

**Use of EBPPs.** Based on qualitative interviews and FGDs at the village level, despite frequent probing, there was little awareness or other evidence of established emergency birth preparedness plans (EBPPs). Only two village health committees reported talking to their villages on EBPP. In a relatively wealthy village, there was a perception that an EBPP was not needed, since each household has its own tractor, or “Iron water-buffalo.” Respondents in a FGD among men in a low income ethnic village were unaware of any type of EBPP, stating that, “We have to rely on family. If no family, you have to pay.” They reported being vulnerable to exploitation by neighbours who had a means of transport. Alternatively, respondents from some remote poor villages reporting have a tradition of physically carrying a sick villager to the nearest HC. This was the only option as there was limited transport, especially during rainy season. Given that obstetric emergencies are a relatively rare event within any given village, the EBPP systems are not used routinely and fall into disuse. In one village where the village leader acknowledged the existence of an EBPP, there was a problem with the EBPP when the designated transport owner was not available.

Based on quantitative data, there is some evidence of EBPPs being implemented. At the District and provincial level, there were reports of large numbers of cases where EBPPs were implemented but it was not feasible to verify or validate these data<sup>42</sup>. For example, one district reported over 500 instances of use, but much of this was for non-EMOC issues. As shown above in Figure 10, despite the absence of any clear criteria for what constitutes an existing EBPP, the data from UNFPA Lao PDR and CIEH show a steady increase in EBPPs, currently more than half of all villages are reported to have EBPPs, ranging from 49% in Nong to over 75% in Vilabouly.

## Section 5.3 Sustainability

### Questions on Sustainability of IFC Interventions:

**Sustainability of the IFC process.** Based on the qualitative interview results, the IFC process, especially the PCA methodology as implemented, is not likely to be sustainable. The overall IFC activity, in particular the PCA process that is both staff and time intensive, clearly requires UNFPA Lao PDR financial support. Nonetheless, substantial capacity has been developed, both nationally and at the provincial, and district level. The overall IFC approach is quite complex and, after extensive training and experience over two UNFPA country programmes, the IFC

---

<sup>42</sup> Evaluation Team requested reports for EBPPs but was unable to obtain them. Apart from interviews and monitoring data, there was no available documentation on numbers of EBPPs from District level staff. There were no established criteria for what constitutes an established EBPP.

concepts are appreciated by national staff at the CIEH and UNFPA. There has been considerable capacity building training and experience at the provincial and district level.

There have been two tracks of IFC activity, one involving trainings for the VHCs and VHVs, the other with the PCA process. They appear to have been somewhat independent of each other because of the delays in implementation of the PCA process. The PCA process was very intensive and time consuming and required a large investment in capacity building. This capacity has been developed, but the long turnaround time for the PCA process has undermined enthusiasm.

There is also an issue of motivation at the district level. Based on the district level interviews, there appears to have been a sense of disappointment and frustration at the district level because of what district level informants perceived as: 1) delays of the PCA process 2) the lack of follow through on the multiple needs identified in the PCA reports, 3) the limited number of activities identified in the PCAs that were supported.

There was little sense of buy-in or ownership of the PCA implementation plans at the district level<sup>43</sup>. This may be a problem of raised expectations that were not realized. Districts appear to have expected to have a concrete implementation role in the IFC activities as identified by the PCA process. This did not take place due to the centralized provincial government role in decision making. Decisions were also taken by national UNFPA Lao PDR staff for good reasons related to the UNFPA's budgeting requirements, but this was not always clearly communicated to the district levels. At the provincial level, which manages the budgeting and administrative aspects of the IFC trainings, there is more commitment and buy-in compared to the District level. The IFC process would be more likely to be continued if the counterparts at the field level had more budgetary and administrative control.

Although it is currently dependent on UNFPA support, compared to the PCA process, the ongoing IFC work to train members of the VHCs is more likely to be sustainable, is perceived to be useful, and to have potential for an enduring impact on access to and use of quality services. Despite the PCA complexity, the PCA recommendations have informed the content of the IFC activities in support of the VHC and VHVs. Senior MoH counterparts made favourable comments on the benefits of the PCA process, stating that it generated useful recommendations, such as the training of additional midwives/SBAs to be posted at HCs, the requests for more equipment for the HCs and district hospitals, and the training of the HC staff in health education (communication skills). For the MoH, the PCA process is an important accomplishment, a community consultation process that uses participatory procedures. The MoH has been introduced to a new way of thinking and planning. The IPC process permits them to hear the voices of the villagers. But it is difficult to measure the benefits from this IFC process. The

---

<sup>43</sup> Despite repeated requests, the evaluation team was unable to obtain copies of the District level PCA reports or District PCA Implementation Plans at the Provincial and District level. It was only on the second to last day of the in-country mission, after returning to Vientiane, that the District Level PCA reports were provided by UNFPA Lao PDR. This is symptomatic of the disconnect between development of the district PCA plans and actual implementation of the IFC process, which is managed at the Provincial level.

training of VHCs and development of supporting materials, such as the VHC and VHV Manual which reflects the priority recommendations of the PCAs, are likely to contribute to the improvements of key MNCH indicators.

**Capacity of CIEH and MCHC to continue to work with communities, not only after the end of programme but to also expand in other areas.** Based on interviews, there was some expression of willingness and clear evidence of capacity to implement the IFC process. But, without external funding, there was little basis for expecting the CIEH and MCHC staff to independently replicate the IFC or PCA process in other districts within SVKT Province or elsewhere. The evaluation has not measured the extent of their capacity improvement, but based on interviews with national and provincial level staff, there is a clear knowledge of the importance and benefits of participatory community assessment and the IFC process. CIEH expressed interest in conducting the IFC in other areas and seeking funding for it. It is conceivable that CIEH would be able to replicate the process, but it is not clear if they have the capacity to do this in other districts without additional external technical support.

#### Section 5.4 Efficiency

Based on responses from senior stakeholders, there was strong concern that, in the short term (over the three years of the IFC implementation) the IFC PCA process was too expensive. Respondents felt that the PCA process was too staff intensive, training intensive, and time consuming compared to the impact from the subsequent IFC programme activities. Nonetheless, there were some respondents who felt that over the long term (greater than three years) there were potential benefits from the capacity building for CIEH, provincial and district level staff, and clear benefits for the trainings for local VHCs.

Apart from incorporating issues from the PCA into training of the VHCs, the PCA was viewed by some senior stakeholders as an extractive process that did not empower the local district level staff or villagers. There was a perception that, because the PCA process was so expensive, the GoL would not invest money in this activity in the future. Alternative, shorter and more efficient community consultation strategies are needed.

There were some limitations in the method with which UNFPA implemented the IFC process that have since been remedied. In addition to internal budgeting problems that have forced UNFPA to stop funding some of the proposed IFC activities, the PCA process was slowed down by a requirement that all four of the districts complete their PCA reports, as well as their quarterly activity reports, before the final planning of the next cycle of UNFPA supported activities. This requirement slowed down the budget process and was a source of frustration at the district level. This requirement has since been dropped, which should reduce delays and improve flexibility as well as effectiveness.

## Section 5.5 Value Added

It is unlikely that the IFC programme would have been undertaken without UNFPA support. The MoH MNCH Strategy SO3 was not adequately supported financially by the MoH and the MNCH Strategy SO3 did not clearly assign responsibilities for the proposed IFC activities. Despite an initial lack of IFC expertise, UNFPA took the initiative to implement IFC activities and was the lead agency committed to implementing the SO3 of the MoH MNCH (primarily within the UN Joint Programme as a collaboration with the MoH, WHO, UNICEF). The IFC was a new approach for the MoH. The government did not have the IFC perspective on how to consult with the community for MNCH using a participatory approach. There were other approaches for participatory community consultation for MNCH that the MoH could have used based on the experience of other NGOs and agencies such as Burnet or CARE.

In terms of IFC, the UNFPA office was not perceived by key informants as being very strong on participatory consultation processes, but the UNFPA was willing to be the lead agency to take on the role for implementing the MNCH SO3. Senior stakeholders pointed out that UNFPA, WHO and the MoH had very limited capacity for participatory consultations and did not really understand the IFC process. The IFC process was needed but it required a long-term process of capacity building. It was a major change, as well as a challenge, for UNFPA to acquire this expertise. At the onset, UNFPA Lao PDR had to rely on external international consultants to do the most important aspects of capacity building to implement the IFC programme. There was a need for continued external consultant support to move the process along more rapidly and effectively. Based on stakeholder interviews, there was a clear sense that the IFC process should have had the benefit of fulltime province and district level field officer staff presence to properly supervise the implementation of the programme.

Aside from its acquired expertise in IFC, UNFPA Lao PDR is recognized for its leadership in Family Planning and RH, including its role in funding FP supplies for the entire country. It has a long tradition of programme implementation in RH and has value added in technical competence working with the government. The Skilled Birth Attendant (SBA) initiative is considered one of UNFPA Lao PDR's major contributions to the country.

## Section 5.6 Gender

In many respects, the IFC programme is gender transformative. A strong example of this is the IFC effort to encourage men to be more supportive of their wives during pregnancy. This is a transformation of traditional male gender roles. In other ways, the IFC programme is implemented in a manner that is gender neutral and does not try to change gender relations or help women to be more assertive. The IFC approach is implemented with both men and women but does not help women to be more assertive towards men. The IFC PCA process is gender balanced, for example it includes both women's and men's groups. The WHO IFC materials have a clear commitment to women's RH and the IFC IEC materials pay careful attention to promoting

the role of the husband to support the women during pregnancy and during delivery (see posters, and the draft VHC manual). Despite working with existing male dominated institutions, such as the village health committee, the IFC has encouraged greater attention to the health needs of women. The evaluators did not see much attention paid to equal rights for women versus men. In general, but especially in the remote areas with ethnic groups, there is not much focus on women's rights and empowerment. The women asked that the districts and the VHCs talk to their husbands. They are not empowered to advocate for themselves. The male-dominant culture of Laos has deeply rooted customs from many generations and it will be challenging to change the mentality of the men in power at so many levels of authority. A gender transformative approach should be encouraged to assist women in exercising their rights to health care, but it will require much more effort before for the people in power change their attitudes and beliefs towards women's rights and facilitate change in the community. While it may be too late to change the status of the current generation of adult women, with a more assertive gender transformative approach over time the younger generation should become more empowered.

