CAPACITY DEVELOPMENT MATTERS

A PRACTICAL GUIDE

UNFPA

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ABBREVIATIONS & ACRONYMS

AHWU	Adolescent Health and Wellness Unit, Ministry of Health of Guyana
AMDD	Averting Maternal Death and Disability Program at Columbia University
APRO	Asia and the Pacific Regional Office
ARO	Africa Regional Office
CARMMA	Campaign on Accelerated Reduction of Maternal Mortality in Africa
CCA	Common Country Assessment
CCH	Country Compact for Health of Nigeria
CIES-UNAN	Center for Research and Health Studies at the University of Nicaragua
CMA	country midwife adviser
CNRSR	National Reproductive Health Referral Center
COAR	Country Office Annual Report
COESPO	State Population Council of Mexico
CONAPO	National Population Council of Mexico
DRF	Development Results Framework
ECSACON	East, Central and Southern African College of Nursing
EmONC	emergency obstetric and newborn care
FASFACO	Federation of Midwives Associations of Central and West Africa
FC	female condom
FGM	female genital mutilation
FHOK	Family Health Options of Kenya
GBV	gender-based violence
GPRHCS	Global Programme to Enhance Reproductive Health Commodity Security
HHA	Harmonization for Health in Africa
HQ	headquarters
IANWGE	Inter-Agency Network on Women and Gender Equality
IATT/CCP	Inter-Agency Task Team on Comprehensive Condom Programming
ICM	International Confederation of Midwives
ICPD	International Conference on Population and Development
IEC	information, education and communication
IHP+	International Health Partnerships and related initiatives
KAP	knowledge, attitudes and practices
LACRO	Latin America and the Caribbean Regional Office
LMIS	logistics management information system
MDG	Millennium Development Goals
M&E	monitoring and evaluation
MHTF	Maternal Health Thematic Fund
MICS	Multiple Indicator Cluster Survey
MISP	Minimal Initial Service Package
MoH	ministry of health
MOVE	Men Opposed to Violence Against Women Everywhere
NAP	National Action Plan
NGO	non-governmental organization
NSHDP	National Strategic Health Development Plan, Nigeria
PRSP	Poverty Reduction Strategy Paper
RHCS	reproductive health commodity security
ROs	regional offices
SCR	Security Council resolution
SDP	service delivery points
SMART	specific, measurable, achievable, realistic and timely
SPRINT	Sexual and Reproductive Health Programme in Crisis and Post-Crisis Situations
SRH	sexual and reproductive health
STI	sexually transmitted infections
SWAp	Sector-Wide Approach
TWG	technical working group
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Fund
UNFPA	United Nations Population Fund
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
VAW	violence against women
WACN	West Africa College of Nursing
WHO	World Health Organization

“Capacity development is not only about supporting people and organizations to become more efficient and effective but also about helping them to flourish – building on their own strength, knowledge, values and motivation. This creates lasting wealth and is at the core of sustainable development.”

—Dr. Babatunde Osotimehin,
Executive Director of UNFPA

INTRODUCTION

Building national capacities so that countries can advance the ICPD agenda has been hailed as the core UNFPA development strategy. However, all said and done, many of us find it hard to define capacity development and to apply the approaches that work. We need to “unpack” and “demystify” capacity development as we continue to strengthen our efforts and learn from our experiences and each other’s work. This booklet is our booklet: the case studies furnished by UNFPA country offices have served to strengthen our evidence-base and pinpoint what capacity development means in national settings and how we can effectively adopt various approaches. “No size fits all” is the message that transpires from our joint experiences. This booklet is an invitation to look “behind the façade,” reflect on what we support and, if needed, make changes.

We must embrace capacity development as a process of change and transformation that is at the core of every national programme. Over the years, UNFPA has been moving away from delivering “things” in favor of delivering “thinking.” [1] UNFPA’s updated strategic plan emphasizes that strengthening capacities at country-level is not just one more strategy, but should be the agency’s main strategy. Furthermore, at the core of capacity development is the realization that, as responsible partners and together with our counterparts, we build upon existing capacities as part of broad national-led processes.[2]

This booklet is a practical guide on what capacity development is and how we are applying it in UNFPA. The first chapter provides an overview of capacity development and some basic definitions; the second highlights examples of practice in action from the field; and the third consists of a series of tools and resources that we have considered useful when developing and implementing capacity development programmes. This guide is primarily meant for UNFPA technical and programme staff but may also serve other United Nations (UN) agencies, partner organizations and Member States.

THE CAPACITY DEVELOPMENT LENS:

AN OVERVIEW

What is capacity development?

Capacity development is *"the process whereby people, organizations and society as a whole unleash, strengthen, create, adapt and maintain capacity over time."*[3] Capacity development is the central thrust of UNFPA programmes. It is not solely a means to an end, but the goal in itself. Experience shows that national ownership is at the core of effective capacity development strategies that have a long-lasting impact. In this sense, the role of UNFPA is to nurture national capacity by providing or facilitating technical assistance at the individual, organizational and systemic (or enabling) levels.

We can think of these levels as entry points at which capacity can be fostered. Strengthening *individual* capacities means providing the tools – skills, abilities, experience and knowledge – to improve a person's performance. However, an individual contributes to broader development goals only to the extent that he or she is committed to those goals and is empowered to transfer knowledge to others. Thus, beyond investing in technical knowledge and skills, we are also very much interested in the multiplier effect of transformed individuals, and therefore in their leadership abilities. At the *organizational* level, developing capacities refers to improving and optimizing procedures, frameworks and management systems so that institutions can operate more effectively. The focus is on government, civil, and faith- and community-based entities that operate nationally, subnationally and locally. The *enabling environment* is the broad social system regulated as much by legislation as by norms and culture within which individuals and organizations operate. To promote an inclusive and empowering environment in which all human rights are respected and which is conducive to human development, it is important to be aware of the formal systems that are the wheels of society, and through which they operate, such as national laws and policies, budgets and procedures. It is equally important to understand and work with the social traditions and power relations that grease these wheels. We tend to intuitively grasp this last point, but often fail to see how we might use them to facilitate formal processes.[4]

Factors at these three levels are critical to the success of capacity development initiatives. During programme design and implementation, we must take into account the realities of the socio-political environment and if it is conducive to our objectives, such as current political priorities and existing policy instruments; the effectiveness of organizational systems, or the rules and procedures that guide institutional actions; and individual factors, such as the availability and capacity of human resources, personal leadership and motivation, and cultural acceptability of interventions. Below are the primary capacity development strategies at each level.[5]

To foster an enabling environment:

- Supporting analysis of policy options;
- Strengthening data systems and facilitating access to data by policymakers;
- Promoting international norms and standards;
- Fostering adoption of international good practices and

UNFPA'S REGIONAL APPROACH TO CAPACITY DEVELOPMENT[7]

Since regionalization, UNFPA regional offices (ROs) have established mechanisms to foster different types of capacities:

Staff development:
Soon after opening, some ROs conducted internal surveys to assess available capacity in relation to the tasks at hand. ROs developed staff learning and training plans, updated annually, which include workshops and seminars, learning afternoons and conversations. The workshops build on existing skills and capacities in managerial, programme, financial, technical and administrative issues. The learning afternoons with guest speakers serve to strengthen knowledge on different topics related to UNFPA's mandate. For example, the Latin American and Caribbean Regional Office (LACRO) invited the United Nations Environment Programme to discuss climate change as linked to population and development issues. Conversations build on existing knowledge among staff about a specific substantive UNFPA topic. For instance, LACRO hosted a conversation to discuss the global proposal on gender equality and women's empowerment.

Partner organization development:
ROs conduct an initial capacity assessment before signing an agreement with a new regional partner. If there are gaps, the office and the partner jointly develop a capacity development plan, which becomes an activity in the annual work plan. In addition, ROs map the capacities that implementing partners consider they contribute to develop. Some ROs have consolidated all capacity development activities, including whose capacities are being developed, where and by whom.

Country office development:
ROs review all capacity development activities as described in the Country Office Annual Reports (COARs) in order to assess what UNFPA is promoting, developing or strengthening at the national level. For example, the Asia and the Pacific Regional Office (APRO) has conducted a region-wide survey on capacity development needs, including technical, programming and operations issues. APRO uses this evidence to prioritize when planning capacity development events, and uses regional planning meetings to report back on the results to its constituents.

What do we want to gain from all this information? The answer is simple:
We want to know what transformations have been observed and what have been the impact and results of our interventions in terms of achieving the International Conference on Population and Development (ICPD) Programme of Action and the Millennium Development Goals (MDGs), promoting human rights and eradicating poverty. We also want to know where to focus what efforts next.

promoting knowledge networking; and
- Encouraging participation of different societal and government actors and building strategic partnerships.

To strengthen organizations:

- Enhancing coordination and management mechanisms within and between organizations, including national entities such as central and line ministries;
- Promoting effectiveness through results-based management tools and systems;
- Providing support for the adoption of innovative practices;
- Supporting needs assessments and mapping of organizational capacities; and
- Strengthening monitoring and evaluation (M&E) systems to ensure accountability for results and transparency.

To empower individuals:

- Empowering vulnerable populations and groups to demand equality and inclusion in health systems and policies;
- Maximizing the use of national and regional technical expertise in development efforts to foment sustainability;
- Promoting integration of a gender perspective and a human rights-based approach;
- Facilitating access to information so that individuals and their social networks may make knowledgeable decisions;
- Strengthening leadership, promoting grassroots level participation and building networks; and
- Developing human resources through better curricula and access to training opportunities.[6]

Capacity development and the UNFPA strategic plan

Building on the directions of the 2007 Triennial Comprehensive Policy Review, the UNFPA strategic plan 2008-2013[8] incorporates capacity development as a core strategic direction. Specifically, the plan states that UNFPA will work in an inclusive manner on *national capacity development*, focusing on supporting systems and institutional development of governmental and civil society organizations. UNFPA promotes interventions[9] that can serve as catalytic entry points to advance the ICPD Programme of Action and achieve the MDGs. The plan outlines four core development strategies:

1) building and using a knowledge base;
2) supporting advocacy and policy dialogue;
3) building and strengthening partnerships; and
4) developing systems for improved performance.

In 2011, UNFPA updated the Development Results Framework (DRF) to accompany the plan's sharpened focus for the period 2012-2013.[10] The DRF articulates 18 outputs under 7 development outcomes, each with specific indicators and targets. UNFPA's principal contribution towards development goals is "its role in developing capacity."[11] Consequently, all outputs relate to capacity development and all have clear indicators, baselines and targets to allow UNFPA to better measure its contribution to the development of national

18 UNFPA STRATEGIC PLAN DEVELOPMENT OUTPUTS

1. Strengthened **national capacity to incorporate population dynamics** and its interlinkages with the needs of young people (including adolescents), sexual and reproductive health (SRH) (including family planning), gender equality and poverty reduction in national development plans, poverty reduction strategies and other relevant national plans and programmes.
2. Strengthened **capacity for development of national health policies and plans** with integrated SRH services (including family planning).
3. Strengthened **national capacity of young people** (including adolescents) for participation in policy dialogue and programming.
4. Strengthened **national capacity** to implement comprehensive midwifery programmes.
5. Strengthened **national capacity** for emergency obstetric and newborn care .
6. Enhanced **national capacity** for prevention, treatment and social reintegration for obstetric fistula.
7. Increased **capacity to implement the Minimum Initial Service Package (MISP)** in humanitarian settings.
8. Strengthened **national systems** for reproductive health commodity security.
9. Strengthened **national capacity** for community-based interventions for family planning.
10. Enhanced **national capacity** for planning, implementation and monitoring of prevention programmes to reduce sexual transmission of HIV.
11. Enhanced **national capacity** for addressing the HIV and SRH needs of young people and sex workers, including through community-led organizations and networks.
12. Strengthened **national capacity** for implementation of international agreements, national legislation and policies in support of gender equality and reproductive rights.
13. Strengthened **national capacity** for addressing gender-based violence (GBV) and provision of quality services, including in humanitarian settings.
14. Enhanced promotion of gender equality and reproductive rights through **engagement of community-led organizations and networks.**
15. **Improved programming** for essential SRH services to marginalized adolescents and young people *(indicator is on capacity development for improved programming).*
16. Strengthened **national capacity** for the design and implementation of comprehensive age-appropriate sexuality education in policies and curricula.
17. Enhanced **national capacity** for the production, utilization and dissemination of quality statistical data on population dynamics, youth, gender equality and SRH, including in humanitarian settings.
18. Strengthened **national capacity** for data analysis to inform decision-making and policy formulation around population dynamics, youth, gender equality and SRH.

TABLE 1. UNFPA Strategic Plan Development Outputs 2012-2013 in the context of capacity development[12]

capacities (Table 1). In other words, within the updated framework, what UNFPA supports is measured in terms of changes in country capacity to advance the ICPD agenda. In the near future, the DRF should inform the realignment of national, regional and global programmes with the current capacity development priorities.

Learning from the field: Capacity development case studies

In Chapter 2 we will be looking at theory in practice as we describe capacity development case studies contributed by UNFPA country offices. Many of them have entry points at the three levels discussed earlier. However, for the purposes of this booklet we have grouped them according to their most prominent actions. Below we can look at some examples of the specific approaches utilized by UNFPA within the three-level framework.

At the *individual level*, the joint UNFPA/ICM midwives programme has set out to develop the foundations for a sustainable global midwifery workforce. The programme has trained a critical mass of national midwife advisers in the developing world who can lead professional associations, build the skills of other midwives, advocate for favourable legislation and provide input to improve training curricula. In Guyana, UNFPA trains health care workers so that they can better respond to the needs of adolescents and youth, with a focus on offering integrated youth-friendly HIV/AIDS and SRH information and services.

At the *organizational level,* UNFPA has worked with the ministries of health (MoH) in several countries, including Madagascar and Uzbekistan, to support the adoption and implementation of national systems for commodity security management. These efforts have strengthened the ability of governments to respond to the family planning needs of the population, including in rural and remote areas. In Costa Rica, UNFPA applied a participatory methodology to define and implement youth-led community actions to promote healthy lifestyles and prevent the spread of HIV among adolescents. The process empowered adolescents to both engage in policy advocacy and raise awareness about the problem among peers.

At the *systemic level*, in Nigeria, UNFPA provided critical assistance to the government in the elaboration of the first comprehensive and overarching national health plan to underlie health sector reform. UNFPA leveraged key multisectoral partnerships to shore-up support to sustain and implement the new norm. In Armenia, UNFPA enabled the first-ever countrywide survey on GBV. UNFPA used survey findings, coupled with a campaign to sensitize the public, to advocate for the formulation of supportive legislation. These efforts resulted in the government's adoption of a national plan to combat GBV. In addition, public attitudes towards GBV-prevention became more favorable. UNFPA and its partners developed a thorough tool to assess existing SRH and HIV linkages in services and policies and identify potential areas for improvement. The tool has been applied in over twenty countries. Assessment results are used to foster broad-based national dialogues to formulate priorities for action.

UNFPA also implements capacity development strategies tailored to nations in fragile contexts, whether in conflict or post-conflict situations or during and after humanitarian emergencies. For example, in China, UNFPA strengthened communities' ability to identify and treat those with psychological stress in areas affected by earthquakes. The SPRINT programme in Senegal trained a critical mass of providers and health managers to address the SRH needs of the population, including HIV treatment and prevention, during emergency situations. In Uganda and Sierra Leone, UNFPA worked with governments to strengthen national capacity to protect and empower women during armed conflicts.

Below, we summarize some of the most important lessons drawn from UNFPA capacity development initiatives.

Capacity development approaches that work

- **National ownership:** Initiatives aligned with national plans and led by local counterparts, including civil society partners, are key to effective and sustainable capacity development programmes.

- **Sustainability:** Implement mechanisms not only to develop but also to sustain capacities. Prioritize strategic initiatives that lead to long-term systemic transformations.

- **Partnerships:** Foster new and existing partnerships at global, regional and country levels from multiple sectors, including government, the private sector and civil society. Over time, UNFPA has spearheaded a number of successful multisectoral campaigns, such as the Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA), the International Health Partnership and related initiatives (IHP+), the Maternal Health Thematic Fund (MHTF), the Fistula Campaign, the 16 Days of Activism against Gender Violence Campaign, and the Adolescent Girls Initiative, among others.

- **Systems strengthening:** Apply a multipronged approach that builds the capacity of multiple partners across different sectors and levels.

- **Approaches:** Always ensure that programme planning and M&E are designed and implemented from a gender, culture and human rights perspective as well as with a capacity development approach.

- **Pool funding:** Participate in initiatives in which partners pool resources and which are aligned with government priorities and budgets. Avoid creating parallel funding mechanisms.

- **Cost-effectiveness:** Utilize resources soundly, incorporating the latest technology and innovation, whenever possible, as well as evidence-based practices. Prioritize the use of national assets and existing structures.

- **Focus on vulnerable populations:** Promote the active participation of women and youth in marginalized settings in all aspects of policy development and programming. This includes facilitating their access to policy-making negotiation tables, such as Poverty Reduction Strategy Papers (PRSPs), Sector-Wide Approaches (SWAps) and the United Nations Development Assistance Framework (UNDAF); consultation on the development of UNFPA-supported programmes; and direct participation in implementation and M&E.

