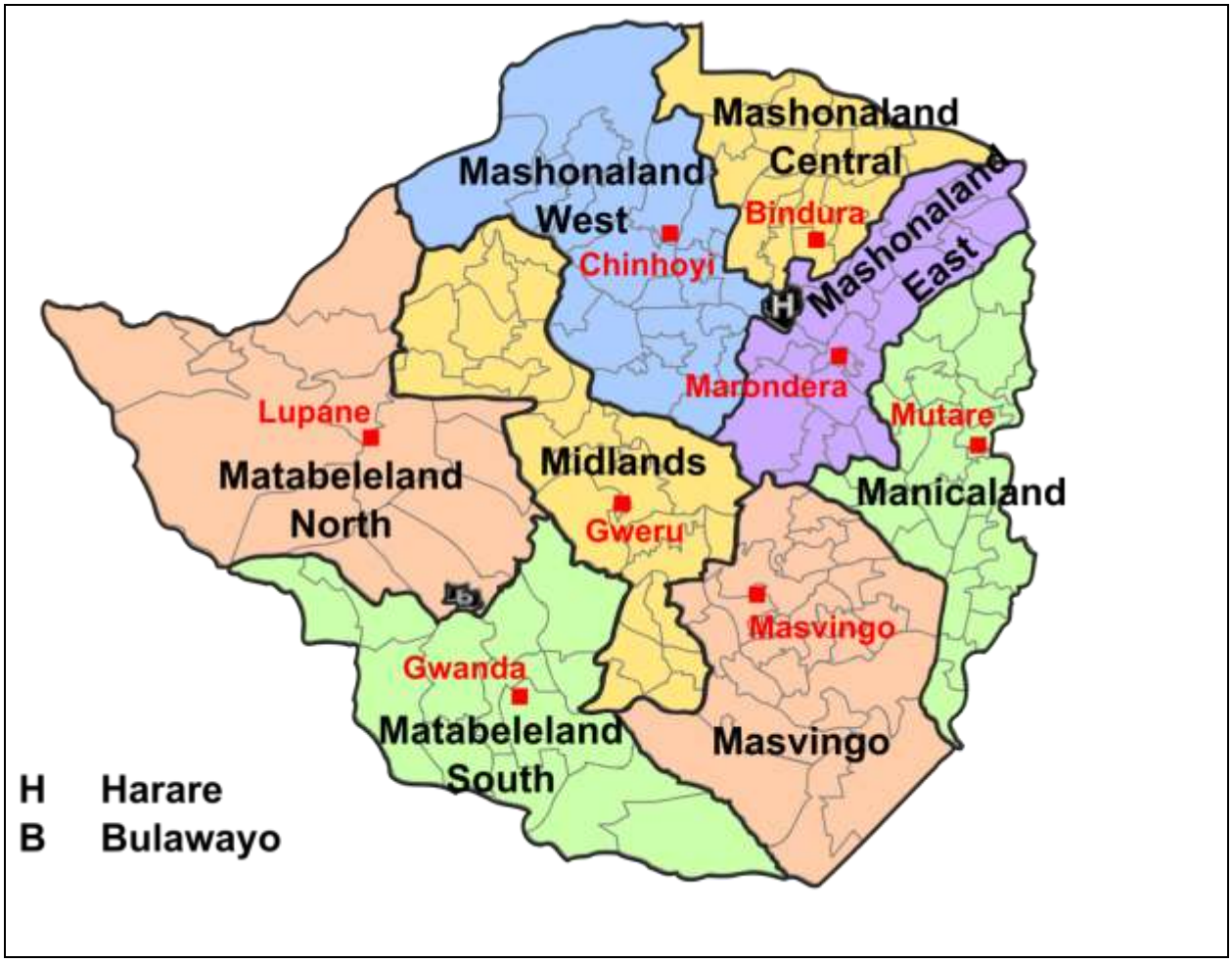
End of the Government of Zimbabwe & UNFPA 6th Country Programme (2012-2015) Evaluation

October 2014

Map of Zimbabwe



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Abbreviations and Acronyms

ADVC	Anti-Domestic Violence Council
AfriYAN	African Youth and Adolescents Network
AIDS	Acquired Immune Deficiency Syndrome
AR	Annual Report
ARC	Anti-Rape Clinic
ART	Antiretroviral Therapy
AWP	Annual Work Plan
ASRH	Adolescent Sexual and Reproductive Health
ASRHR	Adolescent Sexual and Reproductive Health and Rights
BCF	Behaviour Change Facilitator
BEmONC	Basic Emergency Obstetric and Neonatal Care
BRTI	Biomedical Research and Training Institute
CAP	Consolidated Appeal Process
CARMMA	Campaign on Accelerated Reduction of Maternal Mortality in Africa
CBO	Community Based Organisation
C(B)HW	Community (Based) Health Worker
CCM	Country Coordinating Mechanism (of Global Fund)
CIDA	Canadian International Development Agency
CO	Country Office
CAP	Consolidated Appeal Process
CCA	Common Country Assessment
CeSHHAR	Centre for Sexual Health and HIV and AIDS Research (Zimbabwe)
CP	Country Programme
CPAP	Country Programme Action Plan
CPD	Country Programme Document
CPE	Country Programme Evaluation
CPR	Contraceptive Prevalence Rate
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organisation
DANIDA	Danish International Development Assistance
DfDWG	Data for Development Working Group
DfID	Department for International Development (UK)
DNO	District Nursing Officer
DV	Domestic Violence
DVA	Domestic Violence Act (2007)
EA	Enumeration Area
EM	Evaluation Manager
EmONC	Emergency Obstetric and Neonatal Care
eMTCT	Elimination of Mother to Child HIV Transmission
ePMS	Electronic Patient Monitoring System
ERG	Evaluation Reference Group
ET	Evaluation Team
EU	European Union
FACT	Family AIDS Caring Trust
FGD	Focus Group Discussion
FP	Family Planning
FSW	Female Sex Worker
GBV	Gender Based Violence
GDP	Gross Domestic Product
GE	Gender Equality
GIS	Gender Information System

GM	Gender Mainstreaming
GoZ	Government of Zimbabwe
GPRHCS	Global Programme for enhancing Reproductive Health Commodity Security
HIV	Human Immunodeficiency Virus
HMIS	Health Monitoring Information System
HTC	HIV Testing and Counselling
HTF	Health Transition Fund
ICP	International Cooperation Partner
ICPD	International Conference on Population and Development
ILO	International Labour Organization
IP	Implementing Partner
ISP	Integrated Support Programme
JIM	Joint Implementation Matrix
KI	Key Informant
LEEP	Loop Electrosurgical Excision Procedure
M&E	Monitoring and Evaluation
MAC	Matabeleland AIDS Council
MASO	Midlands AIDS Service Organisation
MC	Male Circumcision
MDGs	Millennium Development Goals
MMR	Maternal Mortality Rate
MNH	Maternal and Neonatal Health
MoEPIP	Ministry of Economic Planning and Investment Promotion
MoHCC	Ministry of Health and Child Care (post elections in 2013)
MoHCW	Ministry of Health and Child Welfare (pre elections in 2013)
MWAGCD	Ministry of Women Affairs, Gender and Community Development
MWH	Maternity Waiting Home
MSM	Men having Sex with Men
MTCT	Mother to Child HIV Transmission
MTP	(Zimbabwe) Medium Term Plan
MYIEE	Ministry of Youth, Indigenisation, and Economic Empowerment
NAC	National AIDS Council
NBSLEA	National Baseline Survey on Life Experiences of Adolescents
NPA	National Priority Area
NGO	Non-Governmental Organisation
NHS	National Health Strategy
NIP	National Indicative Programme (of EU)
NPA	National Priority Area
NRHP	National Reproductive Health Policy
OECD	Organisation for Economic Cooperation and Development
OR	Operations Research
PCR	Polymerase Chain Reaction
PDU	Population and Development Unit
PE	Peer Educator
PES	Post-Enumeration Survey
PME	Programme Management and Evaluation
PMTCT	Prevention of Mother to Child HIV Transmission
PNO	Provincial Nursing Officer
PrEP	Pre-Exposure Prophylaxis
PSI	Population Services International
RDS	Regai Dzive Shiri
RBM	Results Based Management
RGN	Registered General Nurse
RH	Reproductive Health
RHCS	Reproductive Health Commodity Security

RHU	Reproductive Health Unit
RRF	Results and Resources Framework (CPAP)
SAYWHAT	Students and Youth Working on Reproductive Health Action Team
Sida	Swedish International Development Assistance
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STERP	Short Term Emergency Relief Programme
SW	Sex Worker
TB	Tuberculosis
TFR	Total Fertility Rate
UN	United Nations
UNAIDS	United Nations Joint Program on AIDS
UNCT	United Nations Country Team
UNDP	United Nations Development Programme
UNESCO	United Nations Education, Scientific and Cultural Organisation
UNEG	United Nations Evaluation Group
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
UNODC	United Nations Office for Drugs and Crime
UZ	University of Zimbabwe
VAW	Violence Against Women
VIAC	Visual Inspection with Acetic Acid plus Cervicograph
VMMC	Voluntary Medical Male Circumcision
WAG	Women's Action Group
WHO	World Health Organization
WLSA	Women and Law in Southern Africa
ZAPP	Zimbabwe AIDS Prevention Project
ZAPSO	Zimbabwe AIDS Prevention Service Organisation
ZDHS	Zimbabwe Demographic and Health Survey
ZiCHIRE	Zimbabwe Community Health Intervention Research Project
Zim Asset	Zimbabwe Agenda for Sustainable Socio-Economic Transformation
ZIMDAT	Zimbabwe National Statistics Data Base
ZIMSTAT	Zimbabwe National Statistics Agency
ZLHR	Zimbabwe Lawyers for Human Rights
ZNASP	Zimbabwe National AIDS Strategic Plan
ZNFPC	Zimbabwe National Family Planning Council
ZUNDAF	Zimbabwe UN Development Assistan**ce** Framework
ZWLA	Zimbabwe Women Lawyers Association
ZYC	Zimbabwe Youth Council

Key Facts Table: Zimbabwe

Land	
Geographical location	Southern Africa, between South Africa and Zambia, also between Limpopo and Zambezi Rivers
Land area	390,757 sq km
Terrain	Mostly high plateau with higher central plateau (high veld); mountains in east
Geographic coordinates:	20 00 S, 30 00 E
People	
Population	13 061 239 (ZIMSTAT, 2012 Census)
Urban population	32.8% (ZIMSTAT, 2012 Census)
Annual Population Growth Rate	1.1% (ZIMSTAT, 2012 Census)
Government	
Government	Republic
Key political events	Independence 1980
Seats held by women in national parliament, percentage	11% (ZIMSTAT, 2012 Census)
Economy	
GDP per capita	$600 (2013 est. from World Bank, 2013)
GDP Growth rate	1.8% (World bank 2013)
Main industries	Mining (coal, gold, platinum, copper, nickel, tin, diamonds, clay, numerous metallic and nonmetallic ores), steel; wood products, cement, chemicals, fertilizer, clothing and footwear, foodstuffs, beverages
Social indicators	
Human Development Index Rank	187 (MDG Progress Report 2012)
Human Development Index	0.376 (MDG Progress Report 2012)
Unemployment	11.7 (employment includes informal sector)
Life expectancy at birth	58 years (ZIMSTAT, 2012 Census)
Under-5 mortality (per 1000 live births)	84 per 1000 (MDG Progress Report 2012)
Maternal mortality ratio (deaths of women per 100,000 live births)	960/100,000 live births in 2010/11 (MDG Progress Report 2012)
Births attended by skilled health personnel, percentage	66% (2010/11 ZDHS)
Total fertility rate	3.8 (Census 2012)
Adolescent fertility rate (births per 1000 women aged 15-19)	115 (2010/11 ZDHS)
Condom use to overall contraceptive use among currently married women 15-49 years	3.1% (2010/2011 ZDHS)

Contraceptive prevalence rate	58.5% (2010/11 ZDHS)
Unmet need for family planning (% of women in a relationship unable to access)	13% (2010/11 ZDHS)
People living with HIV, 15-49 years, estimated number	1,214,126 (including 162,889 children) (MDG Progress Report 2012)
Adult literacy (% aged 15 and above)	99.0% (MDG Progress Report 2012)
Total net enrolment ratio in primary education, both sexes	81.4% in 2011 (MDG Progress Report 2012)
Millennium Development Goals (MDGs): Progress by Goal	
1 - Eradicate Extreme Poverty and Hunger	Unlikely to be achieved by 2015 (MDG Progress Report 2012)
2 - Achieve Universal Primary Education	Likely to be achieved by 2015 ((MDG Progress Report 2012)
3 - Promote Gender Equality and Empower Women	Unlikely to be achieved by 2015. (MDG Progress Report 2012)
4 - Reduce Child Mortality	Can potentially be achieved by 2015 (MDG Progress Report 2012)
5 - Improve Maternal Health	Unlikely to be achieved (MDG Progress Report 2012)
6 - Combat HIV/AIDS, Malaria and other Diseases	Target 6A on HIV likely to be achieved by 2015 if current efforts continue (MDG Progress Report 2012) Targets 6B and 6C can potentially be achieved by 2015 (MDG Progress Report 2012)
7 - Ensure Environmental Sustainability	Target 7A & 7B can potentially be achieved by 2015 (MDG Progress Report 2012) Target 7C is likely be achieved by 2015 (MDG Progress Report 2012) Target 7D unlikely to be achieved by 2015 (MDG Progress Report 2012)
8 - Develop a Global Partnership for Development	Targets 8A, 8C, 8D, 8E unlikely to be achieved by 2015. (MDG Progress Report 2012) Target 8F can potentially be achieved by 2015 (MDG Progress Report 2012)

Executive Summary

1. Purpose: The UNFPA Country Office of Zimbabwe commissioned this CPE in order to:

a) Assess the progress towards achieving the Country Programme Action Plan (CPAP) outputs and outcomes to fulfill the accountability and learning functions of evaluation;
b) Analyse factors facilitating or inhibiting the achievement of results in order to document lessons and make recommendations for the 7th Country Programme.

The target audience for the evaluation is decision makers within UNFPA and the Executive Board, Government counterparts in Zimbabwe and other key development partners.

2. Country Programme Overview and Overall and Specific CPE Objectives: The four-year CP 2012-2015 is aligned to identified population needs in Zimbabwe. It responds primarily to Millennium Development Goals 3 (gender equality), 4 (infant mortality), 5 (maternal morbidity and mortality) and 6 (HIV prevention). CP outputs contribute to four outcomes: 1) Increased utilization of comprehensive gender-sensitive and youth-friendly reproductive health services; 2) Increased adoption of safer sexual behaviour and use of HIV prevention services; 3) Increased availability and utilization of disaggregated data at national and subnational levels; 4) An improved policy and legal environment for gender equality and increased utilization of gender-based violence services. Key vulnerable groups in focus are adolescents, women and female sex workers.

The overall objectives of the evaluation were to:

a) Independently assess progress of the 6th CP towards expected outputs and outcomes as set out in the CPAP RRF, with particular attention to: the extent to which activities were carried out as planned and targets met; programme management effectiveness and efficiency; the relevance, effectiveness, efficiency and sustainability of the 6th CP.
b) Assess CO positioning within the development community and regarding national partners; to respond to national needs in adding value to country development results; and to assess the coordination, leadership and management of the CP.
c) Identify challenges, lessons learned and good practice in the 6th CP to contribute to development of the 7th CP, and to refine the remaining months of the current CP.

The CPE covers CO strategic positioning, management and CPAP activities from 1st January 2012 to 30th June 2014. It focuses on the national, provincial and district level with UNFPA-funded projects for reproductive health, HIV prevention, gender, and population and development. It includes cross-cutting aspects, notably human rights, gender mainstreaming, coordination and partnerships, and overall responsiveness, and focuses on programme synergies. The primary evaluation criteria are relevance, effectiveness, efficiency, sustainability, and organizational systems and resources.

3. Methodology of the Country Programme Evaluation: The terms of reference (ToR) set out the methodology and align to UN criteria and DOS requirements of the UNFPA revised 2013 Handbook. An Evaluation Reference Group was drawn from stakeholders to inform the consultant ToR and provide oversight; for consultant recruitment; and three main phases of work prior to submission of the final report to the UNFPA Regional Office and to headquarters for comment and validation. Phase One involved developing a design report through document review and key informant interviews, and obtaining CO and ERG endorsement. It included stakeholder mapping, setting up field work schedules, and developing evaluation tools. Phase Two involved data capture through further extensive document review, key informant interviews, focus group discussions, and observations from site visits. Phase Three involved data analysis and triangulation, drafting the first report and including CO feedback; presenting to the ERG and stakeholder validation meeting, and finalising the report.

4. Main Conclusions

4.1 Strategic Positioning, Management and Monitoring and Evaluation: Throughout all areas of its mandate, UNFPA appears effectively and strategically positioned to contribute to national priorities, and to the quality of life of the Zimbabwean people. The CO works closely with GoZ

regarding policy and strategy development as well as in capacity strengthening through support for coordination posts in health and extensive health provider training. It has responded to GoZ needs by undertaking a much-valued fund management role while direct donor disbursement has been unavailable. UNFPA is a credible partner within the UN system and amongst donors. The CO has mobilised and managed external funds three times higher than in the previous CP, greatly expanding programming. Its positioning is appropriate with regards the UN division of labour and the UNFPA Strategic Plans. UNFPA has extensive linkages with civil society organisations and, through them and trained community cadres, solid reach into communities to raise awareness, influence social and behaviour change, and generate demand. UNFPA is responsive to Government and country needs, with a human rights focus throughout but insufficient gender mainstreaming across programmes.

UNFPA internal and external coordination and communication, efficiency, monitoring and evaluation, however, have faced challenges, largely linked with rapid escalation of programmes and projects vis-á-vis staff capacity. Also, results based management is insufficient, with the RRF having weak results chain logic in various areas, and inadequate indicators for measuring contributions to outcome let alone impact results, or to track effectiveness and efficiency of programming. This has resulted in a tendency for units to work in silos; for insufficient monitoring of implementing partners (IPs) to identify poor performance early and provide support; non-standardisation of quality assurance within the office; and insufficient results based management and planning to ensure robust results chain logic. CPAP indicators tend merely to measure process rather than tracking results that measure the quality or intensity of programming to contribute significantly to outcomes.

With regards sustainability of results, the contributions of UNFPA to key policies and strategies, to facility refurbishment, and achievement of crucial surveys (census and upcoming DHS) should have sustainable results; and, to a lesser extent, so may some training. However, until the national socio-economic situation substantially improves, maintaining facilities and equipment, procurement, further training and mentoring, and coordination posts in the MoHCC will not be sustainable without external support, and exit strategies are not evident. Gains in gender equality and to reduce GBV are unlikely to be sustained without continued and scaled up efforts by UNFPA and other partners.

4.2 Reproductive Health: Population indicators for several areas of RH remain adverse (e.g. for maternal mortality, cervical cancer, stagnating contraceptive prevalence and adolescent pregnancy). The CP response addressed limited capacity in the health system through support for extensive health provider training in different areas; funding coordinating positions in MoHCC and the National AIDS Council (NAC); procurement; and refurbishment of facilities including maternity waiting homes. Community demand generation was developed through door to door home visits and clubs for vulnerable adolescent girls run by behaviour change facilitators (BCFs), through peer educators and other modalities. Most activities were behind schedule in 2012, particularly owing to funding delays, but are largely on track by mid 2014. External funding for integrated services and for RH and HIV expanded significantly in the 6th CP. Activities in 2012/13 included extensive support for policy and strategy development, and for guidelines and manuals, exceeding targets by 2014.

Various challenges arose in RH. Multiple activities are in place for adolescents across all five areas of the global and regional youth strategy of UNFPA but in the youth friendly corners, service uptake remains low, monitoring is poor, and it is unclear that international guidelines for YFS are followed. Cervical cancer screening services are in high demand, but benefits are limited to treating early pre-cancerous conditions. UNFPA support to reduce maternal morbidity and mortality is not at scale for sufficient impact, although health provider training, support for maternity waiting homes and procurement efforts are in place. The H4+ pilot project to strengthen maternal and neonatal care in six districts will provide lessons for expanded scale up in the 7th CP. Finally, although extensive training is underway in the MoHCC with UNFPA technical and financial support (including for family planning, STI management, integrated services, emergency obstetric and neonatal care, and some for youth friendliness), the outcome of training on sustained improvements in service provision is insufficiently assessed. As noted earlier, insufficient operations research and poor results chain logic impede analysis of the effectiveness of programmes to achieve intended results.

4.3 HIV Prevention: The HIV prevention focus was fully aligned to Zimbabwe needs and policy, and to the combination HIV prevention approach. UNFPA contributed to these and also to extensive service guidelines and tools on integrated services, and health provider training on integration. It addressed relevant vulnerable populations of adolescents and sex workers, with outreach to households to generate service demand, Sista2sista clubs for at risk adolescent girls noted above, and some awareness generation among community leaders. The Linkages Project (three centres of excellence in national institutions) is increasing cross referral for HIV and RH services. UNFPA reached most output targets but evidence for higher results is lacking. The sex work programme has come to scale in 26 districts, increasing RH service uptake including for HTC, STI treatment and condoms, and UNFPA is supporting strategic pilot research to inform future policy. Regarding elimination of mother to child HIV transmission (eMTCT), UNFPA support for Prongs 1 and 2 is not considered sufficient, and jointly with UNICEF, UNFPA is assisting Government on eMTCT strategy. Voluntary medical male circumcision (VMMC) roll out was not on track and is now supported by other partners while UNFPA concentrates on discussions, demand generation and further research, having contributed to key VMMC research during the 6th CP.

4.4 Gender Equality: The gender equality component maintains a special focus on prevention and response to gender based violence. The evaluation found that UNFPA's GE programme has been the mainstay of efforts to end GBV in Zimbabwe. Its policy level support to institutions such as the Anti-Domestic Violence Council, as well as information dissemination on various laws and policies, has been invaluable. More effort is required by UNFPA to support coordination at different levels while capacitating the National Machinery for Women's Advancement and other key ministries within the multi-sectoral response with requisite skills to lead and champion efforts to end GBV. In addition, UNFPA has not fully exploited the consortium of IPs by ensuring strategic release into communities, peer review as well as collective response to emerging issues. Within the UNCT, UNFPA has the mandate to lead on GBV and ensure a coordinated UN system response to GBV and in relating to Government and other partners. The evaluation found that there is insufficient synergy between the SRH and GBV components of the GE programme and it is imperative that in the next country programme UNFPA strengthen this SRH and GBV link. Critically, the CO lacks staff capacity for strong M&E of the GE programme and has an imbalance in regional representation of IPs. Finally, the GE Programme is funded 10 percent from core funds and 90 percent through external resources, making it highly vulnerable when the current donor funding ends in 2015.

4.5 Population and Development: The 2012 Population Census was the main P&D focus in the 6th CP, with successful action to mobilise resources: UNFPA raised USD12.8 million, four times the target. UNFPA supported activities to ensure the reliability of results, including a mapping exercise, training field staff, training programming staff and supervisory visits during enumeration. A Post-Enumeration Survey was undertaken immediately after the Census to check reliability and validity. UNFPA supported ZIMSTAT to operationalize the National Statistical System, populating ZIMDAT with population data for wide user access. UNFPA also supported the undertaking and subsequent analyses of the 2010/2011 ZDHS and the leveraging of funds for the 2015 ZDHS. UNFPA has proactively supported ZIMSTAT to address skills gaps through short-term consultants, although more capacity development is needed. A weak area, however, was low levels of support to the Population Development Unit for the ICPD PoA, integrating population into development, apart from support to prepare the ICPD@20 Report. UNFPA has consistently ensured commemoration of World Population Day to raise public awareness. Despite UNFPA support, integration of population into development planning remains insufficient, requiring more intensive support in future.

5. Recommendations

5.1 Strategic Positioning, Management and Monitoring and Evaluation: Although UNFPA is strategically positioned, the agency needs to: i) prioritise more effectively, strengthen its internal and external coordination to improve efficiencies, and complete key office recruitment.; ii) measure programme effectiveness and efficiency to assess intended results and demonstrate value for money

through a more robust and coherent RRF and results chain logic; iii) review and ensure capacity, particularly in the M&E Unit to deliver on operations research and evaluation at the level required in light of the greatly increased monitoring work load; iv) explore mechanisms to streamline work flow, acknowledge bottlenecks and strengthen inter-unit collaboration and communication to achieve greater synergies within the CO; v) regarding M&E of IPs, standardize criteria for approving quarterly and annual reports.

5.2 Reproductive Health: UNFPA should i) Continue the same broad focus for RH as the needs remain largely the same, but prioritise responses more strategically utilizing evidence-informed approaches with potential to contribute to stronger outcome and impact results, and ensuring effective evaluation to measure results beyond the process level including for the Integrated Support Programme (ISP) activities in 26 districts; ii) utilize findings from H4+ and operational research greatly to strengthen maternal and neonatal care; iii) prioritise the most vulnerable populations in the most-needy districts for programme scale up and intensify programmes that work; iii) be bold and innovative in reconceptualising strategies for adolescent SRH regarding both modalities and implementing partners, learning from ongoing research and assessing how current practice meets international guidelines; iv) continue support to prevent cervical cancer and contribute to policy discussions on treatment.

5.3 HIV Prevention: UNFPA should: i) maintain broadly the same priorities, activities and target populations for combination HIV prevention, but influenced by stronger operations research to demonstrate results and with ongoing responsiveness to emerging evidence for new approaches, needs and technologies for prevention; ii) strengthen Prongs 1 and 2 for eMTCT based on the new eMTCT strategy; iii) assess the efficiencies and effectiveness of integrated programming, ISP-funded activities and, particularly, the Linkages Project, and strengthen integration at different levels of the health system; a time and motion study of ANC/eMTCT services could increase efficiencies; iv) develop closer links with organisations supporting HIV+ adolescents and young people, with BCFs, peer educators and health providers trained further on the Positive Health, Dignity and Prevention agenda; v) expand support for the female sex work programme including support for research; vi) continue support for VMMC at strategic and research levels, with demand generation strengthened throughout HIV and RH programming.

5.4 Gender Equality: UNFPA should: i) support the national machinery to convene policy dialogue between key Government ministries and departments to increase policy commitment and collective actions towards ending GBV; ii) support coordination at different levels to strengthen community capacity and actions against GBV; iii) use its comparative advantage for SRH in the UN to address GBV within SRH programmes to a minimum accountable standard; iv) assist GoZ to develop capacity to prevent GBV in humanitarian settings; v) invest in partner consultation to explore wider strategies to prevent GBV within an evidence-baed strategic framework; vi) strengthen capacity for results based programme management for the GE programme and for partners; vii) undertake an internal gender audit of gender mainstreaming across programmes; viii) explore new funding sources in the context of the heavily donor funded GBV programme; ix) ensure regional balance of CSO IPs.