## Section 6. Conclusions

### Section 6.1 CBD Conclusions

#### Section 6.1.1 Strategic Level

**Overall:** UNFPA Lao PDR support for CBD programmes remains a valid strategy for remote areas without access to HCs. UNFPA supported CBDs clearly provide access to FP for women in remote rural hard-to-reach areas. Virtually all respondents felt the CBD remains appropriate as an approach for women to gain access to FP methods. Until other sources of FP emerge, there is currently no alternative for remote villages that do not have HCs. The Lao PDR has endorsed the National Birth Spacing Policy (1995) that declares that contraceptive methods and services “will be provided free to everyone who needs it.” Free contraception is the only option for many women in remote rural areas.

#### Section 6.1.2 Programmatic Level

**Relevance:** Based on the findings of this evaluation, a sound justification for the continued support for the CBD programme is the use of locally hired CBDs, which ensures culturally appropriate interactions. The presence of cultural barriers to access and use of MNCH services calls for the use of a cadre that knows the local customs; there appears to be untapped potential to leverage the CBDs' knowledge of local traditions to overcome cultural barriers.

UNFPA's support for CBD programmes is based on an extensive evidence base and prior experience. Based on the qualitative interviews and FGDs, there is evidence of a demand for FP (especially injectables) and MNCH services, which CBDs should be able to address. At the same

time, the clear evidence of non-cultural barriers to FP and MNCH services (distance, time and cost loom large based on the qualitative data) also justify further support for CBD programmes.

While there are good aspects to the existing materials, the current IEC materials may be insufficient and additional materials and training should be developed, especially to help CBDs to effectively counsel both women and their husbands regarding the side effects and benefits of contraception. The CBDs as well as their clients need highly visual non-literate materials compatible with their local language.

**Effectiveness:** Despite serious problems, such as stock outs of combined OCs, inadequate training, delay in payments, and inability to provide injectables, the results from this evaluation indicate that CBDs are contributing to use of FP among women in remote villages. This is with the caveat that there are problems of attribution due to other ongoing programmes and the available data are of limited quality. Nonetheless, based on qualitative data and quantitative data on CBD service statistics and District CPR data the CBD programme is likely having some impact.

Acknowledging that the samples of respondents for this evaluation are small and not likely to be representative, it appears that current assumptions about CBD work patterns are not valid. Examples of inaccurate assumptions related to the number work days per month, number of households visited in each village, frequency of use of IEC materials, data collection, and capacity for effective FP counselling.

Based on interviews with CBDs it appears that the impact of training may be undermined by lack of translation into local ethnic languages such as (Bru) or use of trainers fluent in Bru.

Based on interviews with CBDs, there is often a close working relationship between CBDs and VHCs, for example in order to have access to HHs in villages where the CBD is not resident. This relationship does not seem to be adequately considered in the design of both CBD and IFC outreach activities.

Based on interviews with women in CBD catchment areas, there are missed opportunities for CBD to reach out to husbands of women who wish to use FP.

Given that CBDs may not be visiting all households in their assigned villages and are mainly visiting current users, CBDs may be able to collaborate with VHCs to establish regular monthly village meetings to encourage non-users to come forward.

While it is acknowledged that CBDs are intentionally selected to work in villages that are remote from HCs, there was little evidence of ongoing collaboration or linkage between the CBDs and HCs.

Based on interviews with CBDs, CBDs appear to be willing to carry non-FP supplies in a manner consistent with the CBD Plus strategy. Based on stakeholder interviews, the MCHC may be

interested in adapting and expanding the CBD Plus approach. Other senior MoH stakeholders may be supportive.

**Sustainability:** While the current CBD Programme clearly depends on UNFPA Lao PDR support, some provinces and districts may have requested GoL funding for future operations. It is not certain if and when the CBD programme will receive GoL funding. While it is acknowledged that CBD programme is not currently sustainable, donor support for CBD programmes is needed until such time as FP services are available in remote areas as part of a national integrated MNCH service package.

Active CBD clients, women using oral contraception, are **highly vulnerable** to interruption of contraceptive supplies as they are reported to be receiving just one cycle per visit. Qualitative data suggest that women are very dependent on CBD supplies for contraceptives and have experienced unwanted pregnancy due to stock-outs and interruption of supply. To avoid unwanted pregnancies, a transition/exit planning is essential before abruptly ending UNFPA support for CBDs.

Given the substantial existing capacity that has been developed in Savannakhet Province, as well as other provinces, discontinuing CBD program involves serious opportunity costs: the loss of UNFPA investment for building this Provincial and District level capacity.

A strong sense of CBD programme ownership was observed at National, Province, District and Sub-district levels; this may be a factor supporting the continuation of CBD services.

**Efficiency:** UNFPA disbursement of funds for the CBD programme has not been efficient and may have been disruptive and undermined CBD morale due to delays in payment. While delays in submission of reports from GoL counterparts is a problem for all donors, given UNFPA's long-term collaboration experience, these delays might have been avoided, especially if UNFPA had shown more flexibility in allowing districts to submit reports independently of each other.

The finding that CBDs may only be visiting current users suggests that the CBD programme is not efficient and warrants follow-up to be remedied. The CBD programme may benefit from methods for calculation of cost per client visit and or new client. Local resources for cost analysis may be available from PSI Laos.

**Value Added:** It is unlikely that the current CBD programme could have been implemented without UNFPA Lao PDR funding and intervention. While UNFPA has clearly been a lead player for CBD programmes, other agencies, such as CARE, JICA and WB (CBD Plus) have shown interest in the past. There is the possibility that some of these agencies might consider support in the future.

**Gender:** Given the current cultural constraints in Lao villages in remote areas, the CBD programme is quite understandably being implemented in a manner that is gender neutral and gender accommodating. The CBD programme hires primarily male CBD workers because gender

roles permit men to travel overnight to other villages. Older women are considered effective as CBDs because of their age and experience; their sons or husbands can provide transport to their assigned villages. Due to their commitments in their households and in the fields, younger women are not likely to be CBDs. A review of the TOT manual for CBDs revealed that gender is not covered in their training.



## Section 6.2 IFC Conclusions

### Section 6.2.1 Strategic Level

The MoH MNCH Strategy SO 3 was not adequately supported by the MoH and the SO3 did not clearly assign responsibilities for the proposed activities. Despite an initial lack of IFC expertise, UNFPA Lao PDR was the primary agency to commit itself to implementing the SO 3 of the MoH MNCH (primarily within the UN Joint Programme as a collaboration with the MoH, the WHO, and UNICEF).

### Section 6.2.2 Programmatic Level

**Relevance:** The IFC Programme is highly relevant to the needs of the vulnerable populations and SO3, but it faces two important challenges: 1) the current Lao cultural context, which tends to be hierarchical and male dominated within certain ethnic groups, and 2) the MoH's tradition of a centralized management style.

Based on a limited review of the IEC materials, the IFC programme has developed relevant materials for the target population, including a recently developed manual for VHCs and VHVs. Lack of local-language radio programming may have limited the utility of the IEC media work for the remote rural ethnic populations.

**Effectiveness:** It is plausible that the UNFPA Lao PDR-supported IFC programme has contributed to improvements in MNCH, especially ANC visits, FP and HC deliveries. Based on admittedly limited qualitative data and based on the quantitative data, which also has limitations, the MNCH indicators in Savannakhet appear to be improving. Due to problems of attribution (the presence of other programmes as well as potential synergy with CBD programme) this evaluation cannot determine the degree to which the observed improvement in MNCH indicators is due to the IFC programme.

Based on our limited qualitative data, which could be to insufficient to pick up trends of this nature, the empowerment among women to control their own access and use of MNCH services was not very pronounced. There were instances where villagers (both men and women) were hesitant to request more services, such as deworming tablets, which were not provided in sufficient supply. Most respondents appeared quite hesitant to question charges for health services, for example for attended births, diarrheal disease or FP, even when they felt the charges were unjust.

**Perinatal service demand and behaviour:** Based on our limited qualitative data, which could be to insufficient to pick up trends of this nature, there was little evidence of any significant changes in perinatal service demand and behaviour. There was modest evidence of change based on the available quantitative data.

**Functionality of VHCs according to TORs.** Based on interviews with members of VHCs, there was a consistent reporting of VHCs organizing village dissemination meetings shortly after trainings. Dissemination meetings were also confirmed by respondents in FGDs. Based on qualitative data, there was no evidence that VHCs were doing their job as described in a TOR. None of the VHC respondents had any knowledge of a TOR or could show us examples of IFC IEC materials.

**EBPP:** While there was some reporting of awareness about EBPPs among VHC respondents, there was little evidence of much impact based on qualitative data from FGDs. Some districts report relatively large numbers (> 500) emergency transport events in the past year, but these were not limited to obstetric emergencies.

**Sustainability** The IFC training level of effort is quite substantial with significant coverage of district villages. This capacity building for VHCs has potential for significant long- term impact with donor continued support. The IFC PCA process very unlikely to be sustainable without streamlining<sup>44</sup>. Although capacity has been developed and the IFC concepts have been taken on, for example by CIEH and UNFPA, it seems likely that any future IFC activity will require additional UNFPA support.

**Efficiency** Based on qualitative interview results, the IFC training of VHCs and VHV is an efficient approach to reach villagers to support access and use of MNCH services. This is with the caveat that the quality of the training needs to be monitored more closely.

**Value added:** It is very unlikely that the IFC programme would have been implemented without UNFPA support. UNFPA Lao PDR initially had to rely on international consultants to do the capacity building for the IFC and PCA. In contrast, UNFPA Lao PDR is recognized for its leadership in Family Planning and RH, including its role in funding FP supplies for the entire country.

### Section 6.2.3. Transferable lessons learned

The IFC program could be replicated in other districts, so long as the PCA can be streamlined to reduce cost and time and kept within the context of local District administration.

---

<sup>44</sup> The IFC PCA process was perceived as too expensive, staff intensive, training intensive, and time consuming compared to the delayed benefits from the identification of priorities and the modest impact from the subsequent programme activities.