- **Intra-institutional synergies:** Ensure complementary roles within the organization at all levels: headquarters (HQ) consolidates the knowledge base; the ROs act as liaison between the global and national levels; and the country offices are the main partner and supporter of national system-building efforts for better health and development.

- **Intra-programmatic synergies:** Capacity development is interlinked with many other programmatic processes. Identify which other stakeholders and initiatives complement existing capacity development initiatives and ensure that synergies are optimized.

- **Networking:** Promote access and provide support to maintain, expand and, where necessary, help create networks, communities of practice and other mechanisms to enable national stakeholders to access the collective body of knowledge in their areas of expertise. These are inexpensive ways to stimulate the exchange of ideas and experiences, to be complemented by face-to-face interaction as needed.

- **South–South cooperation** is increasingly seen as one of the most effective strategies in successful capacity development efforts. It allows not only for the transfer of knowledge at appropriate stages, appropriate pace, adapted to local circumstances and rooted in real-life experiences, but it also, and most importantly, allows for the creation of communities of practice and horizontal knowledge sharing among practitioners, managers and technical staff in developing countries. If well grounded in efforts to develop the capacities of individuals, organizations and institutions in general, South-South and South-South-North cooperation is one of the best mechanisms to provide essential strategic support.

- Initiatives with **specific, measurable, achievable, realistic and timely (SMART) goals** enable stakeholders to better plan, coordinate, monitor and evaluate programmes. They also enable counterparts to better analyze development progress, identify lessons learned and highlight results to beneficiaries, partners and donors.

Essentially, developing capacities requires leadership, teamwork and knowledge exchange. Above all, it requires thoroughly understanding the *context.* There are two important features about capacity development to consider:[13]

- **A change of mindset:** Capacity development comprises numerous practical activities. Applying them wisely requires thinking outside the box. A focus on capacity implies always being on the lookout for how stakeholders, organizations

and systems may change for the better, and how they may adapt and innovate to face new challenges.

- **A mindset about change:** Capacity development is a process of transformation. Therefore, it is crucial to understand in operational terms when change is possible; how comprehensive it can be; the time-frame involved; what it demands from those engaged; and who it needs to engage.

Challenges to sustainable capacity development efforts

- **Government leadership:** Success can only be achieved with government buy-in and ownership. This process requires time and dedication. Periodical staff turnover in the public sector makes sustaining political support a challenge.

- **Cultural norms:** Modifying traditional harmful practices, such as female genital mutilation (FGM), and reducing risky sexual behavior and GBV require the transformation of community and citizens' believes and traditions. Power dynamics at play and insufficient community understanding of its members' health risks may obstruct the transformation process.

- **Human resources:** Across many sectors in developing countries, retaining highly qualified staff poses a major challenge, and necessitates ongoing training of new recruits.

- **Technical resources:** There are insufficient gender equality, human rights and culture experts in the field. We must collaborate with gender research and training institutions to expand national technical resources and overcome this challenge. We must also secure the right skills mix within UNFPA to support comprehensive programming.

- **Financial resources:** The current economic crisis makes it difficult to ensure sustainable financing for SRH programmes. This is further complicated by the fact that many donors shy away from funding programmes aimed at creating awareness and demand in favor of funding commodities or infrastructure.

- **Monitoring and Evaluation:** The midterm review of the UNFPA strategic plan concluded that measurement systems must be strengthened at all levels – nationally, regionally, and globally. UNFPA needs better mechanisms to capture how the organization supports capacity development and with what results. This means revising the COARs; strengthening communities of practice; documenting and disseminating good practices; and developing a capacity development tracking system, among others.

- **Inter-institutional synergies:** Harmonize activities and ensure complementarities with other development partners and UN agencies, including the United Nations Entity for Gender Equality and the Empowerment of Women (UN Women).

Changing scenarios and emerging trends

UNFPA programmes do not operate in a vacuum. The environment is always changing politically and because of the development of new ideas and innovations. Below are some of the issues that have come to the forefront in recent years and which, in some ways, shape the challenges and opportunities that we have been discussing. Innovation and global connectivity (think of Facebook, Twitter and blogs, for instance) are part of our world today. UNFPA can take even more advantage of new **information and communication technologies** to foster knowledge exchange within and outside the organization.

Capacity development strategies are affected by the **aid effectiveness principles** upheld internationally in the Paris Declaration (2005) and the Accra Agenda for Action (2008) as well as by UN reform. This means that all programmes should consider joint funding opportunities, building synergies with other UN agencies and partners, and applying the principles of harmonization, alignment, results-based management, including incorporating robust M&E systems to measure progress and mid- and long-term impact, and, last but not least, mutual accountability.[14]

Evidence shows that to make an impact on human development, capacity development efforts must **target the most disadvantaged and vulnerable groups**. Within this framework, UNFPA's extended strategic plan places young people, including adolescents, at the center of development initiatives.

Capacity development interventions must also be tailored to **country-specific needs**, such as middle-income countries and nations in crisis. States in fragile contexts pose a special challenge. While people's survival depends on rapid responses and meeting immediate needs, interventions should incorporate longer-term capacity development strategies to restore systems to normalcy and to strengthen nations' ability to respond to future emergencies.

More than ever, UNFPA needs to be clear about its **comparative advantage**, which will differ from country to country, and from cycle to cycle. Particularly in middle-income countries, the capacities that we will be asked to support are already very much developed, and much hinges on our own ability to see where we may contribute meaningfully.

While we focus our programmes more clearly, and by extension limit ourselves to specific areas on which we know we can effectively deliver with the resources at our disposal, the issue of using our limited technical, human and financial resources to leverage much larger national and international resources forces us to always **think of capacity development first, second and last**. Thus, we create lasting wealth because we invest in the national systems that ultimately are the motor of sustainable development.[15]

The way forward

It is clear that although UNFPA has intended to strengthen and promote the use of national systems and respond to national demands, the results have been uneven and sustainability remains a challenge. UNFPA has developed specific guidance for its country offices

to improve programming in response to the changing aid and development environment[16] and on UNFPA's role in national capacity development. Increasingly, UNFPA aims to build sustainable capacity with a focus on systems and institutions rather than on knowledge transfer to individuals. The message is that in our programmatic work we need to assess organizations and networks more systemically and need to understand the contexts within which capacity development interventions take place. Development of human resources should focus more on the use of individual skills as part of a broader strategy for organizational capacity development rather than on individual empowerment – although these may go hand-in-hand.

Professionals can only make a difference in the implementation of the ICPD agenda if they are supported by an *enabling environment at the institutional level.* The right legal framework needs to be in place, political will present and cultural norms and practices should allow for the professional to put his or her knowledge into practice. An enabling environment also requires financial resources to support a sustainable pool of skilled professionals as well as to facilitate equality in decision-making and planning strategies. This might require civil service and legal reform as well as forging new partnerships, for instance with ministries of finance.

Moving forward, UNFPA needs to systematically assess how its capacity development initiatives contribute to advance the ICPD agenda and make the necessary programmatic changes based on the lessons learned. The new DRF indicators provide the foundations for this exercise. As a regional example, LACRO is developing a capacity development strategy based on the findings from the systematization of five national interventions.[17]

We hope that the case studies presented in the following section will offer valuable lessons learned and innovative ideas that will inspire you and that might prove useful in future capacity development endeavors.

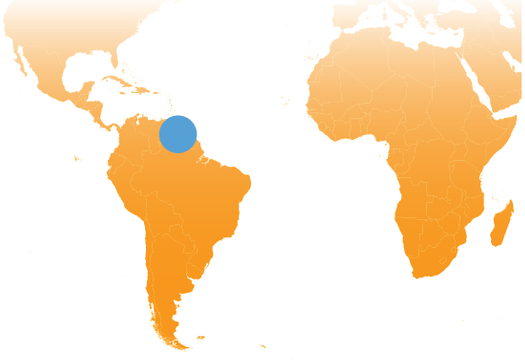
LEARNING FROM THE FIELD:

CAPACITY DEVELOPMENT IN PRACTICE

The cases described in this chapter, taken from all the regions in which UNFPA works, serve to illustrate how colleagues in the field and HQ have gone about putting some or more of the underlying principles of national capacity development into practice. They cover a wide range of thematic areas and modalities, yet all have one thing in common: each one started out from an assessment of existing capacities with counterparts, an ensuing identification of capacity gaps, and the development of a possible response from UNFPA as to how we might address the capacity gap. Each case is also illustrative of the need to monitor how capacities grow and measure whether, eventually, the interventions made a lasting change in individual, organizational or systemic capacities.

Harnessing the power of individuals

Guyana: Health Care Providers and the Needs of Young People



1. Background

Adolescents and youth in Guyana face many challenges with regard to SRH. Adolescent pregnancy and sexually transmitted infections (STIs) are two major concerns. Approximately, 31% of in-school youth and 59% of out-of-school youth are sexually experienced.[18] Surveys show that 11% of teenage girls are mothers and almost 3% are pregnant.[19] It is critical to expand access of young people, including adolescents, to comprehensive SRH services and information.

Beginning in 2004, UNFPA Guyana has helped build the human resources capacities at government youth-friendly health care centers within the framework of a programme to institutionally strengthen these centers. This is one of the key components of its current country programme. UNFPA trains primary health care workers from the Adolescent Health and Wellness Unit (AHWU) of the MoH on comprehensive integrated and gender-sensitive youth-friendly services. Health care workers are enabled to better respond to the needs of young people by offering age-appropriate information and services to prevent STIs and unplanned pregnancies. Key UNFPA partners in this initiative are the United Nations Children's Fund (UNICEF), the Pan American Health Organization and the United States Agency for International Development.

2. Strategy

UNFPA engages in the following capacity development activities:

- Training health care workers to respond to the SRH needs of young people. The programme covers SRH, family planning and condom use, HIV/AIDS prevention, gender and cultural sensitivity, youth friendliness and counseling and self-awareness. Emphasis is placed on enhancing providers' capacity to serve young mothers during the pre- and post-natal period.
- Developing service delivery manuals for health care providers.
- Developing informative, educational and communication (IEC) materials to increase demand for SRH services by young women and men at the community level in the context of HIV prevention.

The programme's direct beneficiaries are adolescents served by the youth-friendly health care centers. UNFPA complements individual-level capacity development activities with other actions aimed at institutional-level strengthening, such as providing materials and equipment to selected primary health care clinics and assisting the AHWU to plan strategically. UNFPA helps to bring youth to the clinics by supporting advertising of the services offered.

3. Lessons learned

By strengthening human resources, the programme helped to build the institutional capacity of the AHWU. The unit is now fully integrated into the MoH and has its own budget allocation. Approximately 27 youth-friendly health care centers currently provide comprehensive SRH services and information, including HIV/AIDS, to young people. In addition, the AHWU staff periodically reaches out to schools and private establishments. The SRH training modules developed as part of the programme have proven to be a valuable resource in ongoing capacity development efforts. The awareness raising activities and materials developed and disseminated at the community level have increased demand for youth services. UNFPA fostered South-South cooperation and learning by facilitating several visits from representatives of other Caribbean countries to the AHWU and the youth-friendly health care centers.

Despite the initiative's success, there are some individual-level challenges, such as:

- The migration of experienced health care workers demands continuous training of new providers.
- The difficulty of changing the norms, values and attitudes of health care workers towards adolescents seeking SRH services.
- The lack of standardized protocols with regard to youth access to reproductive health commodities and services at the health centers, which leave health workers without clear guidelines to attend youth.

UNFPA addresses these challenges through ongoing trainings, including the promotion of self-introspection. In addition, UNFPA leveraged the assistance of the Joint UN Programme on HIV/AIDS (UNAIDS) to work with the AHWU in the design of protocols to guide and inform health care providers on delivery of SRH services to young people.

Overall, the increase in access to youth-friendly SRH and HIV/AIDS services for young people has led to an improvement in health outcomes, including fewer HIV infections and unplanned pregnancies among youth in the areas served by the health care centers. These results attest to the success of the initiative.

> **"Capacity development is helping your partner on the road to self-determination!"**

Mongolia: Telemedicine

1. Background

UNFPA Mongolia supported the establishment of a maternal and newborn health telemedicine network at the Maternal and Child Health Research Center. The network assists rural health care providers in delivering quality reproductive health services in eight provinces. Assistance includes medical scanning, remote diagnostics and clinical resolution in places where highly qualified providers are not available.

Telemedicine, which is the application of information and communication technologies to provide health care at a distance, is extremely well suited for increasing access to quality services in a vast country with a dispersed population such as Mongolia. The system fosters exchanges between rural and urban health professionals across different specialties. To date, medical professionals based at the teaching hospital in the capital have helped to diagnose and manage 287 maternal and newborn cases with complications in eight participating provincial hospitals.

UNFPA collaborated closely with the MoH on the development of the National Strategy on Maternal and Newborn Health 2011-2015, which is currently under review. UNFPA also supported the finalization of the National e-Health Strategy that will serve to expand the use of telemedicine to the whole country.

Since the budget assigned to the e-health strategy is insufficient to fully rollout the initiative, the government is exploring scaling-up health insurance funding to cover additional health care services. Development partners will continue to build the capacity of the MoH to strengthen the telemedicine network in rural Mongolia and to work together to provide more effective support.

2. Strategy

The project began in 2008 with the installation of modern equipment and facilities, including a three-dimensional ultrasound, a colposcope and a newborn intensive care unit, at the reference hospital. This step was essential to the telemedicine network as it enabled clinical consultations, discussions of clinical cases among experts and transfer of images from local hospitals.

By mid-2008, medical experts were supplied personal computers with iPath, a web-based collaborative platform for the exchange of medical knowledge, distance consultations, group discussions and on-line teaching. iPath was instrumental in facilitating communications between qualified providers at the central hospital with district specialists.

3. Progress

In 2008, the project established four clinical networking services between the reference and rural hospitals, namely prenatal diagnostic ultrasound, high-risk antenatal care, fetal monitoring and colposcopy-based cervical screening. Cervical cytology networking was added in 2009. These services ensured early diagnosis of maternal and fetal complications and delivery of integral obstetric and neonatal care services in different parts of the country connected with telecommunications.

4. Lessons learned

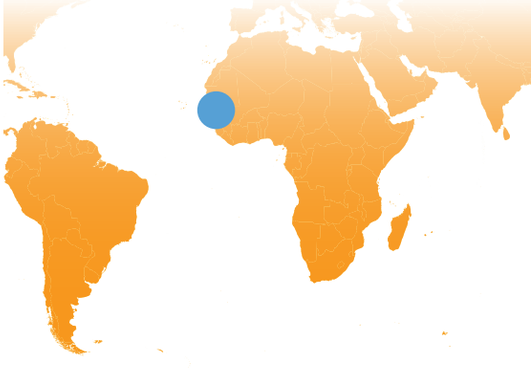
The telemedicine approach has strengthened the capacity of rural health care workers to provide life-saving maternal and neonatal health care services in a timely manner through improved diagnostics and management of complications. In addition, the network not only responds to complications but also serves to install medical capacities in the long-term by allowing for information exchanges and e-teaching.

The project was attractive to the donor community and to specialists in developed countries. This helped to ensure a robust funding base to launch the initiative and to create an international professional support network.

MoH leadership and commitment will be essential to continue strengthening telemedicine in Mongolia. Donor coordination will also be critical to ensure synergies and avoid duplication of activities in the next phases of implementation.

Organizational-level challenges include securing sustainable funding for Internet services and software updates and for equipment maintenance and repair. Among the individual-level challenges to capacity development are the difficulty of hiring and retaining qualified human resources and of providing ongoing training not just to a small core group but also to all relevant specialists.

Senegal: Sexual and Reproductive Health in Humanitarian Crises



1. Background

UNFPA, the International Planned Parenthood Federation and the UN High Commissioner for Refugees jointly developed the SRH Programme in Crisis and Post-Crisis Situations or SPRINT. The objectives of the initiative are to strengthen national capacity to integrate and mainstream SRH, HIV, GBV and population data issues into emergency preparedness, humanitarian response and recovery. The SPRINT programme was launched in Africa in March 2010.

2. Strategy

UNFPA supports the initiative in Senegal through training of middle level managers and senior service providers. The training covers the MISP, key advocacy messages and awareness raising actions, and all aspects of SRH programming in humanitarian settings. Individual-level actions are complemented by the provision of necessary medical supplies. In August 2010, UNFPA and the MoH organized the first ever in-country training on SRH in emergencies. The SPRINT methodology was unique in that it promoted interdisciplinary teamwork. The participants, from the disaster management unit of the Ministry of the Interior, included a broad range of professionals such as medical specialists, general practitioners, paramedical staff and sanitation technicians, programme managers at central administration level, SRH focal points for four flood-prone regions and medical officers in charge of critical flood-prone health districts.

3. Progress

- An interagency team represented by the MoH, the World Health Organization (WHO), the National Red Cross Society, the Family Welfare Association and the Department of Medicine of the National University designed an action plan, which is now being implemented.
- Six trainings of trainers involving eight French-speaking countries in West Africa were conducted. This has helped to build regional capacity to respond to SRH needs in emergencies.
- The trainings are being replicated. For example, a university lecturer organized a one-day module on the MISP as part of the University Forum for Experts on SRH's yearly training programme. Participants came from six French-speaking West African countries.