5.5 Population and Development: UNFPA should: i) support ZIMSTAT to generate population data and integrate them into development planning through capacity building via consultants, skills transfer and training, and through producer-user workshops, awareness raising among policy makers and the public, and contributing to evidence-based research; ii) intensify support for the PDU to clarify its mandate and operationalize the ICPD PoA through developing a strategic plan guided by an inter-ministerial committee; iii) develop capacity in a selected institution to provide training in population and development; iv) support operations research and integration of population issues into Zim Asset through policy dialogue, a clear action plan, and repackaging data for different audiences.

Chapter 1: Introduction

1.0 Background

The End of Country Programme Evaluation (CPE) for the Government of Zimbabwe/UNFPA 6th Country Programme (2012-2015) has been commissioned by the UNFPA Country Office (CO) in line with UNFPA global policy requirements. It has been scheduled to ensure that the results and recommendations are available in time to influence the next country programme. The primary users of the evaluation are the decision-makers within UNFPA and the Executive Board, Government counterparts in Zimbabwe and other key development partners.

1.1 Purpose and Objectives of the Country Programme Evaluation

The main purpose of the Country Programme Evaluation (CPE) is two-fold:

a) To assess the progress of the UNFPA 6th Country Programme (CP) for Zimbabwe towards achieving the Country Programme Action Plan (CPAP) outcomes and outputs, thus fulfilling the accountability and learning functions of evaluation
b) To analyse factors facilitating or inhibiting the achievement of results in order to document lessons and make recommendations for the 7th Country Programme.

The CPAP is for four years, aligned with the Millennium Development Goals target date of 2015, with the evaluation taking place in year three with 15 months remaining; therefore some recommendations relate to the remainder of the current CP. The objectives of the CPE are:

a) To provide an independent assessment of the 6th CP's progress towards expected outputs and outcomes as set out in the CPAP Results and Resources Framework, with special attention to:
    i. The extent to which activities were carried out as planned and targets met
    ii. Programme management effectiveness and efficiency
    iii. The relevance, effectiveness, efficiency and sustainability of the 6th CP.
b) To assess CO positioning within the development community and regarding national partners to respond to national needs in adding value to country development results; and to assess the coordination, leadership and management of the CP.
c) To identify challenges, lessons learned and good practice in the 6th CP to contribute to development of the 7th CP, and to refine the remaining months of the current CP.

1.2 Scope of the Evaluation

The CPE covers the CO strategic positioning, management and CPAP activities during the 30-month period from 1st January 2012 to 30th June 2014. It focuses on the national level, provinces and selected districts with UNFPA-funded projects, focusing on the four technical areas of reproductive health, HIV prevention, gender, and population and development. It includes cross-cutting aspects, notably the human rights based approach, gender mainstreaming, coordination and partnerships, and focuses on integration of different programme areas and related synergies. The design of the evaluation questions is guided by the need to show that the 6th CP has contributed to improving the quality of life in Zimbabwe, especially for vulnerable cohorts of women, young people and female sex workers, in the thematic areas. Each area includes an overarching note and thematic strategic positioning.

The primary evaluation criteria include relevance, effectiveness, efficiency, sustainability, and the organizational systems and resources to achieve results. The timeframe of the CP is too short, at 30 months, to undertake impact evaluation, and the CPE focuses on outputs and short-term outcomes to which UNFPA contributed, although specific attribution to UNFPA inputs remains challenging. The CPE utilized standard evaluation criteria by the UN Evaluation Group (UNEG)/Organization for Economic Cooperation and Development (OECD), and the evaluation ToR (annexed). The evaluation corresponds to the Department of Oversight (DOS) requirements in the revised 2013 UNFPA Handbook on CPEs. Table 1.1 provides evaluation criteria and key questions addressed.

Table 1.1: Evaluation Criteria and Key Questions

Definition and Application	Evaluation Questions
Evaluation Criterion: Relevance	
The extent to which the objectives of the UNFPA country programme correspond to population needs at country level (in particular those of vulnerable groups), and were aligned throughout the programme period with government priorities and with strategies of UNFPA	1. How did the 6th CP address the needs of the population of Zimbabwe in relation to reproductive health, HIV prevention, population and development and GBV service provision? 2. How are the strategic actions, outputs and indicators of the 6th CP contributing to the strategic priorities of the Zimbabwe national development plan and ZUNDAF?
Evaluation Criterion: Effectiveness	
The extent to which CPAP outputs have been achieved, and the extent to which these outputs have contributed to the achievement of the CPAP outcomes	3. To what extent were the programme objectives, expected results and targets met under the 6th CP? 4. What factors influenced the success and effectiveness or failure of the programme? 5. What impact did the 6th CP have on the lives of people of Zimbabwe in terms of reproductive health, HIV prevention; GBV and population and development?
Evaluation Criterion: Efficiency	
The extent to which CPAP outputs and outcomes have been achieved with the appropriate amount of resources (funds, expertise, time, administrative costs, etc.).	6. Could the programme have been implemented with fewer resources without compromising the quality and quantity of the results? 7. What measures were taken during planning and implementation to ensure that the resources are efficiently used?
Evaluation Criterion: Sustainability	
The continuation of benefits from a UNFPA-financed intervention after its termination linked, in particular, to continued resilience to risks. Likelihood that benefits from the CP continue after UNFPA funding is terminated and the corresponding interventions are closed	8. Can the Government of Zimbabwe and other stakeholders continue implementing current interventions without UNFPA support? 9. How did the CP promote sustainability of activities that are being supported in the community?
Evaluation Criterion: Responsiveness	
The capacity of UNFPA to adapt its strategic positioning and programming appropriately to changes in the national development environment and national priorities	10. To what extent did UNFPA anticipate and respond to significant changes in the national development context within its four core focus areas? 11. What were the missed opportunities in UNFPA programming?
Evaluation Criterion: Coordination with the UNCT	
Functioning and consolidation of the existing UNCT coordination mechanisms	12. How is the UNFPA CO aligned with the UN strategic framework (ZUNDAF)? 13. How has UNFPA staff been effectively working together with other UN partners? 14. How effectively did programme staff coordinate with other relevant agencies e.g. UNCT or other UN agencies, NGOs or CBOs in the programme areas?
Evaluation Criterion: Added Value	
The comparative strengths of UNFPA in comparison to other development partners in Zimbabwe – particularly other UN agencies working in similar areas	15. How far did the CP add value to what would have resulted from other development actors' interventions without UNFPA?

In addition to these evaluative criteria, the evaluation team (ET) also assessed the extent to which UNFPA's programmes have integrated gender as a cross-cutting theme and promoted gender equity and gender responsiveness; how far the programme areas are integrated and achieving synthesis, and also how far they have a human rights perspective. These areas of focus are embedded in the

overviews and in relation to relevance, efficiency and effectiveness in the four thematic areas. Also, the evaluation explored UNFPA support to Zimbabwe for data collection and utilization around population and development. The ET submitted the evaluation matrix and tools to the CO and Evaluation Reference Group (ERG) to assess prior to field work.

The CPE ensures that the recommendations for the 7th CP are aligned to the national priorities in each area, UNFPA Strategic Plan 2014-2017, Zimbabwe UNDAF 2016 – 2020, the International Conference on Population and Development (ICPD) and its action plans, and to other international and regional commitments relevant to specific thematic areas. The post-2015 MDG agenda is under formulation and therefore was not available as reference material for this CPE.

1.3 Process and Methodology

1.3.1 Overall Process of the Evaluation

The evaluation involved recruiting external consultants and establishing an Evaluation Reference Group (ERG) from key stakeholders to contribute to Terms of Reference (ToR) and provide quality assurance. By early August 2014 the CO established a team of four consultants, a team leader specializing in reproductive health, an HIV specialist, a gender specialist and a medical demographer for population and development. After submission of the final evaluation report to the CO, the report was forwarded to UNFPA regional office and headquarters for review and finalization.

The first phase involving the consultants was development of the design report to facilitate quality control, buy in and transparency with the UNFPA CO and the ERG. It clarified the evaluation team's understanding of the ToR and ensured conformity to CO and key stakeholder expectations, indicating what is being evaluated and why, and how the evaluation would be undertaken. It thus provided an agreed direction, content and work plan and the tools, data collection and analysis process.

The evaluation by the consultants comprised four main stages that partially overlapped: development and submission of the design report; the data collection and analysis phase; and the synthesis phase of presentation and final report writing on the findings, conclusions and recommendations arising from the evaluation. Table 1.2 provides the work plan that the consultants agreed with the EM.

Table 1.2: Evaluators' Agreed Work Plan

Main Activities	Week						
	1	2	3	4	5	6	7
Orientation, prepare design report, initiate desk review							
Submission of inception/design report							
Approval of design report by CO							
In-depth document review							
Completion of agenda for in-country meetings and interviews							
Preparation of the interviews and adjustments in the agenda							
Data collection							
ERG feedback							
Data analysis, triangulation and write up							
Presentation of preliminary findings to CO							
Presentation of draft report to ERG							
Presentation of report at stakeholders validation meeting							
Submission of final evaluation report							

While this was the planned schedule, the original team leader was so unfocused that the CO had to replace her, with the remaining members tasked to take over through an extension to 11th October (with a one-week gap). The final time period was nine weeks between 4th August and 11th October 2014. After this, further consultant inputs were required to address RO feedback on a schedule intended for completion by 7th November, but this was delayed by the CO and, particularly, the RO.

1.3.2 Data collection and analysis

The evaluation utilised multiple data collection methods and data triangulation to achieve robust analysis and clear understanding of the theory of change underpinning the programme logic. It included extensive document review, key informant interviews and focus group discussions, and field observations (see Annexes). The Design Report elaborates on each method. All the methods were important. Document review formed the most wide-ranging information source given the tight time frame, together with certain KI inputs for triangulation and content analysis.

The team split into two to undertake field work, traveling to five provinces in addition to the key informant interviews in Harare. Each evaluator included core questions relevant to each other's focus areas, as well as considering cross-cutting issues of integration of services, human rights, gender relevance. Semi-structured interview schedules were drawn up in relation to the various stakeholders and according to thematic area of the evaluator, within the frame of the Evaluation Matrix (annexed). Most primary data are qualitative and were subject to content analysis, triangulated with other data sources and subjected to weighting. Statistical and trend data monitored during the 6th CP and, if needed, from an earlier period for comparison, were captured and analysed to document quantitative progress against UNFPA outputs and outcome achievements. The theory of change was applied to different interventions to assess their likely contribution to observed results; however, the RRF indicators and results chain logic are insufficient to allow the desired analysis of intended results from the interventions, and sufficient operations research is not in place to measure many intended results; the findings, conclusions and recommendations reflect this.

1.3.3 Sampling of Stakeholders

Key informants included UNFPA CO management and programme officers; national government policy makers and coordinators; management, programme officers and beneficiaries from implementing partners; researchers; and international cooperation partners drawn from the UN and relevant donors (see Annex). The CO provided the Atlas implementing partner list and sites from which to develop stakeholder mapping and draw a sampling frame. The respective programme officers advised on stakeholder selection. Sampling was purposive to include: consideration of balanced geographical and urban/rural coverage, including feasibility of reaching implementing partners in the field within a one-week period; balanced representation of diverse partners in all key thematic areas; examples of strong, well-established, larger programmes, those for which support has been withdrawn or the project is complete, and of newly developing ones; static and outreach sites; and both national and local implementation levels. Finally, the evaluation team noted the following limitations to the evaluation process, (1.3.4), and steps taken to mitigate their impact.

1.3.4 Methodological Choice, Limitations and Constraints

The methodology was decided by the CO and ERG prior to consultant recruitment, with the aim of ensuring robust findings through triangulation of data from different sources, participation of diverse stakeholders at different levels, and broad coverage of the overall programme. Overarching evaluation questions were decided by the CO and ERG to cover the key issues to address in the evaluation as required in the UNFPA Handbook. Both quantitative and qualitative data were captured, the former mainly from databases tracking outputs and expenditures in line with the RRF and revised M&E plans, and qualitative data primarily from beneficiary and other stakeholder interviews and reports. The participative and multifaceted methodological approach was considered appropriate and feasible to ensure a robust and objective evaluation and to make meaningful recommendations to UNFPA.

Two primary constraints arose: inappropriate leadership of the team, noted earlier, and insufficient time. The Handbook recommends 13 weeks for a high quality evaluation of a substantial country programme, but the initial allocated time was a mere six weeks, obtained through cutting back on recommended time for field work, data collation, triangulation and analysis, and report write up. Both the leadership and the time constraints were raised early on by the evaluation team as serious issues, and various efforts at mitigation were put in place for these and other constraints as in Table 1.3.

Table 1.3: Limitations and Mitigation Efforts

Limitations	Mitigation
Timing and time allocation for the evaluation: CO staff heavily committed in and outside the office, limiting their availability for timely consultation; evaluators coming on board on different dates Very tight time frame, initially 6 weeks then amended to 9 weeks (Handbook recommends 13 weeks but CO cited financial limitations)	• Evaluation manager (EM) and CO staff assisted where possible • Nine extra days allocated from original proposal • Field work restricted to one week (instead of initially proposed three weeks), coverage reduced to 5 provinces outside Harare; division into 2 teams, each to support for each others' areas, but still shorter than ideal • Time allocation for data analysis and report writing condensed including weekends • Field report and presentation to ERG dropped
Programme specialists' tight schedule led to challenges obtaining various key documents timeously	• Consultants followed up repeatedly to obtain essential documents; EM was assisted by programme staff; documents sought from IPs and other stakeholders also
Field work organization was a logistical challenge in the restricted lead time to prepare and for implementation; data from interviews and FGDs were sometimes incomplete	• The CO evaluation staff were flexible and efficient in changing both dates and times as needed, and utilized IP transport and support where feasible to supplement UNFPA provision • Where data were incomplete, further KIs were organized and/or further document review was undertaken
Inappropriate evaluation team leader recommended by RO M&E officer resulted in leadership challenges in the evaluation team	• Evaluation team alerted CO to inappropriateness of original team leader in week 2; she was dropped after 6 weeks, with reallocation of responsibilities and further extended timeline of 15 days for completion, remaining several weeks shorter than the 13 weeks that the Handbook recommends.

1.3.5 Structure of the Evaluation Report

The Evaluation Report is structured according to the Table of Contents and in line with Handbook requirements. After the required starter pages including Executive Summary and Key Facts Table, Chapter One introduces the evaluation including purpose and objectives, scope and methodology. Chapter Two addresses the country context, development challenges and national strategies, and indicates the role of external assistance. Chapter Three elucidates the UN and UNFPA response and strategic positioning, the current UNFPA 6th Country Programme; and provides a brief outline of the previous cycle strategy, goals and achievements. It also highlights the financial structure of the current CP. Chapter Four provides the key evaluation findings and analysis for each thematic area in relation to relevance, effectiveness, efficiency, and sustainability, and addresses cross-cutting themes as noted earlier, UNFPA added value and responsiveness. Chapter Five provides the strategic and programmatic conclusions reached by the evaluation, and Chapter Six the recommendations for the remainder of the 6th CP and the 7th CP that flow from the triangulated evidence and analysis of the findings and the conclusions. The Annexes provide the Terms of Reference, the indicator/ results matrix to date, the evaluation matrix, full sources of primary and secondary data (interviews, focus group discussions, and documents reviewed), and the current CO organogram as stipulated.

Chapter 2: Country Context

2.1 The Country Context

Zimbabwe is a land-locked country in southern Africa covering 390,757 square kilometers. It borders with Botswana, Mozambique, Namibia, South Africa and Zambia. The population is estimated at slightly over 13 million[1]. Although hard data are unavailable, an estimated one-quarter of the total population has moved elsewhere owing to the economic meltdown over the past decade. [2] The loss of skilled labour, e.g. in health and education, impacts negatively on these services, but remittances from the Zimbabwe Diaspora have been a crucial lifeline for families and the economy as a whole. The majority of the population is rural and experiencing widespread and severe poverty. There has been extensive rural-urban migration, particularly to Harare and Bulawayo in search of scarce jobs, and urban poverty is also high.

Zimbabwe has 15 spoken languages, the official, widely spoken language being English. Over 70 percent of the population is Shona, predominantly in the middle and northern regions, with 20 percent Ndebele, more in the south, and several other small cultural and language groups. The country is a republic with a new constitution in place since mid 2013.[3]

The country has extensive mineral resources and the most productive sectors are agriculture, mining, financial services and telecommunications. Unemployment and underemployment are high. Although the unemployment rate is classified at 10.7 percent, it includes 54 percent employed as communal or resettlement area workers, and 35 percent in other sectors; formal employment is low.[4]

The severe economic challenges facing Zimbabwe from 2000-2008 reached crisis proportions in 2007 - 2008, with 231 million percent hyperinflation by July 2008.[5] In response, Zimbabwe established a Short Term Emergency Recovery Programme (STERP) in 2009, and a revised 2009 national budget in US dollars. These measures had positive economic results: the end of hyperinflation and a holistic macroeconomic framework for recovery. Gross Domestic Product grew by an estimated 5.7 percent in 2009[6] and 8.1 percent in 2010. The Zimbabwe Medium Term Plan 2011-2015 builds on these gains, providing the overarching development framework for Zimbabwe to coincide with the MDG objectives and time frame. The MTP prioritizes maintaining macro-economic stability, transforming the economy, reducing poverty and creating jobs.[7] Zimbabwe had harmonized elections in July 2013, ending the Government of National Unity. The post-election political stability, however, has not translated into economic stability, with a continued downward economic trend and severe liquidity constraints. Wide socio-economic disparities and high poverty levels continue.

In 2013, the Government introduced the Zimbabwe Agenda for Sustainable Socio-Economic Transformation (Zim Asset) that prioritizes building social services, food security and physical infrastructure within the overall economic recovery plan. The focus on humanitarian assistance is giving way to a development orientation although, in reality, ongoing economic and other challenges have meant continued heavy reliance on external assistance to address humanitarian needs and rebuild infrastructure and basic social services. Close policy linkages exist between the MTP, the STERP and Zim Asset, and this framework is supported by the ZUNDAF and other external assistance. The situation remains fragile politically and economically, however. During the period of the 6th CP the recovery rate has declined to the extent that, on current projections, Zimbabwe risks negative growth by 2015.

[1] Zimbabwe National Statistics Agency (ZIMSTAT) Census 2012 Preliminary Report at pg. 9
[2] UNDP (2010): *The Potential Contribution of the Zimbabwe Diaspora to Economic Recovery,* Comprehensive Economic Recovery in Zimbabwe, Working Paper Series, Working Paper 11 at pg 9.
[3] Constitution of Zimbabwe Amendment (No. 20) Act 2013
[4] Zimbabwe 2011 Labour Force Survey
[5] UNDP and Government of Zimbabwe (2010) *Country Analysis Report for Zimbabwe* at pg. 3
[6] Ibid.
[7] Zimbabwe Medium Term Plan 2011 – 2015 at pg.1

2.2 The Country Situation and Challenges

2.2.1 Population and Development

Key demographic indices include fertility and mortality trends, maternal and under-five mortality, population distribution and movement, age structure, population growth rates and life expectancy at birth. Most demographic parameters in Zimbabwe have either stagnated or shown worsening trends according to the ZDHS[8] and Census data.

The 2012 Census estimated that Zimbabwe has a population of 13.1 million people, with 65 percent of households male-headed to 35 percent female-headed. The population growth rate was estimated at 1.1 percent. The sex ratio of 93 percent male to female is partly due to male-dominated outmigration. The population is relatively young with 41 percent below age 15, and about 4 percent age 65 and above. Almost two-thirds of the population is rural and one-third urban. The Census estimated the total fertility rate (TFR) to be 3.8, while the 2010 ZDHS showed a TFR of 4.1 births per woman, higher in rural than urban areas. Teenage fertility rose from 21 percent in 2005-06[9] to 24 percent in 2010/11[10], compounded by poverty, gender based violence and limited access to services, the increase being in rural areas where twice as many adolescents become pregnant as in urban settings. Nearly half of all girls have become pregnant by age 19, and one-quarter of girls 15-19. Reported modern contraceptive use in married women was estimated at 57 percent in 2012, fairly stable, but in adolescents the contraceptive prevalence rate (CPR) was only 10 percent.

The Census 2012 showed continuing high mortality, (particularly from AIDS and tuberculosis), although HIV survival is now improving with expanded treatment. Prior to the HIV and AIDS epidemic and the more recent economic crisis, the maternal mortality ratio (MMR) was one of the lowest in sub-Saharan Africa, at 283 per 100,000 live births. By 2005/6 it was 612 per 100,000 live births, and by 2010-2011 it had risen to an estimated 960 per 100,000 live births[11]. Under-five mortality stood at 84 per 1000 live births in 2010/2011, down from 102/1000 in 1999, but far from achieving the MDG target of 34[12]. Around 20 percent of these deaths in 2010/2011 were attributed to HIV and AIDS[13].

Increasing attention is being paid to improving the availability and use of data to guide policy and development programming and projects, particularly through the Census and DHS. Better coordination and administration of the statistics system in the country are crucial, through government capacity development.

2.2.2 Reproductive Health and Rights

As above, many reproductive health indices are poor and, in some cases worsening. The high maternal mortality noted in the ZDHS over time has resulted largely from delays in families deciding to seek access (estimated at 52 percent in 2007), to a lesser extent to transport problems, 31 percent to poor quality of maternal health services[14]. HIV was estimated to have contributed to 25 percent of maternal deaths. In 2010-2011 an estimated 70 percent of notified maternal deaths were considered avoidable[15]. Poor child survival is linked with HIV and with poverty and poor sanitation. Serious inadequacies in the health sector include human and financial resources, infrastructure, drugs and

[8] Zimbabwe Demographic Health Survey 2010-2011
[9] ZDHS 2005-6
[10] ZDHS 2010-2011
[11] ZDHS reports cited in Zimbabwe 2012, Millennium Development Goals Progress Report, Government of Zimbabwe, UN Zimbabwe
[12] ibid.
[13] Ibid.
[14] Maternal and Perinatal Mortality Study 2007, MOHCW
[15] Maternal Deaths Audit Report 2010/2011

commodities, including a poor method mix for family planning commodities. A further burden facing women is high rates of cervical cancer, which is the leading cause of cancer deaths in women.

The high and rising rural teenage pregnancy rate has serious consequences for survival, education and life opportunities for these vulnerable young women. The stagnation in the CPR, particularly for adolescents, results from various factors including: lack of youth friendly health services; limited access to information and overemphasis on abstinence-only messaging; and failure to sustain sufficient contraceptive supply and demand (for adults also). In 2012 an estimated 24 percent of maternal deaths were in adolescents aged 15-19[16]. Only 9 percent had used maternity waiting homes.

Zimbabwe's National Health Strategy 2009 – 2013, National Reproductive Health Policy (NRHP, undated) and Maternal and Neonatal Health (MNH) Roadmap 2007 – 2015 address the national sexual and reproductive health policy, systems and service levels. The National Health Strategy (NHS) provides the framework towards achieving the related MDGs.

The four-year (2012-2015) nationally owned Integrated Support Programme (ISP) aims to improve women and girls' sexual and reproductive health (SRH) and to reduce maternal morbidity and mortality and gender based violence (GBV). It has USD 95 million in committed resources from the UK, Sweden and Ireland, with USD 29 million allocated to UNFPA for interventions in the areas of family planning, cervical cancer screening, and HIV and GBV prevention. Another significant initiative funded by the EU (and previously the Japanese Government) is to reduce maternal deaths by strengthening service provision and supporting institutional deliveries through maternity waiting homes. Overall strengthening of the health system nationwide is essential and underway (see 2.4 as well as Chapter 4).

2.2.3 HIV and AIDS

Zimbabwe has had a high prevalence, heterosexually-driven generalized HIV and AIDS epidemic that peaked in 1997 at 26.4 percent prevalence in the adult population aged 15-49[17]. The gender ratio of infections reflects the greater vulnerability of women, with three women HIV positive for every two men. Urban and rural areas are not markedly different, although there are hotspots for infection, for instance in border towns. The epidemic has reversed the gains of the early post-independence period through high mortality in the productive age group, deepening household poverty as parents and providers die, and leading to widespread orphanhood. Nonetheless, the country has experienced a significant epidemic decline to under 15 percent adult prevalence in 2010[18]. This reflects both incidence decline through sexual behaviour change and high mortality. Prevalence is thought to have stabilized since 2010[19], however, owing largely to increased survival through the scale up and improvement of treatment. Tuberculosis remains a major problem, with 82 percent co-infection rates[20], but by 2011 HIV testing of TB patients was at 92 percent and 71 percent were receiving ART.

Particular challenges for HIV and AIDS programming in 2013 included: inadequate finance and health system staffing capacity and weak health-community linkages; weaknesses in logistics and supply chain management; stock outs of commodities including antiretrovirals (ARVs) and HIV test kits; and low coverage of pediatric treatment and voluntary medical male circumcision (VMMC).

The Zimbabwe National AIDS Council (NAC) leads the multisectoral national response enshrined in the Zimbabwe National HIV and AIDS Strategic Plan (ZNASP 11) 2011-2015. Zimbabwe is committed to addressing the revised targets in the 2011 UN High Level Meeting on HIV and AIDS for new infections, treatment access, elimination of mother-to-child HIV transmission (eMTCT), and

[16] Analysis of Notified Institutional Maternal Deaths: Jan 2010 – December 2011, MoHCW
[17] National HIV and AIDS Estimates Report 2012 in Global AIDS Response Country Progress Zimbabwe 2014, GoZ, UN Zimbabwe
[18] ZDHS 2010-2011
[19] National HIV and AIDS Estimates Report 2012 op cit.
[20] Ibid.

substantially reduced AIDS-related maternal mortality. The country has a strategic combination prevention approach in line with UNAIDS guidelines and WHO 2013 treatment guidelines. Option B+ for eMTCT was launched in November 2013, and multiple policies and strategic documents guide the overall response[21]. Prior to this, infections averted by PMTCT were estimated at over 15,000 in 2013[22] and child deaths averted (0-4) were estimated at 5,400.

Zimbabwe has an AIDS levy of 3 percent from PAYE and corporate taxes that has ensured significant domestic funding since the 1990s, and for the past few years external funds have increased substantially. Through its new funding mechanism, the Global Fund for HIV/AIDS/TB and Malaria has committed USD 60 million to Zimbabwe as one of three pilot countries, with the target of expanding ART uptake from 565,000 to 893,000 by 2016, and strengthening data systems and monitoring and evaluation. Its priority is to reach the most affected populations including sex workers[23]. Also, in 2013 a grant for USD 311 million was awarded and additional funding of USD 126 million in July 2014 for the overall MDG 6 response.