## Section 7. Recommendations<sup>45</sup>

### Section 7.1 CBD Recommendations

#### Section 7.1.1 Recommendations for UNFPA's component on communities

R1. Overall: UNFPA Lao PDR should continue to support CBD programmes with the understanding that current problems (stock outs, delay in payments, lack of training, lack of supportive supervision field visits, and insufficient HH visits) need to be addressed. CBD clients in remote areas are highly vulnerable to interruption of contraceptive supplies; they should be receiving more than just one month-supply of contraceptives per month. At the same time, there should be a recognition that CBDs are a stop gap measure until alternate cadre, such as Village Health Workers (VHWs), midwives, and/or HC services or HC Outreach services are available to all women in remote rural areas. The continuation of UNFPA Lao PDR support will require close consultation with National, Provincial and District level MoH counterparts to develop a detailed work plan that a) resolves mutually agreed priority problems, and b) assigns clear responsibilities to Provincial and District level counterparts for training, supportive supervision and improved monitoring.

R2. Overall: The CBD Plus model appears to be promising and should be considered in remote areas not served by a HC Outreach programme, with the reservation that this should only be considered if and when current CBD programme problems (mentioned in R1 above) have been resolved. The institution of the CBD Plus model requires a mid- to long-term consultation and planning process that achieves a consensus with key stakeholders (GoL MoH, UNICEF, JICA, WB and other interested donors and NGOs) on priority Provinces and Districts and sources of funding. It should include a district level piloting process with a costing study that weighs the costs of the additional services against their potential benefits.

R3. Relevance/effectiveness: As recommended by WHO and other internationally recognized RH authorities, CBDs with a suitable background should be trained to provide injectable contraception. The CBDs should also be trained to effectively counsel and refer women for longer-term options of IUDs and implants. In the short-term, it is acknowledged that the current legal constraints may limit training to CBDs with health experience. Given the logistical challenges and the need for intensive training to assure quality of care, this activity requires piloting at the Province and District level to develop and test an injectable service delivery protocol in close consultation with the relevant MoH cadre responsible for overseeing the CBDs (currently at the DHO level). While the MCHC is clearly capable of providing training for the introduction of injectables, consideration should be given to using international technical assistance from clinical experts who have prior experience with lessons learned in the

---

<sup>45</sup> These recommendations are suggestions for UNFPA Lao PDR to consider and are not intended to be prescriptive. The authors want to acknowledge that other responses to the findings in the report may be as or more appropriate based on the current administrative and financial constraints faced by the UNFPA Lao PDR.

introduction of injectables within other CBD programmes. UNFPA Lao PDR should develop a concrete time-bound advocacy strategy toward revising current regulations on the types of CBDs who are permitted to provide injectables.

**Effectiveness:**

R4. An explicit CBD TOR should be developed in consultation with CBDs so that it reflects realistic performance standards. CBDs should be trained based on this revised TOR. The development of an updated CBD TOR requires in-depth consultation with key stakeholders in the MCHC at the National, Provincial and District level, including the CBDs. The development of this CBD TOR will require UNFPA support to cover the costs of the consultation process. An independent national or international consultant should be hired to take responsibility for the completion of this task. This is a matter of considerable urgency and should be prioritized for completion in 2015 in coordination with the activity described in R5 below.

R5. The finding that CBDs are only visiting current users for re-supply needs to be further explored and confirmed. Efforts are needed to increase CBD interaction with non-users (both men and women). Guidelines for CBD visits to HHs need to be revised so as to increase contacts with non-users, especially women whose husbands are not supportive of family planning. These guidelines should include practical suggestions for regular village meetings to provide outreach to husbands to inform them on FP and MNCH issues and allay fears concerning contraceptive side effects. UNFPA Lao PDR should use existing funds and staffing for monitoring and evaluation visits to confirm the findings at the District level. Assuming these findings are confirmed, the above mentioned consultation in R4 should be used to develop guidelines to ensure greater contact with non-users of contraception. This is a matter of considerable urgency and should be prioritized for completion in 2015.

R6. Promote the introduction of long-term family planning methods (IUD and Implants) and improve CBD knowledge and understanding for effective counselling for these long-term methods to be credible sources of referrals. The promotion of the introduction of these long-term methods requires a long-term strategic planning process that builds on existing UNFPA Lao PDR activities in support of introduction of the IUD and implants (collaboration with MoH). The process of introduction should be piloted at the District level with careful attention to the training needs of CBDs for referrals and follow-up for interested clients.

R7. Provide regular annual refresher training (in minority languages as needed in all Provinces) for CBD counselling skills, especially to address women's and men's concerns for contraceptive side effects. More culturally-specific training is urgently needed to reduce these cultural barriers. The CBDs need training to go beyond standard approaches to address the local cultural issues. The monthly to quarterly CBD visits to the DHO for reporting and resupply present a good opportunity for regular in-service training and should be used accordingly. An external national

or international consultant with expertise in SRH counselling, especially concerning side effects for hormonal methods, should be hired to do a short term assessment of CBD counselling needs and develop refresher training curricula based on this assessment. This is a matter of considerable urgency and should be prioritized for completion in 2015.

R8. Fund capacity building for adequate Supportive Supervision for CBDs at least 2 times per year. The capacity building for supportive supervision for CBDs has to be informed by the updated CBD TOR and the ground-truthing of the current realities of CBD performance (See R4 and R5). The process of instituting genuine supportive supervision will require considerable planning and development efforts. It needs to be based on a common vision of the CBD TOR achieved among all key stakeholders from the CBD programme, including MCHC staff at the National, Province and District level. HC staff should also be consulted. The current management structure for Supportive Supervision requires active participation of DHO staff but HC staff should also be actively involved. Both DHO and HC staff need to be sensitized to the current problems with CBD performance and trained on the concept of supportive supervision in a participatory, non-judgemental basis<sup>46</sup>.

### **Sustainability:**

R9. If CBD activities were not to be funded anymore, UNFPA should develop an “exit strategy” for the CBD programme that ensures a gradual phase out, with a minimum of three-month advance notice that allows women sufficient time to find credible alternate sources of FP. The decision to end funding for CBD activities should be made within a dialog with the implementing partners at the National and Provincial and District level that anticipates the consequences for both clients and implementing staff, the CBDs. Lead time is critical to ensure that CBDs have been fully briefed on how to notify clients well in advance, providing them with at least three months extra supply of their current contraceptive. The CBDs should be trained to counsel FP clients on the alternative sources of their current method or sources of alternative methods of FP available from the nearest HCs or District Hospital. Transport should be provided for those women who are currently using OCs, but decide they would like to opt for longer term methods, such as injectables, IUD or Implants and need to go to a HC or District Hospital.

R10. While it is acknowledged that CBD programme is not currently sustainable, in the short term UNFPA should advocate for GoL and other donor agencies to fund CBD programmes in future. A concrete, time-bound (through 2015) advocacy plan should be developed to encourage alternate donor support for the CBD programme, the highest priority being for the inclusion of the CBD programme within ongoing GoL budget. This could be done with external assistance from a national or international consultant with expertise in developing cost estimates to provide a basis for developing a compelling rationale for GoL funding for CBD programmes in terms of

---

<sup>46</sup> For examples of resources for supportive supervision see: IPPF. Creating a culture of quality: Supportive Supervision for Quality Improvement: a Reference Manual. (2006). PATH. Children’s Vaccine Program at PATH. Guidelines for Implementing Supportive Supervision: A step-by-step guide with tools to support immunization. Seattle: PATH.(2003). and Jon Rohde. Supportive Supervision to Improve Integrated Primary Health Care. Management Sciences for Health NO. 2 OCCASIONAL PAPERS. (2006).

births averted, reduced infant and child deaths and reduced maternal morbidity and mortality (See R11 below). In the longer term, UNFPA should, along with other partners, support efforts to integrate family planning services in remote areas within a GoL MNCH integrated service package.

### **Efficiency:**

R11. Adapt existing PSI IPC or similar cost effectiveness models to the CBD programme in order to better assess comparative District and Provincial performance, especially to identify new clients. UNFPA Lao DPR should establish a dialog with PSI Laos to identify opportunities for sharing experience and expertise in cost effectiveness methods that can be adapted to the UNFPA PDR CBD Programme. If PSI Laos is unable to provide assistance, it should be possible to identify a short term national or international consultant with the required expertise to develop a model tailored to UNFPA Lao PDR requirements.

R12. Also consider collaboration with PSI IPC management for sharing and/or adaptation of IPC systems for monitoring for more rigorous and regular supportive supervision of CBDs. As outlined in R11, PSI Laos has developed rigorous monitoring systems for its IPC programme that might be pertinent for the CBD programme monitoring, such as systematic random follow up of clients to verify the number and quality of CBD visits with FP clients. As with R11, in the absence of PSI Laos collaboration, a short term national or international consultant would be able to address this need.

R13. Fund capacity building to enhance the Provincial and District level M&E data collection and reporting, especially for capacity building to improve the validity of village level denominators for CBD indicators. UNFPA Lao PDR should seek to achieve a coordinated effort between its Population and Development staff and SRH staff to reach out to the responsible entities at the National, Provincial and District level who have recently overseen efforts by HC staff to collect estimates of catchment populations at the sub-district level. The CBD programme's need for accurate village-level estimates of women of reproductive age is closely aligned with these ongoing efforts and should be coordinated to ensure a) access of current data b) coordination and capacity building to ensure improved validity of future data collection.

### **Gender:**

R14. Given the cultural barriers to access and use of MNCH services, future CBD training should have a gender component<sup>47</sup>. Strengthen CBD refresher training to include gender awareness for CBDs with the goal of improved counselling skills for working with husbands and young men in support of women's needs for access and use of MNCH service, especially to address husband and wife opposition to FP based on concerns for side effects. UNFPA Lao PDR should seek

---

<sup>47</sup> It is acknowledged that the scope of need to address gender issues is so large that there is little expectation that this recommendation will be adequate to effect a substantial change in the short term. It will take a multi-generational mainstreamed approach to achieve the desired changes in women's access to health services.

technical assistance to adapt or develop an appropriate gender training module from gender experts, such as from UN Women, or from centres of excellence in gender training with men such as Instituto Promondo or the International Centre for Research on Women.

### Section 7.1.2 Recommendations for future UNFPA programming

R15. Strengthen UNFPA Lao PDR budget and project management procedures to avoid unexpected gaps in disbursements. UNFPA Lao PDR should seek support for an external short-term management consultant to conduct a short-term review of UNFPA Lao PDR's financial and management systems to identify opportunities to streamline reporting and fund disbursement both for short- and long-term programme implementation. This consultant should ideally be from outside UNFPA, but have prior experience in providing technical assistance to UNFPA to reduce financial and management bottlenecks.