4. Measuring progress and results

Since the SPRINT programme was launched recently, no systematic evaluation and/or assessments have taken place. However, initial results are positive.

5. Lessons learned

UNFPA advocacy efforts within the framework of the SPRINT programme ensured MoH buy-in and led, for the first time, to the integration of SRH in emergency planning and implementation in Senegal. After the initial training, staff worked on ensuring that SRH and gender issues were part of government response in emergencies. Participants are now able to carry out rapid assessments and to proactively request relief support and provision.

The SPRINT programme demonstrated that capacity can be strengthened to ensure that more middle level programme managers and senior service providers respond to SRH needs and can manage data effectively during humanitarian emergencies.

Training of trainers has fostered replication of trainings at multiple levels and within different sectors and is expected to have a trickle-down effect so that more providers know how to act in emergency situations. Furthermore, involving participants from countries throughout French-speaking Africa has been an effective way to extend the effectiveness of this initiative to other settings.

However, to ensure programme sustainability, UNFPA has to continue to advocate with the MoH and other government partners for full integration of SRH in humanitarian settings, especially floods, and for its incorporation into the national contingency and response plan and its budget.

Among the challenges are the rapid staff turnover and the inability of untrained staff to cope with emergency situations. In addition, financial support is needed to continue in-country SPRINT training.

Investing in **Midwives and Others with Midwifery Skills** to Save Lives

1. Background

There is global agreement that health systems strengthening and addressing critical human resources shortages lead to declines in maternal deaths and help achieve progress towards MDGs 4, 5 and 6. Furthermore, within human resources for maternal health, there is a strong need for strengthening midwifery services and essential midwifery competencies. The returns on investing in midwives are enormous. When empowered and authorized with all *essential basic life-saving competencies,* midwives can help avert roughly 90 percent of all maternal deaths (MDG 5), reduce a significant number of morbidities such as fistula, and address GBV issues, like FGM. Midwives have a critical role to play in newborn care and averting early newborn deaths (MDG 4) and are the first to detect HIV incidence in pregnant and non-pregnant women (MDG 6). Midwives, and others with midwifery skills, working in primary health care centers and communities provide culturally sensitive counseling and help families make informed choices about family planning to prevent unwanted pregnancies and protect themselves against HIV. They also assist in STI management and care, post abortion care and malaria treatment during pregnancy. Unfortunately, the profession of midwifery is still not adequately recognized and supported in many developing countries. Midwives often have low status and receive little recognition. Education of midwives has been ignored and regulatory mechanisms are weak. Besides, midwives lack a voice due to the absence of professional associations to advocate for their concerns. The result has been insufficient investment in midwifery training, deployment, support and supervision.

UNFPA felt that strengthening midwifery was key to achieve MDG 5 and to move forward a range of SRH initiatives, such as adolescent SRH and skilled attendance at all births, among others. UNFPA and the International Confederation of Midwives (ICM) jointly launched the midwives programme[20] in April 2008 in response to the *Call for a Decade of Action for Human Resources for Health* made at the World Health Assembly in 2006. In April 2009, the programme was merged into UNFPA's MHTF to derive synergies from an integrated approach to addressing maternal and newborn health. The main partners are ICM and the national governments. In addition, a number of other non-governmental organizations (NGOs) and professional associations

support the initiative.

The goal of the midwives programme is to improve skilled attendance at birth in low resource settings by developing the foundations for a sustainable midwifery workforce. The programme seeks to achieve this through the creation of a critical mass of advisers on midwifery who work both nationally and regionally to provide strategic direction and develop midwifery capacities.

2. Strategy

The midwifery initiative employs multiple capacity development entry points that strengthen and complement one another. The initiative has four core areas of intervention:

1) Developing and strengthening education and accreditation mechanisms;
2) Strengthening policy and regulatory mechanisms;
3) Promoting the development of midwifery associations; and
4) Advocating for midwives as key members of the health workforce.

One of the keys to the success of the strategy in the field is based on an individual-level entry point: the deployment of country midwife advisers (CMAs). As national coordinators, CMAs are critical in bringing together midwifes from different national institutions to form or strengthen professional associations and to liaise with regional and global associations. They are also the main policy advocates to integrate midwifes into the workforce; to support policies regulating deployment and retention; and to provide advise on improving education curricula.

UNFPA enhances the capacity of CMAs through periodic workshops on strengthening curriculum design, advocacy skills, and mainstreaming gender issues, among others. International midwife advisers from ICM provide technical support to the CMAs. In addition, UNFPA fosters an enabling environment to facilitate the work of CMAs through conducting gap analyses and disseminating findings, coordinating advocacy activities and engaging relevant stakeholders.

3. Progress

As of 2010, 22 countries implemented programmes aimed at strengthening midwifery; 17 of these were under the direct support of the UNFPA/ICM joint initiative. The programme will be further scaled up in 2011 to include 30 countries. As of August 2011, 21 CMAs have been deployed in 18 countries to strengthen midwifery capacity in collaboration with all relevant national stakeholders and three capacity development workshops for CMAs have been held.

Individual empowerment is complemented by advocacy at the national, regional and global levels to raise the status of midwifery and to bring about commitments and enabling policy environments. Regional partnerships are being strengthened with the East, Central and Southern African College of Nursing (ECSACON), the West Africa College of Nursing (WACN), and the Federation of Midwives Associations of Central and West Africa (FASFACO), among others, to harmonize curricula, attain comparable standards and improve the quality of education in Africa. South-South exchanges among midwifery council members, trainers and associations are promoted. Global partnerships are also being strengthened and an interagency working group on midwifery, led by UNFPA, has been established comprising UN agencies, NGOs, professional associations and bilaterals. A *Joint Global Call to Action*[21] was launched at the Global Midwifery Strengthening Symposium held during the Women Deliver conference in June 2010. It calls upon governments to address and strengthen the following vital areas of midwifery: education and training in all essential competencies; strengthening professional midwifery associations; developing regulatory frameworks to ensure standards of practice and developing adequate retention and deployment policies surrounding midwifery. The interagency working group on midwifery launched the first *State of World's Midwifery* report at the Triennial Midwifery Congress in Durban in 2011.

4. Measuring progress and results

The midwifery programme has a set of seven indicators covering education, association and regulation through which progress is monitored. In addition, the CMAs and international midwife advisers monitor the programme closely through field visits to training institutions, meetings with stakeholders and reports. Global programme and financial monitoring is conducted by the UNFPA programme coordinator. Mid-year and end-year progress reviews are organized with the CMAs.

5. Lessons learned

A midwifery movement has been generated and global and national visibility has increased significantly over the last three years. The ultimate beneficiaries of the programme are the communities, particularly women and children, and midwives who currently lack a voice in policymaking. Partnerships with all major players in midwifery, including civil society, governments, donors, UN agencies and academic institutions, have been critical to the success of the initiative.

The main capacity development challenges are education, association and regulation. In response, the initial gap analysis helps to identify these bottlenecks and develop a joint strategy to respond to them. For example, work is ongoing with ECSACON and WACN to harmonize curricula at the regional level. To gain national recognition about the importance of midwifes, the programme engages in advocacy activities to establish midwifery councils and legislation in countries where none exist for regulation of the profession. Under UNFPA leadership, global partners have joined hands in making midwifery a global priority to address MDGs 4 and 5. The extension of the programme until 2013 and beyond has helped to secure multi-year pledges, ensuring the continuation and expansion of activities.

TRAINING COMMUNITY-BASED MIDWIVES IN THE LAO PEOPLE'S DEMOCRATIC REPUBLIC

UNFPA has a strong investment in the country's human resources development, both at central and subnational levels. In particular, UNFPA has focused on building the capacities of midwives who can provide comprehensive SRH services at primary level care. After almost two decades without midwifery training, UNFPA and the MoH launched a programme to form professional community midwives in 2009. By 2011, the seven existing national public health schools were participating in the programme with updated midwifery curricula. To date, 140 accredited community midwives have graduated and efforts are being made to deploy them in the field. The first graduation ceremony was coordinated with the launch of *The State of World's Midwifery 2011: Delivering Health, Saving Lives* report.

As a complement, UNFPA has provided technical support to strengthen the national regulatory mechanism for midwifes. Indeed, the initiative is a core part of the Skilled Birth Attendance Development Plan launched by the MoH with technical assistance from UNFPA. UNFPA also supported the establishment of the first national licensing examination.

INVESTING IN MIDWIVES: LESSONS FROM ETHIOPIA

Enabling environment:

- Celebration of the International Day of the Midwife on 5 May.
- Advocacy meetings with relevant stakeholders.

System strengthening:

- Conducted gap assessments in midwifery training institutions and disseminated findings.
- Equipment, training models and books provided to seven midwifery training institutions and the Ethiopian Nurse Midwives Association.
- The Ethiopian Nurse Midwives Association developed a five-year strategic plan.

Individual empowerment:

- UNFPA and WHO develop the capacities of midwifery tutors and preceptors in basic emergency obstetric and neonatal care (EmONC).
- Midwifery tutors from nine universities participated in the harmonization of the midwifery curriculum to ensure that it incorporated ICM/WHO midwifery competencies and basic emergency obstetric care.
- Development of tutor skills in a highly underserved area was made possible by the establishment of the Gode Nursing and Midwifery School.
- Six-day effective teaching skills workshops organized for midwifery tutors at teaching institutions.
- CMAs facilitated the establishment of two regional midwifery associations.
- Supported participation of Ethiopia's CMA in capacity development workshops and international symposiums.

Harnessing the power of organizations

Bangladesh: Strengthening National Response to Obstetric Fistula

1. Background

Close to twelve thousand women die every year in Bangladesh due to pregnancy related causes. Thousands more suffer from preventable long-term ailments, such as obstetric fistula. Since 2003, UNFPA Bangladesh has been working with the government to support institutional strengthening to reduce maternal mortality and morbidity rates in the country. The multifaceted interventions range from high-level advocacy, to supporting hospital renovations, training health care providers and engaging in community outreach.

2. Strategy

UNFPA provides instrumental support to strengthen the capacity of the government of Bangladesh to respond to obstetric fistula. UNFPA assisted the MoH in the development of the National Fistula Strategy and the National Reproductive Health Commodity Security Strategy.

UNFPA helps to strengthen health care centers by procuring the necessary equipment to treat fistula and other maternal health complications, and to improve reproductive health services overall. UNFPA also assists in the implementation of logistics and management systems in service facilities to make service provision more effective.

UNFPA trains health service providers, including doctors and midwives, in the public sector on fistula treatment and management and ensures that they are assigned to a service delivery point (SDP). The training includes basic SRH services, including cervical and breast cancer screening, modern contraceptive methods, and EmONC.

UNFPA trains community-based skilled birth attendants to detect early complications and promote referrals, when necessary. This is a key strategy to raise community awareness about pregnancy- and labor-related risks and overcome barriers to seeking care at hospitals.

UNFPA partnered with the NGO Bangladesh Women's Health Coalition to institute a rehabilitation component of the fistula programme that enables women to return home following fistula repair surgery.

3. Progress

UNFPA provided technical and material support to establish the Fistula Patients Training &

Rehabilitation Center in 2005. This was the first center of its kind, providing livelihood training to women following a fistula repair surgery with a view to bridging their reintegration into society.

In 2010, UNFPA trained close to 1000 health care providers. Through training, awareness raising activities and community outreach, in 2010, UNFPA Bangladesh identified and treated more than 344 obstetric fistula patients, a 27 percent increase from 2009.

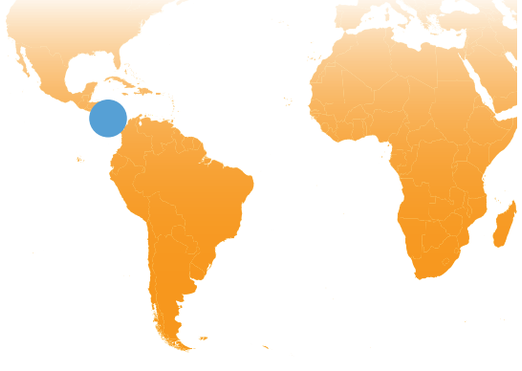
UNFPA Bangladesh also provided technical support on obstetric fistula to Dili National Hospital in East Timor. Medical professionals traveled to Dili to train hospital doctors on fistula treatment and management and share experiences and lessons learned from the rehabilitation programme in Bangladesh. They operated on critical patients in close collaboration with local doctors, operating theatre staff and other health providers. An awareness raising orientation seminar was organized for stakeholders from multiple sectors, including parliamentarians, directors of health and NGO members. A special session was conducted to engage hospital midwives.

4. Lessons learned

It was only through a three-pronged approach that UNFPA could help to strengthen national capacity to treat and prevent obstetric fistula, and thus improve the lives of thousands of women. Advocacy with policymakers and provision of technical assistance for the development of relevant national plans promoted an enabling policy framework. To win over reticent policymakers, UNFPA organized a mission to Hamlin Fistula Hospital in Ethiopia, where a successful programme was underway. First-hand experience and direct observation were critical to gain political support for the obstetric fistula programme.

Strengthening hospital logistics systems helped to ensure faster and more cost-effective service provision. Equipping health care centers with essential tools allowed medical professionals to tend to fistula cases. Training doctors and midwifes on techniques to detect possible complications and treat obstetric fistula improved the health outcomes of many women. Engaging community-based skilled birth attendants to detect early complications was key to reaching women in remote areas and to encourage receiving care at hospitals, when needed. Finally, establishing a center for women recuperating from fistula has enabled these women to eventually return to their homes and secure a livelihood. UNFPA's multipronged approach to capacity development has led to an overall improvement of SRH care in the country.

Costa Rica: Healthy Lifestyles and HIV Prevention in Adolescents



1. Background

The last decade has seen an increase in the rate of HIV infections among adolescents and women in Costa Rica. In response, UN agencies have launched a programme to promote healthy practices and prevent HIV infections among adolescents in two affected port cities. The main strategies are to build the capacity of health care workers and educational institutions to address the SRH needs of adolescents. Giro 180° is a joint programme with a duration of three years implemented by UNFPA, UNICEF and the United Nations Development Programme (UNDP). UNFPA is the managing agency for the pooled funding modality. The principal national implementing partners are the Vice-Ministry of Youth and the National Youth Council.

2. Strategy

UNFPA Costa Rica supports activities to, on the one hand, build the capacities of health care providers and educational institutions and, on the other, empower adolescents, in efforts to promote healthy lifestyles and prevent HIV infections in two cities. The programme seeks to achieve five results that tackle various capacity development entry points.

Enabling environment:

1. Government authorities and policymakers have strengthened their commitment to promote healthy lifestyles and prevent HIV among adolescents.

Organizational strengthening:

2. Health and educational services in the selected communities have developed protective and youth-friendly environments to promote healthy lifestyles and prevent HIV infections among adolescents.
3. A model for the promotion of healthy lifestyles and HIV prevention among adolescents between the ages of 13 to 18 years with a gender perspective and a rights-based approach is developed and adopted by relevant institutions.

Individual strengthening:

4. Adolescents of the selected communities are sensitized and trained as peer educators with access to IEC materials and tools for the promotion of healthy lifestyles and the prevention of HIV and AIDS.
5. Adolescents of the selected communities are informed, sensitizedand trained to lead healthy lifestyles and to protect themselves from HIV and seek care for AIDS.

The beneficiaries are approximately 15,530 adolescents between the ages of 13 and 18 that live in the port cities of Limón and Puntarenas. Other adolescents around the country will indirectly benefit from the information campaigns and political and institutional advocacy activities.

UNFPA provides technical and financial support to (a) coordinate and monitor the programme's technical team; (b) supervise financial and technical execution; and (c) facilitate training sessions for institutional providers and young people.

3. Progress

The main result of the initiative in terms of strengthening the ability of health care centers and

educational institutions to serve youth was the development and validation of a model for the promotion of healthy lifestyles and the prevention of HIV among adolescents aged 13 to 18 with gender, inter-generational and diversity perspectives and a rights-based approach.

In addition, the capacity of youth networks to demand appropriate services was strengthened through supporting youth planned and led community-wide demonstrative experiences and through training peer-educators on the development of innovative and attractive methodologies that will eventually reach approximately 50,000 adolescents.

UNFPA further fostered the capacities of health and educational institutions through support of capacity assessments, systematization and documentation of good practices using participatory methodologies, involving multiple actors in the development of educational materials and knowledge sharing. Staff at both health care centers and educational institutions were trained and sensitized on the problem and on strategies to prevent the spread of HIV among adolescents.

As a complement, UNFPA facilitated an enabling environment by engaging in advocacy activities with education and health leaders to garner support for the creation of adolescent-friendly environments, health promotion and prevention of HIV in adolescents. Grassroots actions served to raise awareness and engage the community at large.

4. Measuring progress and results

A Knowledge, Attitudes and Practices (KAP) study was conducted at the beginning of the programme to set baseline indicators. Thereafter, an external midterm review was commissioned to measure progress and results. A final KAP study measured behavioral changes among young people and, thus, served to assess the effectiveness of the initiative. UNFPA systematized the initiative so as to count with a validated good practices model that can be scaled-up nationally and replicated in other contexts.