Although Zimbabwe needs to continue to expand access to and uptake of both prevention and treatment services, taking on board new knowledge and technologies, the country is partly on track to meet its multi-sectoral coordination, prevention and treatment targets by end of 2015. The Zimbabwe 2014 report to UNAIDS[24] indicates that HIV incidence in 2013 was an estimated 0.98 percent, down from 1.29 percent at the start of the CP, a definite improvement but it will be a challenge to reduce it in the prevailing economic climate to the MDG target by 2015 (about 0.65 percent). The epidemic is viewed as a development and livelihood as well as a health issue, with impacts entangled with the poor macro-economic environment, poor government policies and droughts.

2.2.4 Gender Equality

Gender inequality and inequity and gender based violence (GBV) remain serious challenges in Zimbabwe. In a society marked with patriarchal norms and male dominance across sectors, women lack access to resources, representation in strategic leadership, and access to justice and health care. The majority of women remain in the informal economy with compromised access to credit at macro and micro levels, to education and other services and employment. In 2010 an estimated 63 percent of women did not own a house and 64 percent did not own land.[25]

GBV is a critical impediment to women's participation in development. The ZDHS estimated that 42 percent of women have experienced physical, emotional or sexual violence (or all) at some point in their lives. The National Baseline Survey on Life Experience of Adolescents (NBSLEA) estimated that 32.5 percent of young women aged 18 to 24 have experienced sexual violence prior to age 18, amongst whom only 2.7 percent received professional help from clinics or NGOs. Another growing concern is a rise in child marriages in Zimbabwe, further impeding girls' education and sexual and reproductive health (SRH).[26]

The overarching policy framework addressing gender inequality in Zimbabwe is the new Constitution of 2013 that seeks not only to address gender inequality but also to address past gender imbalances. This was added to a comprehensive framework provided for in the Domestic Violence Act (DVA) of 2007.[27] The Act sets up an oversight mechanism in the form of an Anti-Domestic Violence Council.

[21] Zimbabwe AIDS Response Progress Report 2014, Global AIDS Response Country Progress Report Zimbabwe 2014, GoZ, UN Zimbabwe
[22] ibid
[23] UNAIDS website, country updates and GF
[24] Zimbabwe AIDS Response Progress Report 2014, op cit.
[25] Zimbabwe Demographic and Health Survey 2010-2011 at pg. 231
[26] Zimbabwe Statistical Agency (ZIMSTAT), United Nations Children's Fund (UNICEF) and Collaborating Centre for Operational Research and Evaluation (CCORE), 2013, National Baseline Survey on Life Experiences of Adolescents, 2011
[27] Zimbabwe Domestic Violence Act Chapter 5:16

Zimbabwe has also developed a National Gender Based Violence Strategy, based on the key pillars of GBV programming, namely leadership, prevention, service provision, coordination, research and documentation.

As part of operationalizing the GBV pillar on protection, Zimbabwe has developed Standard Operating Procedures for Safe Shelters (2012) in line with the provisions of the Beijing Platform for Action to assist survivors of gender based violence.[28] Other related policy and legislative frameworks are the Sexual Offences Act that criminalises marital rape and which has been integrated into the Criminal Law Codification and Reform Act[29]. Zimbabwe also has a strategic Multi Stakeholder Approach to the Management of Child Sexual Abuse and Victim Friendly Courts. An Inter-Ministerial Cabinet Committee on Rape and GBV and a National Action Plan on Rape are also in place. Although the policy framework has been strengthened by the enactment of the new Constitution, the harmonization of laws with the Constitution is still to be realized.

2.3 Progress towards MDG and ICPD

Documented performance towards the international development goals has been mixed since the Country Analysis Report (2010) and the 2012 Zimbabwe MDG Progress Report[30]. The main gains relate to MDG 2 (universal primary education), MDG 2 (child survival) and MDG 6 (HIV/AIDS and other infectious diseases). MDGs 1 (eradicating extreme poverty and hunger), MDG 3 (gender equality) and MDG 5 (reducing maternal mortality) are reported as not on track to meet the 2015 deadline. If population growth occurs through rising fertility and reduced mortality, resources to achieve the MDGs must increase. Zimbabwe identifies MDGs 1, 3 and 6 (HIV and AIDS) as future national priorities. See the Key Facts Table for fuller information on MDG progress in Zimbabwe.

Post the 1994 ICPD in Cairo, Zimbabwe worked towards an enabling environment by developing strategies, guidelines and policies to address the ICPD Plan of Action. The Population Policy was developed in 1998 to address the socio-economic and environmental challenges related to population issues in a holistic way. In addition, many policy documents and statutory instruments support the population agenda in Zimbabwe. The ICPD and follow up conferences embraced the new broader concept of reproductive health and rights, including for adolescents (ASRH). ASRH programmes have been developed by the MoHCC, ZNFPC, NAC and various ministries (for youth, women affairs and education) and several NGOs. The ASRH Strategy (2010–2015) reaffirms this commitment through refocusing and realigning its priorities in line with the MDGs.

2.4 The Role of External Assistance

2.4.1 Official Development Aid

Zimbabwe's economic crisis has meant increased reliance on external assistance, loan disbursements and ODA. According to Development Initiatives[31], in 2011 Zimbabwe received USD712.9 million in Official Development Aid (ODA), particularly for health, humanitarian assistance, governance and security, making the country the 48th largest ODA recipient. Largest donors are the US Government, the European Union institutions and the UK. Resource flows into Zimbabwe for loans and ODA form an estimated 83 percent of Government spending. Funding includes grants, mixed project aid and technical cooperation.

[28] See UNFPA, Ministry of Women Affairs, Gender and Community Development and Musasa (2012) Standard Operating Procedures for Safe Homes for GBV Survivors, Zimbabwe
[29] Zimbabwe Criminal Law Codification and Reform Act Chapter 9:23
[30] Zimbabwe 2012 Millennium Development Goals Progress Report, GoZ/UN Zimbabwe
[31] www.devinit.org/wp-content/uploads/2014/02/Zimbabwe.pdf accessed 1 September 2014.

Health takes up one-quarter of all foreign aid to Zimbabwe, half of which supports HIV and AIDS programmes and the remainder, basic health measures including for malaria. The US Government and the Global Fund are the largest donors. GoZ is strengthening the weak health system, including through the Health Transition Fund (HTF), a pool of multi-donor funds for which UNFPA sits on the Steering Committee. UNICEF is grant manager. For 2011-2015, donors have pledged US$435 million[32]. Governance and security are the third/fourth largest recipients, with resources to advance human rights, democratic participation and civil society initiatives. Some resources also cover peace building and conflict prevention initiatives[33] [34]. GoZ is also in discussion to finalise the EU National Indicative Programme (NIP) of EU assistance to Zimbabwe for 2014-2020, at EUR 234 million. In 2010 the EU launched the 1 billion Euro MDG initiative to support maternal health, reduce child mortality and hunger and improve water supply and sanitation. Within this, EU is supporting the Ministry of Health and Child Welfare (MOHCW) through various partners including UNFPA to improve maternal health through promoting institutional deliveries from 2012 – 2015; the budget is EUR 9.9 million (USD 12.4 million[35]).

The country's external debt, roughly US$10.7 billion (about 114 percent of GDP) of which US$7.1 billion is in arrears, presents an impediment to capital flows and for Zimbabwe attaining its own development objectives.[36] ODA by development partner and ODA receipts by thematic sector and year during the period January 2012 to June 2014 were not fully available.

Another mechanism for external development assistance is the Zimbabwe UN Development Assistance Framework (ZUNDAF) that is articulated in Chapter 3.

[32] UNICEF: http://www.unicef.org/zimbabwe/ZIM_resources_htfoutline.pdf. Accessed 3 Sept 2014.
[33] To advance human rights, democratic participation and civil society initiatives. Some resources also cover peace building and conflict prevention initiatives.
[34] Note 15.
[35] http://countryoffice.unfpa.org/zimbabwe/drive/MATERNITYWAITINGHOMES.SUMMARY.pdf accessed 2 September 2014.
[36] Zimbabwe 2012 (supra para 2 at page 14)

Chapter 3: UN/UNFPA Response and Programme Strategies

3.1 UN/UNFPA Response

UNFPA and other UN organizations in Zimbabwe are guided by the common agenda of the ZUNDAF[37] which provides linkages and alignment with Zimbabwe's national priorities and MDGs. The ZUNDAF is the standard basic agreement between the government and the UN that outlines joint concepts and agreements on priorities. External assistance in the current ZUNDAF 2012-2015 has focused on seven national priorities to address national priorities and Millennium Development Goal (MDG) impact results. A monitoring and evaluation framework was also developed to reinforce and consolidate national systems with indicators drawn from existing analyses and reports. The ZUNDAF Results Matrix focuses on the outcome level with a logical results chain and resource estimates for their achievement.

The seven national priorities in the ZUNDAF are:

1) Good governance for sustainable development
2) Pro-poor sustainable growth and economic development
3) Food security at household and national levels
4) Sound management and use of the environment
5) Access to and utilization of quality basic social services for all
6) Universal access to HIV prevention, treatment, care and support
7) Women's empowerment, gender equality and equity.

Within these seven areas are 18 outcomes with specific indicators. While all the areas are relevant to UNFPA in that they impact on achievement of its mandate, the latter three are the most closely aligned to reproductive health, HIV and AIDS, gender, and population and development.

To complement the ZUNDAF, the Consolidated Appeal Process (CAP) is the main tool to plan, fund, implement and monitor humanitarian activities. This takes a programme based approach providing the strategic focus and flexibility to align effectively with priority needs, and to link with other major initiatives. In addition, key entry points for the UN to operationalize the ZUNDAF include pooled funding mechanisms for different development initiatives and assessment of the country's opportunities for recovery.

The UN Country Team (UNCT) mobilises resources in a coherent way, utilizing its comparative advantages and networks to promote effective partnerships across the UN system and with government, civil society and the private sector, building on existing and emerging opportunities for collaboration. The ZUNDAF is costed at slightly under USD 1.5 billion of which, by October 2013, 61 percent of total resources had been secured, leaving a resource gap of around USD 0.5 million. At that time 90 percent of resources for National Priority Area (NDP) 6 on AIDS had been secured, and 30 percent of resources for NDP 7 on gender.

The 2013 ZUNDAF Annual Review Report indicates that 'results were generally achieved' in line with ZUNDAF indicators, but with considerable variation between different outcome areas and indicators. With regards NDP5 on Health and Nutrition in 2013 against the 2015 targets, 100% were reported as on track. NDP 6 on HIV and AIDS, out of 52 outcome indicators in 2013 against 2015 targets, 8 percent were reported as met, 83 percent on track and 9 percent constrained. For NDP 7 on gender, out of four outcome indicators in 2013 against 2015 targets, 67 percent were on track, 33 percent constrained.

[37] Zimbabwe UN Development Assistance Framework 2012 - 2015

All UNFPA interventions for the 6th CP are guided by a global corporate strategy set out in the UNFPA Strategic Plan 2008-2011. The revised UNFPA Strategic Plan (2014-2017) is the guide for organizational programming, management and accountability. In revising the strategic plan, UNFPA adopted a refined strategic focus, which is designed to direct its work largely on sexual and reproductive health and reproductive rights, while facilitating greater progress towards MDG 5 and the ICPD agenda.

The plan provides overall direction for guiding UNFPA support to country programmes to achieve their national development objectives. The plan adopts seven interrelated outcomes for one overarching goal: to achieve universal access to sexual and reproductive health, promote reproductive rights, reduce maternal mortality and accelerate progress on the ICPD agenda and MDGs.

The UNFPA Development Results Framework (DRF) (2012-2015) as approved by the UNFPA Executive Board, contains the following seven results areas:

- Population dynamics and its interlinkages with the needs of young people (including adolescents), sexual and reproductive health (including family planning), gender equality and poverty reduction addressed in national and sectoral development plans and strategies
- Increased access to and utilization of quality maternal and newborn health services
- Increased access to and utilization of quality family planning services for individuals and couples according to reproductive intentions
- Increased access to and utilization of quality HIV- and STI-prevention services especially for young people (including adolescents) and other key populations at risk
- Gender equality and reproductive rights advanced particularly through advocacy and implementation of laws and policy
- Improved access to SRH services and sexuality education for young people (including adolescents
- Improved data availability and analysis around population dynamics, SRH (including family planning), and gender equality.

3.2 UNFPA Response through the Country Programme

3.2.1 Brief description of UNFPA previous cycle strategy, goals and achievements

UNFPA Zimbabwe 5th Country Programme covered the period 2007 to 2011. It consisted of three core components, Reproductive Health and Rights (including HIV Prevention), Gender Equality and Women's Empowerment, and Population and Development. The 5th CP operated during one of the most tumultuous periods in Zimbabwe history. Zimbabwe experienced an extremely difficult socio-economic, financial and political environment characterized by unprecedented hyperinflation, a cholera epidemic, the collapse of the public health system and a massive brain drain. Progress on programming was hampered because of the closing of many public health institutions, the lack of human resources, drugs and equipment.

UNFPA was responsive to the crisis and partly shifted focus from planned interventions to a humanitarian crisis and emergency response, particularly to mitigate the impact on women. For example, UNFPA supported provision of emergency obstetric care assistance and payment of allowances for health professionals to facilitate the reopening of health centers, in addition to its other mandates. Significant achievements included: i) development of several strategic policy and operational documents; ii) building capacity of health service providers in life-saving skills; iii) distribution of equipment and reproductive health commodities, including blood and blood products; iv) furbishing maternity waiting homes in 22 districts; v) providing training for cervical cancer screening and management; vi) revamping the national health information system; and supporting adolescent SRH services in all district hospitals.

3.2.2 Current UNFPA Country Programme (6th CP)

The findings and recommendations of the 5th CP final evaluations guided the preparation of the current country programme. The UNFPA programmatic response is presented in the 6th Country Programme Document (CPD) and in two instruments that guide the implementation of the CP, the Country Programme Action Plan (CPAP) and Annual Work Plans (AWPs). The UNFPA Strategic plan covers a wide range of issues, some of which are linked to the analysis of the programmatic areas and the review of strategic positioning. The 6th CP contributes to national priorities through four outcomes as reflected also in the ZUNDAF, based on the common country assessment (CCA); the current draft Medium Term Plan, 2010-2015; the 2010 MDG status report; and the ZUNDAF joint implementing matrix. The 6th CP focuses on: i) advocacy and mobilization of resources for integrated programmes, particularly reproductive health ii) prioritization of reproductive health programmes country-wide and iii) and culturally sensitive approaches to services for women, adolescents and youth.

Table 3.1: 6th Country Programme Outputs, Outcomes and ZUNDAF Outcomes

Component	Country Programme Output	Country Programme Outcome	UNDAF Outcome
Reproductive health and rights	Output 1: Strengthened capacity of government and civil society partners to deliver reproductive health services. Output 2: Increased availability of reproductive health services and commodities. Output 3: Increased demand for sexual and reproductive health services at the community level.	Increased utilization of comprehensive gender-sensitive and youth-friendly reproductive health services.	Increased access to and utilization of quality basic health and nutrition services
HIV Prevention	Output 1: Increased coverage of the social and behaviour change communication programme. Output 2: Increased availability of HIV prevention services.	Increased adoption of safer sexual behaviour and use of HIV prevention services.	Improved access to (and uptake) of HIV prevention services.
Gender	Output 1: Increased capacity of leaders to address negative social norms and practices that perpetuate gender inequities. Output 2: Increased availability of services to address gender-based violence. Output 3: Increased community awareness of gender-responsive laws, mechanisms and services	An improved policy and legal environment for gender equality and increased utilization of gender based violence services.	Laws and policies established, reviewed and implemented to ensure equality for empowerment of women and girls.
Population and Development	Output 1: Strengthened capacity of relevant government departments responsible for planning to integrate population issues into development plans and monitor sectoral policies and plans. Output 2: Strengthened capacity of Zimbabwe statistical agency and line ministries to produce, analyse, disseminated and promote the utilization of population data. Output 3: Strengthened capacity of ZIMSTAT to coordinate the national statistical system.	Increased availability and analysis resulting in evidence based decision-making and policy formulation around population dynamics, SRH (including family planning), and gender equality. Increased availability and utilization of disaggregated data at national and sub national levels.	Improved generation and utilization of data for policy and programme development and implementation by government and other partners

The programme outcomes for the four focus areas of the 5th and 6th CP have remained constant except that the 6th CP pulls out HIV prevention as a separate outcome area within reproductive health and rights.

Implementation of the 6th CP is jointly done by UNFPA and GoZ, with UNFPA drawing additional support from the UNFPA Regional Office in Johannesburg South Africa and Headquarters in New York. The Ministry of Finance and Development Planning coordinates the overall programme and the population and development component. The programme employs results-based management techniques, building on the existing ZUNDAF, UNFPA and GoZ monitoring and evaluation mechanisms. The Government and UNFPA developed a successful resource mobilization plan to mobilize additional resources for 2012-2015.

3.3 The Financial Structure of the Programme

The Country Programme Document for the 6th CP proposed UNFPA assistance of USD 39.6 million: USD 13.2 million from regular resources and USD 26.4 million through co-financing modalities and/or other, including regular resources for the four year period. Of the USD 39.6 million, USD 29.8 million was allocated to reproductive health and rights, USD 4.8 million for population and development, USD 4.0 million for gender equality and USD 1.0 million for programme coordination assistance. The following tables show budgeted regular and non-regular resources for the period under review.

Table 3.2: CP 2012-2015 Proposed Assistance

Programme Component	**Regular resources (million USD) Budget**	**Other resources (million USD)**	**Total (million USD)**
Reproductive health and rights (incl. HIV)	7	22.8	29.8
Population and development	3	1.8	4.8
Gender equality	2.2	1.8	4
Programme coordination and assistance	1	-	1
Total	**13.2**	**26.4**	**39.6**
Mobilised to date	**10.7**	**79.6**	**90.3**
% of original target	**81 %**	**302%**	**228 %**

As shown in Table 3.2, UNFPA planned to commit USD 39.6 million on the four intervention programmes in Zimbabwe. Thirty-three percent or USD 13.2 million would come from regular UNFPA resources and the remaining 67 percent or USD 26.4 million from funds mobilised from donors. The resources mobilized by UNFPA from other sources have grown by 302 percent from the original target, an impressive achievement suggesting donor confidence in the agency to deliver.

In Table 3.3, the implementation rate by programme area for non-core resources is shown against the budgets in Atlas and not what was actually received (CO feedback). The total column reflects the overall implementation rate against what was actually received, 72.41 percent for the period 2012-2014 (August).

Table 3.3: Actual Total Budget by Source (as per Atlas, table provided by CO)

		NON-CORE RESOURCES			CORE RESOURCES		
	Year	**ATLAS Budget**	**Expenditures**	**Implementation Rate (%)**	**Budget**	**Expenditures**	**Implementation Rate (%)**
Reproductive Health							
	2012	10,856,406.56	1,819,294.76	17	427,000.00	425,078.00	99.55
	2013	11,944,151.08	7,474,234.07	63	679,414.41	672,686.00	99.01
	2014 (Sept)	12,032,265.00	6,524,904.31	54	680,759.00	162,759.25	23.91
HIV Prevention							
	2012	2,427,999.20	1,529,172.95	63	429,024.00	431,102.00	100.48
	2013	6,987,931.29	4,601,022.65	66	403,052.08	396,401.60	98.35
	2014 (Sept)	5,582,245.00	3,275,991.75	59	50,505.00	3,851.69	7.63
Population and Development							
	2012	12,442,847.56	6,688,951.42	54	1,000,000.00	999,999.77	100.00
	2013	5,111,462.00	4,267,488.54	83	123,155.00	29,668.00	24.09
	2014 (Sept)	1,019,690.00	170,345.44	17	-	-	-
Gender Equality							
	2012	1,055,022.60	951,156.21	90	240,000.00	239,013.76	99.59
	2013	3,369,899.00	2,502,922.94	74	183,670.00	183,064.00	99.67
	2014 (Sept)	1,874,552.00	1,622,385.63	87	167,382.00	114,271.87	68.27
PSP & PCA							
	2012				1,703,976.00	1,703,194.00	99.95
	2013				2,210,708.71	2,207,655.52	99.86
	2014 (Sept)				2,401,354.00	2,283,223.66	95.08
Total		**74,704,471.29**	**41,427,870.67**		**10,700,000.20**	**9,851,969.12**	**92.07**
Cash mobilized		**57,269,386.99**	**41,427,870.67**	**72.34**			

The implementation rates for all core resources are very high, almost approaching 100 percent in all the years and averaging about 92 percent for the whole period. However, the implementation rates for the non-core resources are much lower, averaging 72 percent for the whole period. However, this is explained by the fact that the CO continued to receive multiple disbursements for some projects in a given programming year, which in effect constantly reduced the implementation rate for that particular year. Table 3.4 shows the main funding partners and they amounts they have provided for key projects.

Table 3.4: Key Projects for the 6th CP

Project or Programme	**Resources USD**	**Funders**
Integrated Support Programme (ISP)	29 million	UKAid, Sida and IrishAid
Revitalizing MWH and Other Services	13.1 million	EU
2012 Population Census	12.8 million	DfID, AusAID, Sida, Denmark, UNICEF, UNDP,UNFPA
Global Programme in Reproductive Health Commodity Security (GPRHCS)	6.6 million	UNFPA global
H4+ Initiative	5.4 million	CIDA and Sida
Safeguard Young People	1.2 million	Swiss Development Cooperation
Linkages Programme	0.7 million	EU
ZDHS	3.6 million (0.8 million deficit)	Pledges by several donors

The Integrated Support Programme for Sexual and Reproductive Health, HIV Prevention and Gender Based Violence, ISP, is the largest funding mechanism for UNFPA having received USD 29 million from UKAid, Sida and IrishAid. Next most significant financially are the project on revitalizing maternity waiting homes and providing other services to reduce maternal and neonatal mortality that received USD 13.1 million from the European Union; and financing for the 2012 Population Census at USD 12.8 million from DFID, AusAID, Sida, Denmark, UNICEF, UNDP and UNFPA**.**

Chapter 4: Findings

4.1 Reproductive Health and Rights

4.1.1 Overview of the Reproductive Health and Rights Programme

The Reproductive Health and Rights (RHR) component[38] of the Country Programme Action Plan, CPAP has two outcomes to be addressed by five outputs. The first outcome is addressed here: increased utilisation of comprehensive gender-sensitive and youth-friendly RH and HIV integration services. The second outcome, increased adoption of safer sexual behaviour and use of HIV prevention services is addressed in section 4.2. In practice there is overlap between the outcomes and outputs to address them and between the areas of remit of the Reproductive Health and HIV Units with integrated projects and programmes. In developing the evaluation report, the two sections, RHR and HIV, therefore cross refer to avoid repetition of material relevant to both.

The CPAP outputs for the first outcome for RHR are: 1) Strengthened capacity of government and civil society partners to coordinate and deliver reproductive health; 2) Increased availability of reproductive health services and commodities; 3) Increased demand for SRH services at the community level.

The main strategies for Output 1 are cited as:

a) Strengthening coordination mechanisms of the Ministry of Health and Child Welfare (MoHCW[39])
b) Strengthening monitoring and evaluation mechanisms of the MoHCW and other key educational organisations such as tertiary educational institutions
c) Strengthening institutional and technical capacities of the MoHCW to deliver effective midwifery services.

These were to be achieved through: supporting national coordination mechanisms; training provincial and district health teams; training and providing institutional support to focal persons in tertiary educational institutions and youth serving organisations to programme ASRH; re-profiling and raising the visibility of midwifery practice. The main activities undertaken in the 6th CP related to (a). Strengthening of ministry M&E and midwifery were not much developed by UNFPA, with the focus shifting to other partners and funding sources. Other partners and funding sources are involved, but much more is needed. UNFPA is supporting the reopening of one midwifery training school.

For Output 2 the main strategies are:

a) Capacity and system strengthening in reproductive health commodity security (RHCS), including reproductive health commodities for STI control and HIV prevention
b) Support to integrated Emergency Obstetric and Neonatal Care (EmONC) and PMTCT within the context of continuous quality improvement
c) Scaling up of cervical cancer screening services using the VIAC 'see and treat' approach
d) Expanding coverage of youth-friendly services.

The CPAP activities to achieve the output are: supporting review of the RH policy and related documents; supporting RHCS including in humanitarian situations; support to integrated EmONC and prevention of mother to child HIV transmission (PMTCT); support for maternity waiting homes (MWH); support to scale up the cervical cancer programme; and supporting youth-friendly service delivery. Most were undertaken, but support for humanitarian situations was reported as minimal (see section on relevance).

[38] The term 'Reproductive Health and Rights' does not sufficiently include sexual issues, e.g. around HIV and STI prevention, and the evaluation adopts the more usual international term of 'Sexual and Reproductive

[39] Since elections in 2013, the MoHCW is now called the Ministry of Health and Child Care (MoHCC)

For Output 3 the main strategies are:

a) Strengthening communication for social and behaviour change
b) Capacity building of community health workers and advocates to mobilise community members to utilize RH services.

The main CPAP activities to achieve this output were given as promoting safe spaces within communities for young people to access information on SRHR, gender and development through youth interact centres; and training community health workers (CHW) to promote utilization of RH services. CHW were not trained, however, as the focus shifted to behaviour change facilitators (BCFs) undertaking home visits in the community to generate demand for an integrated package of SRHR services. Five BCFs per district (130 trained to date in 26 districts) are mentoring Sista2sista clubs for vulnerable adolescent girls in the community; and youth friendly corners were developed in public health facilities.

The outcomes and outputs range from high level policy and strategy support through to strengthening health services and demand on the ground, providing a logical linkage between the various areas of need. The Results and Resources Framework (RRF) aligns the various outcomes and outputs in RHR to the Zimbabwe UN Development Assistance Framework (ZUNDAF) and to the UNFPA Strategic Plan (SP). However, the logic is not always clear; e.g. CP Outcome 1 relates to gender- and youth-friendly services while the ZUNDAF and SP to which it is aligned relate to maternal and newborn care.

The RH section of the RRF has several indicators that were later found to be inappropriate either because they could not be tracked (hence there being no baseline or target at the time, though some were added later), or they were dropped (Output 1 indicators 1,2,3 and Output 3 indicator 2). This has meant discrepancies between the 2014 Mid Year CPAP Report (see section on effectiveness) and the indicators that appear in the CPAP RRF. Also, there appeared to be confusion regarding where to place certain indicators against outputs in the original RRF, and these have since been moved under more appropriate outputs. Theory of change analysis of the original results chain logic found it to be insufficiently articulated, for example demand generation for SRH services by young people (Output 3) is simply measured by 'numbers reached' without a sense of intensity, types of exposure etc needed for impact, or how this might be measured. With some overlap of outcomes 1, 2 and 3, e.g. in social and behaviour change communication at community level, there are challenges in where to place some outputs and more discrete outcomes might have avoided this ambiguity. The RRF in the next CP should have stronger results logic and SMART [40] indicators that are more robust to measure effectiveness rather than relying on process/numbers reached.