R16. Support capacity building for provincial and District level counterparts for project management and reporting. Based on the outcome of R15, UNFPA Lao PDR financial and management staff should develop a short-term training program to assist implementing partners to anticipate and respond to UNFPA reporting and budget requirements and deadlines.

R17. Obtain funding for designated UNFPA staff or competent local national NGOs (such as Care, PSI or Save the Children, etc.) to have an on-going field presence to provide longer term support for CBD capacity building, especially for CBD Plus. UNFPA Lao PDR should review options for establishing a full time province level presence in support of the management, monitoring and evaluation of both the CBD and IFC programmes. This could involve seconding a national staff member to be placed within the Provincial Health Offices or awarding a contract with a competent NGO to assume administrative responsibility for providing oversight for key management functions of the CBD and IFC programmes.

## Section 7.2 IFC Recommendations

### Section 7.2.1 Recommendations for UNFPA's component on communities

R18. UNFPA Lao PDR should consider continued capacity building for VHCs and VHVs (for EBPPs, Husband support for pregnant women, and empowerment to insist on free quality services) in the four Savannakhet Districts, building on the CIEH work (such as the new VHC VHV manual) and informed by the District level PCA report findings and recommendations. While much work has already been done to provide training for VHCs, stronger oversight from UNFPA Lao PDR is needed<sup>48</sup>. The new VHC VHV manual provides a basis for a new round of capacity building. This should be implemented through the CIEH at the National, Provincial and District level in close collaboration with UNFPA Lao PDR staff with regular monitoring visits to ensure that the trainings are well designed and implemented.

---

<sup>48</sup> Despite repeated requests, the evaluation team was unable to obtain copies of the IFC training materials for VHCs, especially those related to EBPP.

R19. Where feasible, trainings should be done in local minority languages. VHC training impact may have been limited by lack of comprehension among Ethnic language speakers. UNFPA Lao PDR should review Lao based training materials for IFC to ensure that they are appropriate for non-Lao speaking participants. Funds need to be allocated for non-Lao training materials and non-Lao speaking training staff. IEC materials should be disseminated gradually over the life of the programme to avoid stock outs. Where feasible, future training of trainers should be conducted with trainers who are able to speak the local languages.

R20. Establish clear, measurable criteria for determining if VHCs and EBPPs are functional in all target villages. UNFPA Lao PDR should work with CIEH to support the improvement of their monitoring and evaluation (M&E) systems for IFC supported activities<sup>49</sup>. As part of this process, a participatory effort involving VHC members from multiple districts, should be used identify a minimum set of VHC activities that are needed before a VHC can be considered functional. Similarly, based on a consultation with VHCs that have developed EBPPs, define a minimum set of EBPP activities as a basis for determining whether or not a village has a functional EBPP.

R21. Support the implementation of six-month supportive supervisory visits for VHCs and monitor VHC and EBPP functionality. As noted in R8 above, the process of instituting genuine supportive supervision will require considerable planning and development efforts. As noted in R20, the implementation of supportive supervisory visits presumes that a consensus has been achieved on definitions for functional VHCs and EBPPs. An international consultant with prior experience with the WHO IFC protocols should be hired to assist in the development of a district level approach for supervision of IFC activities. This approach needs to be based on a common vision of the role of VHCs achieved among all key stakeholders from the IFC programme, including MoH, MCHC and CIEH staff at the National, Province and District level. The current management structure for Supportive Supervision requires active participation of DHO and HC staff who need to be sensitized to the current problems with VHC performance and trained on the concept of supportive supervision in a participatory, non-judgemental basis.

R22. Develop local language (for example, Bru in Savannakhet; Khamu, Hmong in Northern provinces) radio segments for encouragement of ethnic audiences on access and use of MNCH services. These segments should be developed and pre-tested in close consultation with informants from ethnic groups that speak these languages, taking into account their traditions as pertinent to MNCH. UNFPA Lao DPR should proceed on an incremental basis to use a participatory approach to development of just one or two carefully pre-tested radio episodes for a well-established local language radio broadcast programme in Savannkhet Province with a large Bru-speaking audience. The decision to proceed to develop additional episodes in other languages should be based on the outcome of a brief external assessment of these pilot local language episodes that measure the level of coverage and retention of content of key messages.

---

<sup>49</sup> CIEH staff expressed interest in receiving technical assistance for M&E capacity building.



R23. Consider development of local language video segments compatible with smart phone applications for IFC VHC/VHV and CBD use during household visits. As outlined above in R22, UNFPA Lao DPR could proceed incrementally to adapt one or two local language radio episodes for use on smart phones. The proposed external assessment of the pilot radio programmes in R22 would be responsible the assessment of this initiative.

R24. Coordinate VHC capacity building with other ongoing Province and District programmes, including especially the SBA, when and where applicable, the UNICEF-supported Integrated HC Outreach Programmes, and CBD activities (as well as other NGO supported programmes). UNFPA Lao PDR should maintain regular contact with other agencies that provide training or related capacity building for VHCs. In view of the central role of VHCs in multiple public health and community service interventions, UNFPA Lao PDR should ensure that VHC capacity building is coordinated with other GoL and multilateral supported programmes. For example, if there are other national campaigns being considered by UNICEF or major NGOs, there may be opportunities to leverage these efforts through coordination.

#### Section 7.2.2 Recommendations for future UNFPA programming

R25. UNFPA Lao PDR should consolidate its capacity for IFC activities by working with and/or through NGOs to conduct future community MNCH PCAs and IFC MNCH related empowerment activities in Districts. The IFC process would benefit from a sustained field presence at the District level by an established NGO with prior experience with community consultations related to public health, such as CARE. While UNFPA Lao PDR has acquired considerable capacity to support IFC activities, a more sustained role from local field staff is needed to support CIEH and DHO teams in follow-up on VHC training.

R26. The UNFPA Lao PDR supported IFC PCA process needs to be shortened and simplified to permit a more efficient and rapid community consultation at the District level. UNFPA Lao PDR should support a short-term international consultant to collaborate with CIEH to streamline the IFC PCA process based on the Savannakhet experience in four districts.

R27. UNFPA Lao should not attempt future IFC PCAs without a) revising the process to be more efficient, as mentioned above, and b) continuing to use external international consultants.

R28. Villagers and local village authorities gave compelling testimony about expensive fees at HCs and district hospitals that are being charged against national and district policies. This is a clear barrier to access to MNCH services. While this issue needs be addressed (or even audited) by the GoL, UNFPA Lao PDR needs to develop a clear time-bound advocacy plan, preferably in collaboration with other UN sister agencies, such as the WHO and UNICEF, to encourage action before the end of 2015.

**List of Attachments (contact Country Office for Attachments 2-8)**

Attachment 1: TOR

Attachment 2: List of persons and institutions met/interviewed

Attachment 3: List of documents consulted.

Attachment 2: Evaluation Matrix

Attachment 3: Site Visit Schedule

Attachment 5: Data Collection Instruments

Attachment 7: Key PCA Findings from Four Savannakhet Districts

Attachment 8: Evaluation Questions



# Terms of reference

## Evaluation of UNFPA Laos' maternal health Community programme component

<b>Consultancy:</b>	One international and one national consultants for Evaluation of UNFPA Laos' <i>Community Based Distributors and Individuals, Families and Communities</i> programmes
<b>Location:</b>	Vientiane Capital, Savannakhet Province, Lao PDR
<b>Timeframe:</b>	32 work days (6 ½ weeks) between October and December 2014

### 1. Introduction

Over the past years, UNFPA Laos has been implementing family planning activities with and for communities within the framework of its 5<sup>th</sup> Country Programme (CP5). The programme focused on Community-Based Distribution (CBD) of contraceptives and other reproductive health commodities and the application of the WHO framework for community mobilisation working with Individuals, Families and Communities (IFC) to improve maternal and newborn health.

UNFPA Laos is hiring two external consultants; one national and one international, to conduct an independent Evaluation of these two programme components that have been implemented over the past two and a half years.

The purpose of the evaluation will be to assess progress towards the achievement of outputs, to identify lessons learned, and to develop recommendations to inform UNFPA's future programming in the areas of CBD and IFC.

The intended audience and users of the evaluation are the UNFPA management in the Country Office, UNFPA staff working on CBD and IFC, government counterparts in Laos, and other development partners.

### 2. Context

Lao PDR is a landlocked country, and is categorised among the 'Least Developed Countries' (LDC) worldwide. Geographic conditions pose difficulties in the development of social infrastructure, transport and communication links and trade. A highly dispersed and thinly spread population compounds this.

Since 1975, national development policies have been introduced gradually and the New Economic Mechanism has introduced reforms aimed at the gradual transformation from a centrally planned economy to a more market oriented one.

In 2013, Lao PDR was characterized by a population estimated at 6.8 million, which is projected to grow to 8.3 million in 2025, and 10.6 million in 2050.

Laos is still characterised by a low level of development, including a weak health system and limited access to health services. These affect particularly poor people from minority groups, living in remote rural areas.

The percentage of women making four or more visits for ANC increases sharply with increasing wealth and education level. Only 1 in 10 women from the poorest households, and those with no education received ANC four or more times compared to as many as 8 in 10 women in the richest quintile and women with at least upper secondary education. Similarly, seventy-one per cent of women in urban areas received four or more ANC visits, compared with only 27 per cent of women in rural areas.

Unmet need for family planning is highest among women with no education (26 per cent) and decreases with increasing wealth, with the exception of the richest wealth quintile. It is highest among women from households (31 per cent) in Hmong-Mien minority villages, and lowest in Lao-Tai headed households (18 per cent).

The contraceptive prevalence rate is approximately 50% for all methods and needs to be increased to meet the current unmet need for family planning (20%), and for women to be able to space their births. In 2011/2012, the total **fertility rate** of 4.5 ranged from 2.3 in Vientiane to 6.4 in Huaphan province.

The Maternal Mortality Ratio (MMR) was estimated at 357 deaths per 100,000 live births in 2011/12. Contributing to this were the low percentage (41.5%) of births attended by skilled health service providers, with only 3,7% of births through caesarean section, as well as limited access to emergency obstetric care (EmOC).