5. Lesson learned

The following facilitating factors ensured the success of the programme:

- **Multi-level advocacy:** UNFPA engaged in an active institutional and political advocacy campaign to secure the involvement and the commitment of key decision-makers in health and education at the local, regional and national levels, thus ensuring national ownership and facilitating sustainability.

- **Intersectoral approach:** UNFPA supported actions to generate a broad social dialogue with different sectors, including religious leaders, in order to advance support for youth HIV prevention programmes.

- **Teen and inter-generational perspectives:** All community-based actions were planned and implemented with the active participation of adolescents, institutional staff and other stakeholders, to ensure community buy-in. In addition, all programme materials were developed with youth involvement and ensured a gender and inter-generational perspective.

- **Innovation:** UNFPA promoted the inclusion of innovative strategies in the development of an evidence-based youth-friendly intervention model.

- **Systematization of good practices:** To facilitate replication and sharing of lessons learned, UNFPA supported the systematization of the process.

The main challenge is guaranteeing continuity and sustainability of the capacity development initiative beyond the duration of the programme. Major threats are posed by: (a) the lack of legislation and institutional guidelines to maintain and strengthen activities; (b) the high turnover of health and education providers; and (c) the limited financial and human resources to continue implementation beyond the project period.

Djibouti: Innovations to Improve the Reproductive Health of Nomadic Populations

1. Background

In spite of gradually improving health outcomes, Djibouti's health sector is struggling to deal with insufficient availability of qualified staff, a lack of essential medicines, a focus on curative over preventive care and major geographic disparities in access to care. Nomads, in particular, face great difficulties in accessing care and, as a result, have generally inferior health than their sedentary counterparts.[22] The MoH has established a system of ambulatory service delivery; but the number of mobile health clinics is still very limited. Over the last decade, UNFPA Djibouti has undertaken concerted efforts to support the national government in its quest to expand accessibility and utilization of quality reproductive health services among rural and nomadic populations. Recognizing that a holistic approach would generate valuable synergies, UNFPA set out to strengthen the health system integrally. By aligning with a national policy priority and focusing on the national capacity to address this priority, UNFPA Djibouti contributed to the development of a national health system that is better equipped to meet the reproductive health needs of rural and nomadic populations. In terms of health impact, this enables an increasing number of rural women to access and use family planning and antenatal care services, deliver with the assistance of skilled personnel in health facilities, receive emergency obstetric care when required, and learn about HIV prevention and the harmful consequences of FGM.

2. Strategy

To address disparities, UNFPA applied a holistic approach to health systems strengthening: the country office has promoted and supported adaptation of six interconnected and mutually reinforcing health system building blocks to better meet the reproductive health needs of nomadic populations.

UNFPA has developed government capacity to collect reproductive health data and utilize it in the development of evidence-based health care policies that target nomadic populations; empowered communities to access health services through micro health insurance programmes; strengthened human resources through trainings of providers and community outreach workers; advocated for the development of a national reproductive health commodity security plan to prevent stock outs; and established the first national reproductive health referral center.

In this case study, we will focus on UNFPA's application of innovative strategies to remove barriers to access health services by empowering communities and by creating novel health delivery systems. In particular, we will discuss *micro financing schemes, mobile clinics and reproductive health referral systems.*

3. Progress and results

1) Community empowerment through health financing

Officially, rural health units offer services free of charge. Nevertheless, accessing these services can be challenging for nomads due to travel expenses, informal payments, and the cost of non-generic drugs. In response, the MoH and UNFPA established small-scale community health insurance schemes, which focus on women's reproductive health. Each insurance scheme targets a specific nomadic sub-population and pools modest and voluntary monetary contributions from its members to enable participants to access pregnancy-related health services when required. The initiative is institutionalized within the MoH and coordinated by the Directorate for Health Promotion. Since 2008, UNFPA has provided start-up funds for the establishment of 75 community health insurance schemes. By 2009, the insurances had enabled over 1000 women to access care before, during and after pregnancy, EmONC and family planning services in a health center. Some of the insurance schemes have established direct relationships with the MoH mobile health teams and now provide funds for fuel to ensure that the mobile clinics regularly pay them a visit. In the future, UNFPA plans to train local management committees on management, bookkeeping and identification of emergency obstetric health conditions. The community-run insurance schemes have not only empowered communities to remove barriers to access but have also raised social awareness of the importance of receiving reproductive health care.

2) Bringing services to the community

UNFPA has helped to bridge the gap between nomadic populations and health care services by bringing services to the community and establishing a national reproductive health referral center to serve more complicated cases.

UNFPA has strengthened the capacity of mobile health units by training health teams on management of reproductive health commodities, microplanning and routine reproductive health-related M&E, including maternal death registration. In addition, UNFPA procures contraceptives, equipment and supplies for the mobile health clinics.

> **"Capacity development is helping to build a system that works without you."**

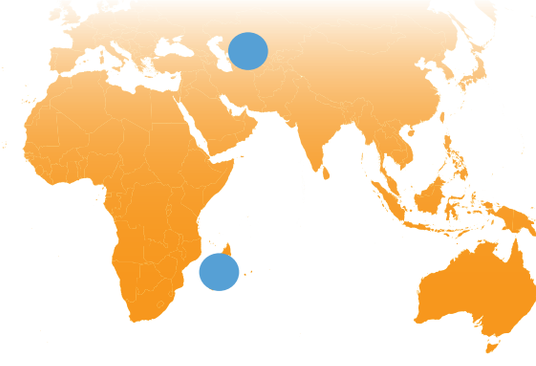
As a complement, UNFPA has trained community outreach workers to provide basic services and information to the community with regard to reproductive and child health services.

To address gaps in service delivery at different levels, in 2009, UNFPA provided the MoH with instrumental support to develop, establish and manage a national referral center that provides all essential reproductive health services and serves the entire country. UNFPA trains health staff at the center and ensures provision of drugs, contraceptives and equipment as required. UNFPA also fostered South-South cooperation for Tunisia to provide technical assistance to the center.

4. Lessons learned

UNFPA, together with key development partners, participated in and supported all stages of the national led process that enabled the government of Djibouti to formulate feasible and evidence-based measures to achieve universal access to quality reproductive health, particularly for nomadic and rural populations. On the other hand, UNFPA provided instrumental support to empower communities to access care. This illustrates how UNFPA can build the capacity of national health systems to achieve MDG 5b by applying innovative strategies at community and government levels.

Madagascar and Uzbekistan: Ensuring Access to Commodities



1. Background

A well-functioning logistics management information system (LMIS) is a basic requirement in any country seeking a secure supply of reproductive health commodities. Such a system requires accurate data related to contraceptive consumption. In order to ensure accurate forecasting and distribution of contraceptives in the public health distribution system, UNFPA's Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS) introduced a user-friendly software that enables countries to better manage reproductive health supplies.

2. Strategy

LMIS was implemented in Madagascar and Uzbekistan. Both initiatives began with national situation analyses to identify system gaps and advocacy meetings with health authorities to secure MoH buy-in and ensure national ownership. LMIS rollouts required extensive

training of staff at SDPs and national and subnational distribution centers; delivery of computer and software; provision of ongoing assistance to address technical difficulties; and development of comprehensive contraceptive logistics guidelines. UNFPA also assisted institutional strengthening through contraceptive procurement and improving storage practices.

3. Progress

The system was introduced in Uzbekistan in 2005 and Madagascar in 2007. It is used at the district level to manage commodities for multiple reproductive health services – family planning, STI/HIV/AIDS and EmONC – and fifteen priority essential drugs. The software allows individual warehouses to track their supply stock as soon as commodities enter or leave storage, and to generate simple reports and requests.

The governments of both countries have adopted the system as part of their national health strategies. Overall, LMIS has strengthened the national capacity to forecast the consumption and distribution of contraceptives. The system has permitted to stock modern contraceptives at SDPs based on actual consumption data, rather than on demographic factors. In addition, health care workers can report on and forecast consumption of contraceptives to higher distribution levels, which are equipped to respond to these requests.

In Uzbekistan, MoH statistics show that every SDP offers all modern contraceptives and has adequate contraceptive stock levels. In Madagascar, the percentage of SDPs reporting no stock-out of contraceptives during the past six months has increased from 63.3 percent in 2008 to 74.7 percent in 2009.

4. Lessons learned

LMIS ultimately benefited users of reproductive health services because of the better supply of commodities and fewer stock outs. The new system undoubtedly strengthened the capacity of government to respond to the reproductive health needs of the population.

The following strategies helped to further the initiative along:

- Excellent cooperation and continued advocacy efforts of UNFPA made the MoH and other stakeholders very committed and supportive to the introduction and implementation of LMIS.
- The MoH has taken full ownership of the system making it an integral part of national health plans.
- UNFPA optimized the use of resources by ensuring synergies with other relevant components of the country programme, such as family planning services and demand creation. In addition, multiple partners pooled resources to implement the system.
- South-South exchanges facilitated replicability and adoption of LMIS in other countries, including Senegal, Sudan, Lao People's Democratic Republic and Saint Vincent, among others.

The main challenges faced by the initiative are:

- National logistics and distribution systems are not fully ready for the introduction of a comprehensive reproductive health commodity security (RHCS) system, for instance some areas lack storage facilities for contraceptives.
- Managing logistics can be frustrating because of structural deficiencies such as lack of electricity to operate computers.
- National counterparts and research centers do not have the technical expertise to conduct facility-based surveys and research.

UNFPA is working on overcoming these challenges through continued advocacy efforts, establishing new and strengthening partnerships and conducting regular monitoring visits.

Mexico: Capacity Development of State and Municipal Population Councils

1. Background

In a country as diverse as Mexico, it is essential to decentralize population activities. Therefore, since the 1990s, UNFPA has prioritized institutional strengthening of the state population councils (COESPOs), responsible for demographic planning at a subnational level. The main purpose has been to build the technical and operational capacity of state and local governments to fulfill their mission of formulation, promotion, coordination, implementation, monitoring and evaluation of population activities taking into consideration the demographic, economic, social and cultural diversity of the country.

2. Strategy

In the 1980s, the National Population Council (CONAPO) recognized the limitations of a centralized model of population planning that did not address Mexico's demographic heterogeneity. In response, it promoted the creation of state and municipal population councils to lead the implementation of population programmes at the state and local levels. Since then, UNFPA Mexico has supported national planning efforts on population issues, with particular emphasis on the *institutional* capacity of the population councils. UNFPA strategic partners include CONAPO and other government institutions involved in population issues, such as the social development, health and finance ministries.

Between 1997 and 2007, UNFPA helped to formulate state cooperation programmes to provide direct support to COESPOs and to strengthen their coordination role among state partners. UNFPA and CONAPO jointly planned and monitored the process with full participation of government and non-governmental institutions in each state. UNFPA provided training and equipment to make operations more effective. In addition, UNFPA and its partners advocated strongly with state and local authorities to ensure

buy-in. The current UNFPA country programme emphasizes the design and implementation of a platform to conduct training activities, and to promote documentation and sharing of good practices among the COESPOs. The direct beneficiaries of this capacity development initiative are the local institutions.

3. Progress

In ten years, activities expanded from five to eight states (Chiapas, Guerrero, Hidalgo, Michoacán, Oaxaca, Quintana Roo, San Luis Potosí and Zacatecas). The current country programme includes agreements and supports initiatives in the following six states: Chiapas, Oaxaca, Guerrero, Puebla, Hidalgo and San Luis Potosí. In addition, the programme supports the development and implementation of a knowledge-sharing platform, which is available to all thirty-two states through CONAPO.

The strategy has an impact on both state and municipal levels, since it targets local populations, and takes into consideration the socioeconomic implications and consequences in the short, medium and long terms of factors such as population size, dynamics, structure and distribution. Now, development programmes and projects can be tailored to the local context and the needs of specific groups, such as indigenous and other vulnerable communities.

4. Measuring progress and results

Between 2004 and 2008, UNFPA Mexico supported the development and implementation of the *Survey forthe Detection of Development Opportunities in the COESPOs*, which measures progress towards indicators related to the councils' technical and operative capacities. UNFPA also conducted a series of studies on the institutionalization of the state population policy. UNFPA and government partners analyzed findings to implement good practices and improve strategies to strengthen the institutionalization of population policies in state entities. Partners are currently adapting the survey, to be conducted again in 2011, so that it can capture more in-depth information on the capacities and functioning of COESPOs.

5. Lessons learned

Due to frequent personnel changes in federal and state administrations, the main bottleneck has been guaranteeing continuity and sustainability of capacity development strategies. Often, new leadership is not committed to state capacity development and recent hires have to be trained all over again. Nevertheless, UNFPA considers this a successful example of capacity development because it contributed to the *decentralization* of population activities and has strengthened the institutional capacity of subnational institutions in charge of planning, coordinating and implementing population activities, programmes and policies. State and municipal population councils in six states have adopted innovative institutional development approaches and are successfully managing population policies locally. The efforts have led to strong inter-institutional coordination among academic institutions, the government and civil society organizations for the implementation of state programmes. The initiative has also served to align state and local population and development policies to national priorities and to garner the commitment of the Mexican government to these issues.

The Philippines Joint Programme on Violence Against Women

1. Summary

In 2006, the United Nations Secretary-General published an in-depth study on the universality, scope and extent of GBV and the related challenges and gaps in public responses.[23] As a follow-up, the General Assembly adopted a comprehensive resolution[24] to intensify and coordinate global efforts to eliminate violence against women (VAW). In February 2006, the Inter-Agency Network on Women and Gender Equality (IANWGE) established the *United Nations Task Force on Violence against Women*[25] to coordinate and support national level efforts by UN agencies to eliminate VAW.

In 2007, the task force, co-chaired by UNFPA and UNIFEM (now part of UN Women), launched a joint programme to address VAW in ten countries involving all relevant national stakeholders, including government, the United Nations Country Team and civil society. The initiative seeks to address issues of VAW from a comprehensive and multi-sectoral perspective, via support to sustainable national efforts. The multi-stakeholder programme is aligned with national and UN planning frameworks, such as the Common Country Assessment (CCA) and UNDAF. With UNFPA Philippines as the lead implementing agency at the country level, the Philippines is one of the ten pilot countries.

2. Strategy

Launched in 2008, the Philippines Joint Programme on VAW is dedicated to: 1) developing and pilot-testing a national VAW documentation system with local governments and NGOs as partners; 2) assessing the capacity of the justice system to implement the national Access to Justice Plan for women and children; 3) establishing gender-sensitive rooms in prosecutors' offices; 4) ensuring that sexual harassment in the workplace is addressed in the Implementing Rules and Regulations of the Philippines Magna Carta of Women; and 5) strengthening the institutional capacities of an NGO – Men Opposed to VAW Everywhere (MOVE). Programme partners come from multiple sectors, including UN agencies, government and NGOs.

This case study focuses on the implementation of two innovative capacity development activities. One is aimed at strengthening the institutional capacity of government to develop and implement public policies to prevent violence through improved data tracking systems. The second seeks to build the capacity of civil society to respond to the problem.

Developing a national VAW documentation system to be piloted locally and then implemented nationally.
Without a centralized tracking mechanism, the country had no reliable VAW data. This had made relevant policy development, resource allocation, and government programming difficult. A national documentation system would give a clearer picture of the magnitude of the problem and provide an evidence-base for government and other relevant stakeholders to effectively plan local and national GBV-prevention programmes and policies.

Strengthening the capacities of male advocates to combat GBV.
Often, programmes and campaigns to eliminate VAW ignore men and boys, forgetting that they can be effective partners. MOVE's vision is that the only way to eradicate VAW is to proactively involve men and boys as advocates and educators. Since 2006, the NGO has worked to empower men and boys to tackle GBV. Within the framework of the joint initiative, UNFPA provides support to strengthen MOVE institutionally and to build the advocacy capacity of its members.

The end beneficiaries are women and girls; the secondary beneficiaries include: a) men and boys, as their capacities to prevent GBV are strengthened; and b) public sector stakeholders, as their capacities to develop, use and scale up the national VAW documentation system are enhanced.

3. Progress

UNFPA introduced the national VAW documentation system in ten *bangarays* (local government units). Capacity development activities focus on training service providers and social welfare officials on software use and data collection and entry methods. The computerized system collects homologeous data that can be compiled and compared across regions. Eventually, it will enable real-time national tracking of GBV cases.

UNFPA promotes men's and boys' potential as advocates for social change by strengthening the NGO MOVE and its members. Institutionally, UNFPA provides financial and technical support to establish MOVE chapters that can help sustain a grassroots movement. At the individual level, UNFPA fosters the development of members' advocacy capacity so that they can be more effective promoters and communicators of issues surrounding GBV.

4. Measuring progress and results

A steering committee – chaired by the government and co-chaired by UNFPA and the Philippines UN Gender Mainstreaming Committee – has been formed to track progress and results. The programme has also partnered with an academic institution to document and evaluate interventions, using quantitative and qualitative research techniques. Results will inform future activities and serve to plan similar efforts in other contexts.