In the evaluation, it was a challenge how best to present the findings across the whole reproductive health and HIV component, e.g. by funding source, by thematic area (e.g. FP, HIV, maternal mortality), by population group, by outcome, output or activity, or by management base in the RHU or HIV Unit. Whichever route was followed, there were considerable areas of overlap risking duplication of material or gaps. There was also a requirement to include separate sections on relevance, efficiency, effectiveness and sustainability to address key evaluation questions, with strategic positioning, added value and responsiveness embedded in these sections. To reduce duplication and streamline the findings, cross-references are made where needed for additional material relevant to a particular section (e.g. adolescent SRH/HIV is reported on in sections of its own and only briefly referred to elsewhere). Decisions on where to place material had to be made taking into account a combination of factors relating to the multiple dimensions noted rather than selecting one single dimension to follow. The CO acknowledges this issue and has indicated that they are working towards rationalizing the RH and HIV integration CPAP more effectively in the 7th CP.

[40] Specific, Measurable, Achievable, Relevant and Time-bound (although some slightly different definitions occur)

4.1.2 Relevance

4.1.2.1 Policy and Strategic Level

Relevance here and throughout means relevance to identified country needs, government priorities and development plans, and to the ZUNDAF and UNFPA priorities and mandate. UNFPA contributes to SRHR predominantly through the Ministry of Health and Child Care (MoHCC) including city health departments, Ministry of Women Affairs Gender and Community Development (MWAGCD), the parastatal Zimbabwe National Family Planning Council (ZNFPC) and the Ministry of Youth, Indigenisation, and Economic Empowerment (MYIEE). The National AIDS Council (NAC) and Zimbabwe Youth Council (ZYC) are also key partners.

The main areas of focus for sexual and reproductive health and rights (SRHR) in the 6th CP are wide, including: family planning; prevention and management of sexually transmitted infections including HIV; male circumcision; cervical cancer screening; and emergency obstetric and neonatal care (EmONC) including prevention of mother to child HIV transmission (PMTCT). Particular attention was also given to two priority groups, adolescents and female sex workers (FSW) whose needs are insufficiently addressed. All these focus areas are highly relevant to Zimbabwe where there is high and avoidable maternal and child mortality, a serious HIV epidemic, high rates of cervical cancer, low rates of male circumcision, high and rising teenage fertility and a contraceptive prevalence rate (CPR) that is too low. The CPR in sexually active adolescents was 10 percent (ZDHS 2010/2011).

The orientation and activities of the 6th CP are fully relevant to the Zimbabwe situation at policy, strategic and activity level, with government ministries, city health departments and parastatals being the main partners of the RHU and recipients of financial and technical support. UNFPA has also contributed financially and technically during the 5th and 6th CPs to the development of a number of policies and strategies, including: Zimbabwe's National Health Strategy (NHS) 2009-2013 (now extended to 2015); the Adolescent Sexual and Reproductive Health (ASRH) Strategy 2010-2015; the National Reproductive Health Policy (NRHP) (development started in 2012 but still in draft[41]), the Maternal and Neonatal Health (MNH) Roadmap 2007-2015; the National Strategic Plan for Elimination of New Paediatric Infections 2011-2015; revision of STI management guidelines and, currently, a new family planning strategy. These policies and strategies together provide the orientation and guidance on strengthening SRHR. Policies and strategies for HIV and AIDS are noted in 4.2. UNFPA CO's contributions in the 6th CP are fully aligned to the policies and strategies, to the UNFPA Strategic Plan and the Zimbabwe UN Development Framework (ZUNDAF) as expressly stated in the CPAP. They are relevant to the Zimbabwe response to address the Millennium Development Goals (MDGs) 4 (child survival), 5 (reduced maternal mortality) and 6 (on AIDS, TB, malaria and other infectious diseases). UNFPA also sits on numerous SRHR and HIV national technical working groups, steering committees and other bodies.

Support for humanitarian situations, high in the 5th CP with USD 2.5 million mobilised, was limited in the 6th CP mainly to 2012 and at a low level of support according to the CO as other partners were assisting internally displaced persons and there was no major humanitarian crisis requiring UNFPA support. UNFPA has no core funding in the 6th CP for humanitarian situations, and the Humanitarian Response Officer post ended in 2012. However, UNFPA gave some GBV and commodities support to antenatal women displaced with their families (12,000 people) by flooding at the Tokwe Mukorsi Dam in 2013. In June 2014 at a regional meeting on humanitarian situations, the CO agreed to instate a humanitarian contingency fund in the 7th CP and to designate an existing officer as focal point to sit on a national committee developing contingency plans and to attend relevant cluster meetings.

4.1.2.2 Integrated Support Programme for SRH, HIV and GBV

Aiming to improve women and girls' sexual and reproductive health and rights, to prevent HIV and to reduce gender based violence (GBV), the ISP is by far the most extensively funded programme that

[41] According to the CO delays stem from the MoHCC, which is not prioritizing the NRHP although the current one dates from 2002. It may be finalized in 2014, but this is not certain.

supports UNFPA to deliver. Internationally UNFPA and other stakeholders identify multiple benefits through integration of SRH and HIV services, including more streamlined provision to meet SRH/HIV needs of individual clients, potential for greater efficiencies and cost effectiveness, and strengthened service uptake if several services are available at one site. Three bilateral donors (the British, Swedish and Irish governments) provide most support for the ISP, at around 64 percent of all UNFPA external programme funding. The programme cuts across the RH, HIV and gender units of the CO, with overall management by the HIV and SRH Technical Specialist in the HIV Unit. The programme is nationally coordinated through the MoHCC, MWAGCD and NAC. MoHCC established a Coordination Unit in early 2104 with ZNFPC and funders also as co-chairs.

The ISP addresses unmet needs of women and girls' SRHR through focusing on maternal morbidity and mortality, family planning (FP) services, cervical cancer screening and treatment, HIV prevention, GBV prevention and response, and related research and evaluation. It strengthens both health and community systems for improved service provision and community access to and utilisation of these services. These areas are all highly relevant in Zimbabwe given the extent of unmet needs and prevailing health indices.

The ISP is implemented through four complementary pillars namely i) Social marketing of integrated SRH/HIV/GBV services; (ii) Public sector integration of SRH/HIV/GBV services; (iii) Procurement and distribution of FP commodities; and (iv) Research and evaluation. UNFPA leads on Pillar 2 to expand demand for SRH/HIV/GBV services, to strengthen public sector delivery of integrated services, and supporting overall coordination with government. Section 4.2 addresses the social and behaviour change programme, HIV prevention and female sex workers, and 4.3 the GBV focus.

The Zimbabwe National Cancer Registry (2009) identified cervical cancer as the most common cause of cancer-related deaths in women in the country, contributing one-third of all cancer diagnoses[42] in 2009 in black women. Immune compromised patients have a faster rate of progression to cervical cancer when infected with Human Papilloma Virus, so that reaching women at high risk for HIV or known to be HIV positive is highly relevant. UNFPA contributes financially and technically to a National Cancer Prevention and Control Committee, particularly around cervical cancer. The Committee developed the Zimbabwe Cancer Prevention and Control Strategy 2014-2018. Mainly through ISP funding, UNFPA supports cervical cancer screening by visual inspection with acetic acid and cervicography, VIAC (see also sections on efficiency and effectiveness). This is a highly relevant area of contribution to the needs of women in Zimbabwe, as diagnosis through Pap smears have been available only to those who could afford them. Most women in the past were diagnosed late.

The family planning (FP) component is also highly relevant, including for adolescents amongst whom teenage pregnancies and maternal mortality are high. UNFPA CO is strengthening reproductive health commodity security (RHCS) also through the Global Programme for Reproductive Health Commodity Security (GPRHCS). This includes support for ZNFPC to develop the Zimbabwe National Family Planning Strategy, currently awaiting finalization, and procurement of STI drugs. Demand generation, condom programming and male circumcision are discussed in 4.2 on HIV.

4.1.2.3 H4+, Emergency Obstetric and Neonatal Care (EmONC) and Maternity Waiting Homes

High maternal mortality rates in Zimbabwe (see Chapter 2) and infant mortality make it imperative to address the needs through improved access to and uptake of basic emergency obstetric and neonatal care (BEmONC). Delays in seeking care and poor quality care on arrival at facilities have been the most significant of the three delays in access to effective emergency care. UNFPA has responded in the 6th CP through the CIDA and Sida-supported H4+ project from 2011-2015[43], and strengthening

[42] National Cancer Prevention and Control Strategy for Zimbabwe 2014-2018, Epidemiological and Disease Control Non Communicable Disease Unit, MoHCC

[43] Accelerating Progress Towards Maternal, Neonatal and Child Morbidity and Mortality Reduction, MDGs 5 and 4

capacity for EmONC and refurbishment of maternity waiting homes nationwide. These approaches align with the Campaign on Accelerated Reduction of Maternal Mortality in Africa, CARMMA.

The H4+[44] programme was conceptualized with CIDA support for the period 2011-2015 to provide catalytic support to ongoing efforts by MoHCC to accelerate achievement of MDG 5 and also to improve child health and to provide innovations with potential for scale up. In 2013, Sida came on board with complementary support. The programme operates in six remote districts, three in the north-west and three in the south-east. The H4+ Programme Mid Term Review [45] found the programme to be highly relevant and coherent with the country's health priorities and population needs with its focus on improving the quality of care, increasing demand and service uptake, and improving quality, collection, analysis and use of data to assess programme performance. UNFPA provided financial and technical support to MoHCC for a needs assessment in early 2014 to examine the status of EmONC services in order to strengthen capacity in the selected facilities. It also generated benchmark data against which to measure progress during the project[46]. The aim is to learn lessons from the six districts of the programme to inform wider scale up country wide to reduce maternal mortality, under 5 mortality and to eliminate new HIV infections in children (eMTCT). The latter is addressed in Section 4.2 on HIV.

The national project to refurbish maternity waiting homes (MWH) funded by the EU is also highly relevant as it addresses two of the 'three delays' in access to emergency care: delay in deciding to seek emergency care and delay in travel to a facility. MWH is not a new concept in Zimbabwe but existing homes had become run down and were not functioning as they should. The refurbishment project is part of the Zimbabwe National Maternal and Neonatal Health Road Map 2007-2015.

In line with the UNFPA Strategic Plan outcomes 3 and 4, and CP Output 2 under Outcome 1, UNFPA is supporting MoHCC and ZNFPC to strengthen access to FP. The most significant activity in 2013/14 was support for ZNFPC to develop the Zimbabwe National Family Planning Strategy, currently awaiting finalization. Training has commenced for implant insertion and for placing intrauterine contraceptive devices, IUCDs. UNFPA also fills gaps in contraceptive and drug procurement for STIs and in contraceptive and related commodity procurement, including widening the range of choice within the overall method mix. Currently FP is skewed towards the pill. These are highly relevant activities to address unmet need, including for young people. Demand creation is discussed under the ISP.

4.1.2.4 Support for adolescent sexual and reproductive health and rights (ASRHR)

UNFPA's support for adolescents and young people is broad based within different programmes and funding sources, and integrated in all RH outcomes and outputs. The CP addresses all five prongs of the regional and global UNFPA adolescent and youth strategy.

i. Evidence based advocacy: UNFPA Zimbabwe has generated key data on young people, conducted advocacy campaigns and supported networking and coordination
ii. Comprehensive sexuality education, CSE: UNFPA supported the Life Skills, Sexuality, HIV and AIDS Education Strategic Plan development in the 5th CP and has provided continued support for curriculum review, peer education in tertiary institutions, community dialogues and use of social media to reach young people
iii. Capacity development for SRH services: this has involved youth friendly service provision with youth corners, peer education and clinic services, and support for youth interact stand alone services

[44] H4+ refers to the initial 4 UN partners (WHO, UNAIDS, UNFPA, UNICEF), and the '+' to partners joining later
[45] H4+ Canada supported activities: mid-term review in Zimbabwe Country Report, 22 April 2014
[46] Emergency Obstetric and Neonatal Care Service Needs Assessment for the H4+ Sida/CIDA Supported Districts. MoHCC. April 2014

iv. Reaching disadvantaged adolescents and youth: establishing Sista2sista clubs for at risk girls and young women through mentors, a pilot programme
v. Promoting youth leadership and participation: support for the Young People's Network on SRH and HIV, affiliated to the regional African Youth and Adolescent Network, AfriYAN, and also recruiting youth internships with NAC.

All these are highly relevant to the Zimbabwe situation, as ASRHR have not been sufficiently addressed to date. Linkage with adolescents and young people living with HIV is also being initiated (see HIV section), another highly relevant area of focus. Various ASRHR approaches are discussed further under efficiency and effectiveness, as well as complementary discussion under HIV prevention.

4.1.3 Efficiency

4.1.3.1 The UNFPA CO Reproductive Health Unit (RHU)

Overall, the RHU has responded positively and quite efficiently to some identified challenges by revising activities, revising indicators and in strengthening its capacity to address the challenges it has faced during the 6th CP. The RH Unit has faced a hugely increased work load during the 6th CP, however, and the staffing complement has not yet increased commensurate with the scaling up of programmes through greatly increased non-core funding in this cycle (KI interviews, document review). This in itself has had negative consequences on programming in addition to the stress on unit staff to deliver; for instance it has led to reported delays in work planning, programme implementation, and withdrawal/less regular participation in various national and sub-national fora. It has put pressure on the unit's capacity to undertake sufficient operations research to establish baselines and monitor progress, to provide timely support to IPs to meet their needs, and to undertake timely follow up with other UN partners (internal and external KI interviews and documentation). Procurement is a particular challenge, as the same two officers in place in the 4th and 5th CPs have to process all procurement across all areas of RH, with only the addition of one assistant in 2013. This reported work overload causes delays, inefficiencies in tracking and related challenges that result in failure to meet commitments timeously, and hold up programme implementation. In addition, it means that staff in different units tend to work in silos, as noted elsewhere also, despite willingness to communicate and cooperate in principle. However, CO interviews confirm that collaboration is definitely improving, for instance with the HIV Unit around training and other areas.

Recently RHU capacity has increased through recruitment in 2014 of the international technical specialist and one extra programme assistant in late 2013, with anticipated recruitment before year end of another programme analyst and a programme associate. Collectively these posts should significantly contribute to greater responsiveness and efficiencies of the unit.

Regarding resource expenditures, despite the challenges noted, in 2012 and 2013 the RHU core resource implementation rate was fully on track at almost 100 percent, but to September 2014 it was only 24 percent (Atlas). This reflected delays in planned work, particularly for midwifery. However, the CO reports that in October and November 2014 expenditures to reopen a midwifery school are expected to utilize most of the remaining budget, and implementation should be on track by year end. Non-core resources had a low implementation rate in 2012 (17 percent) primarily reflecting the EU Linkages Project start date being 15 November that year. The implementation rate for 2013/2014 is a major improvement (see Chapter 3 table) and any remaining resources will be rolled over to 2015.

4.1.3.2 Support for youth friendly service provision

Continued adverse indicators, despite many years of support for ASRHR suggest that the core approach premised on youth friendly corners has not been efficient and effective. The parastatal Zimbabwe National Family Planning Council (ZNFPC) has claimed the space as custodian of adolescent sexual and reproductive health demand creation and service provision, but has been unable

to produce statistics for the extent of programme roll out, numbers reached by peer educators and service uptake among adolescents and young people, or the quality of service provision. Many reasons are provided for this (KI interviews), but ultimately the failure to provide robust M&E and quality assurance leads to the conclusion that there needs to be a change in the modalities of reaching adolescents and in the institutional mechanisms and partners involved. At national level, although the Reproductive Health Unit in the Family Health Department of MoHCC reports close collaboration with ZNFPC (and the deputy of the Unit is on the board of ZNFPC), on the ground, KI interviews indicate that confusion does sometimes arise with the respective mandates of the two bodies overlapping. This led to the CO reviewing its support and approach to this area, beginning in December 2013. With regards other areas of ASRH support, see the section on effectiveness.

4.1.3.3 H4+, EmONC, and maternity waiting homes

The focus on maternal health includes the H4+ project in six districts, EmONC training, refurbishment and services at maternity waiting homes (MWH), maternal death surveillance and response, and FP services. These are funded through various projects (H4+ by CIDA and Sida, the EU-funded MWH project, ISP and the Global Programme for Reproductive Commodity Security (GPHCS). The mid term review of the H4+ programme found it difficult to measure efficiency of roll out in the absence of provision of adequate data, and the programme is too new to assess value for money. However, funds to achieve results were considered overall to be insufficient. UNFPA received Sida-funding of USD 2,208,376 in October 2013, but the fund utilization was only 4.6 percent at June 2014, the lowest utilization rate of all five partners receiving Sida funds. KI interviews noted that the lack of a coordinator in the MoHCC until August 2014 meant that there was confusion about responsibilities and many activities were not scheduled (e.g. setting up committees at district and provincial levels). Since the post was filled, however, a noticeable improvement has occurred and should continue to show results, indicating the importance of having a dedicated officer in place rather than responsibilities being shared with no clear leadership to move things forward. Programming and planning issues were also reported (KI interviews) within UNFPA RHU, with lack of clarity on occasion as to how best to implement activities. Implementation modalities, feasibility of programming and other planning issues were complex and demanding of time on an already heavily stretched team, so that roll out started late. The strengthened staff complement in the RHU is improving coordination and implementation in house, with improved tracking systems and follow up to detect bottlenecks and other challenges early. Likewise, despite delays in initiating the maternity waiting home project nationwide, progress has speeded up in 2014 (see effectiveness section) and is clearly coming on track. Efficiency and effectiveness of ASRH within the H4+ programme are discussed under the ASRH sections.

4.1.3.4 Capacity support for MoHCC and ZNFPC

Feedback from KIs indicates that the support from UNFPA for capacity building in the MoHCC through key coordinating and other support posts has been crucial. These posts could not be supported by the ministry and the training of health providers in STIs, FP, condoms, VIAC and integrated services would not proceed at the same level without UNFPA financial and technical support. Demonstrable benefits have accrued once coordinators were in place, an example being the recruitment of a VIAC and FP programme officer that has helped speed up service provision (see later section). Thus investment in these posts has been an efficient and effective use of resources. Ideally, further posts should also be supported.

However, the efficiency of support from UNFPA could be improved, for instance through reinstating quarterly meetings with UNFPA-supported staff that have stopped without explanation in 2014. These fora allowed early discussion of challenges and issues, e.g. regarding transport or regulations on workshop disbursements, and promoted integrated working and synergies, e.g. around training. On the other hand, the inclusion of the ministry staff for the first time in UNFPA's mid-year strategic planning meeting for the next CP was seen as a very positive development. Their inclusion in CO retreats has also reportedly been agreed but not implemented. Various ministry staff also raised other issues such as the need for further ministry staffing posts, and reflected that the balance of numbers of

posts in UNFPA CO compared with the MoHCC appeared inappropriate, given that the key need is for implementers. The heavy workload of UNFPA CO has already been noted, part of which is because the office has responsibility for fund management for work through the public sector. If this changes in the next CP, the administrative burden on CO programme staff would significantly decrease and lead to efficiency gains.

In the various areas of training, the main measurement is numbers trained, which is insufficient to ensure efficient use of resources to change practice on the ground. Some quality assurance is in place such as six-week review after training, but this needs to be strengthened through supportive supervision, mentoring and review over time. The piggy-backing of training on existing courses rather than establishing completely discrete, separate courses (see 4.1), is another means of ensuring more efficient resource use and reduced disruption of staff work time.

The UNFPA CO, in collaboration with Futures Group, has also supported ZNFPC to do an economic analysis of FP providing critical analysis of investments required to meet the country's 2020 FP commitments from the London Family Planning Summit in 2012. This included indications of potential savings across sectors if adequate FP investments are made, that would increase efficiency.

4.1.4 Effectiveness

4.1.4.1 Overview of results

The effectiveness of RH programming in meeting output results by mid-2014 is generally strong, despite a slow start in the 6th CP in various areas, largely as funds were received late in the year. More rapid scale up has occurred in 2013 and 2014. Table 4.1.1 highlights key achievements against targets. Details of achievements by year against all CP output indicators and baselines are provided in Annex 2, the Updated Planning Matrix for M&E, June 2014. See the M&E section for overarching comments, including challenges and pitfalls and some inconsistencies noted.

Table 4.1.1: Achievement of RH Results by mid-2014 against 2015 Targets*

CP Outcome 1: Increased access to and utilization of quality maternal and newborn health services			
CP Output 1: Strengthened capacity of Government and civil society partners to coordinate and deliver reproductive health services			
Indicator	**Baseline and Target by end of 2015**	**Achievement by mid 2014**	**Comments**
Number of central, provincial and district hospitals supported to offer comprehensive EmONC services	Baseline: 0 Target: 148 by 2015	83	Largely on track and should meet target by end of 2015; roll out has accelerated
Number of hospitals supported to offer cervical cancer screening using VIAC	Baseline: 5 Target: 71 by 2015	42	Not yet on track but rapid scale up underway and could meet 2015 target
Number of women screened for cervical cancer	Baseline: 0 Target: 115,000 by 2015	73,742	On track except for female sex workers
Number of service delivery points supported to offer youth-friendly SRHR services	Baseline: 37 Target by 2015: 75	73	On track. However, the outcome results from this approach do not appear strong and the approach is being reconsidered

# of RH/HIV reference documents (policies, guidelines, protocols) developed, reviewed and/or revised with programme support	Baseline: 0 Target: 8	10	On track, achieved in 2013; exceeded original expectation; an essential area of contribution
CP output 2: Increased availability of reproductive health services and commodities			
# of supported facilities in the public health sector with at least one health care worker trained in FP provision including implant insertion	Baseline: 0 Target: 300	258	On track Roll out was delayed in 2012 owing to late procurement of commodities and other factors but catching up
# of service providers trained in family planning provision	Baseline: 0 Target: 850 by 2015	769	On track
# of supported district hospitals[47] with functional maternity waiting homes, in line with the minimum requirement as specified in the MWH operational guidelines	Baseline: 20 Target: 125 by 2015	83 (includes 20 from baseline)	Appears largely on track. The CO reports that refurbishment should be finalized in 2015 with a no-cost extension
# of implant insertions for women aged 16 years and above at UNFPA supported sites	Baseline: 0 Target: 49,650 by 2015	23,817	Largely on track given the late start in 2013 and rapid catch up in 2014
CP Output 3: Increased demand for sexual and reproductive health services at the community level			
# of young people reached through peer education on behaviour change in SRH and HIV prevention	Baseline: 300,000 Target: 600,000 above baseline by end of 2015	86,789	Not on track The target was originally 900,000 which was clearly too high; the present target also appears unrealistic after a delayed start

Source: Mid Term CPAP Review 2014, M&E Analysts UNFPA CO

* On track means should meet 2015 target; largely on track means likely to meet 2015 target; not on track means falling substantially behind and unlikely to meet 2015 target without rapid escalation

One indicator for Output 2 for Outcome 1 in the original CPAP RRF is the contribution of UNFPA to numbers of reference documents (e.g. policies, guidelines, protocols and clinical mentorship guidelines) with a target of eight by 2015 (but only two in the revised M&E framework above). By September 2014, the CO had provided technical and financial support to at least[48] training and guidance documents, apart from policies and strategies, and two documents were finalized late in the 5th CP[49]. These are highly relevant, quality products that are being utilized for training and directly to strengthen capacity.

[47] Indicator reads district hospitals but Zimbabwe has only 62 districts and this must include other facilities (health centres, clinics, rural, mission and provincial hospitals). UNFPA 2014 report on MWH (see below) reports 104/5 facilities scheduled for refurbishment under this budget. The CO needs to clarify the disconnect in figures.

[48] Survey of medicines in the public sector and the private sector respectively; Facilitator's and Participants' manuals for basic emergency obstetric and newborn care (BEmONC); BEmONC Training of Trainers Facilitator and Participant manuals, and a referral manual; multiple IEC leaflets in different areas of RH

[49] VIAC Based Cervical Cancer Screening and Management and the ASRH Standard Training Manual for Service Providers.

Even where indicators show the programme to be on track, however, questions arise as to how far these results contribute to meaningful results at outcome let alone impact level. Activities measured such as outreach to a given number of beneficiaries is insufficient to indicate the quality or intensity of coverage, and whether this results in any behaviour change or demand creation. In addition, a drawback for evaluating most social and behaviour change efforts is that reported sexual behaviour is an unreliable indicator, particularly if obtained through survey methodologies.

4.1.4.2 Family planning, cervical cancer screening and STI management

Support for family planning, cervical cancer screening and STI management, such as training of service providers is supported by the ISP, by the GPRHCS programme, and in the adolescent programmes, and is reported as on track. However, there remain significant gaps in FP, both for long-term methods and insufficient condom use. FP is constrained by a narrow range of options within each FP method, so that if one method, e.g. the contraceptive pill does not suit a beneficiary, there may be no alternative available. UNFPA supports training of care providers to provide long acting and reversible methods, particularly implants. Community demand creation for FP, including for condoms, and promoting leadership support for adolescent access, are greatly needed (see ASRH).

Demand generation and supply of cervical cancer screening services are generally on track in the 26 districts of the programme, except within the sex work programme where procurement of equipment is a year behind schedule but will be distributed to all static sites in late 2014. The main benefit is early detection through VIAC[50] of pre cancerous conditions that can be treated with cryotherapy or LEEP[51], undertaken free in the clinics. Roughly 8-9 percent of all women screened through VIAC test positive for a pre-cancerous or cancerous condition (CO M&E records). Of these, roughly 60 percent, or 5.4 percent of all women reached, are treated to prevent cancer, provided commodities and competent medical staff for cryotherapy and LEEP are available. In 2014 UNFPA has scaled up procurement of equipment, and is putting in place systems to facilitate easier access to commodities having found fluctuating trends in cryotherapy access because of late procurement of gas by facilities (CO M&E Unit), and task shifting is being developed to strengthen medical capacity for LEEP. Currently demand is being generated in an important and neglected area, particularly for FSW who are at high risk and for HIV positive women, but this is not translating routinely into increased treatment access for the poor. Access to effective treatment and care needs to improve as for all cancer treatment in Zimbabwe, and UNFPA sits on the national cancer committee. Service providers report that a side benefit of VIAC is that women seek other SRH services when coming for screening, although this was not quantified. HIV testing is routine at VIAC sites, with referral as needed. Around 26 percent of women seeking screening are HIV positive, making this a highly strategic entry point to boost HIV treatment access.