### 3. Programme Context and Intervention Components

The goal of *'Increasing demand for and uptake of public health services, before, during, after pregnancy and for childbirth and childhood care'* is part of the National Strategy and Planning Framework for the Integrated Package of Maternal and Newborn Child Health (MNCH) services. UNFPA supports the government in Lao PDR to reach targets related to this goal, including through its support to CBD and IFC, aimed at *ensuring that individuals, families and communities in priority areas have access to an integrated package of services on maternal, neonatal and child health* (Output 2).

The outcome that this intervention strategy is expected to contribute to is that *by 2015, people in the Lao PDR will benefit from equitable, promotive, preventive, curative and rehabilitative health services*. Priority is given to selected remote and vulnerable populations by

- (a) *expanding the scope and coverage of community-based family planning services,*
- (b) *training health-care providers,*
- (c) *empowering and mobilizing communities, including through data collection,*
- (d) *developing integrated information, education and communication materials, and*
- (e) *supporting partnerships for resource mobilization, joint planning and the implementation of district and provincial health plans for the integrated package of maternal, neonatal and child health services.*

**Community-based distribution (CBD)** is a strategy that relies on trained non-professional members of the community to provide health services directly to other members of the community. In the case of family planning, these services provide information and modern temporary contraceptive methods, including pills and condoms. CBD of contraceptives can be used to supplement other government and private family planning services to make family planning more widely available. It involves providing FP services in community settings, basing these services on the needs and resources of the community.

CBD can be an important addition or alternative to clinic-based services. It is usually less costly than clinic services, easier for many people to reach, and available in a wider range of settings.

In that sense, this approach represents a way of improving access to family planning services in remote communities. Furthermore, because the community is directly involved, the services are more likely to be accepted.

UNFPA's programme in the area of **CBD** has been shared as a good practice after the first two years of its implementation. A first evaluation, in 2011, highlighted its major contribution to an increasing CPR in target areas. Under CP5 (2012-2015), CBDs have been supported in 4 UN target provinces, which are Savannakhet (South), and Phongsali, LuangNamtha and Oudomxai in Northern Laos. CBDs provide FP services to communities, each of them being responsible for 3 to 6 target villages. The villages have been selected based on their distant location from village health centres.

Prior to being deployed, the CBDs received a 5-day training course. The training course covered family planning, modern contraceptives, maternal and child health, prevention and treatment of common diseases, communication with clients, expectations, reporting TOR and a pre-test for the trainees. After the initial training, the CBDs received a 3-day refresher training every 2 years, including discussions on the problems faced in the field.

CBDs are supposed to work for 16-20 hours per month to provide information and family planning services, as well as primary health care services to mothers and children in the selected villages. Their tasks also include working with, and providing counselling to men, unmarried youth and adolescents. They try to target people who are at risk of unwanted pregnancy and STIs including AIDS, travelling within target villages for 3 to 6 days, distributing contraceptive pills, condoms, injectable drugs, iron, and vitamin A.

Currently, there are 75 UNFPA-supported CBDs travelling monthly to villages in the target provinces, and covering a total of 321 communities/villages, with 85,561 villagers living in 24,076 households, of whom 25,237 are women of reproductive age. 32 of these CBDs work in the main target province of Savannakhet, to address the RH needs of 34,604 citizens, including 7,444 women in reproductive age in 139 villages.

UNFPA covers the CBDs' travel costs and allowances. The management of CBDs has been taken over by the government with CBDs reporting to health centres or the District Health Office (DHO). CBDs report every 1 to 3 months, and at the same occasion replenish their stocks of contraceptive pills, Vitamin A, Iron, and others. They further cooperate with the government health system, encouraging pregnant women to have safer deliveries at facilities and with skilled birth attendants. When health centre or district staff come to provide health check-ups for mothers, newborns, and children, they help to gather communities.

Monitoring and follow-up among CBDs and clients in communities is done on a 3-monthly basis by MCH staff from the District Health Office, provincial officials and/or the Maternal and Child Health Centre (MCHC), with technical assistance from UNFPA.

CBDs seemed to be generally satisfied with their functions. DSA or lunch allowance of about \$5 per day is paid for totally 6 days per month. The extent of turnovers remains limited among CBDs, those having resigned doing so because of their age, or declaring that they have moved to other villages, often due to in-marrying of men.

At community level, in addition to working with CBDs, UNFPA works with **Individuals, Families and Communities (IFC)**. The IFC approach is considered to be the critical link in ensuring continuum of care throughout the perinatal period. It is recognized that the availability of quality services will not produce the desired health outcomes where there is no possibility to make healthy decisions and to act on these. The aim of working at the IFC level is to contribute to the empowerment of women, families and communities to improve and increase their control over maternal and newborn health, as well as to increase the access and utilization of quality health services, particularly skilled birth attendance. Interventions at the IFC level are meant to foster the supportive environments for survival but also for healthier mothers, newborns, families and communities. The IFC approach, developed by WHO, can be seen as a process of enabling people and groups to increase control over, and to improve, their health and quality of life. Empowerment, in this context, is defined as a process through which women, men, families and communities gain control over maternal and newborn health and related potential problems.

Interventions are organized into four priority areas:

1. Developing capacities to stay healthy, make healthy decisions and respond to obstetric and neonatal emergencies
2. Increasing awareness of the rights, need and potential problems related to maternal and newborn health
3. Strengthening linkages for social support between women, men, families and communities and with the health care system
4. Improving quality of care and health services, and of their interactions with Individuals, Families and Communities

These aims should be achieved through strategies of education, community action for health, partnerships, institutional strengthening and local advocacy, to be implemented largely in the settings of household, community and health services. Special attention is to be given to the different interventions that address the status of women, in particular within the family, as health outcomes are largely determined by decisions made within the households

In Laos, UNFPA initiated its **IFC** component in 2009, under its 4<sup>th</sup> Country Programme. It has been adapted in CP5, based on lessons learned from the WHO methodology for community mobilisation, and the recommendations of an external evaluation. Its interventions aim at empowering village community structures through community involvement, by identifying needs of the population through participatory workshops. Once needs are identified, they are addressed through Village Health Committees (VHC) and Community/Peer Motivators (CM) who organize health education and health promotion activities to raise awareness, encourage positive health behaviour and promote access to services. Emergency Birth Preparedness Plans (EBPP) have been established in every target village, including village emergency funds, which give pregnant women the opportunity to seek transportation to health facilities and use skilled birth attendance. Furthermore, service providers in health facilities in target areas are trained to provide user-friendly reproductive health services and are encouraged to organize open-door days at health facilities. Monthly meetings are organized between village and district levels. IFC interventions supported by UNFPA are exclusively implemented in the target province of Savannakhet; more precisely in 80 target villages.

The expected outcome is that the communities will develop their capacities and support mothers, pregnant women and other community members to take responsibility for their own health.

#### 4. Objectives and scope of the evaluation

The overall objectives of the Evaluation are:

- (i) To provide an independent assessment of UNFPA’s contribution to the progress made through the CBD and IFC programme towards the expected output 2 set forth in the results framework of the country programme;
- (ii) Enhanced accountability of the Laos Country Office, as well as UNFPA as a whole, for the relevance and performance of its CBD and IFC programme components, and
- (iii) A broadened evidence-base, documented lessons learned, as well as a set of actionable recommendations, based on credible findings, to be used for organisational learning and the design of future UNFPA programming.

The Evaluation will cover a 34 months implementation period, from January 2012 to October 2014.

#### 5. Evaluation questions and criteria

The evaluation will analyse the programmatic areas based on the evaluation criteria of relevance, effectiveness, efficiency and sustainability, as well as UNFPA’s added value.

<i>Evaluation questions</i>	<i>Issues to be covered</i>	<i>Evaluation Criteria</i>				
		<i>Relevance</i>	<i>Effectiveness</i>	<i>Efficiency</i>	<i>Sustainability</i>	<i>Added value</i>
1. To what extent is the UNFPA support in the field of community-based distribution and IFC <u>adapted to the needs of the population</u> , in particular vulnerable groups?	Evaluators need to consider: (a) the extent to which the UNFPA country office has correctly analysed the on-going needs of the target population (b) the extent to which UNFPA’s CBD/IFC programme was appropriate to address the population needs (c) The extent to which CBD/IFC IEC and advocacy materials and activities were relevant to the needs of the target groups.	X				
2. To what extent have IFC / CBD interventions supported by UNFPA contributed to (or are likely to contribute to) <u>individuals, families and communities in priority areas having access to an integrated package of services on maternal, neonatal and child health</u> (Output 2), in particular for women and young people from vulnerable population groups?	Evaluators need to consider: (a) How the health seeking behaviour regarding pregnancy and family planning has evolved among women and men in target areas, (b) To what extent the demand for family planning services and commodities among targeted communities has been developed through CBD/IFC interventions? (c) to what extent CBD/IFC activities have contributed to district/provincial health facilities’ utilization (d) To what extent SRH services, including FP, are accessible to communities, particularly vulnerable groups (e) To what extent SRH services, including FP, meet the needs and expectations of the clients (f) What the communities’, especially women’s and young people’s care preferences are.  <b>CBD</b>		X			

	(i) If the CBD provide (culturally) sensitive, respectful services to all population groups in target areas (ii) If CBD still serve the initially planned purpose (iii) The skills levels of CBDs <b>IFC</b> (i)How the behaviour in terms of perinatal service demand has evolved through IFC interventions, (ii)If VHCs are functional (according to their ToR), (iii) If EBPPs are being used					
3. To what extent have <b>IFC</b> interventions supported by UNFPA contributed to (or are likely to contribute to) a <u>sustainably improved access to and use of quality services</u> in the field of reproductive health and family planning, in particular for pregnant women, mothers and young people from vulnerable population groups?	The extent to which benefits endure. Evaluators need to consider: (a) the actual flow of benefits after the interventions have ended; (b) the overall resilience of benefits to risks that could affect their continuation. (c)the extent to which partnerships promoted national ownership of supported interventions, (d) The extent to which the capacityof CIEH and MCHC has been developed to enable them to continue to work with communities, not only after the end of programme but to also expand in other areas?		X		X	
3. To what extent has UNFPA been able to support its partners and the beneficiaries in developing <b>CBD</b> and community <u>capacities and knowledge</u> , thereby ensuring <u>ownership and durability</u> of effects?	Even though CBD was supposed to be a stop gap while the government outreach programme improves access and use of care, are there benefits which will endure? Evaluators need to consider: (a) the actual flow of benefits after the interventions have ended; (b) the overall resilience of benefits to risks that could affect their continuation. (c)the extent to which partnerships promoted sustainability through coordination and national ownership and absorption.				X	
4. To what extent has UNFPA made good <u>use of its financial resources</u> to pursue the achievement of Output 2 of the UNFPA country programme through its CBD / IFC interventions?	This question examines how UNFPA has utilized the resources at its disposal. In particular, evaluators need to consider: (a) if the investments made in CBD / IFC activities have an impact justifying their amount, (b) if the return for investment in terms of time and financial resources is appropriate;			X		
5. To what extent would the results observed in terms of access to services through CBD / IFC have been <u>achieved without UNFPA support</u> ?	Under this criterion, evaluators will check whether there are any visible benefits specifically resulting from the UNFPA CBD / IFC programme component and they will assess their magnitude. When assessing this criterion, evaluators should give special attention to the comparative strengths of the UNFPA CO in relation to other stakeholders working in the area.					X
6. To what extent has UNFPA successfully facilitated the mainstreaming of provisions to advance gender equality in the CBD / IFC programme and its interventions?	This question examines the extent to which UNFPA has successfully ensured that its interventions were developed and implemented in a way that has considered women’s and men’s needs, interests and experiences.		X		X	

These questions serve as a basis to the evaluation. The final evaluation questions will be determined in cooperation with the evaluator, and presented in the design report.