5. Lessons learned

- Early stakeholder consultations – that included participation in baseline needs assessments and workshops – ensured the political buy-in of multiple partners and helped to identify champions and change agents. These exercises also helped to address likely bottlenecks in a timely manner.
- Via top-down capacity development strategies, the Philippines Joint Programme on VAW is strengthening institutional processes in the public sector on addressing the issue. This includes changing business practices and building relational capacities, such as increasing performance within a broader institutional context, promoting intra-governmental coordination arrangements, and promoting leadership capacities and capacities for communication and outreach to ensure transparency and client responsiveness.
- At civil society level – and using bottom-up capacity development approaches – the joint programme is developing the capacity of communities to respond to and prevent VAW; to demand for the development and implementation of GBV laws and policies; to lead community programmes; and to take on a watchdog role.
- One of the programme's main constraints is that stakeholders are at different levels of sophistication in terms of capacities and skills. Bringing all partners to the same level has proven time-consuming and resource intensive.

The **Emergency Obstetric and Newborn Care** Needs Assessment

1. Background

By mid-2000, growing evidence showed that most maternal deaths and complications arise during childbirth. It was acknowledged that full access and improved utilization of EmONC services would have a significant impact on reducing maternal and newborn deaths. Particularly, if accompanied by other proven strategies such as access to family planning and skilled birth attendance. In response, UNFPA, UNICEF and WHO partnered with the *Averting Maternal Death and Disability Program* (AMDD) at Columbia University's Mailman School of Public Health to produce monitoring guidelines and provide technical assistance with training, data collection and management, reporting, and dissemination of findings at countries' requests. In addition, in 2009, UNFPA, AMDD and UNICEF jointly developed and launched a handbook on EmONC needs assessments in order to support planning and scale up of maternal and newborn services in countries with high maternal mortality ratios.

The main functions of the EmONC needs assessments are to:
1) Set a baseline for district-level service delivery against which to measure progress;
2) Support evidence-based advocacy and resource mobilization for EmONC;
3) Provide data for district microplanning to improve service delivery, quality of care and supply chain management.

By assisting health managers to plan and monitor services provision and scale up, the assessments improve access to and quality of life-saving emergency care.

2. Strategy

UNFPA uses a *multipronged strategy* to strengthen country

capacity to expand access to emergency services:

- The technical assistance partnership with AMDD ensures that government programme managers and decision-makers count with accurate EmONC data, enabling them to plan, budget and develop relevant policies according to national needs and priorities.
- The seed funding channeled through the MHTF ensures that priority countries with high maternal mortality ratios conduct an EmONC needs assessment every five years to monitor the state and evaluate scale up of services.
- The programme is committed to identifying and strengthening the technical capacity of local and regional centers and experts. UNFPA routinely selects national institutions or regional centers for excellence, such as the Center for Research and Health Studies at the University of Nicaragua (CIES-UNAN) in Latin America, to conduct the assessments. This has fostered national ownership and promoted programme sustainability.

3. Progress

UNFPA has supported EmONC needs assessments in fifteen countries: Afghanistan, Benin, Burkina Faso, Burundi, Cambodia, Chad, Ethiopia, Ghana, Guyana, Haiti, Ivory Coast, Liberia, Madagascar, Malawi and Niger. In addition, plans are underway to conduct assessments in nine others. In each country, the needs assessment was carried out following an inception mission. The process was shored up by national steering committees. Selected national and regional research institutions and national statistics bureaus implemented the surveys with technical support from AMDD.

4. Measuring progress and results

At country level, progress towards indicators is measured by survey results and their application in district microplanning for upgrade of EmONC services. For example, Ethiopia developed a factsheet for each health district. Assessments are conducted every five years. UNFPA, UNICEF and AMDD monitor the status of current needs assessments. At regional level, UNFPA, UNICEF, and WHO coordinate efforts to provide technical support to countries.

5. Lessons learned

The selection and strengthening of a regional pool of institutions and experts to independently conduct the EmONC surveys is needed. This is essential for the sustainability of technical assistance and monitoring of EmONC services provided by UNFPA and its partners in priority countries. The needs assessments have strengthened the capacity of governments to better plan for and address obstetric complications.

Developing National Capacities to Link **Sexual and Reproductive Health and HIV**

1. Background

In the changing aid and development environment, harmonization, collaboration and increased accountability are needed to make headway towards reaching the MDGs over the next five years. The importance of linking SRH and HIV responses is increasingly gaining momentum. The rationale, laid out in 2004 with the *New York Call to Commitment*, is indisputable: a) most HIV infections are sexually transmitted or are associated with pregnancy, childbirth and breastfeeding; and b) the risk of HIV transmission can be increased by the presence of certain STIs. Moreover, sexual and reproductive ill-health and HIV share root causes, including economic and gender inequality, limited access to appropriate information, harmful cultural norms and marginalization of the most vulnerable populations.

UNFPA – through advocacy, financial support and training – has supported governments and other key stakeholders in about 40 countries to undertake rapid needs assessments. *The Rapid Assessment Tool for Linking SRH and HIV: A Generic Guide* permits nations to assess HIV and SRH bi-directional linkages at the policy, systems, and service-delivery levels. By identifying current critical gaps in policies and programmes, the assessment process contributes to the development of country-specific action plans to forge and strengthen integration. While it focuses primarily on the health sector, it can be linked to assessments of other relevant sectors, such as education and community development.

2. Strategy

The rapid assessment tool is a joint effort of UNFPA, WHO, UNAIDS, the International Planned Parenthood Federation, the Global Network of People Living with HIV, the International Community of Women Living with HIV/AIDS and Young Positives Ministries responsible for SRH and HIV programming lead the process in collaboration with key national partners.[26] The assessment can be a stand-alone activity or part of a broader review of national responses. It includes desk reviews; individual and group interviews with multiple stakeholders including policymakers, programme managers and clients; and site visits to clinics. Following the assessment, partners come together to share findings and identify priorities for action. Activities are country-specific; however, every plan includes developing a coordination mechanism and a strategy to integrate SRH and HIV policies and services.

Upholding human rights is intrinsic to the linkages agenda. Beneficiaries include all clients of SRH and HIV services, and anyone standing to benefit from improvements in human rights such as people living with HIV, men who have sex with men, people who use drugs, sex workers, transgender persons, women and girls, and youth.

3. Tracking progress and results

Since its launch in 2008, the tool has been promoted through international and regional platforms. Twenty assessments were conducted between 2008 and 2011; an additional 19 will be carried out in 2011.

Based on the experiences of the past three years, the initiative is currently developing a standardized monitoring system to track progress made towards linking SRH and HIV at country level, including a set of appropriate indicators.

4. Lessons learned

Clearly there are gaps and challenges in establishing linkages between SRH and HIV at all three levels: policy, systems (partnerships, coordination mechanisms, capacity development, M&E and logistics, among others), and integrated service delivery. The tool's main strength is that it serves to generate national dialogue on the steps needed to forge SRH and HIV linkages based on concrete evidence. It enhances the ability of government institutions to respond to both SRH and HIV service needs.

The countries that conducted the assessment identified the following challenges:

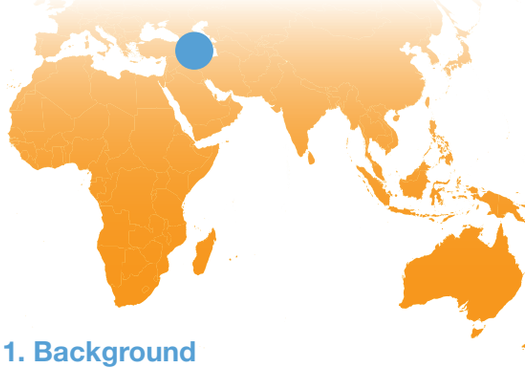
- **At the policy level:** policy inconsistencies regarding sexuality education and providers, among others; legislation limiting universal access to services and education and not supportive of human rights; political commitment to linkages doesn't translate into action; lack of joint funding and donor conditionality; and weak consensus about scope of linkages.

- **At the systemic level:** vertical planning and management of SRH and HIV programmes with separate budgets and limited coordination; inherent weaknesses of health systems, e.g. scarce human resources and commodities; lack of integrated protocols and a human rights-based approach; and deficient and late engagement of civil society partners and communities, particularly of people living with HIV/AIDS.

- **At the service delivery level:** limited access to services by key populations; integrated services are not implemented uniformly across facilities and many opportunities for further integration are missed; SRH and HIV components are fragmented internally; and health care providers are over-burdened, lack skills or pursue discriminatory practices. Clients tend to prefer integrated services but have concerns over confidentiality, competence and stigma.

Fostering an enabling environment

Armenia: Developing National Capacity to Combat Gender-Based Violence



1. Background

The lack of reliable and representative data on the prevalence of VAW in general and intimate partner violence in particular constitutes one of the main impediments for developing targeted policies and programmes for combating GBV.

UNFPA Armenia supported the government in conducting the first nationally representative sample survey on VAW in the country. It was unprecedented in its scope, scale, methodology and the magnitude of the results. In order to promote an enabling environment for the elimination of GBV, UNFPA disseminated the findings broadly among stakeholders. The data has enabled the government to make informed policy decisions and develop an effective national response, which includes referral mechanisms and targeted campaigns against GBV. In addition, UNFPA launched a countrywide awareness raising campaign to sensitize the general population on the scope of the problem of GBV. This has been critical in a country in which VAW was largely invisible.

2. Strategy

The key partners in this initiative were UNFPA, the Ministry of Labor and Social Issues, the National Statistical Service, regional administrations, faith-based organizations and local NGOs. UNFPA fostered South-South collaboration and knowledge exchange with Georgia and Azerbaijan, two project countries which have implemented similar activities.

The direct beneficiaries were members of the Regional Councils on Gender Equality and the National Interagency Committee to Combat GBV in Armenia, as well as representatives of the MOH, the Ministry of Labor and Social Issues, the National Statistical Service, medical workers, the police, faith-based organizations and clergy, and journalists.

High-school and university students, representatives of international and foreign organizations, NGOs, women's groups, men's groups, refugees, community leaders, educators, and the general population in both rural and urban areas benefited from the awareness raising campaign.

Prior to conducting the survey, UNFPA worked with the National Statistical Services and international experts to adapt the relevant tools. UNFPA also trained field staff on gender issues, gender-based discrimination and violence; explained the goals and methods of the survey; built their interviewing skills; and enhanced their skills in using the survey questionnaire. The project also supported the establishment of a multisectoral group of experts to prepare the national report. Following the completion of the survey report, UNFPA provided considerable support to disseminating the results through a large-scale awareness-raising campaign and a capacity development initiative.

3. Progress

The *Nationwide Survey on Violence against Women* was conducted in 2008. Data processing and analysis were completed in 2010. UNFPA disseminated the initial findings among key stakeholders. After incorporating feedback, UNFPA Armenia organized a countrywide campaign to broadly present survey findings. The awareness-raising campaign was launched in 2010 in 18 cities in Armenia's eleven regions. A total of 5800 individuals participated. The campaign, which focused on different aspects of VAW, targeted a broad and diverse audience through visual materials, factsheets, and a documentary presenting the key findings. It received nationwide media coverage.

In addition, UNFPA facilitated a series of capacity development workshops on how to use survey data. Participants included members

of the Regional Councils on Gender Equality and the National Interagency Committee to Combat GBV, representatives of the MOH, the Ministry of Labor and Social Issues, the National Statistical Service, and the police, as well as field-based providers. UNFPA also shared key survey results with high-level policymakers, including the Armenian President and Prime Minister, parliamentarians and other influential government officials.

4. Measuring progress and results

In December 2010, an assessment of the capacity development components was conducted to determine effectiveness of activities. The assessment showed that awareness of GBV issues and the national and international legal framework among the population increased, the degree of silence towards GBV – especially among men – was reduced and different social networks were created, planting the seeds for a pro-human rights grassroots movement in the country.

The awareness-raising and capacity development activities positively influenced political will. In June 2011, the government adopted the National Action Plan to Combat GBV (2011-2015). A separate law on domestic and GBV is currently under review. In addition, the use of a GBV hotline and demand for psychological counseling greatly increased among the population. Activities to sensitize religious leaders have helped to identify families at risk of domestic violence.

5. Lessons learned

The survey findings helped to convince policymakers and the general public that VAW is a reality. This realization in itself is already an important step given the denial of GBV in Armenia. Official commitment is demonstrated by the adoption of the national plan against GBV, which is largely based on survey results and expert recommendations. The new plan would not have been possible without public pressure resulting from the intensive efforts to disseminate survey findings and bring attention to the issue. One of the unexpected, but positive, outcomes is that the government now co-chairs the UN Expanded Gender Theme Group together with UNFPA. In addition, Armenia has developed a model for a much-needed national referral mechanism.

The main bottleneck in terms of fostering an enabling environment for the elimination of GBV has been cultural norms and gender stereotypes. Changing values, attitudes and perceptions is a long and arduous process. Even though programme activities increased knowledge about the issue, more work is needed to effect a deep transformation. Hopefully, the civil society networks that were formed as part of the process will continue to keep VAW in the public eye.

The Integration of Sexual and Reproductive Health and HIV/AIDS Services in **Kenya**

1. Background

Kenya has a rapidly growing population (3% per year) of around 40 million.[27] Its contraceptive prevalence rate is 46% with large discrepancies ranging from 3.5% in the North Eastern Province to 66.7% in the Central Province.[28] HIV prevalence is 7.1% in the general population and 9.6% among pregnant women.[29] Overall unmet need for family planning supplies is 24%; and 52% among people infected with HIV. A majority of pregnant women made at least one antenatal care visit and 78.6% were tested for HIV.

Evidence shows that integration of SRH and HIV/AIDS care leads to a higher and more effective utilization of services and resources. Thus, UNFPA Kenya supported the government's Division of Reproductive Health and the National AIDS and STI Control Programme in the development and implementation of the national SRH and HIV/AIDS integration strategy.

2. Strategy

UNFPA advocacy on the benefits of integrating SRH and HIV/AIDS services led to the government taking ownership of the programme early on. UNFPA helped to establish a technical working group (TWG), chaired by the government, to provide guidance for the formulation, implementation and M&E of the pilot programme and strategy. TWG members also include the National AIDS Control Council, the National AIDS and STI Control Programme, WHO, FHI 360, the Centers for Disease Control and Family Health Options of Kenya (FHOK).

In the first phase, the TWG conducted a situational analysis and, with UNFPA support, FHOK piloted the integration of family planning into HIV services and of HIV counseling and testing into SRH services. The results were the basis for the development of an integrated SRH-HIV/AIDS service model.

The initiative, which aims to increase access to comprehensive, high-quality, effective, efficient, affordable, and sustainable SRH and HIV/AIDS services, is based on the following pillars:

- Strengthening systems to improve the performance and quality of service delivery, with a major focus on institutional capacity development at all levels.
- Facilitating evidence-based advocacy and policy dialogue with key stakeholders and decision-makers.
- Building a knowledge base through research and M&E.
- Fostering resource mobilization and accountability mechanisms.
- Promoting, strengthening, and coordinating partnerships and collaborations among relevant stakeholders

through information sharing.

Once the strategy was finalized, the second phase involved national rollout. The TWG selected five provincial hospitals to begin offering integrated services both at maternal and child health and comprehensive care clinics. Support centered on training health care workers on provision of different services and, in some cases, task shifting so that care could be offered under one roof.

3. Progress and tracking results

In the first phase, UNFPA supported FHOK to pilot the integration of family planning into HIV services and of HIV counseling and testing into SRH services. The pilot included training HIV counselors on provision of family planning services. An evaluation of the pilot programme, conducted after two years, showed that integration of services led to higher enrolment and follow-up in care and treatment of mothers on prophylaxis and antiretroviral therapy. Moreover, there was improved accounting of the exposed children, of which the majority was negative at six weeks. Maternal and child health services improved access to antiretroviral therapy and other HIV/AIDS-related services. Family planning services seemed to reduce mother-to-child transmission. Mothers expressed more willingness to seek services at antenatal rather than comprehensive care clinics. Financial commitments from government and development partners for SRH and HIV/AIDS integrated services increased. The TWG and other interagency coordination mechanisms strengthened partnerships and harmonized actions.

The TWG continues to support the initiative through advocacy and resource mobilization, assistance in the development of standard guidelines for integrated SRH and HIV/AIDS services, training of health professionals, and renovating and equipping health centers.

UNFPA Kenya fostered South-South cooperation with Eritrea. In 2010, UNFPA hosted an Eritrean delegation to visit Nakuru Provincial Hospital – one of the pilot sites – and learn about the integration model.