4.1.4.3 H4+, emergency obstetric and neonatal care, and maternity waiting homes

Given the slow roll out of EmONC training and procurement under H4+, it is too soon to measure the effectiveness of the H4+ programme. However, the May 2014 intermediary report[52] flags that coordination is now in place and reporting will be facilitated by UNFPA. UNFPA received Sida-funding of USD 2,208,376 in October 2013, but the fund utilization was only 4.6 percent by mid 2014, the lowest utilization rate of all five partners receiving Sida funds. However, with the recruitment of the MoHCC coordinator the implementation rate is escalating. Trainers of trainers are already in place and can cascade training on key areas (such as for manual vacuum aspiration after miscarriage) now that the kits are being procured, and EmONC training has already started in the H4 districts and is expected to be on track by year end. UNFPA's portion of funding was higher than that of the other partners combined, and spending is rising. Prevention of mother to child HIV transmission is addressed in section 4.2 on HIV prevention, and ASRH under the relevant sections. An additional initiative in 2014 has been UNFPA support to develop a clinical mentorship manual for

[50] Visual inspection with acetic acid plus cervicograph
[51] Loop Electrosurgical Excision Procedure
[52] Zimbabwe H4+ Sida Intermediary Report, May 2014

reproductive, maternal, neonatal and child health services in Zimbabwe, under H4+ funding. Clinical mentoring is underway in three provinces. This is particularly needed in light of the brain drain of skilled professionals over the past years. Also, the maternal death surveillance planned earlier took place in mid 2014, and the feedback will help inform the programme for the way forward in addition to, for example, development of maternal and perinatal death audit guidelines. UNFPA is also assisting the MoHCC develop an electronic maternal death database. Community awareness efforts on accessing EmONC have not been implemented as planned, but in reality demand is already high; the key gaps are provision and access to quality services.

Nationwide capacity development for EmONC services (separate from the H4+ funded project) is largely on target and has been so throughout the 6th CP with regards numbers of central, provincial and district hospitals supported. However, there is concern (KI interview) that the emphasis now should include the provincial level to ensure not just the basic services but the full WHO seven signal criteria for effective emergency care; most district and lower level sites cannot offer the full services and need to refer complex cases upwards, but provincial hospitals often lack the full resources also. An additional UNFPA contribution is procurement of 62 ambulances, one for each district hospital, to transport emergency referrals from clinics or to refer complicated cases on to provincial level.

Refurbishment of maternity waiting homes (MWH) is also coming on track after a slow start (see the table for specific results). The work should be completed in 2015. The findings from field visits to four MWHs, however, found certain limitations[53]. Particularly for the poorest women, the non-provision of food was a challenge. Also, although the women can attend ANC clinics for health education talks, further opportunities for sharing information on neonatal care, exclusive breastfeeding, and other SRH/HIV and/or GBV services could usefully be provided. The homes visited were also oversubscribed with women sharing beds or sleeping on the floor; levels of need and demand appear not to have been accurately assessed. Despite the drawbacks, however, FGDs with the women were positive; they felt the benefits greatly outweighed the limitations. The effectiveness of the programme over time in contributing to reduced maternal mortality and improved infant survival will be closely monitored and is potentially considerable, provided the actual service provision in the facilities meets minimum standards. In one interview a district nursing officer commented: 'In the past year we have recorded very few maternal deaths at our district hospital compared to past years. Those that we record will be having other illnesses besides emergencies of pregnancy, and so the facility is helping the women.'

Improving midwifery training schools has not taken place as planned by UNFPA, as other partners have come in (under the Health Transition Fund, HTF) who could contribute to this. UNFPA is supporting refurbishment of one provincial hospital for on site training for a range of reproductive health related services, including midwifery, EmONC, FP and other areas.

However, given that reducing maternal mortality, MDG 5, falls under the mandate of UNFPA within the UN division of labour and that the HTF will come to an end, it is important that UNFPA show considerably stronger leadership and focus on this area than it is at present. This should include overall support for EmONC nationwide at all levels from policy through to service provision, training, funding and technical assistance. H4+ is a platform from which to develop synergies and learning for what works, and it should help inform the way forward.

4.1.4.4 Support for adolescent SRHR and HIV prevention

The support for adolescent SRHR and HIV prevention has taken several forms under Outputs 1, 2 and 3 and addresses all five prongs of the overarching UNFPA strategy as noted earlier. One approach, the

[53] E.g. beds so close together that women have to climb across them; inadequate light and water and sanitation; no provision of food; structural defects; non-durable furniture; and reliance on firewood for cooking that necessitated heavily pregnant women gathering and carrying firewood.

stand-alone youth interact centres (under Output 3) was initiated in 2011 but dropped in 2013 when UNFPA realized that the youth ministry lacked sufficient capacity to implement them effectively.

One key challenge for ASRHR in Zimbabwe is the high teenage pregnancy rate and low contraceptive rate among sexually active adolescents. This has not been sufficiently addressed during the 6th CP. UNFPA is working with GoZ to study the factors contributing to high teenage pregnancies with a view to establishing a better focused programme in the 7th CP to address the root causes, and to reduce teenage maternal deaths. In the H4+ project maternal deaths among adolescents are of considerable concern. Seventy-three sites have been supported to offer youth friendly services through support of H4+, Safeguard Young People and ISP.

The strategy of youth friendly services or corners in public health facilities has not been effectively implemented or shown good results in service uptake (KI interviews, documentation, field visits), whether or not corners are well provisioned. At one well-provisioned site the registration book showed service uptake ranging from none to three or four adolescents a day. Another site primarily served as a (valued) meeting point mainly for street boys to socialize and access washing and other facilities, with peer educators and others also utilizing the facilities to meet. Trained peer educators are available in many corners but are poorly monitored by ZNFPC through low capacity of the community based distributors, and UNFPA has been unable to learn what work peer educators are doing, particularly in the community. Also, most corners refer adolescents for most RH services to adult clinics where staff may not be youth friendly. Field visits and KI interviews indicate challenges in management, staff and volunteer retention. UNFPA is in process of withdrawing direct support for the corners in favour of sensitizing all staff at health facilities to be youth friendly, including guards, cleaners and health providers. An intensive approach is being developed in six districts and will be closely monitored. It also includes sensitisation of wide ranging community leaders. UNFPA is supporting MoHCC to establish sub-committees to work within existing Rural Health Centre Committees to advocate for SRH for adolescents and to support youth friendly health service provision. If effective, the intention is to expand this approach into the 7th CP; UNFPA also needs to investigate how far the current youth friendly corners have met internationally recognized standards for effectiveness (based on WHO-led Steady, Ready, Go guidelines[54]), what the limitations are, and how they might be effectively addressed.

Another community initiative is support to the Young People's Network on SRH and HIV (set up in 2008) as Zimbabwe's chapter for AfriYAN, This 1,800 strong national membership organization operates at national, provincial and district levels, coordinated by the NAC Youth Coordinator whom UNFPA supports with two youth interns. UNFPA provides funding and technical support for network activities at all levels, including coordination meetings and initiatives such as screening films to reach young people. The network contributes the youth voice to the ASRH Coordination Forum. This is chaired by the MoHCC with ZNFPC as secretariat working with the Zimbabwe Youth Council to coordinate implementation of the ASRH strategy nationwide. The network also sits on the Technical Working Group on HIV and Young People under NAC. The influence of the network at district, provincial and national levels needs to be better quantified, and UNFPA should contribute to monitoring and evaluation.

UNFPA collaborates with UNESCO and UNICEF to support comprehensive sexuality education (CSE) in primary and secondary schools. Although the GoZ has had mixed reactions to the CSE agenda, as have school staff themselves who find it challenging to teach sensitive issues around sexuality, the ministers of education and health in Zimbabwe signed the regional ministerial commitment to CSE and ASRH services in December 2013, one target of which is that 'A good quality CSE curriculum framework is in place and being implemented in each of the 20 countries'[55].

[54] Preventing HIV/AIDS in Young People: A systematic review of the evidence from developing countries; 2006. WHO Technical Report Series 938. UNAIDS Interagency Task Team on Young People.

[55] Ministerial Commitment on comprehensive sexuality education and sexual reproductive health services for adolescents and young people in Eastern and Southern Africa (ESA), 7 December 2013, p7. Meeting supported by UNESCO, UNICEF, UNFPA and WHO.

This is testament to the advocacy by UN partners, including UNFPA, and other key stakeholders to bring about this policy commitment. Recent Cabinet approval for curriculum review of life skills education, including a strong emphasis on HIV and AIDS, is reportedly in place (KI interviews), and the education ministry intends to re-establish a unit for life skills and sexuality education. The intention is to train two counselors per school to teach CSE. NGOs could also assist if the ministry found this acceptable. The opportunity is there for much more effective work with schools in the 6th and 7th CPs.

Peer education for teacher trainees in SRHR/HIV could be a particularly strategic entry point to support both the trainees and in-school students for SRHR and HIV prevention if it cascades into the incorporation of effective CSE teaching when they graduate. UNFPA currently supports two tertiary colleges, one a teacher-training institution, and will double this in 2015, but the aim is primarily to benefit college students themselves. It would be useful to strengthen the link with sexuality education in schools. A field visit to the teacher-training institution found, in an FGD with 12 peer educators (PEs) that participants were highly motivated and active in orientating new students on SRHR and HIV and providing ongoing support. They are keen to utilize their learning in school settings on placement and after they graduate, feeling empowered to cope with SRHR/HIV themselves. They reported high uptake by students of HTC and condoms, and 'many' males opting for VMMC; on the other hand, pregnancies among teacher trainees were reported to be high. No triangulation of data with the FGD findings from this one college was possible, however, so these cannot be considered robust findings.

The Sista2sista clubs under the ISP aim to help empower vulnerable girls aged 10-19 in relation to SRHR/HIV/GBV. FGDs with three clubs found that the girls had good basic knowledge of SRHR/HIV and they reported no longer stigmatizing people living with HIV. However, they focused almost entirely on abstinence alone as a safer sexual behaviour. FGDs with BCFs confirmed the emphasis on abstinence, although they said they introduced condoms also and messaging around monogamy. The data overall are not sufficiently robust and there could be reporting biases, but the findings suggest that the balance of discussion and information giving around HIV, STI and pregnancy prevention needs to improve, taking account of the differing needs of sexually active and non-sexually active members, and age. Also of concern is the growing number of adolescents and young people living with HIV. Close links with MoHCC AIDS and TB Unit and Reproductive Health Unit and organisations such as Africaid's Zvandiri Programme for HIV positive youth could build mentor capacity to support HIV positive adolescents in the clubs and at home. They could also support HIV positive adolescents in the Linkages centres of excellence.

4.1.5 Sustainability

UNFPA has extensively supported policy, strategy, guideline and training manual development, which should strengthen SRHR orientation and capacity development, and promote integration long term. UNFPA support to build health system capacity through training, facility refurbishment, procurement of equipment and commodities, and community demand generation may also have some lasting impact.

The extent to which the health staff training will lead to lasting benefits remains to be demonstrated, and will depend on several factors: the quality of the training; the extent to which trained health providers utilize their new skills and knowledge, and how far they cascade these to other staff; and, critically, the extent to which they remain within the MoHCC in positions in which they can utilize their learning. Considerable risks remain regarding staff demoralization and attrition, continued freezing of posts in the health sector, and for equipment and facilities to be maintained at sufficient levels. Continued involvement of BCFs and peer educators may also be subject to risk of attrition given the low remuneration of volunteers (USD15.00 per month).

In some areas of procurement, UNFPA contributions may have relatively long-term benefits provided equipment can be maintained in good working order (e.g. VIAC equipment, ambulances); however, it is unclear that MoHCC can sustain running costs and normal wear and tear without ongoing support.

Regarding ASRHR some strategies are likely to show sustainable results, such as the advocacy for rethinking the life skills education at school and to develop comprehensive sexuality education; and perhaps the youth network. Youth corners, however, do not appear to have achieved significant results given poor indicators of high and rising teenage pregnancy and high STIs, and sustained benefit from present programming is unlikely. UNFPA sees that modalities and priorities to reach adolescents and young people effectively need to be reconsidered.

Overall, the conclusion is that, for the foreseeable future, continued financial and technical support will be required from UNFPA for SRH, particularly for adolescents, female sex workers and for women, particularly regarding EmONC. This will remain the case while the political and economic situation in Zimbabwe remains fragile.

4.2 HIV Prevention

4.2.1 Overview of the HIV Programme

The outcome to which UNFPA is contributing in the 6th CP for HIV prevention is the increased adoption of safer sexual behaviour and use of HIV prevention services, to be achieved through two outputs: CPAP Output 4) Increased coverage of the social and behaviour change communication programme; and CPAP Output 5) Increased availability of HIV prevention services[56]. This is the second outcome under the component Reproductive Health and Rights, with a degree of overlap with some approaches, projects and programmes of the first outcome.

The CPAP identifies the following main approaches to achieve Output 4:

a. Interpersonal communication at district and community level;
b. Capacity development of leaders as role models and advocates for HIV prevention;
c. Technical assistance in the development and implementation of social and behaviour change communication (SBCC); and
d. Continued gathering of evidence for informing HIV prevention SBCC interventions.

The main activities to achieve Output 4 are given as: providing technical assistance to the national HIV prevention behaviour change programme; supporting capacity development for community behaviour change facilitators (BCFs) and for community leaders; developing and updating SBCC materials; supporting decentralized interpersonal communication by BCFs including home visits, community workshops and BC messaging at local events; supporting peer education on SRH/HIV among sex workers and young people; operations research on effective communication approaches to support universal access to combination HIV prevention; and reviewing and updating the basic life skills education curriculum in schools around HIV prevention.

The main CPAP approaches to achieve Output 5 are:

a. Scaling up availability of safe and voluntary medical male circumcision services;
b. Capacity and systems strengthening in condom programming;
c. Expanding coverage of services for sex workers; and
d. Promoting SRH/HIV policy, system and service integration.

The main activities cited include: technical assistance for the Combination HIV Prevention strategy (subsequently called implementation approach); strategic research in various areas to generate

[56] UNFPA CPAP 2012-2015, Annex 1, Results and Resource Framework

evidence; strengthening health provider capacities; support for male circumcision roll out; support to effective health sector management of HIV prevention programmes and condom programming; and providing integrated SRH/HIV services to sex workers through specific referral clinics and outreach sites.

The two outputs (increased SBCC coverage and increased availability of HIV prevention services) fit logically together, given that the former focuses on behaviour change including demand generation for services. During the 6th CP new funding opportunities emerged to expand integrated sexual and reproductive health and rights and HIV prevention programming, as noted in Section 4.1.

It is a challenge to measure effectiveness of outputs against outcomes, let alone impacts, particularly regarding social and behaviour change and in the short time frame of the evaluation (24 months). This said, the output indicators in the CPAP are essentially process measures and it is not clear that the theory of change logic is sufficiently robust. The CPAP measures extent of coverage and does not sufficiently address quality or intensity of programming, or whether outputs are likely to have contributed to outcomes. Operations research (OR) and reviews supported by UNFPA have been undertaken by, amongst others, Zimbabwe Community Health Intervention Research Project (ZiCHIRE) linking with Zimbabwe HIV/AIDS Prevention Project (ZAPP). This provides important supplementary information in some areas. In the second quarter of 2014 the Biomedical Research and Training Institute (BRTI) has also come on board. These partners provide further evidence of what is or is not working well, and their findings help guide the way forward. For FSW, CeSHHAR's strengths in research are valuable in measuring results at different levels.

The logic and relevance of the CPAP outcomes and outputs for HIV prevention are consistent with the ZUNDAF and the UNFPA Strategic Plan. Baselines and targets are in place for all CPAP HIV prevention outcome and output indicators, baselines dating mainly from 2010 or, in one instance, from the ZDHS of 2005/6. Most outcome indicators are for reported sexual behaviours, however, which are not well captured through survey methodologies, hence the importance of more sensitive OR approaches. Mid-2004 achievements against indicators are reported in the tables and, for the overall CPAP, in Annex 2. This updated matrix includes new indicators reflecting further programme opportunities, notably the Integrated Support Programme for Sexual and Reproductive Health, HIV prevention and GBV, the most significant funding mechanism. These complement the RRF but remain largely process measures, such as numbers reached.

4.2.2 Relevance

UNFPA CO has positioned itself strategically for HIV prevention in relation to high level international and national policy commitments, and to the Government of Zimbabwe (GoZ) and, in particular, to the Ministry of Health and Child Care (MoHCC), UNAIDS cosponsors and other stakeholders at policy, planning and implementation levels. The CO has claimed space according to its mandate and areas of comparative advantage, and has demonstrated clear added value to the overall HIV response in Zimbabwe.

The 6th CP outcome and outputs for HIV prevention are fully aligned with the Zimbabwe National AIDS Strategic Plan (ZNASP) II 2011-2015 and with the new Combination HIV Prevention implementation approach launched in 2013, to both of which UNFPA actively contributed. The country and UNFPA policy and programmes are fully aligned with MDG 6, and with the revised international commitments at the UN High Level Meeting to halve HIV infections by 2015, and eMTCT and substantial reduction in AIDS-related maternal mortality. The CPAP indicates complete alignment also with the outcomes of UNFPA Strategic Plan to 2013, and to the Zimbabwe UN Development Assistance Framework, ZUNDAF.

With respect to the UN Division of Labour under UNAIDS, UNFPA CO is reported as a strong cosponsor in Zimbabwe in its joint leadership roles for reducing sexual transmission, the focus on female sex workers (FSW), addressing HIV needs of women and girls, and empowering young people

to protect themselves (as with FSW, mainly through integrated SRHR/HIV programming and community Sista2sista clubs). UNFPA CO also currently sits with UNAIDS on the Zimbabwe Country Coordinating Mechanism (CCM) of the Global Fund (from which a substantial grant has been awarded under the new funding modality, including for demand creation with behaviour change facilitators, BCFs, in the remaining 37 districts to achieve national coverage).

The CO supports multiple implementing partners (IPs) to implement projects and programmes for social and behaviour change and demand creation. This is a relevant focus because indicators for SRH, particularly for young people and for women, indicate continuing high unmet need, and that uptake of SRH services, including around HIV, is insufficient (see Chapter 2). The decline and near collapse of public health services in years prior to the 6th CP also justify the close collaboration with and extensive capacity development for health services, the AIDS and TB Unit and Directorate for Preventive Services in the Ministry of Health and Child Care (MoHCC), and with NAC. UNFPA strengthens MoHCC capacity through:

- During the 5th and 6th CPs, providing technical and financial support to develop policy[57], strategies and service guidelines variously for HIV and integrated services
- Financial and technical support for training on SRHR/HIV integration, updated STI syndromic management guidelines and CCP
- Funding key posts in the ministry in relation to HIV and SRH: e.g. the SRHR and HIV Linkages Programme Coordinator; the STI Prevention and Control/CCP Coordinator; the Male Circumcision Programme Coordinator; a quality assurance programme officer originally recruited to work on male circumcision; and, in process, recruiting a National Coordinator for Key Populations, particularly for sex workers, in the National AIDS Council (NAC)
- The EU-funded Linkages Project[58], a seven-country project for integrated SRH, HIV and GBV that currently has three pilot centres of excellence in Zimbabwe (two MoHCC referral hospitals and a ZNFPC-run centre).

Following the national rapid assessment on SRH and HIV in 2011[59], UNFPA's strategy for HIV prevention in the 6th CP is closely integrated with sexual and reproductive health and rights (SRHR) at policy, strategy and service levels. Integration is achieved through various programmes addressing the two outputs, notably the Integrated Support Programme for Sexual and Reproductive Health, HIV and GBV, a funding modality outlined in 4.1.

In late 2013 and 2014 Zimbabwe has adopted and initiated roll out of Option B+ for eMTCT, and UNFPA contributes through demand generation and support for Prongs 1 and 2[60] as part of the ISP and through the Linkages Project and MoHCC training and within H4+, although the input appears not to be sufficiently developed (see below).

The special focus in the ISP on female sex workers (FSW) and young women as vulnerable groups is highly relevant to Zimbabwe given the evidence of their respective risks for HIV and their need for enhanced protection, empowerment and increased service access and uptake. The ISP FSW funding massively expands NAC's HIV and STI prevention programme for sex workers initiated in 2009, Sisters With a Voice. The ISP for FSW is implemented through the Centre for Sexual Health and HIV/AIDS Research Zimbabwe (CeSHHAR) in close collaboration with the MoHCC and using MoHCC facilities with trained staff funded by UNFPA. An estimated 13% of new infections were

[57] Notably contributing to the Zimbabwe National HIV and AIDS Strategic Plan, ZNASP II, 2011-2015; to the Combination HIV Prevention Implementation Approach for Zimbabwe, 2013; and to comprehensive condom programming and the STI strategy.

[58] UNAIDS/UNFPA joint project on 'Linking HIV and Sexual and Reproductive Health and Rights in Southern Africa' 2011-2015 (DCI-SANTE/2010/248-682), that aims to overcome barriers to strengthening linkages between SRH and HIV policies, programmes and services.

[59] Zimbabwe National Rapid Assessment on SRH and HIV Integration and Linkages, March 2011, MoHCW

[60] Prong 1 is prevention of HIV infection in adults of reproductive age and Prong 2 is prevention of unintended pregnancies in HIV positive women.

taking place in sex work settings in 2010[61], with estimates of FSWs who have HIV ranging from 50-70% in a three-site study in 2011 by CeSHHAR[62].

4.2.3 Efficiency

4.2.3.1 Overview in relation to HIV prevention and integration

The efficiency of UNFPA CO support for HIV prevention and integration of services does not appear optimal according to reports from donors, national partners and implementing partners on the ground, and from both documentation (annual and quarterly reports) and KI and group interviews. For example, it appears that the CO supports the multiple approaches to integrated services (e.g. home based demand creation, sex worker services, Linkages, ASRH and eMTCT) to some extent in silos, missing some opportunities for synergies and mutual learning, with gaps in achievement and some delays in achieving results. Greater synergies and better results might have been achieved if the two units jointly explored alternative actions, options and partners. Nonetheless, integration has improved during the 6th CP, for instance with the HIV Unit supporting the MOHCC to train reproductive health officers on SRH/HIV linkages, cadres who are to integrate linkages training into FP, EmONC and cervical cancer training. Staffing capacity issues have contributed to slow programme implementation, particularly relating to some areas of procurement for IPs, slow refurbishment of a building at one Linkages Project site, and training of health staff and peer educators and M&E.

The CO has responded appropriately to specific challenges identified for HIV and AIDS programming that included: inadequate finance and health system staffing capacity and weak health-community linkages; weaknesses in logistics and supply chain management; stock outs of some commodities, e.g. HIV test kits and STI drugs. Coverage of paediatric treatment and low achievement of male circumcision were two areas that UNFPA was not able to contribute to significantly. However, overall the CO during the 6th CP demonstrates responsiveness to critical findings.

With regards resource utilization for HIV prevention, according to Atlas the implementation rate during the 6th CP from core resources has been fully on track for 2012 and 2013, but very low at 7.63 percent to September 2014. Most costed activities for 2014 are scheduled for the last quarter, however, and the implementation rate is expected to reach 100 percent (largely to support World AIDS Day Commemoration according to the CO). The implementation rate for non-core resources has been between 59 and 63 percent, a reflection of delays in receipt of funds, and of the substantial expansion of funds during the 6th CP which, in itself, is a positive reflection of donor confidence in UNFPA. UBRAF funding for HIV is fully spent. Other donor funds, notably from DfID, Sida and Irish Aid for the ISP that constitutes 90% of HIV-related funding, are rolled over with an anticipated expenditure rate of 80 percent by the end of 2014.

Regarding comprehensive condom programming (CCP), UNFPA provided financial and technical support to the MoHCW review of male and female condom programming in 2012[63], as the previous strategy was outdated. This review led to the development of the National Male and Female Condom Operational Plan 2012-2015. In the review, condom programming in Zimbabwe is reported as relatively successful compared to many countries, with USAID the main procurer of male and female condoms. In the 6th CP UNFPA has responded to the review's conclusion that of greatest need are demand creation and support system strengthening.

4.2.3.2 Integrated Support Programme

Areas of concern regarding the ISP include long delays in work plan development in 2013, with poor coordination and delays in programme roll out (KI interviews, document review). The 2014 AWP,

[61] NAC/UNAIDS 2010: Modes of Transmission Analysis

[62] Engagement with HIV Prevention, Treatment and Care among Female Sex Workers in Zimbabwe: a Respondent Driven Sampling Survey. 2013. Cowan FM, Mtetwa S, Davey C et al. PLOS ONE, October 2013, 8:10:e77080.

[63] A Review of the National Male and Female Condom Programme in Zimbabwe, Dec 2012, MoHCW, UNFPA

however, was signed in January 2014, reflecting strengthened in-house capacity. Coordination and M&E by UNFPA were reported in both national counterpart and ISP KIs as needing to be stronger, with more rapid detection of challenges on the ground and review of IP performance.

IPs and BCFs for demand generation and Sista2sista clubs also reported that different NGOs within the same geographical area provide similar services around HIV and SRHR and GBV but without effective collaboration or standardization of messages. Efficiencies and effectiveness could be improved if UNFPA explores how to develop more effective collaboration and partnerships at local as well as national and provincial levels to achieve better alignment of implementers, avoid duplication of effort and identify gaps in provision. Likewise, there does not appear to be sufficient coordination and collaboration between different agencies supporting the same IPs (observation, IP and other KI discussions). A further factor that challenges the overall efficiency of ISP coordination is the complexity of institutional arrangements in GoZ.

4.2.3.3 Linkages Project

Progress was slow in 2012 in the Linkages Project but stepped up in 2013 and, particularly, in 2014. To achieve its full planned results, it will need to extend into 2015. Of the three centres of excellence (United Bulawayo Hospitals, UBH, Harare Central Hospital and ZNFPC's Spilhaus Centre) only one, UBH, was included in field visits because of time. There it was observed that considerable inconsistency exists in the quality and size of facilities for the different areas of service, that facilities were not commensurate with different levels of demand, and registers were not integrated although client cross-referral was in place. Specifically, family planning and ANC appear under-resourced compared with cervical screening and adolescent services. More balanced UNFPA support across service areas could improve efficiencies.

Regular quarterly meetings of the SRH and HIV Linkages Steering Committee provide an opportunity for information sharing and trouble shooting, and to generate ideas regarding the way forward. In addition, a sub-committee to strengthen monitoring and evaluation was established in 2013 between UNFPA-supported ministry staff and UNFPA CO. Both committees continue to function, although attendance is reported as not optimal because of high travel schedules and other staff commitments.

4.2.3.4 MoHCC training

Particularly during 2012 challenges in UNFPA capacity led to delays in guideline production in some cases, and in training (partly as a consequence), so it was not on track with several targets. Printing of final documents also occasioned delays, in one instance (integration guidelines) for a whole year. Delays then arose in the roll out of training of trainers and hence the cascade of training in districts, although a rapid catch-up is now in progress (see section 4.2.4). Some delays have arisen for reasons beyond CO control, including late disbursement of donor funds and complexities of functioning and collaboration within the ministry itself.