## 6. Methodology and approach

The evaluation will use a multiple-method approach including desk review, group and individual interviews, focus groups and field visits as and where appropriate.

A variety of methods to ensure the validity of the data collected will be used. Besides a systematic triangulation of data sources and data collection methods and tools, the validation of data will be sought through regular exchanges with the CO programme managers and officers.

The assessment will be inclusive, involving a broad range of partners and stakeholders, including the beneficiaries of the interventions.

The evaluation team will perform a stakeholders mapping in order to identify both direct and indirect partners and stakeholders.

The evaluators will propose the methodology, sample frame, target groups, interview and field work techniques in the design report. After its presentation, a discussion on the approach and the tools will take place. The methodology and approach will be considered final after acceptance of the design report by the Evaluation Reference Group (ERG).

## 7. Evaluation process

### 1) Design phase (9 work days)

The design phase will include the following activities:

- Desk review of all relevant documents available;
- Mapping of stakeholders relevant to the evaluation, including state, civil-society and beneficiary stakeholders and the relations between them;
- Analysis of the intervention logic of the programme,
- Finalization of the list of evaluation questions;
- Development of a data collection and analysis strategy as well as a concrete workplan for the field phase.
- At the end of the design phase, the evaluator will produce and present a **design report**, displaying the results of the above-listed steps and tasks. The Evaluation Manager will circulate the design report to relevant staff for their review and comments and to the APRO Regional M&E Adviser quality assurance. The Evaluation Team Leader will incorporate relevant comments into the final draft design report for endorsement by the ERG.

### 2) Field phase (13 work days)

After the design phase, the evaluation team will undertake a 13 days in-country mission to collect and analyse the data required in order to answer the final evaluation questions.

During the first days at the country office premises, the evaluators shall meet with relevant CO staff with a view to validating the evaluation matrix. Central level government counterparts, UN partner agencies, and other relevant stakeholders can be interviewed in Vientiane. This time can also be used to make final arrangements regarding agendas, logistics and security matters. Evaluators then have to proceed with the strategy they devised for collecting information with a view to answering all evaluation questions. The main part of the field mission will represent a trip to the Southern province of Savannakhet, which is the main focus area of the UNFPA Country Programme. This may involve travel to remote and difficult to reach areas.

At the end of the field phase, the evaluation team will provide the ERG and the CO with a **debriefing presentation** on the preliminary results of the evaluation, with a view to validating preliminary findings and testing tentative conclusions and/or recommendations.

### 3) Reporting phase (10 workdays)

The evaluation team will continue the analytical work and prepare a first draft of the final evaluation report, taking into account comments made at the debriefing meeting.

The **first draft final report** will be submitted to the ERG for comments, which will be consolidated by the evaluation manager, and will allow the evaluation team to prepare a **second draft of the final evaluation report**.



This second draft final report can form the basis for a second round of commenting. The **final report** will be drafted shortly after, taking into account comments made by the participants.

## 8. Expected deliverables

- The **design report**, including a stakeholder map, the final list of evaluation questions, the evaluation matrix, the overall evaluation design and methodology, and a detailed description of the data collection plan for the field phase, for the evaluation (maximum 20 pages);
- The **debriefing presentation** to be presented and discussed with the CO during the debriefing meeting at the end of the field phase, synthesizing the main preliminary findings, conclusions and recommendations
- The **evaluation report** (about 50pages plus annexes), should be based on two rounds of commenting on drafts evaluation reports, taking into account potential comments from the ERG. The Evaluation Team (ET) will be requested to draft an evaluation report with two separate sections; one for CBD, and a second on the IFC component. The final evaluation report should also contain two separate sets of conclusions and recommendations.

All deliverables will be drafted in English, and will be considered the property of UNFPA.

## 9. Composition of the evaluation team

- The international **Team leader** will have overall responsibility for providing guidance and leadership, and for coordinating and producing the draft and final reports. S(he) will also be responsible for the quality assurance of all evaluation deliverables.
- One national **Evaluation Associate**, with expertise in the area of UNFPA's mandate, and knowledge of capacity building and maternal health sectors in Laos. S(he) will also act as an interpreter, during the field phase, and for the conduct of focus groups with final beneficiaries.

### Profiles and Qualifications of the evaluation team members

#### Team leader

- Post-graduate degree in public health, social sciences, or reproductive health related field
- Between 7 and 10 years of relevant working experience in conducting evaluations in the field of development cooperation for UN agencies and/or other international organizations
- A solid understanding on the use of evaluation methodologies
- Documented experience in leading evaluations
- Proven experience in the field of community work and/or community mobilisation
- Strong inter-personal, teamwork and organizational skills
- Substantive knowledge on family planning and maternal health issues
- Familiarity with information technology, including proficiency in word processing, spreadsheets, and presentation software
- Demonstrated capacity for strategic thinking and policy advice are essential.
- Familiarity with UNFPA or United Nations operations will be considered an advantage.

#### Evaluation Associate

- Degree in public health, social sciences, or reproductive health related field
- Proven experience in the field of development cooperation in Laos, in the area of community work and/or community mobilisation
- Strong inter-personal, teamwork and organizational skills

- Substantive knowledge on maternal health in Laos, and its institutional and social contexts
- Familiarity with information technology, including proficiency in word processing, spreadsheets, and presentation software

All team members should have in-depth knowledge of UNFPA programmatic areas related to communities, and related issues and challenges in the country and/or region.

They should have a good knowledge of the national development context and be proficient in written and spoken English. Knowledge of Lao/Thai, or other local languages, is considered an advantage.

All must be committed to respecting deadlines of delivery outputs within the agreed timeframe, and must be able to work in a multidisciplinary team and a multicultural environment. All should be knowledgeable of issues pertaining to gender equality and human rights.

## 10. Remuneration, duration of contract and logistical arrangements

Remunerations will be based on the consultants' experience and along the UNFPA guidelines for fee for service for consultants. The 32 Workdays (6 ½ weeks) will be distributed between 01 October and 20 December 2014.

Payment of fees will be based on the delivery of outputs, as follows:

- Upon acceptance of mission: 20%
- Upon satisfactory submission of the draft evaluation report: 50%
- Upon satisfactory submission of the final evaluation report: 30%

Daily Subsistence Allowance (DSA) will be paid per nights spent at the place of the mission following UNFPA DSA standard rates. Travel costs will be settled separately from the consultant fees.

The consultants are encouraged to use the UNFPA premises to work on the reports, where Internet and printing facilities will be provided. The UNFPA drivers can assure transportation to the field throughout Lao PDR.

## 11. Management and conduct of the evaluation

The UNFPA M&E Officer will serve as the **Evaluation manager**. The Evaluation manager will ensure consistency throughout the evaluation process, and will be the main contact person for the evaluation team. (S)he will coordinate the activities of different actors involved in the CBD / IFC Evaluation, and organise and supervise the different phases. (S)he will draft the ToR, establish the ERG, prepare the initial documentation package, and support the team by providing quality assurance on the design report. Regarding the field phase, the EM takes care of developing the agenda, facilitating access to stakeholders; organises the debriefing meeting, and supports the team with other logistics arrangements. (S)he will provide comments on the draft evaluation report, and conduct an Evaluation Quality Assessment (EQA) which will be discussed with the evaluation team. After the evaluation, the EM will coordinate the contributions to the management response, promote the use of evaluation recommendations to inform decision-making processes and programme implementation.

The **Evaluation Reference Group (ERG)** will be composed of a selected group of representatives from the UNFPA Laos CO, national government and other partners. The ERG will be chaired by the Evaluation Manager, and tentatively includes

- UNFPA Representative and/or Deputy Representative
- SRH/Community Mobilisation Programme Officer
- RH Coordinator
- Ministry of Health
- ASRH Programme Officer
- Gender Officer
- SRH/ Community Mobilisation Officer
- Care international

The main functions of the ERG will be:

- To contribute to the selection of evaluation questions,
- To facilitate access of the evaluation team to information sources (documents and interviewees) to support data collection,
- To provide technical inputs and comments on the main deliverables of the evaluation, including the design, draft, and final reports,
- To advise on the quality of the work done by the evaluation team, and
- To assist in the integration of the findings, conclusions and recommendations of the evaluation into future programme design and implementation.

### **Evaluation Team Members**

The team leader coordinates and oversees the work of the evaluation team, and will be responsible for the quality of the deliverables. (S)he

- Checks contributions from team members for adherence to Design Report Template,
- Ensures that the team uses the evaluation matrix to produce appropriate interview guides and other data collection tools,
- Ensures balanced selection of interviewees and other information sources,
- Ensures that interview protocols are adequate; and that other records reflect the required level of detail,
- Ensures adequate quality of contributions from all team members.

The ET members are responsible for the draft of their respective chapters of the evaluation reports. Furthermore, all team members are expected to work with UNFPA staff and other programme stakeholders in a conducive and respectful manner.