4. Lessons learned

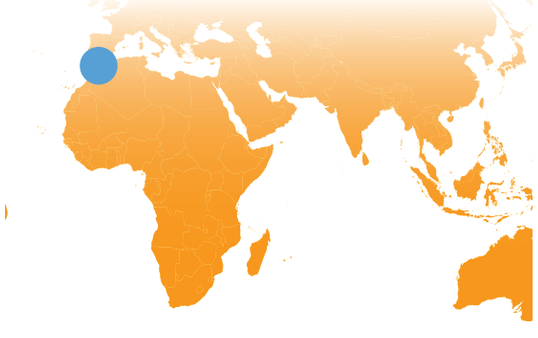
The strategy helped to build an enabling environment for services integration through a multipronged approach, which included:

- Advocacy to ensure government ownership over the process.
- A broad-based SRH and HIV/AIDS coordination committee.
- Fostering a supportive policy framework by assisting the development of the Contraceptive Commodity Security Strategy and the Maternal and Neonatal Roadmap.
- Strengthening systems through operationalization of the Contraceptive Management Unit and LMIS.
- Development of standard guidelines for health centers on the provision of integrated family planning and voluntary counseling services.
- The ability to leverage partners' funds for integration.
- The availability of quality training materials and competent trainers.
- The formulation of an integrated strategy with solid M&E and tracking mechanisms.
- Public support through the launch of CARMMA and the implementation of awareness-raising initiatives targeting at-risk and vulnerable groups, such as commercial sex workers and young people.

On the other hand, the government of Kenya is planning to scale up the integration strategy nationwide but faces serious challenges, such as:

- Insufficient financial, human and infrastructure resources.
- Weak SRH commodity distribution systems resulting in stock-outs at local level.
- The need for buy-in from both public and private SRH and HIV/AIDS service providers.
- Limited capacity of health care providers to offer comprehensive services.
- Lack of M&E capacities.

Morocco: Mainstreaming Gender Issues into Health Sector Reform



1. Background

Over the last two decades, the Moroccan health system has undergone multiple reforms at various levels: human resources, equipment, service delivery, financing and governance. Evidence shows that gender and human rights in the context of health care systems are major determinants of health. UNFPA Morocco has embraced capacity development in those two areas as a strategy to strengthen the change process.

2. Strategy

The overall aim of health sector reform is to establish national norms and guidelines to improve health care delivery throughout the system in terms of quantity, quality and accessibility of services. The reform process has clear government ownership. The programme, aligned with priorities set forth in the country's health plan, rests on the following three pillars:

- Establishment of evidence-based national norms and guidelines and promotion of mechanisms to measure performance to improve health service provision in primary care centers;
- Strengthening public health care systems in terms of geographic and cultural accessibility, particularly for vulnerable populations; and
- Improvement of the quality of care.

UNFPA's role is to institutionalize gender issues within the national health care system in order to reduce inequalities of access to SRH care for women, particularly young women, women of reproductive age and those in remote and underserved areas. To that end, UNFPA provides technical assistance to integrate a gender perspective into MoH norms and guidelines.

UNFPA also conducts monitoring missions to assess progress made against a set of national indicators. Mission findings inform policy decisions. Thus, UNFPA is in a position to advocate for the

inclusion of a gender perspective and a human rights-based approach and to raise awareness among decision-makers about gender inequality as a major determinant of health outcomes.

To increase capacity, UNFPA engages high-level maternal health, public health and gender experts to serve as advisers, tapping into national, regional and global resources within and outside UNFPA. UNFPA leverages additional resources for reproductive and maternal health by forging alliances with donors.

3. Progress

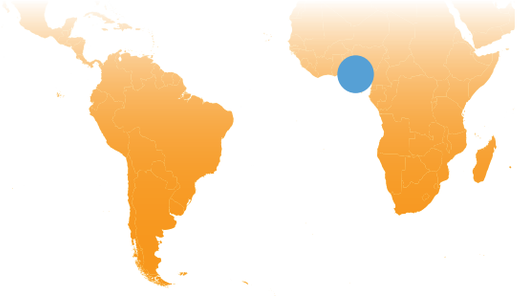
Capacity development actions led by UNFPA in the form of technical assistance have resulted in the mainstreaming of gender issues within the national health system. Below are a number of specific results:

- Staff from the MoH and the Ministry of Finance have been sensitized to the critical importance of incorporating a gender perspective and a human rights-based approach to public policies. As a result, in 2011, the MoH adopted a legal framework for the health care system that includes the integration of gender dimensions in health services. Furthermore, article 19 of the new Constitution, voted in July 2011, pertains to gender equality while its article 31 pertains to the rights to health and social protection.
- In the wake of these positive developments, the MoH requested UNFPA's assistance to conduct a gender audit to evaluate the degree of integration of gender in public policies, planning and programming processes and budget allocation. The audit also aims to evaluate the level of knowledge on gender perspectives as well as the level of gender sensitivity of MoH staff. The gender audit should result in enhanced integration of a gender perspective in health policies and programmes.
- In 2011, a national maternal health forum was organized to share advances and progress in maternal health and maternal mortality reduction among relevant partners. The forum resulted in the establishment of a peer review mechanism to make policy recommendations based on available evidence and set the foundation for the development of the next maternal health strategy.

4. Lessons learned

- Considering the specific needs of Morocco as a middle-income country, UNFPA's role in capacity development has focused on the provision of high-level technical assistance, policy dialogue and advocacy that takes national priorities into account. This exemplifies UNFPA's strategic shift from delivering things to delivering thinking.
- UNFPA fostered an enabling environment for women to gain equal access to the health care system through:
  - Applying new approaches to mobilize financial resources, such as sector budget support and pooled funding;
  - Focusing on UNFPA's comparative advantage and mandate; and
  - Developing the capacity of research institutions to respond to increasing demands in the combined areas of human rights, gender and reproductive health.

Nigeria: Fostering Harmonized Partnerships to Achieve MDGs 4, 5 and 6



1. Background

As the most populous nation in Africa, Nigeria has substantive political and economic influence across the continent. Improved health outcomes in the country are critical for achieving the global MDGs. Unfortunately, Nigeria is not on track to attaining the health-related MDGs. Nigeria's health sector faces a number of challenges, including: underfunding at all levels of the health system; weak human resources in terms of quantity, quality, distribution and motivation; large inequalities both in health status and resource distribution; a dilapidated health infrastructure; fragmented health service delivery; and poor governance and oversight.

The government of Nigeria acknowledged that to address such challenges and improve the health of the population, particularly of the poorest and most vulnerable, there was an urgent need to revitalize the health sector. To this end, the government supported the development of an overarching and comprehensive health plan. Hence, UNFPA provided critical assistance to the elaboration of the National Strategic Health Development Plan (NSHDP), the first comprehensive and costed national health plan with a well-defined results matrix. In addition, UNFPA facilitated the creation of the Country Compact for Health (CCH) to follow-up on the plan's implementation. UNFPA harmonized efforts with other UN agencies and bilateral partners at the country level, while leveraging the support of global and regional entities, such as IHP+ and the Harmonization for Health in Africa (HHA).

2. Strategy

The NSHDP was developed through a participatory and inclusive process. It reflects the MoH's strong leadership, effective management and consensus-building efforts. The national initiative strengthened federal and state level capacities in the areas of strategic planning and budgeting, priority setting, costing, policy dialogue and harmonization and alignment.

Development partners actively participated in the process and were critical to the mobilization of technical, financial and material resources to complement government efforts. At the same time, Nigeria capitalized on global commitments such as the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action, and utilized its IHP+ membership and the regional HHA partnership to further cement the work.

UNFPA Nigeria was part of the plan's management and oversight group and the technical working group in charge of developing the plan's overarching framework. The country office involved the UNFPA Africa Regional Office (ARO) and HQ during critical stages. By working effectively across the three levels of the agency under

the leadership of the country office, UNFPA was able to strategically engage, technically support and strengthen national capacities.

3. Progress

Under MoH leadership, the NSHDP was the result of an extensive 18-month consultation process that involved state and local governments, civil society and development partners. It included:

1) undertaking background studies to assess the state of the health system and potential constraints to scaling up;
2) formulating a government-endorsed framework to guide the elaboration of the NSHDP; and
3) developing and costing local, state and federal health plans, which served as the basis for the NSHDP.

In 2010, the highest levels of political and health governance, including the Federal Executive Council, chaired by the President of Nigeria, and the National Council on Health, the main policy-making body within the health sector, approved and committed to implementing the plan.

In December 2010, the government and selected development partners established the CCH. The CCH is a national mechanism for strengthening partnerships and harmonizing national and subnational actions to support the implementation of the NSHDP, including ensuring financial sustainability. In addition, a monitoring framework was developed to track CCH commitments. UNFPA provided technical and financial support at all levels. At the subnational level, UNFPA Nigeria supported the development of state and local strategic plans in six states. Nationally, the country office supported the development and subsequent launch of the plan and the formation of the CCH. Regionally, UNFPA provided technical and financial support to the documentation of the plan's development process. Within the context of IHP+, it is hoped that the systematization will serve as a guide for strengthening health systems in other African countries. Since 2011, UNFPA provides funding to implement the NSHDP in UNFPA programme states.

UNFPA Nigeria sought the technical guidance of ARO and HQ during critical points in the plan's development. ARO and HQ technical experts participated in HHA and IHP+ policy and technical missions as well as a costing mission. UNFPA, along with other partners, worked with senior policymakers in the MoH to develop NSHDP's National Results Framework, which includes an M&E system to track progress. During the mission, UNFPA also trained national experts on evidence-based quality assurance, planning, costing and budgeting. In addition, the technical team provided feedback to MoH officials on draft state plans. In parallel, participants in a multi-agency policy mission discussed with key country stakeholders the global principles of an IHP+ compact and options for adapting these principles to the Nigerian context. A roadmap with timelines, benchmarks, roles and responsibilities detailing deliverables for government and partners was also developed for the CCH.

4. Measuring progress and results

A national results framework with a clear set of indicators was developed to measure national progress towards implementing the NSHDP. Conducting joint annual reviews to assess progress made against the indicators was deemed critical to the process. Hence, UNFPA provided technical and financial support, alongside other partners, for the conceptualization, planning and conducting of Nigeria's first Joint Annual Review, which was an objective and transparent monitoring process.

5. Lessons learned

Following are some of the main strategies that made this an effective capacity development initiative:

- The leadership and commitment of the government of Nigeria to embark on a very complex but inclusive health-sector reform process.
- UNFPA was able to engage in successful broad-based partnerships by remaining flexible, while also adhering to the agency's accountability rules and procedures.
- Responding rapidly to government requests, alongside other partners, enabled UNFPA to be present at the table for all discussions. This was reinforced by the strong commitment and support of UNFPA's global and regional levels to national processes.
- Although not a major financing partner, the country office was recognized as a key counterpart due to its technical expertise. This was augmented by the on-demand assistance of ARO and HQ.
- To engage and sustain partnerships, UNFPA maintained good working relationships with all agencies, even in times of differing opinions. It pursued dialogue and consultations to resolve such issues.
- A dedicated national staff member with experience in health systems strengthening, health financing and health economics, facilitated multi-level engagement.
- The initiative was strengthened by UNFPA's ability to leverage the IHP+ and HHA partnerships in support of the national process.

This exercise shows how UNFPA can effectively strengthen national capacities by utilizing its technical expertise at each level. By tapping into UNFPA resources, the agency could act at different entry points and leverage critical partnerships to provide strategic support to the government. This culminated in the development of an overarching health framework in Nigeria with harmonized donor contributions that will serve to improve national health services and outcomes and to achieve the health-related MDGs.

Sierra Leone and Uganda: Protecting and Empowering Women and Girls during Armed Conflicts

1. Background

The UN Security Council Resolutions (SCR) 1325 (2000) and 1820 (2008) address the impact of war and conflict on women as well as women's role in conflict prevention, resolution and sustainable peace building. SCR 1325 makes multiple stakeholders accountable for ending impunity, protecting human rights and guaranteeing access to justice and the rule of law for women and girls in peace building processes. Other important aspects of the resolution relate to the need to consolidate data on the impact of armed conflict on women and girls; the need to involve multi-stakeholders in the adoption of a gender perspective when negotiating and implementing peace agreements; and the need to take special measures to protect women and girls from all forms of GBV. However, SCR 1325 does not have clear accountability and monitoring mechanisms. At the core of accountability are adequate data collection systems, and these depend upon appropriate indicators to monitor progress.

The UN Secretary-General 2004 report on SCR 1325 highlighted the importance of developing a set of indicators and mandated the formulation of National Action Plans (NAPs) as mechanisms to track progress towards the advancement of gender issues. Since then, around 32 countries have developed NAPs to implement various components under the resolution's four pillars: *Protection, Prevention, Participation and Empowerment, and Promotion*. NAPs act as monitoring tools – containing suggested outputs, timelines, progress indicators and an extensive list of stakeholders.

However, a review of existing NAPs revealed that indictors to implement, monitor and evaluate SCR 1325 activities were often not present at the local level. If they were included, they were sometimes poorly designed and could not accurately monitor and evaluate progress and capture lessons learned for scaling up or for replication on a macro scale.

Lack of relevant capacities at the local level is the principal challenge in designing locally appropriate indicators that can successfully monitor and evaluate the implementation of SCR 1325. To address this capacity gap, UNFPA and UNIFEM (now part of UN Women) launched a pilot programme that engages multiple stakeholders. This work contributes to build a shared set of global indicators on SCR 1325 and 1820. Four countries were proposed to participate in the pilot effort: Ivory Coast, Nepal, Sierra Leone and Uganda. This case study will describe the capacity development activities carried out in the last two.

2. Strategy

The main partners of the multi-stakeholder joint programme included UNFPA and UNIFEM, the relevant ministries in Uganda and Sierra Leone and civil society organizations in both countries.

UNFPA and UNIFEM provided capacity development assistance to Uganda and Sierra Leone to finalize the draft NAPs and to review or develop indicators. The process was rolled out under the following phases:

Phase I: Country Status Reports. The first step was to identify the key stakeholders working on this issue in both countries via country capacity mapping. The exercise, coordinated by UNFPA and UNIFEM country offices in each country, led to the identification of key agencies and people to engage in the initiative. The mapping highlighted strategic entry points and linkages with existing interventions on SCR 1325 and permitted the division of responsibilities among UN agencies, government and civil society groups.

Phase II: Capacity Development Workshops. Based on the mapping, workshops were held to refine or design indicators to implement, monitor and evaluate SCR 1325 under the existing or draft NAPs. Tailored to the needs of each country, the workshops aimed at catalyzing the full adoption and implementation of NAPs and developing a set of priority indicators suited to the local context. The workshops were organized by the lead ministry and by UNFPA and UNIFEM country offices and facilitated by international, regional and national experts. They involved the active participation of national stakeholders. Attendance of regional participants was encouraged to foster replication in other countries.

Phase III: Establishment of Stakeholder Coordination Mechanisms. One of the expected outcomes of the capacity development workshops was the creation of national advisory teams with key stakeholders that could sustainably take the process forward. The teams would facilitate synergies, foster communication and assume M&E functions around SCR 1325 implementation. UNFPA and UNIFEM would provide technical assistance and support.

3. Progress

The primary beneficiaries of the programme were government and civil society stakeholders; the secondary beneficiaries included national UN officers. The capacities of both groups were enhanced to develop, use and monitor the NAPs.

In Uganda:

- With the support of UNFPA and UNIFEM, a capacity development workshop was held to revise NAP indicators and baselines. As a result, 15 priority indicators were selected from the original 400.
- UNFPA and UNIFEM hosted an orientation session for civil society organizations highlighting their possible role in NAP monitoring and implementation as well as service provision.
- The Ugandan Cabinet approved the NAP and underscored the principle of implementation via a multisectoral approach. In 2009, the Chief Justice launched the plan at a high-level event during the *16 days of activism campaign.*

In Sierra Leone:

- At the capacity development workshop held in Bo in 2009, NAP indicators were prioritized from 63 to 43.
- Through a series of meetings with key stakeholders, the indicators were further refined to 36 by the beginning of 2010.
- A NAP M&E framework was developed to ensure progress assessment.
- In 2010, the Sierra Leone NAP received international recognition as it was launched during the fifty-fourth session of the Commission on the Status of Women in New York.
- A government–civil society national task force on 1325 (WANMAR 1325) was established to shore up support for implementation and track progress.

4. Measuring progress and results

Improving the NAP M&E framework by developing clear, focused and measurable indicators has strengthened national capacities to measure progress made towards protecting the rights of women during conflicts. The results listed below attest to the fact that the process concomitantly strengthened government commitment and fostered the development of enabling policies and mechanisms to prevent GBV. UNFPA is currently facilitating South-South exchanges to develop NAPs and indicators in other countries.

In Uganda:

- Four GBV bills were passed into force following the adoption of the NAP. A related bill on marriage and divorce and property rights was also introduced in parliament.
- Nearly 80 percent of the actions prioritized in the NAP were incorporated into the five-year Ugandan 2010 National Development Plan.
- The Peace, Recovery and Development Plan – the government framework for recovery in post-conflict Northern Uganda – was revised with input from gender activists to include NAP indicators.
- While there is no stand-alone budget allocation for the NAP, partners were able to mobilize resources for its implementation.
- Under the Joint Programme on GBV, a system was piloted to capture data on reported incidents of GBV. UNFPA is evaluating the pilot for possible rollout in other humanitarian response settings.

In Sierra Leone:

- WANMAR 1325 members have adopted a plan of action, which includes lobbying for at least 30 percent representation of women in parliament and political parties.
- The plan lobbies for the appointment of women into key ministries and commissions.
- Members promote men's involvement in GBV-prevention strategies, the establishment of an independent court for rape victims, and community monitoring of the practice of rape.