4.2.3.5 VMMC

As noted above, UNFPA support for VMMC roll out did not prove efficient and donor funding has been withdrawn. The COAR 2013[64] also reports delays in procuring reusable MC kits and training of teams. Nonetheless, in other respects (see later) UNFPA support for VMMC has been both efficient and effective.

4.2.4 Effectiveness

4.2.4.1 Overview

With respect to achievement of specific results, e.g. around numbers trained or reached in different programmes, documented progress was slow or nil in various HIV and SRH programming areas in 2012, including in part of the ISP, the EU Linkages Project, some MoHCC training and support for voluntary medical male circumcision (VMMC). During 2012 the emphasis was more at the policy

[64] 2013 Country Office Annual Report, Zimbabwe, UNFPA, December 2013

level and ensuring that policies, strategies, and guidelines were in place. Achievement of HIV prevention outputs has achieved or surpassed several targets by mid 2014, however, as shown in Table 4.2.1, including some revised and dropped indicators (although a full new CPAP RRF was not developed). Table 4.2.2 highlights achievements in the ISP according to donor-agreed indicators. Data presented were validated by the M&E team.

Table 4.2.1: UNFPA Achievements regarding CPAP Outcomes and Outputs for HIV Prevention and Integrated SRH Programming

CP Outcome 2: Increased adoption of safer sexual behaviour and use of HIV prevention services			
CP Output 4: Increased coverage of the social and behaviour change communication programme			
Indicator	**Baseline and Target by end of 2015**	**Achievement by mid 2014**	**Comments**
# of person exposures during community meetings	Baseline: 2.09 million for 2000 BCFs in 2010 Target: 10.49 million by 2015 (includes repeat exposures)	No longer tracked	UNFPA strategy has changed from community meetings to door-to-door home visits by behaviour change facilitators
# of people completing the home visits course	Baseline: 0 Target: 840,000 by 2015	Not applicable	The intention was to offer courses but this was changed to one-off home visits, therefore the RRF indicators changed as marked * for the ISP
* # of new households visited	Baseline: 0 Target by 2015: 690,275	End 2013: 75,875 (84% annual target) Jan to June 2014: 110,690 (of 307,200 annual target)	High achievement in 26 districts after delayed start. Review found that 16 new households per month per BCF is unrealistic, and target will be revised to take account of need for longer visits and for repeat visits to promote quality and reach more household members
* # of person exposures to home visits	Baseline: 0 Target by 2015: 2,723,080	End 2013: 267,135 (99% of annual target) Jan - June 2014: 368,640 (80% of mid year target)	
Updates on research evidence provided on an annual basis	Baseline: 0 Target: 1 per annum	Supported research by CeSHHAR in 2012 plus see VMMC research	No research evidence reported in 2013 but Q4 2014 planning OR on home visit effectiveness; second OR planned for 2015
CP Output 5: Increased availability of HIV prevention services			
Indicator	**Baseline and Target by end of 2015**	**Achievement by mid 2014**	**Comments**
Availability of a national combination HIV prevention strategy[65]	Baseline: 0 Target: 1	Combination HIV Prevention implementation approach finalized in March 2013	On track, widely disseminated through NAC and through MoHCC to DNOs, needs to go further
Availability of service guidelines and tools on provision of integrated	Baseline: 0 (2011) Target: 2	6 guidelines and manuals on SRH and HIV developed by mid 2014[66]	Exceeded target; tools on how to integrate services across sectors of RH and

[65] The Combination HIV Prevention document is an implementation approach, explicitly not a strategy as it supports the existing and overarching ZNASP II.

[66] Integrated HIV, SRH and GBV Support Programme Demand Generation Home Visit Guide, November 2012, used by all BCFs; Service Guidelines on Integrating SRHR and HIV Programmes and Services, August 2013

SRH and HIV services			HIV to strengthen UNFPA
# of male circumcision service delivery points strengthened with UNFPA support	Baseline: 0 Target: 9 by 2013	8 sites strengthened by end of 2013 at district and rural hospitals (commodity procurement and TA)	Site strengthening mainly on track but UNFPA contribution stopped after low achievement of # circumcised; plan for ISP VMMC to be all under PSI support
Availability of evidence on the safety and effectiveness of alternative adult male circumcision device(s)	Baseline: Safety study completed in 2011; first report due 2012 Target: Evidence from safety and comparative studies on at least 1 device available in 2012; Evidence on cost effectiveness of at least 1 MC device available in 2013	Funded comparative study (Prepex and forceps guided method) including cost effectiveness, 2012, available 2013 WHO pre-qualification for PrePex device granted in May 2013 based on Uganda and Zimbabwe studies	On track, additional operations research and training being supported with PSI into lower level implementation of VMMC by RGNs and primary care nurses, including for Prepex

Sources: UNFPA Updated Planning Matrix for M&E for 2013; CO M&E and Programme Staff, IP reports, COARs.

Table 4.2.2: Progress against Output Indicators for ISP-Funded HIV prevention activities by UNFPA to March 2014

Indicator	Expected results Milestone 2[67]	Achieved results Milestone 2	Indicator on track
Output 1: Demand creation: increased knowledge of and demand for family planning and HIV prevention services			
# of person exposures among sex workers to SRH and HIV prevention messages (delivered by peer educators)	19,000	9,233	Serious under-performance due to late recruitment and training of peer educators, but rapid escalation now underway
# of person exposures to programme messages through interpersonal communication, home visit sessions	500,280	436,378	Largely on track using existing cadres of BCFs and new recruits
# of person exposures to mass media messages on areas linked to the programme (GBV)	127,350,000	127,350,000	On track, mainly through radio slots reaching estimated 2.5 million listeners each episode, and TV slots
Output 2: Reducing barriers: a more favourable environment for sexual and reproductive health and reduced barriers to access to services			
# of facilities supported by the programme offering an integrated package of SRH-HIV prevention services (defined as providing at	36	32	On track; UNFPA only reports on the FSW clinical

(printing completed mid 2014 and to be distributed); Advocacy Package for Integration of SRHR and HIV Programmes and Services, 2014, printed and being distributed; SRHR and HIV Linkages, Facilitators Training Curricula for 1) Health Service Managers; 2) Health Service Providers; 3) Community Based Health Workers, 2014, being printed; revised STI management guidelines being utilized.

[67] DfID works to a different annual timeline from UNFPA, hence numbers presented here in the two tables cover different periods; data are to end of March 2014

minimum HTC and oral contraceptives)			sites. However, the minimum package is narrowly defined by DfID[68]
Output 3: Service supply: improved supply of quality family planning, HIV prevention and broader SRH services in the public and private sectors			
# of males aged 13-29 circumcised	17,500	3,025	Not meeting expectations

Source: DfID Annual Review: Zimbabwe Sexual and Reproductive Health Programme (Integrated Support Programme – ISP), May 2014.

Donor withdrawal has contributed to UNFPA CO withdrawing support from certain areas of provision, notably VMMC roll out. Table 4.2.3 provides data on training against main targets, and see Annex 2 for fuller tracking over the CP.

Table 4.2.3 Training in MoHCC for health providers against targets

Indicator: Number of service providers trained to deliver integrated SRH and HIV services					
Target January to December 2013	Actual January to December 2013	% Achieved (2013)	Target January to June 2014	Actual January to June 2014	% Achieved (2014)
870	0	0 %	1,550	628	40 %
Indicator: Number of service providers trained in the revised syndromic management of STI guidelines					
500	540	108%	298	432	145 %

UNFPA supported MoHCC to revise, field test and roll out training guidelines on syndromic management of STIs in 2013 and supports staff training on this nationwide, surpassing the target. Late initiation of training for integrated SRH and HIV arose because of delays in development of training guides and manuals and late disbursement of funds leading to delays in training of trainers (ToT). Training of trainers only started in July 2014, but the target of training 212 trainers is being rapidly implemented and appears on target for the end of 2014, despite the late start. Once these cadres are in place, the service provider training should escalate much more rapidly. Meantime, the STI and CCP training are systematically delivered as add-ons to RH and HIV training. This minimizes staff time away from work and the integration concepts are directly applied throughout the technical training. Assessment of the effectiveness of training in changing clinical practice and increased benefits to patients will require monitoring and evaluation, and this needs to be planned for. GoZ/UNFPA's July 2014 Mid Year Review notes the importance of follow up and quality assurance support visits after training to ensure the guidelines are fully implemented.

4.2.4.2 Integrated Support Programme, HIV prevention

The main modalities of social and behaviour change are: generic demand creation around SRH/HIV/GBV through door to door home visits by trained behaviour change facilitators (building on BCF recruitment and deployment in the 5th CP); the female sex work programme; and prioritising adolescent girls with demand generation and integrated SRH/HIV/GBV services. Non-governmental organisations[69] implement the BCF programme in 26 districts with UNFPA financial and technical support, linked with government services.

High achievement of door-to-door home visits by BCFs has been achieved, but it is not clear how far this translates into behaviour change and demand generation. A national baseline on behavioural risk factors was undertaken in 2007 and reviewed in 2009, but more recent data in the 26 districts are not

[68] In the FSW programme a full SRHR package is monitored, except for OI/ART

[69] CeSHHAR, MAC, MASO, ZAPSO, WV, FACT Mutare, ZAPP, UZ, RDS, ZiCHIRE, Musasa Proejct, Padare, ZWLA, SAYWHAT, WAG, ZYC (see acronyms list for full titles)

available as a baseline for behaviour change. The CO has advocated successfully with the HMIS to include a new indicator on 'referral by community cadres' into their data collection for uptake of key SRH services to provide regular long term national data tracking the effectiveness of the demand creation efforts. During 2014 bar codes are being added to the referral slips provided to households by behaviour change facilitators (BCFs) in six districts as a pilot initiative. A related concern is whether services are actually available when people try to access them, with challenges noted in progress reports and beneficiary feedback (e.g. regarding access to cryotherapy and LEEP for clients with pre-cancerous lesions).

Access to HTC appeared extensive, building on earlier achievements, and has reached near universal coverage in health facilities. Uptake is relatively high particularly among women, although couples HTC lags seriously behind. Couples HTC appears highest in ANC/eMTCT settings (KI interviews with health providers), although the extent of male HTC uptake when male partners attend ANC was not confirmed. The extent to which HTC results in HIV prevention outside the ANC settings is not clear, and treatment access is dependent on CD4 tests that, at two field sites investigated, were reported as slow to get results. During the evaluation the extent of ART uptake was not a primary focus of investigation as this does not fall under the mandate of UNFPA, although ART adherence contributes to HIV prevention. The MoHCC is not adopting a test and treat model, but is investigating both pre-exposure prophylaxis (PrEP) and early offer of ART for key vulnerable populations such as sex workers and MSM (see reference to CeSHHAR research below).

The DfID-funded ISP annual review (Table 4.2.2) ranks the female sex worker *peer education* as seriously under-performing, low coverage being due to late recruitment and training; also, despite late implementation of the programme, targets were not revised from the timelines originally set and therefore became unrealistic. However, with improved support and monitoring of peer educators by the IP, documented performance has substantially improved (e.g. 155 peer educators trained by end of 2013[70] and 4,393 FSW reached by peer educators in Q1 of 2014[71]). The programme was slightly delayed reaching its 2013 target for the 6th CP of establishing three new static sites and 17 further outreach/mobile sites (building on the previous CP target of 13[72]), to reach a total of 35 functional sites (and one emerging one). However, the GoZ/UNFPA Mid-Year Review, July 2014[73] indicates that new sex workers seeking SRH and HIV services during 2014 has exceeded target (3,617 new attendees compared with the target of 2,500), with 1,531 HIV tests performed against a target of 700, and 4,842 treated for STIs against a target of 3,000. Sex worker uptake of the female condom stands at 43% of target, but uptake of male condoms is double the target (at 906,429 pieces). Technical support from UNFPA CO for training for FSW peer educators is evaluated highly (FGDs with peer educators and IP feedback), as is the UNFPA-supported peer education manual currently being translated into Shona and Ndebele.

CeSHHAR research indicated that during the programme antiretroviral treatment uptake had increased from an estimated 25-35% to 40%, with 61% of HIV positive FSW knowing their HIV status[74]. The finding noted above that an estimated 50-70% of sex workers had HIV infection in three study sites in 2011, provides a baseline against which to measure changes over time. At seven sites and seven controls CeSHHAR is investigating pre-exposure prophylaxis, PrEP for prevention and ART for prevention through a respondent driven sampling survey. Sex workers testing negative are offered PrEP and those testing positive, ART. PSI provides OI/ART in trial sites through mobile outreach, with UNFPA covering all other related costs. Results are due in 2015 and should guide future programming.

[70] UNFPA 2013 Country Office Annual Report Zimbabwe, 13 December 2013
[71] CeSHHAR Quarterly Report for January to March 2014
[72] ISP for Sexual and Reproductive Health and HIV Prevention 2012-2015,
[73] GoZ and UNFPA Mid Year Review of HIV Prevention Services, July 2014
[74] The SAPPH-Ire Trial – ART for HIV prevention among female sex workers in Zimbabwe, Cowan FM et al, CeSHHAR

UNFPA covers almost all costs for the main FSW programme (apart from drugs), and should continue to support both the programme itself and the rigorous research programme given the evidence for positive results among this vulnerable group and the potential to reduce HIV incidence. High level advocacy to ensure sex workers have the same SRH/HIV/GBV rights as other women is essential, with possible discussion of decriminalizing sex work (although this is highly controversial).

FGDs with a total of 26 female sex workers at one static and one outreach site found that the services are greatly appreciated, FSW feel valued and empowered and want the SRHR and HIV prevention services offered. Lack of cervical screening was a concern. GoZ/UNFPA report STI drug shortages, and this was reported at one outreach site visited. Support around GBV is noted in Section 4.3. In both FGDs FSW reported high consistent male condom use, but with limitations. Several reported non-condom use if offered sufficient cash, or with repeat clients they liked and wanted to reward. Female condoms were sometimes used but FSW said they like and use male condoms much more, corroborating the distribution figures.

Overall, the FSW programme has now rapidly expanded both its coverage and range of services and is on track, according to IP and GoZ/UNFPA reports, the log frame and KI interviews. The programme appears to be a highly effective response to addressing the needs of a high-risk population, having greatly expanded the GoZ Sisters with a Voice programme. CeSHHAR as a strong research centre brings significant added value to the programme that will allow effective outcome and impact monitoring. WHO recognizes the programme as good/best practice that is acclaimed internationally.

4.2.4.3 Linkages Project

An assessment of the Linkages Project centres of excellence undertaken in mid 2013[75] made 13 substantive recommendations that are at least in part being implemented, although it was not possible to obtain robust data on this. The core finding was that integration had improved in the previous year and most clients expressed satisfaction with the services, as well as appreciating having integrated services in one location. The seven-country mid term review[76] of March 2014 was also positive, indicating that the project is on track in all seven countries, with 'significant progress … in adapting and strengthening SRH and HIV policies, systems and service delivery to incorporate the concept and practice of integrated HIV-SRH services' (p7). Thus despite some outstanding challenges, UNFPA support seems on track but should address further the issues of service efficiency and effectiveness, synergies between clinics and to continue support for the integration of clinic registers to improve patient tracking.

As lead of the country team on Linkages, the CO is opening discussions on how to cascade the project to lower level facilities nationwide to achieve greater efficiencies in SRH, HIV and GBV service provisions. Lessons are being learned from other countries in the seven-country EU project, and need to be learned also from within the Zimbabwe integration programmes. Regarding non-integration of registers in the different clinics, electronic consolidation is needed in the HMIS and to align with the electronic Patient Monitoring System (ePMS) of AIDS and tuberculosis (although there are challenges in achieving register integration). Both UNAIDS and UNFPA are reportedly exploring this and aim to finalise an electronic system for implementation in 2015. A time and motion analysis (who does what, where and when) in Namibia, another of the seven participating countries, also identified that the principle of 'one nurse, one patient, one room' might improve nurse productivity by 2.5 times, and cut patient waiting times in half[77] in integrated ANC/eMTCT settings. A strategic role for UNFPA could be to initiate such analysis in Zimbabwe in the three pilot centres of excellence, and

[75] Baseline Survey for three learning sites/centres of excellence for the delivery of integrated SRH and HIV services, Assessment Report, August 2013, Ray S and Kureya T, Development Data.

[76] 3rd Interim Annual Report. March 2014, UNAIDS/UNFPA joint project on 'Linking HIV and Sexual and Reproductive Health and Rights in Southern Africa', DCI-SANTE/2010/248-682.

[77] 3rd Interim Annual Report, UNAIDS/UNFPA joint project on 'Linking HIV and Sexual and Reproductive Health and Rights in Southern Africa', March 2014, DCI-SANTE/2010/248-682.

also in lower level integrated facilities such as ANC sites, a recommendation independently endorsed in several KI interviews.

4.2.4.4 eMTCT

UNFPA support for Prongs 1 and 2 of eMTCT was reported in KIs with four international cooperation partners and in documentation as needing strengthening. The national programme itself is reported as not adequately coordinated, with the MoHCC concentrating on the treatment Prongs 3 and 4, while Prongs 1 and 2 fall under NAC and the AIDS and TB Unit. Given that Option B+ is moving ahead but that, after under a year of roll out, anecdotal reports are emerging of mothers dropping out after ART initiation once they stop breastfeeding (KIs with health staff) the importance of Prongs 1 and 2 cannot be overemphasized. Recognizing the limitations in current support for eMTCT, UNFPA has engaged a consultant to support development of a national strategy to guide MoHCC and stakeholder programmes for Prongs 1 and 2, working closely with a consultant hired by UNICEF to address Prongs 3 and 4 and, with national stakeholder buy in, to produce a coherent overarching eMTCT strategy. UNFPA support for Prongs 1 and 2 should be planned during 2015 and be explicitly stated and fully operationalized in the 7th CP CPAP with SMART indicators that go beyond process monitoring.

4.2.4.5 VMMC

ISP funds for VMMC roll out have shifted to PSI, after the UNFPA-supported approach relying solely on MoHCC leadership and implementation encountered challenges in delivery (12% of target achievement in 2013 for circumcisions performed according to UNFPA M&E). UNFPA made significant contributions during the 6th CP including funding a coordination post in the MoHCC, key research as indicated in Table 4.2.1, and procurement of reusable kits; and also for advocacy, awareness and demand creation through the door-to-door home visits and peer educators in tertiary institutions. UNFPA will continue to collaborate with PSI in further research around VMMC and to participate in the national Technical Working Group to formulate future priorities, e.g. for neonatal or adolescent MC.

4.2.5 Sustainability

The contributions of UNFPA to national policies, strategies and guidelines including training tools, should have lasting value. Also, the key research supported by UNFPA is already influencing long-term approaches, for example research on Prepex and surgical methods for male circumcision that is leading to changed VMMC practice.

The focus on integration of SRH, HIV and GBV (through health staff training in ISP, Linkages and GPRHCS, and support for key coordinating positions in the MoHCC and NAC) is a commendable programming approach that should lead to increased efficiencies and effectiveness on the ground and thus potentially contribute to long-term sustainable results. However, there is no MoHCC funding to continue these posts and, given the severe resource constraints in the country and within the MoHCC, continued financial and technical support from UNFPA will clearly be needed in the 7th CP across all areas. Exit strategies for sustainable results are not apparent. The previous section on reproductive health comments on staff training, the long-term benefits of which depend on multiple factors.

In the sex work programme, the extent of peer education and increased FSW uptake of services, including training on their rights, is likely to lead to continued empowerment and benefits among this vulnerable group. However, the maintenance of static and outreach sites, albeit linked with the MoHCC, and of staffing and equipment, will need continued donor funding for the foreseeable future. At the same time as supporting the services for sex workers, it is important to continue to sensitise health providers in all clinics not to stigmatise FSW but to be supportive and encourage service uptake. In one rural outreach site, changed clinic staff attitudes were reported, so it appears there may

be a wider spill over from the sex work programme into the mainstream clinics that could be sustained if sufficient effort is made to support this.

Overall, there remains the real threat that current gains in demand and health service provisions may not be sustained if the political and economic environment continues to be constrained. In addition, domestically raised funds (notably the 3 percent AIDS levy on personal and corporate incomes) could decline during the coming years unless the economy picks up. Should the service provision decline, UNFPA needs to remain abreast of this and may need to tailor its demand generation approach.

4.3 Gender Equality Programme

4.3.1 Overview of the Gender Equality Programme

The Country Programme Action Plan (CPAP) 2012-2015 notes that gender equity, equality and women's empowerment are identified as the 7th national priority, as articulated in the Medium Term Plan (MTP) and the National Gender Policy, and underpin the achievement of all Millennium Development Goals (MDGs). The gender equality (GE) component contributes to the ZUNDAF Outcome 7.1: Laws and policies established, reviewed and implemented to ensure gender equality and empowerment of women and girls and UNFPA Global strategic outcome 5 on GE and reproductive rights advanced particularly through advocacy and implementation of laws and policy. The programme maintains a special focus on protection and fulfilment of reproductive rights, and prevention and response to gender based violence (GBV).

The outcome of UNFPA's gender programme is: An improved policy and legal environment for gender equality and increased utilization of gender based violence services.

Three outputs contribute to this outcome:

1. Increased capacity of leaders to address negative social norms and practices that perpetuate gender inequalities
2. Increased availability of services to address gender-based violence
3. Increased community awareness of gender-responsive laws, mechanisms and services.

The programme has two pillars, prevention of GBV through public education addressed by outputs one and three and survivor centred support services through treatment, crisis counselling, psychosocial support, legal advice and assistance as well as sheltering services addressed by output two. These are necessary and relevant intervention strategies to end GBV. In a context where there is limited government funding and high prevalence rates of GBV, it is strategic to give balanced emphasis to prevention and service provision.

The GE programme works with a consortium of seven partners namely Ministry of Women Affairs, Gender and Community Development (MWAGCD), Adult Rape Clinic (ARC), Musasa, Padare Men's Forum, Women's Action Group (WAG), Women and Law in Southern Africa (WLSA) and the Zimbabwe Women Lawyers Association (ZWLA).

Musasa and ZWLA provide both training and survivor centred support services. ARC provides health support services. Padare and WAG work on prevention work while WLSA trains traditional leaders and paralegals at community level. In addition to the consortium, UNFPA also works with contractors Patsime for edutainment; CONNECT for systemic counselling training and Emtonjeni Women's Trust, working with male perpetrators.

4.3.1.1 Policy level support

UNFPA has been central in supporting the Anti-Domestic Violence Council, supporting the salaries of key staff as well as with supporting activities of the Council. The Anti-Domestic Violence Council is a key national institution with oversight role for service provision to survivors of GBV. From key respondents in civil society organisations (CSOs) and in Government, the evaluation team heard that from 2012 to date, UNFPA has been central in disseminating information and knowledge of the National GBV Strategy and developing multisectoral approaches to ending GBV. They are supporting

funding to the National Machinery for Women's Advancement to support pre-service training for the judiciary; police and health service providers as well as convening commemorative events such as the International Women's Day and the 16 Days of Activism to end Violence against Women.

4.3.1.2 Prevention work

UNPFA has supported community education and dialogues on gender relations and the importance of gender equality (documentation and KI interviews). The CO has also supported partners to disseminate accurate information on policies, laws and mechanisms for ending GBV. The community education takes rights based approaches that raise community consciousness to recognise and demand their rights and to realise their own agency. The public education work has targeted hard to reach areas, young people, people living with disabilities, and communities with lifestyles disproportionately affected by conventional norms such as sex workers. The education has particularly targeted community leaders and gate keepers, traditional and religious leaders, cadres known to be important to reach. UNFPA partners particularly engage men and male leaders in churches as the religious sector has particular challenges with the notion of gender equality. UNFPA also supports a multimedia public education campaign on national television and radio and bill boards spread across the country. The community mobilisation and community education on gender relation is in 26 Integrated Support Programme (ISP) districts and the multi media coverage is nationwide.

4.3.1.3 Survivor centred services

Services are guided by the national referral pathway within the context of Promoting a Coordinated Multi-sectoral Response to GBV (November 2011). The priorities for the referral pathways are the provision of health services, psychosocial support and justice/legal aid. In addition, to service providers are trained in the multi sectoral framework. In the context of the pathway, ARC, ZWLA and Musasa essentially cover service provision, while Padare and WAG cover prevention work, and WLSA trains traditional leaders and paralegals for both prevention and service delivery.

In service provision UNFPA has supported the establishment of three one stop centres in Harare, Rusape and one will soon be opened in Gweru (KIs, site visits, documentation). UNFPA planned to support the establishment of 10 one stop centres, one in each province. To date UNFPA has supported shelters in Harare, Bulawayo, Gweru and community based shelters in Nyathi/Bubi and Marange Districts, with Standard Operating Procedures that UNFPA also supports.

ZWLA provides mobile legal aid clinics in Murehwa, Hwange and Chinhoyi in addition to their static sites in Harare, Bulawayo and Gweru. Musasa offers shelter, counselling and legal services in Harare, Bulawayo and Gweru. The paralegal and multi sectoral training of the health, legal and psychosocial service providers takes place in all the 26 ISP districts. The counselling of male perpetrators is by Emthonjeni Women's Trust in Bulawayo and Padare in Harare.

Table 4.3.1: Results for the Gender Equality Component as at Mid-Year 2014

CP Outcome 4 An improved policy and legal environment for gender equality and increased utilization of gender-based violence services.			
CP Output 9: Increased capacity of leaders to address negative social norms and practices that perpetuate gender inequalities			
Indicator	**Baseline and Target by end of 2015**	**Achievement by mid 2014**	**Comments**
# of leaders who have adopted and are reporting implementing the 4 Ps campaign	Baseline: 0 Target 2,700 by 2015	4282 as at end of 2013	Exceeded target
# of simplified operational guidelines for mainstreaming gender	Baseline: 0 Target: 4 by 2015	3 as at end 2013	On target UNFPA supported Government to develop

developed and disseminated			Standard Operating Procedures for safe Shelters in Zimbabwe in accordance with the Beijing platform for Action
Availability of evidence on key determinants of gender inequalities	Baseline: 0 Target 1	UNCT produced its first baseline on VAW, Peace begins @ Home(2013) Violence Against Women(VAW) Baseline Study in Zimbabwe.	On target Baseline study completed and publication readily available in hard copies and on line.
CP Output 10: **Increased availability of services to address gender-based violence**			
Indicator	**Baseline and Target by end of 2015**	**Achievement by mid 2014**	**Comments**
# of centres supported by UNFPA for quality gender based violence service provision.	Baseline: 7 Target: 10 by 2015	3 One Stop Centres As at September 2014	Not on target
# of service providers (legal, health, psycho-social and traditional court officials) trained through UNFPA support in survivor friendly approaches including in humanitarian settings	Baseline: 0 Target: 11208 by 2015	3,769 by June 2014	Not on target
# location specific referral pathways developed and printed.	Baseline: 4 Target: 20 by 2015	13 developed as at middle of 2014.	On target Localized referral pathways developed for 13 districts. Referral pathways translated into Shona and Ndebele.
Number of centres supported by UNFPA for quality gender-based violence service provision	Baseline: 7 Target: 20 by 2015	9 as at September 2014	Exceeded target
Number of GBV survivors who received services at One Stop Centres	Target 5882	1 ,949 by June 2014	Not yet on track
Number of GBV survivors provided with legal services	Target: 9652 by 2015	3,657 by June 2014	Not yet on track
CP Output 11: **Increased community awareness of gender-responsive laws, mechanisms and services**			
Indicator	**Baseline and Target by end of 2015**	**Achievement by mid 2014**	**Comments**
# of person exposures to messages on gender responsive laws and mechanisms, and services including through young people's forum discussions)	Baseline: 0 Target: 5 million by 2015	7,000,000	Exceeded target
# of multimedia	Baseline:0	2013 –26 Radio	On target

campaigns on gender and reproductive	Target: 30 by 2015	programmes (13 with star FM and 13 with Radio Zimbabwe) 2014 – 26 billboards; Roadshows in 13 districts (13 shows)	
# of community based cadres trained in counselling and paralegal service provision	Baseline: 0 Target: 3000 by 2015	2007 by middle of 2014	On target
Number of persons exposed to messages on gender and reproductive rights through community level dialogues.	Baseline: 0 Target: 193860 by 2015	267,053 by June 2014	Exceeded target

Source: Mid Term CPAP Review 2014, M&E Analysts UNFPA CO, GE Programme records.