Team members will adhere to the Ethical Guidelines for Evaluators in the UN system and the Code of Conduct, also established by UNEG. The evaluators will be requested to sign the Code of Conduct prior to engaging in the evaluation exercise.

**Quality assurance** will occur at different points throughout the Evaluation, and is primarily the responsibility of the evaluation manager. However, the team leader and the ERG also have major roles in ensuring that all the deliverables meet the quality assurance criteria. During the design phase, the EM checks if the evaluators have correctly understood and if the design report correctly reflects why UNFPA is doing the evaluation, what is being evaluated and how this will be done. Throughout the field phase, the team leader needs to ensure that all members of the team use and update the evaluation matrix with interview protocols and entries reflecting the required level of detail, reviews the selection of interviewees and documentary sources. The EM checks the evaluators' selection of interviewees and data sources, and assesses the validity of preliminary findings. During reporting and analysis, the quality of the draft and final reports are assessed on the basis of the Evaluation Quality Assessment Grid.

## **12. Initial bibliography and resources**

Initial list of documents and websites to be consulted by the evaluation team

- UNFPA Laos CP5 Country Programme Document, <https://data.unfpa.org/docs/lao>
- Country Office Development Results Framework, (updated 2014 version will be provided by EM) <http://countryoffice.unfpa.org/lao/drive/CP5PROGRAMMEFRAMEWORK.pdf>
- Annual Work Plans for Output 2, 2012-2014
- Country Office Annual Reports, 2012-2013
- Field Monitoring Visit reports
- Bi-weekly Programme meeting reports on Output 2
- List of CBDs; population and village coverage
- Budget revision for Output 2, DHHP & SVK, March 2014

- Final Evaluation Report, Evaluation of UNFPA RH programme component 3: RH demand creation and IEC/BCC for RH/MNCH in 3 Southern provinces in Lao PDR, 2011
- Participatory Community Assessment for developing a work plan for increasing MNCH service utilization in Savannakhet Province, 2012
- UN Joint Maternal and Newborn Child Health Programme Mid-Term review
- LSIS, Laos Social Indicator Survey, <http://countryoffice.unfpa.org/lao/?reports=7237>
- UNFPA Laos homepage : [lao.unfpa.org](http://lao.unfpa.org)
- Relevant elements of the Handbook on How to conduct a Country Programme Evaluation at UNFPA, <http://www.unfpa.org/public/home/about/Evaluation/Methodology>
- Community- based distribution of contraceptives - A guide for programme managers, [http://whqlibdoc.who.int/publications/1995/9241544759\\_eng.pdf?ua=1](http://whqlibdoc.who.int/publications/1995/9241544759_eng.pdf?ua=1)
- Working with Individuals, Families and Communities to Improve maternal and newborn health, [http://whqlibdoc.who.int/hq/2010/WHO MPS 09.04\\_eng.pdf](http://whqlibdoc.who.int/hq/2010/WHO_MPS_09.04_eng.pdf)

## **Annexes**

- A. Ethical Code of Conduct for UNEG/UNFPA Evaluations*
- B. Short outline of the design report*
- C. Short outline of the final evaluation report*
- D. Evaluation Quality Assessment template and explanatory note*
- E. Management response template*

### **A. Ethical Code of Conduct for UNEG/UNFPA Evaluations**

Evaluations of UNFPA-supported activities need to be independent, impartial and rigorous. Each evaluation should clearly contribute to learning and accountability. Hence evaluators must have personal and professional integrity and be guided by propriety in the conduct of their business. In particular:

1. To avoid **conflict of interest** and undue pressure, evaluators need to be **independent**, implying that members of an evaluation team must not have been directly responsible for the policy-setting/programming, design, or overall management of the subject of evaluation, nor expect to be in the near future. Evaluators must have no vested interests and have the full freedom to conduct impartially their evaluative work, without potential

negative effects on their career development. They must be able to express their opinion in a free manner.

2. Evaluators should protect the anonymity and **confidentiality of individual informants**. They should provide maximum notice, minimize demands on time, and respect people's right not to engage. Evaluators must respect people's right to provide information in confidence, and must ensure that sensitive information cannot be traced to its source. Evaluators are **not expected to evaluate individuals**, and must balance an evaluation of management functions with this general principle.

3. Evaluations sometimes uncover suspicion of wrongdoing. Such cases must be reported discreetly to the appropriate investigative body.

4. Evaluators should be **sensitive to beliefs, manners and customs** and act with integrity and honesty in their relations with all stakeholders. In line with the UN Universal Declaration of Human Rights, evaluators must be sensitive to and **address issues of discrimination and gender equality**. They should avoid offending the dignity and self-respect of those persons with whom they come in contact in the course of the evaluation. Knowing that evaluation might negatively affect the interests of some stakeholders, evaluators should conduct the evaluation and communicate its purpose and results in a way that clearly respects the stakeholders' dignity and self-worth.

5. Evaluators are responsible for the clear, accurate and fair written and/or oral presentation of study limitations, evidence based findings, conclusions and recommendations.

For details on the ethics and independence in evaluation, please see UNEG Ethical Guidelines and Norms for Evaluation in the UN System

<http://www.unevaluation.org/search/index.jsp?q=UNEG+Ethical+Guidelines>

[http://www.unevaluation.org/papersandpubs/documentdetail.jsp?doc\\_id=](http://www.unevaluation.org/papersandpubs/documentdetail.jsp?doc_id=)

Team members will adhere to the Ethical Guidelines for Evaluators in the UN system and the Code of Conduct, also established by UNEG. The evaluators will be requested to sign the Code of Conduct prior to engaging in the evaluation exercise.

## **B. Outline of the design report**(max. 20 pages)

Introduction (about 5 pages)

- . Purpose and objectives of the CBD and IFC Evaluation
- . Scope of the Evaluation
- . Purpose of the Design Report
- . Country context
- . Development challenges and national CBD/IFC-related strategies
- . The role of external assistance in the area of maternal health
- UNFPA strategic response and CBD/IFC programme component (about 3 pages)
- . UNFPA strategic response
- . UNFPA response through CP's CBD/IFC component
- Evaluation methodology and approach (about 8 pages)
- . Evaluation Criteria and Evaluation Questions
- . Methods for data collection and analysis
- . Selection of the sample of stakeholders
- . Evaluability assessment, limitations and risks
- Evaluation process (about 3 pages)
- . Process overview
- . Team composition and distribution of tasks

- . Resource requirements and logistics support
- . Workplan

### **C. Outline of the final evaluation report(about50pages)**

1. Executive Summary (about 3 pages)
2. Introduction (about 2pages)
  - 2.1. Purpose and objectives of the CBD / IFC Evaluation
  - 2.2. Scope of the Evaluation
  - 2.3. Methodology and process
3. Country context (about 3pages)
- 4.5. Development challenges and national CBD/IFC-related strategies
- 4.6. The role of external assistance in the area of maternal health
4. UNFPA response and CBD/IFC strategies (about 3pages)
  - 4.1. UNFPA response through CP's CBD/IFC component
  - 4.2. Brief description of UNFPA'sCBD/IFC strategies, goals and achievements
5. CBD Findings: answers to the evaluation questions (about12pages)
  - 5.1. Answer to evaluation question 1
  - 5.2. Answer to evaluation question 2
  - 5.3. Answer to evaluation question X
6. IFC Findings: answers to the evaluation questions (about 12 pages)
  - 6.1. Answer to evaluation question 1
  - 6.2. Answer to evaluation question 2
  - 6.3. Answer to evaluation question X
7. Interrelated findings – CBD and IFC (about 2 pages)
8. Conclusions (about 8 pages)
  - 8.1. CBD Conclusions
    - 8.1.1. Strategic Level
    - 8.1.2. Programmatic Level
    - 8.1.3. Transferable lessons learned
  - 8.2. IFC Conclusions
    - 8.2.1. Strategic Level
    - 8.2.2. Programmatic Level
    - 8.2.3. Transferable lessons learned
9. Recommendations (about 6 pages)
  - 9.1. CBD Recommendations
    - 9.1.1. Recommendations for UNFPA's programme component on communities
    - 9.1.2. Recommendations for future UNFPA programming
  - 9.2. IFC Recommendations
    - 9.2.1. Recommendations for UNFPA's programme component on communities
    - 9.2.2. Recommendations for future UNFPA programming

#### Annexes

- ToR
- List of persons and institutions met / interviewed
- List of documents consulted
- The evaluation matrix

The above listed annexes to the final report are to be considered as the minimum required. Please do also add the templates of the methodological tools used during data collection and analysis, as well as any other documentation which you consider relevant to the audience.

## D. Evaluation Quality Assessment template and explanatory note

**Title of Evaluation Report:**  
**Name of Evaluation Manager:**  
**Name of EQA Reviewer (if different to above):**  
**Budget and time frame allocated for this evaluation:**

**Overall Assessment:** Note that the overall assessment must address, as a minimum, the following issues: *scope of the evaluation; methodological design; findings and analysis; credibility of data; recommendations; conclusion; executive summary.*