5. Lessons learned

The main challenges related to these in-country capacity development processes include:

- There are no direct budgets allocated to the implementation of the NAP; rather, the particular ministry – often the ministry of gender or women's affairs – under whose responsibility the identified NAP actions fall are urged to finance the activities from their sectoral budgets. While this approach is good in that it allows various line ministries to be responsible for NAP actions, it may pose a challenge if ministries do not support the initiative.
- There is no mechanism to harmonize actions across ministries. This limits accountability and effectiveness.
- The lack of capacities of some civil society groups working with affected populations hampers implementation. Some groups have no in-depth understanding of the resolutions and NAPs and have limited monitoring skills. This puts into question their effective watchdog role. Furthermore, some groups have expressed fatigue over UN resolutions, pointing out that what is needed is pressure on government to fulfill its responsibilities.
- The traumatic effects of sexual and GBV still hinder those affected from meaningfully engaging with and participating in the peace, recovery and development processes. Moreover, low conviction rates for sexual violence cases poses a barrier for effective and meaningful participation. For instance, Lawyers Without Borders found that there was only a 2 percent conviction rate in North-Eastern Uganda in 2009.

Some of the effective programme strategies to foster an enabling environment to address GBV were:

- The broad consultations, including the country mapping and workshops, facilitated political buy-in by multiple stakeholders and committed champions and change agents from the beginning. This helped to ensure national ownership and long-term sustainability.
- The programme strengthened the capacities of officials to understand and be sensitive to issues related to gender, peace and security; fostered inter-ministerial coordination; improved business processes within ministries; encouraged civil society participation; and built the advocacy capacity of community-based organizations.

Sri Lanka: Partnerships to Eliminate Violence Against Women

1. Background

Sri Lanka is recovering from a 26-year civil war, which ended in 2009. The conflict left hundreds of thousands dead and many more displaced. The country was also severely affected by the 2004 tsunami in the Indian Ocean. Girls and women are at increased risk of sexual violence during humanitarian emergencies, which disrupt the rule of law and weaken national responses. During post-conflict and post-disaster reconstruction, UNFPA has partnered with national and local governments, UN agencies and

faith-based organizations to mitigate added risks and promote an enabling environment to protect women and girls from violence.

2. Strategy

In Sri Lanka, UNFPA leads the Joint UN Programme on Prevention of and Response to GBV, which seeks to develop the *capacity of communities to protect women and girls from violence and the capacity of the public sector to respond to the needs of survivors.* At the community level, UNFPA has partnered with faith-based organizations to engage religious leaders as advocates to prevent GBV. Leaders can play a critical role in raising community awareness about the problem, discussing with men the importance of a violence-free family environment, and detecting and referring cases of domestic violence. To assist women transition out of a situation of violence, UNFPA supported the establishment of women's centers that provide legal and counseling services to victims of GBV and their families and offer livelihood training. The centers also engage the participation of boys and men through awareness-raising recreational activities.

3. Progress

UNFPA Sri Lanka implements a sociocultural intervention aimed at mobilizing the support of faith-based organizations to address GBV. UNFPA has forged partnerships with leaders from the country's four major religions to work at the grassroots level to prevent VAW. In particular, leaders can leverage their influence to sensitize men to the problem and slowly modify cultural norms.

UNFPA has supported the establishment of fifteen women's centers in Sri Lanka. The centers offer counseling and livelihood training as well as referrals to health services and the judicial system. They are based in hospitals to facilitate sustainability. The centers organize community-level awareness-raising activities targeted to men and boys in an effort to prevent GBV.

As a complement, UNFPA launched the campaign *Kick the Ball-Not the Woman* to steer young men in rural areas, many of whom are army deserters, away from violence and alcohol abuse through sports and recreational activities.

4. Measuring progress and results

UNFPA Sri Lanka engages in a number of activities to monitor progress and results, including measuring levels of usage of women's centers and assessing changes in attitudes following community-level awareness-raising actions.

5. Lessons learned

UNFPA has had to implement innovative and multipronged strategies adapted to a country in recovery. At the national level, UNFPA worked with the government to enact protective legislation. However, many of the efforts have centered on sensitizing and empowering rural communities that have been most affected by instability, displaced populations and unemployed youth and former fighters. Eradicating VAW requires a deep change process involving multiple stakeholders in government and civil society. Cultural norms and attitudes are not fast changing. Weak institutional systems do not improve overnight. A critical challenge has been ensuring continued high-level commitment and support as well as a sustainable donor base. A myriad capacities must be developed, placing great demands on UNFPA and other UN agencies both in terms of technical expertise as well as resources. To illustrate, the experience has included capacity development activities geared towards the different needs and expectations of community leaders, service providers at women's centers, men and boys and women and girls.

"Capacity development is thinking together how best to solve a problem and improve the lives of citizens."

Zimbabwe's Female Condom Programme

1. Background

Since 2002, UNFPA serves as lead agency for the Inter-Agency Task Team on Comprehensive Condom Programming (IATT/CCP). The team's purpose is to enhance condom programming on behalf of the UN system and its partners. Within UNFPA's strategic framework, condom programming is viewed as a means of ensuring that every sexually active person at risk of STIs, including HIV, and/or unintended pregnancy is motivated to use male or female condoms, has access to good quality condoms when and where she or he needs them, and has the information and knowledge to use them consistently and correctly.

In 2005, UNFPA launched the *Female Condom Initiative* to increase the availability of and access to female condoms (FCs) and increase the demand for the commodity. Zimbabwe was one of the first countries to join the initiative. The FC was first introduced in Zimbabwe in 1997, following positive results from acceptability studies and a petition to government by 30,000 people, mostly women. The FC was intended not only to widen safer sex options but also as a tool to empower women to negotiate for safer sex and discuss other reproductive health issues with sexual partners.

2. Strategy

Introduction of the FC started with social marketing and a pilot project in the public sector. However, due to erratic supplies and limited strategic direction, the programme did not flourish. Recognizing the need for a more targeted marketing approach, UNFPA, in collaboration with the MoH, Zimbabwe National Family Planning Council and Population Services International, facilitated the formation of a Technical Support Group on Condom Programming in 2005. The interagency group assisted the government in the development of a five-year national male and female condom strategy based on a situation analysis.

Beyond training service providers, highly creative ways to educate the public about condom use

were employed. Billboards, radio spots and TV commercials helped break down taboos against talking about condoms, and thus helped overcome the stigma sometimes associated with them. Programme activities also included intensive social marketing of the FC through hair salons and training of hairdressers and barbers. The MoH, with UNFPA assistance, formed provincial and district condom programming support groups to facilitate the implementation of the strategy at community level, and worked with provincial and district chapters of women's organizations on community sensitization and mobilization and with provincial and district chapters of Men's Forum on Gender to make FCs acceptable in stable relationships. Also, the Zimbabwe National Family Planning Council, through its community-based distributors, informed women at grassroots level about risks, correct FC use and negotiation skills.

Simultaneously, a large-scale behavior change survey was undertaken to guide evidence-based programming on prevention of sexual transmission of HIV. This review showed that whereas significant strides had been made in making male condoms available and utilization in casual sexual relationships had increased significantly during the past 10 years, use of male condoms in stable relationships remained low. Review findings, together with recommendations from a national FC stakeholders meeting held in March 2006, were the basis for a five-year phased female condom strategy. The rationale for phasing the strategy was to facilitate a gradual move from uncoordinated targeted distribution to generalized distribution within the context of the national AIDS response and reproductive health programmes. In addition, phasing was intended to accommodate incremental capacity development while securing adequate resources and supplies, leading to universal access to FCs. The programme targeted women at high-risk for STIs, including those in stable relationships and engaging in inter-generational sex. However, it was recognized that male involvement was essential to promote FC use.

3. Progress

From 2005, when the strategy was launched, to 2009, FC distribution by the public sector in Zimbabwe increased six fold, from about 400,000 to almost 2.6 million. Most FCs were supplied for free. Sales of FCs through social marketing rose from about 900,000 to more than 2.1 million. Sales of male condoms also increased.

The impact is far-reaching: government figures estimate that HIV prevalence among adults in Zimbabwe had dropped below 14 percent by the end of 2009, from a high of more than 26 percent in 1997. HIV prevalence among young women, a good proxy indicator for the trend in new infections, declined even more steeply: from 24 percent in 1997 to 7 percent in 2009. Researchers attribute the decline in part to behavioral changes, including fewer sexual partners and high levels of condom use with casual partners.

A partnership was established between UNFPA and SUPPORT to prepare master trainers on male and female condom use, counseling and promotion, followed by cascade trainings of service providers. The curriculum and training materials were based on the Zimbabwe FC programme experience.

In addition, the model to market condoms through hairdressers was replicated in Malawi. Some 2400 hairdressers now sell and serve as advocates for the FC in that country.

4. Measuring progress and results

M&E is a participatory process involving all stakeholders.

5. Lessons learned

The campaign promoted the acceptance of FC as a contraceptive method of choice among couples. The process was shored up by the development of national enabling and evidence-based policies.

Successful aspects of the campaign include:

- Dedicated and committed leadership within the government to take this process forward facilitated the establishment of an enabling policy framework.
- The campaign has served as a model for other countries, such as Malawi and Zambia. Both countries have seen considerable increases in condom uptake.

Some challenges and next steps:

- The process requires time and dedication, and retaining highly qualified staff remains challenging.
- Building upon lessons learned, next steps include: conducting a baseline survey; costing the strategy; and developing a business plan, a human resource capacity strengthening plan, a FC commodity security plan and a promotion plan.

USEFUL RESOURCES & TOOLS

In the preceding chapter we saw how UNFPA country offices apply capacity development principles in different ways and towards different objectives. Developing national capacities is UNFPA's core strategy to advance the ICPD agenda whether the specific aim is to promote gender equality and human rights through the elimination of GBV; to ensure healthy SRH outcomes for young people; or to save the lives of pregnant women and mothers through better health systems. The take home message is that capacity development can and must be incorporated into every programme. The good news is that strengthening national capacities does not require complicated or unattainable approaches, but simply tweaking what we do now towards those ends.

In this chapter, we present some basic principles and considerations to enable us to plan, implement, monitor and evaluate effective capacity development programmes. Here we will discuss how developing capacities entails a change process; the various roles and responsibilities of actors within this process of change; and the main steps for planning capacity development interventions, such as conducting a thorough assessment early on.

We hope that the concrete examples presented in this guide coupled with the conceptual framework introduced at the beginning and the practical tips provided below will serve to demystify capacity development, making it easier for each one of us to incorporate it in our daily work.

What are the characteristics of a change process?[30]

Capacity development is a change process. This is true whether the aim is incremental improvements or comprehensive reform. Those wishing to foster and accelerate development must embrace change proactively, not just let it happen.

There are three fundamental requirements for change to occur: there must be *an enabling context, change management capacity* and *an inspiring vision*. Together, these three elements determine change readiness. Below we will take a closer look at each one.

An enabling context:

The drivers for change – both in the broader political, institutional and economic context and within organizations – must be stronger than the barriers to change. Change does not happen just because it is needed from a technical point of view. It happens when sufficiently powerful external and internal stakeholders are dissatisfied with the current situation and have incentives to invest in changing it. This explains why change in the private sector can be very successful in settings where public sector development is slow. Strong competition on prices and services creates strong incentives. Such strong incentives are rare in the public sector and, when incentives are weak, change can be slower, less comprehensive, or simply not happen.

Change management capacity:

Individuals affected by the change process must be convinced that those in charge are capable of enabling the process. Commitment and perseverance, for instance, help others become engaged and believe that positive changes will happen. Below is a list of questions that should be asked about the capacity of change teams:

- ✓ Who is in charge of managing reform and supervising the process?
- ✓ How committed are high-level decision-makers? Will they support the change process?
- ✓ Does the change team have adequate capacity in terms of leadership, clarity of goals and priorities, communication skills, technical competencies and logistical support?
- ✓ Will users, clients or customers be engaged in the reform process? Will the change team be able to reach out to users as needed?
- ✓ Are important stakeholders supportive? Can the change team influence them?

An inspiring vision:

The vision must be appealing and clearly address the question of *what is change for.* This requires a balance between boldness and realism, and a focus on tangible results that can be achieved within a reasonable timeframe. Staff, managers, politicians, decision-makers and external stakeholders will remain unimpressed by a vision that only promises to deliver years down the road. A vision that only focuses on internal or preliminary processes (e.g. staff trained or procedures revised) will not impress either.

The three elements must be in

balance: if "enablers" and change management capacity are limited, change will happen in smaller, incremental steps. On the other hand, across-the-board dissatisfaction and an inspiring vision will not lead to change without strong leadership and management capacity.

When considering how to balance the *change equation* it is important to recognize that the three elements are of a different nature: the vision can quickly be made more grandiose or reduced to business as usual. The drivers and constraints in the environment, on the other hand, change slowly over time. The change management capacity can be bolstered and expanded, but not always as quickly as desired.

Therefore, understanding the *enabling and constraining factors* and the *change management capacity* is the starting point for forming a realistic vision for developing capacities.

Roles in capacity development processes: Owners, stakeholders and helpers[31]

Capacity development processes take place inside individuals, organizations and systems. External partners can be process catalysts, but not leaders. Therefore, it is important to clearly define roles and carefully consider the nature of involvement in particular tasks.

Owners: Without owners, there will be no sustainable change, as there will be no drivers of change. The more these owners are in charge and involved in every phase, the better the chances that change will happen and solidify. There can be multiple owners. For example, developing opportunities for women to start a business may eventually be the task of every single district administration in a country, in close collaboration with women's organizations, micro-finance institutions and producers' associations. Owners can and do delegate tasks, but they cannot delegate the ultimate managerial and leadership responsibility.

Stakeholders: It is crucial to clarify who are the primary stakeholders, and when and how they should be involved. Activities can range from consultations to proactive participation during a particular phase. Stakeholders can own certain aspects, and owners can be stakeholders in other processes. Some of these roles will emerge during implementation, and change processes will have to adapt accordingly. However, not carefully planning stakeholder involvement can lead to failure.

External partners and facilitators: These include development partners, consultants and technical assistance providers. External partners can play an important role as brokers and technical advisers. However, experience shows that this works well and contributes to sustainable results only when leadership and managerial control remain in the hands of owners.

Actors in change processes must periodically assess their role and consider whether it continues to be appropriate and effective.

Key steps in the capacity development process[32]

As we learned from the real life examples described in the case studies, our preferred approach to capacity development is when *transformation* is generated and *sustained over time* and from *within.* Simply put, **if capacity is the means to plan and achieve, then capacity development is the way to those means.**

What are the barometers of capacity development? As mentioned in Chapter 1, UNFPA identifies three levels or entry points in which capacity is grown and nurtured: in an enabling environment, in organizations, and within individuals. Key to the UNFPA approach to capacity development is asking – and addressing – the right questions to ensure that the planned strategies are relevant to the context:

- ✓ **WHY** should we develop this particular capacity or set of capacities? To achieve what short- and long-term ends?
- ✓ **WHOSE** capacities should we foster? Who are the target groups or individuals that can have the most impact on the development goal we are trying to reach?
- ✓ **WHAT** types of capacities need to be developed to achieve the objectives? What kinds of capacities will have a stronger impact given the national context?
- ✓ **HOW** should we develop this particular capacity or set of capacities? Which approach should we take?
- ✓ **WHERE** should we start developing capacities? What is our most strategic entry point?
- ✓ **WHEN** should we start developing capacities? How is the political and social environment? Do we have enough funding commitment to achieve sustainable results? How do our initiatives fit with other development partners' plans and priorities?

The following steps are necessary to ensure that capacity development efforts lead to lasting changes and system-wide transformations:

STEP 1: Engage stakeholders. At the very beginning of the process, forge broadbased partnerships and foster multisectoral dialogue with all relevant stakeholders to ensure national ownership, leadership and commitment to the enterprise. This is the basis for sustainability. At this stage, define clear roles and responsibilities.

STEP 2: Assess capacity. What are the existing national capacities? What are the gaps that need to be addressed? What are the national priorities? What is the situation on the ground? Who else is doing what? What are the potential barriers to fully developing capacities within this context? Once the assessment is complete, share results with relevant counterparts to set realistic goals and baselines against which to measure progress later on.

STEP 3: Formulate a response. Based on the assessment,

determine what and whose capacities should be prioritized. Discuss with partners what strategies are most suitable to address gaps within the national context. Cost the strategies and develop a clear action plan, including a monitoring framework with indicators to measure progress. All strategies should strive to incorporate and build-on existing national systems and strengths.

STEP 4: Implement. Now that the planning is completed, it's time to rollout the capacity develop programme. Foment leadership by state institutions to ensure ownership. Rely on national resources and structures whenever possible. Develop an exit strategy. Measure progress periodically to change course or refine approaches as needed.

STEP 5: Evaluate. Measure results against the M&E framework developed earlier. Try to assess impact and changes in practices, values and attitudes at all relevant levels: individual, organizational and systemic. Share and discuss results widely to provide feedback to ongoing processes. Systematize the experience and the lessons learned so that these can be applied in other contexts and situations. attitudes at all relevant levels: individual, organizational and systemic. Share and discuss results widely to provide feedback to ongoing processes. Systematize the experience and the lessons learned so that these can be applied in other contexts and situations.