Overall, the programme is on course at 68 percent implementation rate to date. There is a chance of achieving 100 percent implementation with the target of setting up an additional seven one stop centres by 2015. There is a clear logic between the outcome and outputs and planned activities. The areas of focus are highly relevant and needed in Zimbabwe.

The CPAP indicators for the GE Programme are quantitative and not qualitative thus posing challenges for measuring effectiveness for users, knowledge attitude and individual and society wide behaviour change. The programme recently started collecting most significant change stories. For the remainder of the 6th CP into the 7th, there is need to collect both quantitative and qualitative data.

Important to note is that the 6th Country Programme (CP) is not aligned to UNFPA's policy approach to GBV programming. The said policy states 'Addressing GBV through UNFPA supported SRH programmes is the minimum standard to which all UNFPA operations are held accountable'. UNFPA should play a leadership role to ensure that GBV is addressed as an integral part of SRH.[78] The Inter-Agency Standing Committee (IASC) designated UNFPA as lead agency to address GBV in humanitarian situations. UNFPA is also a lead player in implementating UNSCR 1325, 1820 and related resolutions.[79] This role is not addressed in the current country programme.

4.3.2. Relevance

The Gender Equality Programme is highly relevant to Zimbabwe. Zimbabwe is party to several key human rights instruments, e.g. the Convention on all Forms of Discrimination against Women (CEDAW) and the Beijing Platform for Action that enshrine the principle of gender equality. At sub-regional level, Zimbabwe is party to the SADC Protocol on Gender and Development. In the most recent Zimbabwe SADC Gender Protocol Barometer for Zimbabwe, on average, Zimbabweans scored their government at 72 percent of where they need to be by 2015 in terms of GBV related issues.[80]

At national level, the recently enacted Constitution provides a strong foundation for gender equality in the country by identifying gender equality as one of its founding values and principles.[81] The National Gender Policy identifies ending GBV and specifically violence against women as one of the eight priority areas[82]. The Policy elaborates strategies to create a supportive policy and programmatic

[78] UNFPA Strategy and Framework for Action to Addressing Gender Based Violence 2008-2011at page 12
[79] Ibid at page 2
[80] SADC Gender Protocol 2013 Barometer Zimbabwe at page 71
[81] Section 3 (g) of the Constitution of Zimbabwe
[82] Ministry of Women Affairs, Gender and Community Development (2013), The National Gender Policy 2013-2017

environment for non-tolerance to all forms of GBV, one such mechanism being the development and adoption of the National Gender Based Violence Strategy 2012 – 2015.[83]

The UNFPA Strategy and Framework for Action to Addressing Gender Based Violence 2008-2011notes that UNFPA has an ethical, programmatic and fiscal responsibility to redouble its efforts in addressing GBV.[84] UNFPA has obligations to tackle this systemic and universal violation of fundamental human rights through its policies and programmes.[85]

The reality of Zimbabwe makes the gender equality and GBV programme of UNFPA highly relevant. In Zimbabwe, despite the legal and policy framework discussed, GBV remains a serious concern and impediment to girls' and women's active participation in development with GBV levels remaining unacceptably high. Despite the enactment of laws such as the Domestic Violence Act of 2007, girls and women in Zimbabwe continue to be survivors in 99 percent of GBV cases. According to the Zimbabwe Demographic Health Survey (ZDHS) 2010-11, 42 percent of women in Zimbabwe have either experienced physical, emotional or sexual violence (or both) at some point in their lives. A recent baseline study on VAW in Zimbabwe indicates that about a quarter of women in Zimbabwe experienced some form of violence perpetrated by an intimate partner in the period 2011-2012.[86] The National Baseline Survey on Life Experience of Adolescents (NBSLEA) showed that 32.5 percent of young women and girls aged between 18 and 24 have experienced sexual violence prior to age 18.[87]

The UNFPA programme is critical in Zimbabwe as it aligns with national, regional and global priorities on advancing gender quality generally and GBV in particular. The Zimbabwe Medium Term Plan 2011-2015 recognises several challenges and constraints to women's empowerment including gender based discrimination and violence in both public and private space.

4.3.3. Efficiency

4.3.3.1. Coordination

With key ministries The MWAGCD, justice and health ministries are at the forefront of dealing with SRH, GBV and gender equality, but the evaluation found limited evidence of facilitated coordination of between them at policy levels. The referral pathway steps implicitly involve the Ministries of Justice, Home Affairs representing the Zimbabwe Republic Police; Health and Child Care and Primary and Secondary Education. At community level, interventions cover the spectrum of UNFPA's programmes, namely HIV and AIDS, SRH, ASRH and gender equality. KI and beneficiary interviews and discussion and documentation indicated good coordination. Whereas operationally, GBV implementing partners are dealing with SRH, this can be enhanced through policy advocacy with relevant Government ministries, which would culminate in ownership of the problem and a commitment to deal with it collectively, based on a common understanding of the causes and effects of GBV. For the rest of the programming cycle into the next country programme, it is imperative that UNFPA support the National Machinery for Women's Advancement to broker and convene policy level dialogue with a view to influencing greater multi-sectoral commitment to ending GBV.

With the National Machinery for Women's Advancement the UNFPA gender outcome has a policy and a service provision dimension. UNFPA supports the National Machinery in order to enhance gender equality in general and coordination and leadership for GBV work in particular. However, the evaluation (KI interviews and literature review) did not find evidence of enhanced leadership and coordination support for the MWAGCD itself, although there was evidence of facilitation and

[83] Ministry of Women Affairs, Gender and Community Development (2012), Zimbabwe National Gender Based Violence Strategy 2012-2015

[84] UNFPA Strategy and Framework for Action to Addressing Gender Based Violence 2008-2011

[85] Ibid at pg. 2

[86] Peace begins @ Home (2013) Violence Against Women (VAW) Baseline Study Zimbabwe at page 11

[87] Zimbabwe Statistical Agency (ZIMSTAT), United Nations Children's Fund (UNICEF) and Collaborating Centre for Operational Research and Evaluation (CCORE), 2013, National Baseline Survey on Life Experiences of Adolescents, 2011

mobilisation of communities for CSO IPs. In a focus group discussions convened by Padare in Lupane and attended by a wide range of respondents, district and ward development officers discussed their roles as community mobilizers for the different CSO IPs. They talked about 'their programmes' and that 'our role is to mobilise community members for CSOs'. Describing the process, one officer noted that 'when Musasa, WLSA, WAG and Padare come to our offices, we always have to mobilise communities for them. We treat all CSOs the same way. They tell us where they want to go and who they want to see and we mobilise for them'[88]. We did not find evidence of a guided and UNFPA led strategy for engaging communities. UNFPA can play an important role in affirming and supporting the strengthening of the leadership and coordination role on the Gender Machinery away from community mobilization for CSOs to leading and coordinating their operations.

With likeminded UN Agencies The evaluation did not find strong evidence of UNFPA's leadership in coordinating the GBV Programme within the UN Country Team (UNCT). Coordination will enhance and deepen programming as it provides a platform that can facilitate gender analysis of the causes and effects of GBV, and can assist in deepening interventions. Increased coordination within the UNCT in dealing with GBV will increase efficiency. It will afford a better opportunity for a joint problem and issue analysis. It will deepen the work of UNFPA and the country team, allowing each UN agency to bring in its expertise and comparative advantage to bear. UNFPA's comparative advantage of dealing with GBV through is SRH programmes and its leader position in dealing with GBV in humanitarian settings.

With IPs The consortium of partners is well thought out within the context of Promoting a Coordinated Multi-sectoral Response to GBV, with partners who are leaders and authorities in their field. Regrettably, the IPs are mainly Harare based and headquartered posing regional bias in their selection. Also the evaluation team did not find evidence that the GBV consortium works effectively as a coordination mechanism and strategy for using partner comparative advantage for maximum impact in communities. Regular partner coordination meetings that deal with strategy and programming issues were not apparent, nor were written guidelines that would guide community entry for IP programmes. Only annual partner review meetings are in place. UNFPA has not taken the role of thought and strategy leader and coordinator of partners.

Patriarchal values are strong in some communities in Zimbabwe, and given that GE programming seeks to achieve knowledge, attitude and practices supportive of the equality of humanity, there would be added value in UNFPA leveraging the comparative advantage of project partners to maximise impact. For greater community impact, it is important to start with partners who deal with attitude change. The current fragmented approach to dealing with social change issues is undermining potential impact. For example, from the testimonies of Padare project beneficiaries and the review of partner reports, Padare looks at institutionalisation of patriarchy and works to change that. They call for the reformation of men, noting that 'men of quality are not afraid of equality'.

Given that UNFPA targets hardest to reach areas and those most affected by GBV, it makes sense that in a deliberate and purposeful way, there be a strategy for launching the IPs into communities. Going forward, the efficiency and effectiveness of UNFPA programming will be greatly enhanced by the coordinated and strategic use of partners, so that their work builds on and into each other's work, and also creates a platform for IPs to peer review and also to better inform each other's work.

4.3.3.2 Challenges facing UNFPA's Gender Equality Programme

The evaluation team noted understaffing of the GE programme in relation to adequately managing the size of budget, the number of IPs and to offer technical and strategic leadership and support to the extent required. Similar challenges were identified relating to M&E, with respect to UNFPA itself and its implementing partners. It was noted that the IPs do not have a culture of managing for results and that they lack adequate skills for effective M&E. Although UNFPA has supported extensive community education campaigns such as the 4Ps campaign and supported the placement of billboards

[88]Padare mantra or clarion call

across the country, the evaluation did not find documentation to demonstrate effectiveness of these investments and the resultant individual, family and community behavioural changes.

The GE Programme has responsibility for stand-alone programmes and gender mainstreaming (GM). It was not evident to the team that practically and logistically, the GE Programme is providing GM support expected of them. The staff complement is low (currently staffed by a gender analyst/specialist, a GBV UN fellow and a programme assistant). The evaluation recognises that the programme implements through IPs and that notwithstanding, some additional high level technical expertise would boost the effectiveness of the programme. In addition, there was no evidence of deliberate GM support. As discussed on partner and UN coordination, if there is no planned coordination and programme integration, it may not happen, and if it does, may be haphazard. The Sista2sista and sex work programmes revealed that they are dealing with huge GBV issues. For the Sista2sista programme there was no apparent feedback mechanisms for dealing with these issues by the GE Programme partners. For the female sex workers (FSW), UNFPA is supporting a new initiative to train FSW peer educators as paralegals, with half of them recently trained and the remainder to follow. All this is building up towards the FSW network doing their own outreach and support work around human rights and GBV independent of the host organization. This is a significant development and supportive of sustainability and is good practice to share within UNFPA programmes.

4.3.3.3 Partner selection and related issues

For all the IPs whose projects were sampled in the evaluation, focus group discussions (FGDs) and IP periodic reports noted that the IPs had no community face. They felt that the organisations were headquarter based and did not sufficiently visit project sites to follow up on their work or appreciate the impact of their efforts. The Ndebele speaking focus group participants felt alienated because IPs rarely spoke their language. This presented cultural challenges, affecting local communities negatively, and generated negative attitudes towards messages conveyed.

Traditional leaders in Mberengwa noted that repeated visits to communities by IPs were critical. They cited previous projects which they said had taken the community by storm once and did not come back, leaving communities without recourse. They noted that GBV is embedded in culture, so change has to be a process, and it takes sustained effort to realise change. Nonetheless, the focus group participants acknowledged the importance of WLSA working with traditional leaders, training them on the Domestic Violence Act, and orienting them on national laws governing the operations of chiefs. They also expressed appreciation of training on HIV and AIDS, the referral pathways for GBV survivors and the multi-sectoral approaches in dealing with the issue.

In addition to sporadic visits to communities, literature review and FGDs in Gweru and Mberengwa noted that IPs often target growth points and town centres, and seldom go into communities where the majority of the people are. One respondent noted that 'Lupane has villages that need the Padare message'. Respondents also noted that too little time is allocated for community dialogues and other activities. After community dialogues or legal education, Lupane, Gweru and Mberengwa focus group members noted that local structures and committees were set up to develop the work on personal and relevant messages, but without resources to do this. Channels are needed to integrate the work of IPs in local communities, so that it continues long after the IPs have gone back to their headquarters.

Community members in Midlands Province noted that in addition to working with local structures and communities to end GBV, it was important to engage some of the drivers of GBV, such as poverty. They noted that in communities, there is a correlation between poverty, hunger and GBV. When there are bumper harvests and no food shortages, communities are less violent, but when there is hunger, invariably cases of GBV increase. Based on this, some focus group participants underscored the importance of linking strategic issues of behaviour change initiative with practical needs of people. They called for out of the box strategies of synergies between GBV programming, capacity building for economic empowerment and enterprise development.

4.3.4 Effectiveness

Indicator limitations notwithstanding, discussions with stakeholders and beneficiaries of UNFPA support as well documentation indicated that the GE Programme is effective, although current services for GBV survivors are insufficient to meet demand[89]. As indicated above, apart from the national multi-media campaign, all other preventive work is in the 26 Integrated Support Programme (ISP) Districts. Support services are limited in their geographical coverage and are inaccessible to some who need them. Visits to Musasa and ZWLA offices in Bulawayo and Gweru found long queues of around 20 women waiting to see a counsellor or lawyer, and this was reported to be a common situation. Review of counselling and legal assistance files of both organisations showed high service demand and responsiveness. The biggest challengs is that only three of 10 provinces have one stop centres with all critical, high quality services under one roof, and these are urban and far removed from their main client base. The one stop centre concept is resource intensive to set up and manage, in a context where GBV services are wholly donor funded. In 2012, UNFPA commissioned an evaluation of its survivor friendly services, undertaking a sound cost benefit analysis of services. UNFPA should seriously consider and work with the findings of that evaluation.[90]

The evaluation team received several significant testimonies on the impact of UNFPA's support on the lives of survivors from senior government officials, individuals and communities. Padare, Musasa, ZWLA and WLSA beneficiaries noted that their communities and individual lives have changed through the legal and public education, counselling and community dialogues, supported by UNFPA. Men testified that they have become better husbands, partners and community leaders. They talked about the psychological and lifestyle changes that have come from the public education campaign supported by UNFPA. Chiefs and other community members testified to a major paradigm shift and their intolerance for violence and abuse. Some testified how out of their personal change, they were influencing other men and how some chiefs have become champions of women's rights.[91] The chiefs noted that after their training they are no longer second guessing their mandate. Secretaries of chief's councils who sat in the focus group discussions in Mberengwa testified to significant changes in how the trained chiefs were now approaching their work. They also noted that up until they were trained by WLSA, they had not been trained on the legislative provisions of their mandate. They were remorseful that only 10 out of 16 chief had been trained in Mberengwa. They felt that the training was so important for their work that all chiefs needed to be trained and provided with the relevant statutes as reference material. They also felt that one-off training was not enough. They needed refresher training courses and suggested that the programme seriously consider instituting a training of trainers with the trainers drawn from suitable candidates in their communities.

Similarly, women beneficiaries of Musasa, WLSA and ZWLA projects testified to the effectiveness of legal aid and advice, education and protection and the support services provided. One woman said 'ZWLA is more than a brother, more than a father'[92]; another testified 'I was empowered by the process….I am no longer afraid of courts….My husband knew my fears. Now he knows I am a changed person, I am no longer helpless; I know what I am doing'[93]. 'Musasa helped me when my elderly husband and his children were abusing me'[94].

4.3.4.1. Adequacy of the programme

Field observation of selected shelters and one stop centres indicated solid progress in initiating such services for GBV survivors. However, KIs with service providers highlighted continued challenges in securing sufficient grant funds to run these establishments effectively. Budgets for one stop centres do

[89] ZWLA

[90] Evaluation report : The relevance, Effectiveness, Efficiency and Sustainability of GBV Survivors Friendly Services in Zimbabwe, March 2012

[91] Reference was made to a Chief Njelele in Gokwe district who has instituted sanctions for men who fail to escort their wives/partners to antenatal classes

[92] Testimony of a woman who received legal aid from ZWLA

[93] Ibid

[94] A woman who received counselling and legal advice from Musasa Project

not provide for staff costs, although they provide life-saving services. UNFPA needs to review the extent of its support to partners to run the existing and upcoming one stop centres.

4.3.4.2. Prevention of GBV

The prevention work was done primarily through a multimedia campaign and community dialogue and education on what GBV is, and remedies available for survivors. While dialogue is important and recent studies on peacebuilding show that face-to-face dialogue reduces violence, more needs to be done on prevention work. Prevention is an important part of ending GBV, and requires a multifaceted strategy that targets among others religious leaders, community gate keepers, opinion leaders, young girls, women, boys and men. It must be well coordinated, broad based, and have a strong capacity building element for quality delivery. Responding to GBV is costly at many levels, and investing in prevention is essential.

The following change stories highlight the effectiveness of concerted public education on the burden of gendered roles and the added value of supporting and living out gender equality. Young men at the Midlands State University in Gweru gave personal testimonies on how the philosophy of Padare has become 'their full time job'[95]. The young men noted that they now have police relationships on campus and are intolerant of abusive young people. They are so driven, they testified, that they are engaging with their university to change the curriculum and include gender studies. Some Padare men have taken it upon themselves to engage religious sects like the 'VaPostori[96]. From the oral evidence presented to the evaluation team, there is a case for supporting a national strategy on working with men and boys for gender equality.

4.3.5. Sustainability

Sustainability of programmes was addressed with regards community ownership, programme financial and technical resources, usefulness to the community, effectiveness.

4.3.5.1 Ownership issues

UNFPA-supported interventions addressed strategic needs of communities with to some extent sustainable results: communities testified on life style and world view changes that stay with them. Without exception, all respondents highly valued all the programmes supported by UNFPA. They appreciated both the prevention and response programming, noting that they had received accurate information on laws, policies and mechanisms for dealing with GBV. They were appreciative of the elaborate partner efforts to disseminate information and raise awareness of communities to recognise and demand their rights. Respondents ranged from indigent women receiving legal assistance from ZWLA, Musasa Project and WAG, to chiefs who had been trained by WLSA on legal provisions and policies to end GBV and on the operations of traditional and formal justice systems. Women and girls in MWAGCD and Musasa shelters appreciated the safe havens provided and protected from harm.

4.3.5.2 Technical and financial resources

Multiple key informants acknowledged the significant contribution of UNFPA to ending GBV in Zimbabwe. One senior UN official noted that UNFPA has supported key processes in Zimbabwe, such as the development of GBV handling protocols and systems. It is not possible to imagine efforts to end GBV in Zimbabwe without UNFPA support. One senior Government official commented: 'Remove that organisation (UNFPA) and what do you have remaining?'

Nonetheless, certain limitations remain. One senior IP member noted that although Government has prioritised GBV in its policy instruments, this has not led to requisite resource allocation; human rights work in Zimbabwe, including ending GBV, has been funded by donors. Another key informant noted that Government had committed USD 10 million to ending GBV, but that this finance was not

[95] A Padare changed young man

[96] VaPostori are a religious sect that condones multiple and underage girl marriages

forthcoming. In going forward, the KI recommended that partners such as UNFPA insist that Government meet its commitment to financing gender equality and ending GBV. If UNFPA and like-minded partners withhold funding, programming for gender equality and GBV in Zimbabwe will cease. Even within UNFPA itself the bulk of GBV funding is from donors, with very little core funding for GBV and gender equality programming. UNFPA financial reports indicate that core funds cover only ten percent of the programme while ninety percent comes from donor funding, mainly through the ISP. To the extent that the Government of Zimbabwe has not sufficiently supported GBV programming, there are serious challenges for sustainability of the programme.

4.3.5.3 Programming

Insofar as the UNFPA programme is run by Harare based IPs with limited local structures and often one-off activities, it is not sustainable. KIs in Lupane noted that although local committees and structures have been set up, these are not often financially and technically supported, and that the IPs work with volunteers in a volatile socioeconomic environment, challenging long term commitment. There was unanimity, however, that working with traditional leadership by all UNFPA gender programme partners was significant and resulted in sustainability. Traditional leaders and community gate keepers are key to sustainable interventions, as also noted by a Lupane senior NGO worker. Some Lupane focus group participants pointed to a weakness in the way UNFPA works with community based civil servants and other key stakeholders, however. They noted the need to intensify capacity building for provincial, district and ward level structures. It was suggested that UNFPA support coordination efforts of local structures so that they lead community based efforts to end GBV through public education and locally based support services for survivors. The respondents underscored the need to support coordination and capacity building of local level structures consisting of locally based civil servants, church leadership, and community based organisations, traditional and community leaders to form sustainable local movements to end GBV.

4.4 Population and Development

4.4.1 Overview

For UNFPA, the Population and Development (P&D) component looks at placing population issues at the centre of development, mainly through collecting the necessary data and supporting their use. In the CPAP (2012-2015), the P&D component has one main outcome and three outputs[97]. The main outcome is the increased availability and utilization of disaggregated data at national and subnational levels. The first output is to strengthen capacity of relevant government departments responsible for planning to integrate population issues in development plans and monitor sectoral policies and plans[98]. Second, is to strengthen the capacity of the Zimbabwe National Statistics Agency (ZIMSTAT) and line ministries to produce, analyze, disseminate and promote utilization of population data[99]. Third, is to strengthen the capacity of the ZIMSTAT to coordinate the National Statistical System[100]. Thus the programme strongly emphasizes the capacity strengthening of the government institutions involved in the production and utilization of statistics. The results from implementing the activities are shown in the table below.

Table 4.4.1: Results for the P&D Component at Mid-Year 2014

CP Outcome 7: Improved data availability and analysis resulting in evidence-based decision-making and policy formulation around population dynamics, SRH (including family planning), and gender equality

[97] GoZ/UNFPA CPAP 2012 - 2015
[98] ibid.
[99] Ibid.
[100] Ibid.

CP Output 6: Strengthened capacity of relevant Government departments responsible for planning to integrate population issues into development plans and monitor sectoral policies and plans			
Indicator	**Baseline and Target by end of 2015**	**Achievement by Mid 2014**	**Comments**
Number of publications on key population issues (research reports, ICPD at 20), produced with UNFPA support	Baseline: 0 Target: 9 by 2015	5	On target
Number of progress reports on selected population programmes and projects articulated in the MTP/ZIMASSET	Baseline: 0 Target: 8 by 2015	4	Likely to be achieved
Availability of a population monitoring and evaluation database	Baseline: 0 Target : 1 by 2015	0	Not on target
CP Output 7: Strengthened capacity of the Zimbabwe Statistical Agency and line Ministries to produce, analyze, disseminate and promote utilization of population database			
Number of staff trained in latest data processing techniques (including Web-based database systems)	Baseline: 0 (2011) Target: 30 by 2015	35	Exceeded target
Proportion of national census and ZDHS budgets mobilized/leveraged by UNFPA	**ZDHS** Baseline: 0 (2011) Target: 5% **Census** Baseline: 0 Target:5%	50% 29.2%	Exceeded target on ZDHS Exceeded target on 2012 Population Census
Number of census and ZDHS thematic/in-depth reports produced with UNFPA support	Baseline: 0 (2011) Target: 8	7	
CP Output 8: Strengthened capacity of ZIMSTAT to coordinate the national statistical system			
Number of sectoral statistical committees supported by UNFPA	Baseline: 0 Target:15	0	Not on target
Availability of a publication on standardized concepts, definitions and methods used across the national statistical system produced and distributed.	Baseline: 0 Target: 1	1	Achieved
Number of statistical inquiries, consultative meetings and user-producer symposiums on statistics supported by UNFPA	Baseline: 0 Target: 5	2	Likely to be achieved

Source: Mid Term CPAP Review 2014, M&E Analysts UNFPA CO, P&D programme records.

The context in which the activities for the P&D component was prioritized during the period under review was determined by where the needs were highest and where maximum contributions could be made by UNFPA. While activities were undertaken for all three outputs, the major technical and financial support by UNFPA focused on strengthening the capacity of ZIMSTAT to produce valid, reliable, relevant and timely population data. UNFPA supported ZIMSTAT in undertaking the 2012 Population Census, preparations for conducting the 2015 ZDHS and strengthening the National Statistical Systems. UNFPA commenced providing assistance for the preparations of the 2012 Population Census as far back as in 2009, which was in the 5th CP, and some activities that could not be undertaken were rolled over into the 6th CP.

4.4.2 Relevance

Because of the prevailing economic conditions in Zimbabwe in 2012, which crippled major government operations (especially the 2012 Population Census), UNFPA took a leading role in mobilizing and managing the financial resources for the 2012 Population Census (Output 2). UNFPA became the relevant partner through whom development partners could channel and manage funds for the 2012 Population Census. In executing the 2012 Population Census, UNFPA was actively involved in monitoring the implementation of activities, including mapping and enumeration exercises, in identifying and mitigating problems, and in procurement of the required equipment, including vehicles. UNFPA also supported the post enumeration survey (PES) training of trainers, training of enumerators, fieldwork and printing of the Census reports.

The relevance of the support provided by UNFPA to ZIMSTAT for Output 2 relates to the value of the Census. KI interviews and documentation review show that the 2012 Population Census fulfills standard criteria of individual enumeration, universality, simultaneity and defined periodicity. Despite some delays in the preparatory phase, the 2012 Population Census was conducted on schedule. The mapping exercise was completed prior to fieldwork and relevant maps were available to enumerators for use during fieldwork, although there were minor errors in identifying boundaries of a few enumeration areas. Thus, the contribution of UNFPA in having a credible, usable and reliable Census needs acknowledgement and attests to its commitment in contributing to generation of reliable data.