Quality Assessment criteria	Assessment Levels			
	Very Good	Good	Poor	Unsatisfactory
<p><b>1. Structure and Clarity of Reporting</b>  <i>To ensure report is user-friendly, comprehensive, logically structured and drafted in accordance with international standards.</i></p> <p>Checklist of minimum content and sequence required for structure:</p> <ul style="list-style-type: none"> <li>• i) Acronyms; ii) Exec Summary; iii) Introduction; iv) Methodology including Approach and Limitations; v) Context; vi) Findings/Analysis; vii) Conclusions; viii) Recommendations; ix) Transferable Lessons Learned (where applicable)</li> <li>• Minimum requirements for Annexes: ToRs; Bibliography List of interviewees; Methodological instruments used.</li> </ul>	Please insert <u>assessment level</u> followed by your main <u>comments</u> .			
<p><b>2. Completeness and concision of the executive summary</b>  <i>To provide an overview of the evaluation, written as a stand-alone section and presenting main results of the evaluation.</i></p> <p>Structure (paragraph equates to half page max):</p> <ul style="list-style-type: none"> <li>• i) Purpose, including intended audience(s); ii) Objectives and Brief description of intervention (1 para); iii) Methodology (1 para); iv) Main Conclusions (1 para); v) Recommendations (1 para), Maximum length 3-4 page</li> </ul>				
<p><b>3. Justification of the design and of the methodological approach</b>  <i>To provide a clear explanation of the following elements/tools</i></p> <p>Minimum content and sequence:</p> <ul style="list-style-type: none"> <li>• Explanation of methodological choice, including constraints and limitations;</li> <li>• Techniques and tools for data collection provided in a detailed manner;</li> <li>• Triangulation systematically applied throughout the evaluation;</li> </ul>				
<ul style="list-style-type: none"> <li>• Details of participatory stakeholders' consultation process are provided.</li> <li>• Details on how cross-cutting issues (vulnerable groups, youth, gender equality) were addressed in the design of the evaluation.</li> </ul>				
<p><b>4. Reliability of Data</b>  <i>To clarify data collection processes and data quality</i></p> <ul style="list-style-type: none"> <li>• Sources of qualitative and quantitative data have been identified;</li> <li>• Credibility of primary (e.g. interviews and focus groups) and secondary (e.g. reports) data established and limitations made explicit;</li> <li>• Disaggregated data by gender has been utilized where necessary.</li> </ul>				
<p><b>5. Soundness of the analysis and credibility of the findings</b>  <i>To ensure sound analysis and credible findings</i></p> <p><u>Findings</u></p> <ul style="list-style-type: none"> <li>• Findings stem from rigorous data analysis;</li> <li>• Findings are substantiated by evidence;</li> <li>• Findings are presented in a clear manner</li> </ul> <p><u>Analysis</u></p> <ul style="list-style-type: none"> <li>• Interpretations are based on carefully described assumptions;</li> <li>• Contextual factors are identified.</li> <li>• Cause and effect links between an intervention and its end results (including unintended results) are explained.</li> </ul>				
<p><b>6. Validity of the conclusions</b>  <i>To assess the validity of conclusions</i></p> <ul style="list-style-type: none"> <li>• Conclusions are based on credible findings;</li> <li>• Conclusions must convey evaluators' unbiased judgment of the intervention.</li> </ul>				
<p><b>7. Usefulness of the recommendations</b>  <i>To assess the usefulness and clarity of recommendations</i></p> <ul style="list-style-type: none"> <li>• Recommendations flow logically from conclusions;</li> <li>• Recommendations must be strategic, targeted and operationally-feasible;</li> <li>• Recommendations must take into account stakeholders' consultations whilst remaining impartial;</li> <li>• Recommendations should be presented in priority order</li> </ul>				
<p><b>8. Meeting Needs</b>  <i>To ensure that evaluation report responds to requirements (scope &amp; evaluation questions/issues/DAC criteria) stated in the ToR (ToR must be annexed to the report).</i>  <i>In the event that the ToR do not conform with commonly agreed quality standards, assess if evaluators have highlighted the deficiencies with the ToR.</i></p>				



Quality assessment criteria (and Multiplying factor *)	Assessment Levels (*)			
	Unsatisfactory	Poor	Good	Very good
5. Findings and analysis (50)				
6. Conclusions (12)				
7. Recommendations (12)				
8. Meeting needs (12)				
3. Design and methodology (5)				
4. Reliability of data (5)				
1. Structure and clarity of reporting (2)				
2. Executive summary (2)				
<b>TOTAL</b>				

(\*) Insert the multiplying factor associated with the criteria in the corresponding column e.g. - if "Finding and Analysis" has been assessed as "good", please enter the number 50 into the "Good" column. The Assessment level scoring the higher number of points will determine the overall quality of the Report  
**OVERALL QUALITY OF REPORT:** [Insert overall Assessment Level based on highest score above – see Explanatory Note for further guidance

## Explanatory Note for further guidance

### 1. Explanations regarding the Quality Assessment criteria

#### 1. Structure and Clarity of Reporting

Does the report clearly describe the evaluation, how it was conducted, the findings of the evaluation, and their analysis and subsequent recommendations?

Is the structure *logical*? Is the report *comprehensive*?

Can the information provided be *easily understood*?

#### 2. Completeness and concision of the executive summary

Does it read as a stand-alone section, and is a *useful* resource in its own right?

Is it brief yet *sufficiently detailed*, presenting the main results of the evaluation, and including *key elements* such as methodology and conclusions and recommendations?

#### 3. Justification of the design and of the methodological approach

Is the *methodology* used for the evaluation clearly described and is the rationale for the methodological choice justified?

Have cross-cutting issues (vulnerable groups, youth and gender equality) been paid specific attention (when relevant) in the design of the evaluation?

Are key processes (tools used, triangulation, consultation with stakeholders) discussed in sufficient detail? Are *constraints* and *limitations* made explicit (including limitations applying to interpretations and extrapolations; robustness of data sources, etc.) and discussed?

#### 4. Reliability of Data

Are *sources* of data clearly stated for both primary and secondary data?

Is it clear why case studies were selected and what purpose they serve?

Are all relevant materials related to case studies, interviews (list of interviewees, questionnaires) etc. annexed to the report?

Are the limitations, and methods to address them, discussed?

What other *data gaps* are there and how have these been addressed?

#### 6. Validity of the conclusions

Do the conclusions amount to a reasonable *judgment* of the findings and are their links to evidence made clear?

Are there any limitations and are these made clear?

Do they present an *unbiased* judgment by the evaluators of the intervention or have they been influenced by preconceptions or assumptions that have not been discussed?

#### 7. Usefulness of the recommendations

Is there a *logical flow* from the conclusions to recommendations?

Are they strategic and clearly presented in a priority order which is consistent with the *prioritization* of conclusions? Are they *useful* – sufficiently detailed, targeted and likely to be implemented and lead to *further action*?

How have the recommendations *incorporated* stakeholders' views and has this affected their *impartiality*?

#### 8. Meeting Needs

Does the report adequately address the information needs and responds to the *requirements stated in the ToRs*?

In particular does the report respond to the evaluation questions, issues or criteria identified in ToR?

### 2. Explanations regarding scoring and weighing

#### a. Why and how to score the quality of evaluation reports?

The scoring of EQAs serves two main purposes:

- to express an objective judgment both on the overall quality of an evaluation report as well as on each evaluation criterion used in the quality assessment (synchronic approach) ;
- to assess the progress (or lack thereof) over time, either in the overall quality of UNFPA funded evaluation reports or for each specific quality criterion (diachronic approach).

As indicated in the EQA grid, the scoring scale comprises four levels: (1) unsatisfactory, (2) poor, (3) good, (4) very good.

#### b. Why and how to weigh the different criteria of the EQA grid?

Each EQA criterion has been associated with a weight (or a multiplying factor) which is proportionate to, and illustrates its relative importance as regards the overall quality of the report. As you will see (Table

below) the **critterion 5 (Findings and analysis)** is the most prominent of all 8 criteria as a good analysis and credible findings are considered the backbone of a good quality report.

In fact, a report containing sound analysis and credible findings is useful even if the conclusions and recommendations are poorly formulated, as sound analysis and credible findings provide the reader with accurate information on the evaluated programme as well as potentially useful “lessons learned.”

In contrast, conclusions that appear convincing or recommendations that seem well-articulated cannot and should not be used when they are not grounded in sound analysis and related robust findings.

As a result: fulfillment of *critterion 5 is indispensable to the production of a good quality report*, and, for this reason, *it is associated with a weight accounting for half of the total quality score.*

**c. The detailed weighing scale for EQA criteria**

Quality assessment criteria	Multiplying factor
5. Findings and analysis	50
6. Conclusions	12
7. Recommendations	12
8. Meeting needs	12
3. Design and methodology	5
4. Reliability of data	5
1. Structure and clarity of reporting	2
2. Executive summary	2
<b>TOTAL</b>	<b>100</b>

**d. Guidance on how to compile the scoring grid**

Insert the multiplying factor associated with the criteria in the corresponding column e.g. - if “Finding and Analysis” has been assessed as “good”, please enter the number 50 into the “Good” column. The Assessment level scoring the higher number of points will determine the overall quality of the Report.

Quality assessment criteria (and Multiplying factor *)	Assessment Levels (*)			
	Unsatisfactory	Poor	Good	Very good
5. Findings and analysis (50)			50	
6. Conclusions (12)		12		
7. Recommendations (12)		12		
8. Meeting needs (12)	12			
3. Design and methodology (5)	5			
4. Reliability of data (5)			5	
1. Structure and clarity of reporting (2)			2	
2. Executive summary (2)	2			
<b>TOTAL</b>	<b>19</b>	<b>24</b>	<b>57</b>	

Therefore, in this example, as the highest score is 57 in the Good column, the overall Assessment Level is Good.

**E. Management response template**

<b>UNFPA Management response</b>	<b>Country Programme Evaluation (from-to): .....(name of the country)</b>
--------------------------------------	---

*Note: The following management response lists the recommendations as they appear in the evaluation report. Please refer to the report for more details on each recommendation. Recommendations may be organized by clusters, e.g.: strategic recommendations and recommendations associated with the country programme. Within each cluster, recommendations should be ranked by priority levels (high, medium, low).*

Instructions for completing the management response:

1. Boxes in white to be completed upon receiving the present request
2. Boxes in grey to be completed one year later.

Cluster 1: Strategic recommendations				
Recommendation #	To ..... (e.g. Office of the Executive Director)	Priority Level: high, medium, low		
<b>Management response - Please provide your response to the above recommendation. Where recommendations (or parts of) are not accepted, please provide detailed justification. Where accepted, please indicate key actions for implementation:</b> ..... ..... ..... .....				
Key action(s)	Deadline	Responsible unit(s)	Annual implementation status updates	
			Status (ongoing or completed)	Comments

Recommendation #	To .....(e.g. Country office)	Priority level .....
<b>Management response - Please provide your response to the above recommendation. Where recommendations (or parts of) are not accepted, please provide detailed justification. Where accepted, please indicate key actions for implementation:</b> ..... ..... ..... .....		

Key action(s)	Deadline	Responsible unit(s)	Annual implementation status updates	
			Status (ongoing or completed)	Comments

**Cluster 2: Recommendations associated with the programme**

Recommendation #	To .....	Priority level .....
------------------	----------	----------------------

**Management response - Please provide your response to the above recommendation. Where recommendations (or parts of) are not accepted, please provide detailed justification. Where accepted, please indicate key actions for implementation:**.....  
 .....  
 .....  
 .....

Key action(s)	Deadline	Responsible unit(s)	Annual implementation status updates	
			Status (ongoing or completed)	Comments