A closer look at capacity assessment[33]

Capacity assessment is one of the first steps in any capacity development initiative and is critical to planning and formulating sound and effective strategies. A capacity assessment provides an analysis of the capabilities and competencies of the main national actors responsible for development as well as of the underlying systems and structures. An assessment allows for the identification of priorities to be addressed and the existing resources to address them with. Compared to a needs analysis, it goes beyond identifying gaps in resources – whether human, physical or financial – to examine functional and technical capacities and core issues at the systemic, organizational and individual levels.

A "good" capacity assessment entails *active stakeholder involvement* and *a clear design*. It considers the following interrelated dimensions:

- **Functional capacities,** including situation analysis; policy design and strategy formulation; resources and budget allocation; project implementation; learning; and M&E.
- **Technical capacities:** capacities relevant to the specific sector or thematic context.
- **Core issues,** which include public sector accountability; access to information, knowledge and technology; inclusion, participation, equality and empowerment; and external or international relations.
- **Points of entry:** strategic opportunities at the environmental, organizational and individual levels.

A thorough capacity assessment:

- Identifies the key organizations and population groups that are most critical to the achievement of the specific development objectives under consideration.
- Identifies environmental and common capacity assets and needs as well as high-level organizational capacity assets and needs.
- Determines the need to conduct more detailed capacity assessments of specific organizations or groups as part the action plan.

Capacity assessments are *useful* in several ways as they:

- Support policy dialogue and strategy formulation as part of the analytical work that precedes development investments.
- Contribute to effective design of capacity development interventions by being integrated into diagnostic work used to design development programmes and projects.
- Enhance M&E by providing data for baselines necessary for tracking process and progress. Iterated assessments over time are the basis to improve capacity development programme design and effectiveness.
- Promote institutional learning and empowerment as an internal learning exercise.
- Can serve as tools to advocate for reform and transformation by fostering interest and desire to change for the better.

THE TEN MUST DO'S OF CAPACITY DEVELOPMENT

- **Don't rush.** Capacity development is a long-term process. Avoid delivery pressures, quick fixes and the search for short-term results.
- **Respect value systems and foster self-esteem.** The imposition of alien values can undermine confidence. Capacity development builds upon respect and self-esteem.
- **Scan locally and globally; reinvent locally.** There are no blueprints. Capacity development draws upon voluntary learning, with genuine commitment and interest. Knowledge cannot be transferred, it needs to be acquired.
- **Challenge mindsets and power differentials.** Capacity development is not power-neutral, and challenging mindsets and vested interests is difficult. Frank dialogue and a collective culture of transparency are essential steps.
- **Think and act in terms of sustainable capacity outcomes.** Capacity is at the core of development; any course of action needs to promote this end. Responsible leaders will inspire their institutions and societies to work accordingly.
- **Establish positive incentives.** Motives and incentives need to be aligned with specific capacity development objectives, including through governance systems that respect fundamental rights.
- **Integrate external inputs into national priorities, processes and systems.** External inputs need to correspond to real demand and be flexible enough to respond to national needs and agendas. Where national systems are not strong enough, they should be reformed and strengthened, not bypassed.
- **Build on existing capacities rather than creating new ones.** This implies the primary use of national expertise, resuscitation and strengthening of national institutions, as well as protection of social and cultural capital.
- **Stay engaged under difficult circumstances.** The weaker the capacity, the greater the need. Low capacities are not an argument for withdrawal or for driving external agendas. People should not be held hostage to irresponsible governance.
- **Remain accountable to ultimate beneficiaries.** Any responsible government is answerable to its people, and should foster transparency as the foremost instrument of public accountability. Where governance is unsatisfactory it is even more important to anchor development firmly in stakeholder participation and to maintain pressure points for an inclusive accountability system.

Source: Lopes C & Theisohn T, *Ownership, leadership and transformation: can we do better for capacity development?* (London, UK: UNDP, 2003), p.13.

ANNEXES

ANNEX 1: Resources and tools

Capacity assessment tools and methodologies

- *A Human Rights-Based Approach to Programming.* A practical implementation manual with training materials. UNFPA and Harvard School of Public Health, 2010.
- *UNFPA's Role in National Capacity Development: Technical Guidance Note*, 1 December 2009. Guidelines to inform UNFPA national programming processes by providing country offices with a number of principles and strategic options.
- *The Capacity Development Results Framework: A strategic and results-oriented approach to learning for capacity development.* The World Bank, June 2009. The framework is a step-by-step guide to assist the design, implementation, monitoring management, and evaluation of development programmes. It promotes a common, systematic approach to capacity development.
- *Technical Brief on UNDG Programming Principles: Capacity Development,* March 2009. This technical brief is intended to help practitioners quickly grasp the core messages of the UNDG programming principles and offers useful examples. The brief is revised on an ongoing basis to address emerging issues and new evidence.
- *Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages.* WHO, 2009.
- *UNDG Capacity Assessment Methodology – User Guide: for National Capacity Development,* 1 February 2008. The tool was developed to help United Nations Country Teams (UNCTs) assist national partners in analyzing their capacity assets and needs and designing capacity development strategies.
- *Enhancing the UN's Contribution to National Capacity Development: A UNDG Position Statement,* 21 December 2006. The document provides background information and a definition, and summarizes key messages about capacity development by the UN at country level. It assists UNCTs in integrating and mainstreaming capacity development in their common programming efforts.

For further reading

- *Strengthening country office capacity to support sexual and reproductive health in the new aid environment* (New York, USA: WHO and UNFPA, 2011). The report summarizes the assessment of the 2008-2011 UNFPA-WHO collaborative project and includes four case studies: Lao People's Democratic Republic, Malawi, Senegal and Tajikistan.
- *Good Practices.* A compilation of good practices selected according to the following criteria: relevance, innovation, impact and replicability. (New York, USA: UNFPA 2010).
- *ECOSOC Report 2010,* Chapter 3: "Contribution of United Nations operational activities to national capacity development and development effectiveness."
- *Recent Success Stories in Reproductive Health Commodity Security* (UNFPA, 2010).
- *NEPAD Capacity Development Strategic Framework* addresses capacity issues in thematic sectors and programmes in Africa, December 2010, www.nepad.org.
- *Capacity Development: A UNDP Primer.* (New York, USA: UNDP, 2009). The primer addresses the basic elements of the UNDP approach to capacity development focusing on smart institutions.
- *The Challenge of Capacity Building: Working Towards Good Practice* (Paris, France: OECD-DAC, 2006). An interesting summary of useful capacity development strategies and tools.
- "Amartya Sen's Capability Approach" as described in Sen, Amartya K. 1979. In Ross Harrison, ed., *Informational Analysis of Moral Principles*, Rational Action (Cambridge: Cambridge University Press, 1979), pp 115-132; and in his book *Development as Freedom* (New York, US: Knopf, 1999).

On-line resources

www.capacity.org
The website focuses on the policy and practice of capacity development within international development cooperation. It is designed with development researchers, practitioners and decision-makers in mind, and draws on publications, reports, viewpoints and experiences of individuals and organizations involved in capacity development work.

www.capacity.undp.org
UNDP's capacity development website provides information on a number of its flagship programmes and activities as well as links to various capacity development resources including publications, operational tools and partners.

www.oecd.org/dac/capacitydevelopment
This websites offers a wealth of resources on capacity development from an aid- and development-effectiveness perspective.

www.LenCD.org
Collection of very useful resources related to capacity development such as case studies, analyses, guidance tools and methodologies.

CIDA Network on Capacity Development
The Canadian International Development Agency's (CIDA) extranet site promotes sharing of capacity development experiences, information and analysis within the context of development cooperation. Requires user registration.

www.developmentgateway.org
The goal of the Development Gateway is to forge a broad network of individuals and organizations, made up of governments, civil society groups, think tanks, and other organizations. The website facilitates knowledge-sharing on capacity development experiences relevant to the MDGs. It includes news, data, publications, programmes, best practices, organizations, training tools and research.

www.hd-ca.org
The Human Development and Capability Association's website contains a host of resources, including educational material, research and grey literature, related to poverty, justice, and well-being. The user can also join thematic groups on specific development subjects. The aim is to foster interaction and to build an intellectual and policy community around issues of human development.

www.devinfo.org
DevInfo is a database for monitoring human development. It serves as a tool for organizing, storing and presenting data in a uniform way to facilitate data sharing at the country level across governments, UN agencies and development partners. Users can produce tables, graphs and maps for inclusion in reports, presentations and advocacy materials.

www.intrac.org
INTRAC promotes a multidimensional approach to capacity development. It links development practice with research, training and analysis and has a strong focus on participatory approaches.

ANNEX 2: Sample worksheet

Example: **National capacity development for UNFPA's priority assistance areas**

Area: **Strengthen national systems and management capacities in RHCS**

Institutional and systemic context:

Desired national capacities	Potential UNFPA support	Resources
A broadly representative, competent and functioning RHCS national coordination committee exists		
Civil society demand for RHCS is driven by factual, rights-based information and counseling		
A national budget line for RHCS is established		
National budgets dedicated to RHCS are periodically increased		
Registration procedures for new products are formalized and simplified		

Fragile states and post-conflict context:

Desired national capacities	Potential UNFPA support	Resources
A system is in place to meet the RHCS demands of displaced populations		

Organizational context:

Desired national capacities	Potential UNFPA support	Resources
Programme managers incorporate RHCS into SRH programmes, SWAPs and PRSPs		
A national RHCS Plan of Action is established, which covers inter alia, costing needs, analysis of funding gaps, flaws in the existing LMIS and market segmentation		
Quality of care of RHCS is ensured		
A forecasting, logistics and distribution system for RHCS is operational		
Pertinent institutions possess functioning units for handling procurement of RHCS		

Individual context:

Desired national capacities	Potential UNFPA support	Resources
Staff with the capacity to analyze supply and consumption data and financial requirements are employed in adequate positions		
Staff with the capacity to handle local procurement are employed in adequate positions		

NOTES

Introduction

1 DP/FPA/2011/11.

2 Based on the contribution of Ana Angarita from UNFPA/LACRO to "Conversations for a Better UNFPA."

The Capacity Development Lens: An Overview

3 The definition, adopted by the United Nations Development Group, originally appeared in: Organisation for Economic Co-operation and Development, The Challenge of Capacity Development: Working Towards Good Practice, DAC Guidelines and Reference Series, A DAC Reference Document (Paris, France: OECD Publishing, 2006), p 12. Available from www.oecd.org/dataoecd/51/50/40945568.pdf.

4 Adapted from United Nations Development Programme, Capacity Development: A UNDP Primer (New York, USA: UNDP, 2009) and Richard Morgan, The approach of UNICEF to Capacity Development, Informal Session of the UNICEF Executive Board, 21 October 2010.

5 United Nations Development Group, Enhancing the UN's contribution to National Capacity Development: A UNDG Position Statement, October 2006. Available from www.un.org/esa/cdo/documents/UNDG_PositionPaperCD_21_Dec_2006.pdf.

6 A/RES/62/208, paras. 35-47, 14 March 2008.

7 Based on contributions by Ana Angarita from UNFPA/LACRO and Caspar Peek from UNFPA/APRO.

8 DP/FPA/2007/17.

9 Reinforcing state capacity: A harmonized United Nations system approach to national capacity development. Background document. Joint Meeting of the Executive Boards of UNDP, UNFPA, UNICEF and the World Food Programme, New York, 23-26 January 2009.

10 DP/FPA/2011/11.

11 Ibid, p 13.

12 See Report of the Executive Director: Midterm review of the UNFPA strategic plan, 2008-2013 (DP/FPA/2011/11) for details on indicators and targets.

13 Adapted from The New Partnership for Africa's Development, Capacity Development Guidance Note No. 2: Addressing Capacity Issues in Thematic Sectors and Programmes (December 2010).

14 See chapter on capacity development in From Policy to Practice: UNFPA's Role in the Changing Aid and Development Environment, Guidance Note on Aid Effectiveness Policies and Procedures Manual (Programme) (New York, USA: UNFPA, 2009).

15 Based on the contribution of Caspar Peek from UNFPA/APRO to "Conversations for a Better UNFPA."

16 United Nations Population Fund, From Policy to Practice: UNFPA's Role in the Changing Aid and Development Environment, Guidance Note on Aid Effectiveness Policies and Procedures Manual (Programme) (New York, USA: UNFPA, 2009).

17 LACRO is documenting capacity development best practices from Colombia, Guatemala, Jamaica, Mexico and Venezuela.

Learning from the Field: Capacity Development in Practice

18 Ministry of Health of Guyana, Guyana Behavioral Surveillance Survey, 2005.

19 Ministry of Health of Guyana, Responsible Parenthood Association, and ORC Macro, Guyana HIV/AIDS Indicator Survey 2005 (Calverton, USA: Ministry of Health, GuyanaResponsible Parenthood Association, and ORC Macro, 2006). Available from www.measuredhs.com/pubs/pdf/AIS4/AIS4.pdf.

20 For more information on "Investing in Midwives and others with Midwifery Skills," please visit www.unfpa.org/public/mothers/pid/4384.

21 The call for action was endorsed by the following partners: UNFPA, ICM, WHO, UNICEF, the World Bank, Jhpiego, the Global Health Workforce Alliance and the International Federation of Gynecology and Obstetrics.

22 World Health Organization, "Health System Organization," in Health System Profile-Djbouti, Regional Health Systems Observatory, Eastern Mediterranean Regional Office. Available from gis.emro.who.int/HealthSystemObservatory/PDF/Djibouti/Health%20system%20organization.pdf.

23 United Nations Secretary-General, Ending violence against women: From words to action (UN, 2006).

24 A/RES/61/143.

25 For more information, please visit www.un.org/womenwatch/ianwge/taskforces/tf_vaw.htm.

26 Please visit www.srhhivlinkages.org for a complete list of partners, countries that applied the tool and assessment reports.

27 Republic of Kenya, Kenya Census 2009.

28 Kenya National Bureau of Statistics and ICF Macro, Kenya Demographic and Health Survey 2008-09 (Calverton, USA: KNBS and ORC Macro, 2010). Available from www.measuredhs.com/pubs/pdf/FR229/FR229.pdf.

29 National AIDS and STI Control Programme, Ministry of Health, Kenya, Kenya AIDS Indicator Survey 2007: Final Report (Nairobi, Kenya: Republic of Kenya, September 2009).

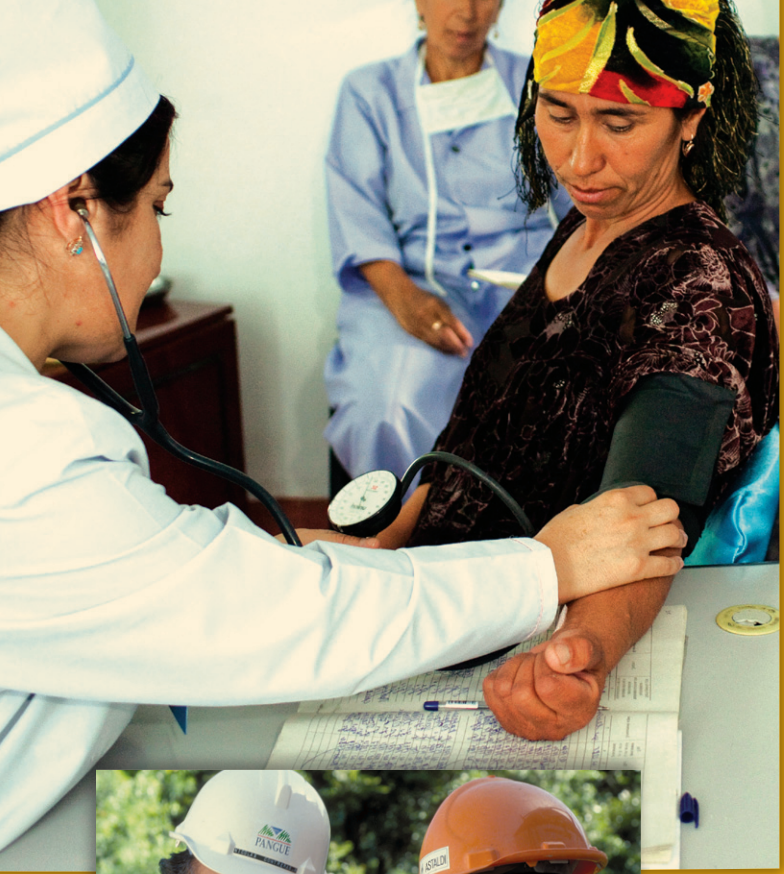
Useful Resources and Tools

30 Adapted from The New Partnership for Africa's Development, Capacity Development Guidance Note No. 2: Addressing Capacity Issues in Thematic Sectors and Programmes (December 2010).

31 Ibid.

32 This section was adapted from United Nations Development Programme, Capacity Development: A UNDP Primer (New York, USA: UNDP, 2009).

33 This section was adapted from United Nations Development Group, UNDG Capacity Assessment Methodology – User Guide: for National Capacity Development (1 February 2008).



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