The Census is also essential in providing data needed for planning, a critical component of Output 1. In Zimbabwe, a country undergoing some rapid population dynamics due to the political, economic and social changes, census data are crucial in determining the consequences of such trends. Thus, the 2012 Population Census is crucial and relevant in providing the levels, trends and differentials in fertility, mortality, migration and other socio-economic data. These data are vital for designing, programming, implementing and making decisions on issues affecting all sectors of the economy.

In respect to Output 3, UNFPA has supported ZIMSTAT to operationalize the National Statistical System (NSS). The support by UNFPA to better coordinate the statistics system in the country is crucial for availing the statistics on platforms that are accessible to users, and the support to the administrative statistical sources is fundamental to ensure the regular provision of basic statistics. Zimbabwe National Statistics Database (ZIMDAT) has been established at the statistical agency and this has facilitated the availability of sex- and age-disaggregated population and development data at national and sub-national levels. Relevant data have now been populated in ZIMDAT and are available for public use. ZIMDAT is a system that organizes, stores and displays data in a uniform format that facilitates information sharing. For population and health indicators, the database was populated with data from the 2010/2011 ZDHS. Although the database is still being improved in terms of navigability and user-interactivity, essential data are available for public use on the internet.

UNFPA has supported the undertaking and subsequent analyses of the 2010/2011 ZDHS as activities to fulfill Output 2, with the ZDHS extensively used by government and other stakeholders (KIs and document review). The ZDHS results were used to update about 60 percent of the health and population indicators in the 2012 Medium Term Plan (MTP) and Millennium Development Goals (MDG) progress reports. Some stakeholders, notably USAID, UNICEF and UNFPA have undertaken relevant secondary analysis of the 2010/11 ZDHS data; e.g. UNFPA supported research on market segmentation analysis for Family Planning.

To check the reliability and validity of the 2012 Population Census required a Post-Enumeration Survey that was undertaken in November 2012. This activity is aligned to Output 2. The main purpose of the PES was to measure coverage errors for the national population living in private households as well as to assess the comprehensiveness of the delimitation of enumeration areas.

During the 6th CP, the GoZ formulated a new economic strategy, Zimbabwe Agenda for Sustainable Socio-Economic Transformation, Zim Asset. While the strategy does not specifically mention

interventions in population issues, its pro-poor approach will entail monitoring of Zim Asset. The current blueprint does not have an M&E framework. Thus, data from the 2012 Population Census and 2010 ZDHS that were supported by UNFPA would provide baseline indicators for the economic blueprint. In this respect, there are proposals for the development of a data inventory matrix from Zim Asset that would show the indicators that need to be tracked, their means of verification (data sources), baselines and targets. Zim Asset does not explicitly mention population and development interrelationships, unlike the previous economic blueprint (the Medium Term Plan) which devoted a whole chapter to these issues. This omission or oversight might have been due to the non-involvement of relevant experts such as UNFPA with capacity in integrating population in development plans.

UNFPA has been supporting Population and Development Unit (PDU) in the Ministry of Finance to advocate for the integration of population variables in all policies. Addressing this issue is highly relevant because 'The everyday activities of all human beings, communities and countries are interrelated with population change, patterns and levels of use of natural resources, the state of the environment, and the pace and quality of economic and social development[101]. However, the support has not been substantial. While capacity building in the integration of population variables in planning is essential, there is no evidence that this is being provided to officials in other ministries. Possibly this is a limitation which was introduced in the design of the CPAP, which states only that 'PDU staff will be trained in integrating population issues in national development planning tools'[102]. The statement excludes other government officials in the capacity-building process, who need to integrate and mainstream population issues in the various sectors. The PDU staff can only act as influencers and advocate for integration as they cannot dictate what is incorporated in various policies.

UNFPA has minimally supported activities related to the integration of population in development planning as outlined in Output 1. The PDU is well positioned to play a catalytic role, which is central and relevant in bringing to the fore the integration of population in development in policies and programmes. However, the PDU has not developed a clear action plan, and hence funding agencies are not clear what components of the PDU to support. The appropriate skills, mainly on integration of population variables in development planning are available in the PDU, and they should use their comparative advantage to develop fundable projects. Lack of funding for the PDU has hampered progress in undertaking the activities, yet it should be spearheading the ICPD Plan of Action. The staff at the PDU indicated they have limited capacity to undertake activities such as training other government departments in integration, hence they rely on UNFPA to provide such expertise.

UNFPA has been trying to refocus the role of the PDU in a manner appropriate for fulfilling its mandate. The PDU is responsible for tracking and reporting on the Millennium Development Goals and other policies and programmes, which is in line with one of the outputs of UNFPA. Tracking these national indicators needs a multisectoral approach. Thus, the PDU should be responsible for convening fora for reviewing and preparing progress reports in each sector. However, this function can only be performed by an institution with a good understanding of the ICPD PoA, capacity that UNFPA has and contributes.

UNFPA has systematically supported previous reviews, ICPD@10 and ICPD@15. The year 2014 marks ICPD@20 and a review has been conducted although the report is not yet available for public use. These reviews have been critically important in indicating how far Zimbabwe has progressed in implementing the ICPD Plan of Action. The ICPD remains an influential instrument for future population and development policy, and the consistency with which Zimbabwe has remained committed to the PoA will need to be maintained.

UNFPA has financially supported developing baseline development through operations research and evaluation, including for condom use among women and men, and reasons for teen pregnancies. Research has focused on providing information relevant for programming itself, rather than providing

[101] ICPD, PoA (1994)
[102] GoZ/UNFPA CPAP 2012 - 2015

evidence on which programmes have health impacts. However, because of limited skills in the country to conduct operations research, UNFPA cannot undertake such activities on a large scale: poor research can lead to wrong decisions.

UNFPA is the convener of ZUNDAF Outcome 2.3: Government and Other Partners Generate and Utilise Data for Policy and Programme Development and Implementation[103]. Objective reviews have been undertaken quarterly by the Data for Development Working Group (DfDWG). The DfDWG provides a mechanism for planning the data needed for planning, a forum that has tracked its annual plans and shared information on data generation projects.

UNFPA has consistently commemorated World Population Day in Zimbabwe in order to raise awareness on population issues. In 2012, the World Population Day was commemorated under the theme 'Universal Access to Reproductive Health Services: Re-energizing family planning in Zimbabwe'[104] and, in 2013, 'Adolescent Pregnancy: A call to Action'. These themes are relevant in highlighting population issues in the context of national development plans and programmes.

4.4.3 Efficiency

In order to address the human capacity needs created by the brain drain, which has become a common feature of all institutions in Zimbabwe because of unfavorable salary scales and other factors, UNFPA has facilitated the training of ZIMSTAT staff through short courses. UNFPA has facilitated human resource development for key ZIMSTAT staff in short-term internal and external training programmes. For example, some staff were trained and equipped with skills in data editing and analysis. This included courses on CSPro programming, the Gender Information System (GIS), and advanced survey methodology. Some participants interviewed have indicated that they have been able to utilize the training effectively in their work, indicating the value of on-the-job training in mitigating the skills gap. In addition, UNFPA has facilitated government officials to attend conferences where they can jointly share information with other experts. As good practice, for both the population census and demographic health survey exercises, both subject matter specialists and computer programmers need to attend all the scheduled training and technical committee meetings.

UNFPA provided materials support such as vehicles and computers and also technical assistance to ZIMSTAT for the 2012 Population Census through funds mobilized from donors. However, because of the high risk rating of the public financial management system, development partners channeled funds through UNFPA rather than directly to ZIMSTAT. This created another administrative layer in the implementation of the 2012 Population Census and affected operations, especially in procurement of essential goods and services. The management of funds by UNFPA meant that procurement had to follow the UN format and procedures, which ZIMSTAT staff did not have training on and had not used before. This caused some challenges, as ZIMSTAT officials considered some procedures inflexible and lengthy, while UNFPA was hamstrung by ZIMSTAT administration staff not providing timeously the full information required to process payments. There appear to be considerable differences between the accounting and procurement systems of the UN and GoZ.

The Data for Development Working Group (DfDWG) has contributed to the operational efficiency of organizations that have to undertake specific tasks in the generation of statistical data. Regular DfDWG meetings review progress, identify problems and establish mitigation measures; e.g. the DfDWG provides a platform to leverage funds for the 2015 ZDHS from potential donors.

4.4.4 Effectiveness

The experience of the 2012 Population Census demonstrates the effectiveness of UNFPA in mobilizing resources to achieve the objective of providing data needed for planning. Although the

[103] ZUNDAF Results Matrix for 2012-2012

[104] http://countryoffice.unfpa.org/zimbabwe/?events=5348

undertaking of the Census incurred some administrative, financial and logistical problems, the ultimate objective of having a credible census was effectively met. As indicated earlier, UNFPA exceeded its target by 400 percent in providing funding for the Census.

While UNFPA has effectively assisted the institutions involved in the production of data, conversely the demand side, i.e. the users, is not yet well appraised regarding utilizing data for planning or integrating population variables in development planning. Evidence from interviews with potential users such as ministries, universities and NGOs showed that use of data from ZIMSTAT by other government entities, academic institutions and other organizations is limited. There is concern over the utilization and correct interpretation of available data. According to the ZIMSTAT directorate, users need to be thoroughly appraised to avoid any misinterpretation and drawing the wrong conclusions from data, and this appraisal needs to be formalized for instance through producers and users workshops.

During the period under review, UNFPA has facilitated some dissemination workshops for the 2012 Population Census at the national and provincial levels. Also, the main results of the 2010/11 ZDHS were disseminated during the 6th CP. The workshops offer the opportunities to restore confidence in the 2012 Population Census, especially among politicians who usually raise issues of omissions in their constituencies. It is anticipated that such workshops will generate demand for the use of census data. In addition, academic institutions should be encouraged to use these data for academic purposes. However, in the absence of continuous appraisal of users through workshops for producers and users of statistics, use will remain limited. The main constraint in running workshops has been financial.

Currently, UNFPA has been facilitating the further analysis of the 2012 Census data using thematic groups. The main aim has been to produce user/demand-driven census thematic reports useful for programme planning, monitoring, evaluation and reporting. Recognising the skills gap created by the exodus of experienced statistical and other professional staff, including demographers and statisticians, the thematic groups will be led by external consultants with the necessary professional experience in the themes to be analysed. However, the consultants will work with ZIMSAT staff, who are not well experienced in this type of analysis. This approach should provide a platform for skills transfer to staff at ZIMSTAT. The thematic reports will be utilized in programming as they will be able to show the causes and effects of population variables on development. In addition, further analysis and repackaging of information increases the utility of census data, adding value to the undertaking of the 2012 Population Census in the first place.

UNFPA identified skills gaps in relation to the 2012 Population Census, and attempted to ensure skills transfer from the consultants to local staff. For example, consultants for the master sample and the PES were understudied by the two sampling statisticians at ZIMSTAT, and so too were the GIS consultants attached to the cartographic section of ZIMSTAT. However, triangulated KI interviews indicate that the skills transfer has not been effective because of the time period being too short.

UNFPA has funded further analysis of the ZDHS. The results from these studies have wider applicability to programming as the statistical analyses used clearly segment to the population according to need and risk factors. For example, one study showed the factors associated with low uptake of male circumcision, and another the factors associated with teenage pregnancy. These studies have wide relevance to organizations that intend to design intervention programmes in these areas.

The DfDWG, which UNFPA co-chairs, appears effective and operational (documents and KIs). Its work is guided by a costed annual work plan and reviewed every quarter. Technical staff and, at times, organizational heads, represent participating organisations and agree data requirements.

4.4.5 Sustainability

Reports and KI interviews showed that most P&D activities have been largely funded by external donors, although GoZ contributed significantly to the 2012 Census. Donor support remains essential in the current economic situation, but it is uncertain how long donor support will continue. Government contributions are primarily personnel salaries not programme activities. The forthcoming ZDHS is wholly donor-funded, placing uncertainty on the future of these crucial scheduled surveys. Also, ZIMSTAT, the main implementing partner for UNFPA P&D retains ownership of activity implementation but lacks an adequate budget to build staff capacity. UNFPA-supported training is intermittent, designed for specific tasks and does not address the overall needs. However, it is difficult for UNFPA to determine ZIMSTAT's long-term needs without a comprehensive training plan.

The main aim of UNFPA has been to strengthen government ministerial capacity to implement the programmes. However, KIs report that the brain drain from the public sector to NGOs and abroad remains a major threat to institutional sustainability. Government has failed to stem out-migration, and it remains a challenge to sustain the benefits within GoZ of capacity development by UNFPA and other partners. In addition, some equipment purchased, for example, computers, scanner and some vehicles obtained for the 2012 Population Census and previous surveys with UNFPA assistance, has been transferred to ZIMSTAT to strengthen its operational capacity. However, ZIMSTAT is reported to lack the budget to maintain the equipment or internet connections.

The DfDWG, however, has become institutionalized and should sustain the production of data for development. Evidence of regular and consistent quarterly meetings to review the implementation of the joint annual work plan indicates the commitment of this group and their institutions to support the production of demographic and socio-economic data for planning and development.

4. 5 Management and Coordination

4.5.1 UNFPA Country Office

The Zimbabwean CO is one of the largest in the region in terms of financial and human resources, a response in part to changes in funding of development assistance to the GoZ that is currently channelled through UN agencies. A new typology was developed after a negative donor assessment in 2012 that found inefficiencies in internal and programme management for results. The CO reported to be in process of making offers to successful candidates to come on board by year end. This should assist the office to address the extremely heavy work loads arising from fund management as well as substantially increased non-core funding and programmes (reflecting successful mobilisation in response to high levels of unmet need in the areas of UNFPA's mandate). See Annex 6 for the full typology. Post holders appear to be by and large experienced and competent Zimbabwean nationals with appropriate qualifications and skills, with the recent addition of two senior international posts (deputy director and an international specialist in reproductive health) as well as the international HIV technical specialist and junior international interns to support various programmes. Donors and IPs commented that additions to the staff complement are already proving of value in improved overall efficiencies and responsiveness. Further comments on CO units are under the relevant thematic areas.

UNFPA's procurement regulations, despite their value for oversight control, were reported by several IPs and coordination partners as rigid and slow, leading to delays in programme activities and service provision and other inefficiencies, and incurring opportunity costs. This has been especially true for new areas of procurement, such as reusable VMMC kits.

4.5.2 GoZ Coordination Mechanism

The Ministry of Finance and Economic Planning is the co-signatory of the current CPAP. A Population and Development Unit has been established within the ministry with the main responsibilities of managing and monitoring the implementation of population frameworks. Progress

reports have been prepared periodically through an established monitoring system; however, the system is limited in terms of its correspondence with indicators outlined in the CPAP tracking tool.

4.5.3 Implementing Partners (IPs) and Partnerships

Wide ranging partners implement the CP within different outcome areas. Currently, at least 18 IPs are involved including CSOs, government ministries and departments, and parastatals. The number of IPs has increased significantly between the 5th and the 6th CPs, thus greatly increasing the demands on effective monitoring and reporting, and M&E could be improved. Efforts are in place to coordinate partners working with UNFPA, but for those partnering with other UN agencies coordination, several KI interviews found that coordination is poor, with duplication of effort reaching the same geographical and population group, lack of standardised messages and so forth (KI interviews).Partnerships have also been forged with other UN agencies within the context of 'UN delivering as one' to avoid duplication and generate synergies and effective coordination. UNFPA actively participates in one cluster with UNICEF and WHO. UNFPA has shown institutional leadership, e.g. leading the UN group on data for development, chairing the TWG on HIV prevention, and chairing the UNCT Programme Management and Operations Management teams. UNFPA is reported (KI interviews) to have high standing among UN partner agencies.

4.6 Monitoring and Evaluation

The CPAP 2012-2015 clearly articulates the role of M&E and activities to be carried out during the 6th CP, especially stakeholder responsibilities, the frequency of reporting and operationalization of the system. Programme M&E is the joint responsibility of UNFPA, GoZ and the implementing partners (IPs). The CO M&E Unit is to operationalize the results based management system and undertake evidence-based research, jointly with the CO, donor agencies and other stakeholders. Operations research is being scaled up but is insufficient, impeding effective measurement of intended results.

Table 4.6.1 Outline of Functions and Frequency of M&E in the UNFPA CO

Component	Type of Report	Frequency
Planning	• CPD and CPAP • CPAP M&E Matrix • Annual Work Plan • Office Management Plan • Different Office Plans	• Every 4 or 5 years • Every 4 or 5 years with annual updates • Every year • Every year
Monitoring	• AWP Monitoring Tool • AWP Progress Report	• Every year • Every year
Evaluation	• Determined by programmatic needs	Determined by need, outlined in CPAP
Reporting	• Country Office Annual Report to HQ • Bi-Annual Report to Regional Office • Country Monitoring System • Standard Progress Report for Each Output • Donor reports	• Annual • Bi-annual • Every quarter • Annually • Intermittent

The CO M&E Unit has a current staff complement of three, supporting the four programme areas: two experienced analysts, one for gender and HIV and one for reproductive health and P&D, and an assistant supporting both. Resources for M&E activities are allocated from the programme components, with no dedicated budget controlled by the M&E Unit. This limits the Unit's activities to those determined and scheduled by each programme unit, which is cost effective. A significant limitation is the sheer work load on M&E staff keeping abreast of routine monitoring of greatly expanded overall programmes (donor, data and CO KI and document reviews), and confirmed by the Unit to explain failure to achieve sufficient operations research. Yet strong M&E is essential to understand better CO efficiency and effectiveness and achievement of results to show value for money. In addition, programme officers' quality assurance of IP quarterly reports is not standardized, allowing for inconsistent quality of reports. According to MoHCC and IPs, different partners within

programmes undertake M&E independently and measure different indicators, although there is a checklist, suggesting that UNFPA needs to strengthen M&E activities, coordination and alignment to achieve more efficient measurement of processes and results across programmes.

The CPAP Results and Resources Framework defines targets, outcomes, outputs, strategies and programmatic activities, means of verification, risks and basic resources, and it indicates alignment to the ZUNDAF and the UNFPA Strategic Plan. However, the indicators in the CPAP tend to be quantitative process ones, such as numbers reached, and across the different thematic areas they do not always meet 'SMART' criteria. This makes it difficult to assess the level of contribution to outcome results. This is particularly true for gender and for social and behaviour change relating to reproductive health, where qualitative assessment is needed. Some have been revised during the CP, particularly to relate to new funding sources such as the extensive Integrated Support Programme. The gender programme, demand generation BCFs and Sista2sista clubs have also started collecting significant change stories. For gender, RH and HIV, operations research to measure qualitative results with SMART indicators should increase in the next CP and the unit needs the capacity to ensure this. Target setting of indicators in the 6th CPAP is done jointly by the programme staff and the M&E Unit, with the aim of ensuring that targets are aligned to available resources. This has not always been effective, however, and some unrealistic targets have been changed (e.g. for adolescent outreach).

Two platforms have been introduced for implementing partners to report their activities. They submit completed templates for quarterly and annual work plan progress reports (paper-based), including financial and narrative reporting. The quality of reports varies widely, however, according to IP capacity, and the M&E team organizes highly valued onsite training to those performing poorly (IP KIs). The second platform for reporting, mainly used for the HIV demand generation project database, is web-based using SurveyMonkey.com. The link opens up to the electronic questionnaire that IPs complete to submit their statistics electronically. This platform is useful for computer literate groups, e.g. some youth projects, and that have good internet access; it is less useful in rural areas.

Data compilation from the HIV IPs uses a database, with programme staff able to access the data to compile reports for internal and external use. Overall, monitoring is adequately synchronized for the CPAP and the IPs, and allows for the determination of programme performance toward the outputs. The M&E frameworks are harmonized with the ZUNDAF M&E framework. The M&E Unit meets IPs annually and those working on the same outcome areas address emerging issues together, and identify training needs. In some areas, such as the Linkages project, partners meet quarterly. The M&E Unit takes advantage of various meetings to retrain or advise IPs on reporting compliance.

UNFPA indicated that its core approach of government capacity support is not easily amenable to quantification and evaluation, while acknowledging donor requirements to show value for money and impact. Data to measure impact can also be obtained from other sources such as the ZDHS, MIMS and HMIS. The evaluation team recognizes the value of impact evaluations to identify public health benefits of UNFPA-supported activities. Finally, as the CP is only for four years, there was no mid-term evaluation. The present evaluation annexes the mid-year CPAP indicator quality assessment tool, and the various sections include summary results by mid-2104 against 2015 targets.

Chapter 5: Conclusions

5.1 Strategic Positioning of UNFPA and M&E

Throughout its mandate, UNFPA is effectively and strategically positioned to contribute to national priorities and the quality of life of the Zimbabwean people, and in relation to the UN division of labour and the UNFPA Strategic Plan. The CO works closely with GoZ in policy and strategy development as well as capacity strengthening, and its fund management role for government is greatly appreciated. UNFPA has credibility in the UN system and amongst donors, having mobilised and managed funds three times higher than in the previous CP, greatly expanding its programming.

All programmes need strong operations research to assess whether they are achieving results, exploring efficiencies and effectiveness, bottlenecks and challenges so that timely modifications can be made, and programmes be redesigned, scaled up or dropped as required for efficient and effective resource use. Monitoring and evaluation processes have been insufficient, however, in the light of increased workloads and staff capacity. The RRF has poor results chain logic, insufficient operations research. Weak and mainly process indicators have limited the CPE in tracking contributions to outcomes and impacts to demonstrate programme effectiveness.

Briefly, regarding specific programme areas, the need for population data to inform development is clear, and Zimbabwe lacks sufficient expertise or resources to undertake the critical surveys required. UNFPA provides direct technical assistance, training and resources to mount successful demographic and health surveys and, in the present CP, a successful census. Addressing the extensive unmet need across all areas of sexual and reproductive health, including to turn back the HIV epidemic, is also beyond the capacity of Government resources; and the attainment of gender equality and reduction of gender based violence has seen insufficiently-operationalised political commitment. Without the inputs of UNFPA at strategic level, they would remain a low priority. Finally, UNFPA has extensive linkages with civil society organisations and, through them and trained community cadres, solid reach into communities to raise awareness, influence social and behaviour change, and generate demand. The thematic sections below elaborate on the main programmatic conclusions of the evaluation.

5.2 Reproductive Health

5.2.1 Relevance

All areas of work in sexual and reproductive health (SRH) were relevant and responsive to identified needs, as well as being fully aligned to the UNFPA Strategic Plan and to ZUNDAF, and to addressing MDGS 4, 5 and 6. UNFPA supported the development of several national policy and strategy documents, and multiple guidelines, training manuals and other materials to boost capacity for reproductive health delivery in facilities and demand in the community. Specifically the programme responded to identified needs to reduce maternal morbidity and mortality, teenage pregnancy and cervical cancer, and to strengthen family planning and the access to and uptake of integrated SRH services by adolescents.

5.2.2 Efficiency

The RH Unit has experienced high staff workloads because of the expansion of budgets and programmes in the 6th CP, leading to some inefficiencies, e.g. in procurement, and leading to programme delays, a tendency to work in silos (e.g. in relation to other units), and some missed opportunities for synergies. Further recruitment is gradually redressing human resource challenges. It has been difficult to assess the efficiency of resource use and whether the same results could have been achieved with fewer resources, as highlighted above.

5.2.3 Effectiveness

Overall, the added value of UNFPA's contributions appears considerable, with no other partner in a position to contribute the same expertise and financial support to MoHCC capacity building across SRH, to integrating SRH and HIV services, and to support key vulnerable populations of sex workers and adolescents. UNFPA CO has also worked effectively particularly with UNICEF and UNESCO and other partners in implementing its programmes according to KI interviews and reports.

The majority of RH activities and outputs for the 6th CP are on track in terms of numbers reached, training undertaken, facilities strengthened and so forth, despite a slow beginning in 2012. As above, there is insufficient operations research, however, to assess how far the measured outputs will translate into meaningful results for behaviour change or uptake of services, or the availability of full services for which demand has been generated. The effectiveness of demand generation and of service provision for cervical cancer screening through VIAC also has limitations because of limited access to treatment[105]; however VIAC attendance was documented to provide a useful entry point for other integrated SRHR services.

The ASRH programme has incorporated multiple strategies integrated under all RH outputs. Data showed that certain areas have not functioned effectively, however, notably the youth interact services and youth friendly corners that were found to be underutilized and not cost effective. UNFPA is reconsidering the modalities for support for ASRH and the engagement of implementing partners. At present the extent to which the youth friendly corner programme follows international guidelines for success is unclear, as the full barriers and limitations are not effectively documented.

Regarding maternal health, the support of UNFPA for emergency obstetric and neonatal care through the H4+ programme, EmONC training and maternity waiting homes refurbishment is well focused; upcoming surveillance results will identify outcomes and, over time, impact. KI interviews and documentation indicated that UNFPA, however, needs to greatly scale up and consolidate its efforts in this crucial area, including to bring EmONC up to WHO signal standards.

Support for RH in humanitarian situations has been low during the 6th CP, with no budget and only limited support provided for antenatal women displaced through flooding in 2013.

5.2.4 Sustainability

The important contributions of the RHU and the HIV Unit to RH and HIV policy, road map and strategy development, as well as to materials including an advocacy pack, guidelines, training manuals and so forth, should contribute to sustainable results across the reproductive health and rights (RHR) component. Extensive training of public service health providers in EmONC, STI management, family planning, condoms, VIAC and, to some extent in youth friendliness, together with training on integrated service provision, should contribute to sustainable improvements in capacity. The outcomes of training need to be carefully assessed and on-the-job mentoring be provided. However, given the challenging economic situation in Zimbabwe and the extent to which the public health system is under-resourced with high staff attrition and inadequate facilities, it is not certain how sustainable the results will be. UNFPA and other partners' continued financial and technical inputs will continue to be required in the next CP. Exit strategies from programme and capacity support (premised on domestic resources becoming sufficient for continuity, or that sustainable results have been achieved) are not generally in place.

5.2.5 Responsiveness

During the 6th CP substantial review of indicators was undertaken, as shown in the evaluation matrix of mid 2014 compared with the CPAP RRF. Some activities were dropped when they were not showing results, and others were modified. UNFPA has thus shown responsiveness to challenges in

[105] The primary purpose was to identify early pre-cancerous conditions that VIAC does provide, but it remains a limitation to the overall patient benefits that further treatment is not widely accessible.

these and other areas. The overall situation in the country has not substantially changed during the CP, however, so no major change of focus or prioritisation was needed (unlike in the 5th CP when the economic and humanitarian crisis reached its peak). This applies also to HIV prevention within RHR.

5.3 HIV Prevention

5.3.1 Strategic Positioning and Relevance

UNFPA CO has positioned itself strategically in relation to high level international and national policy commitments, the MoHCC, UNAIDS cosponsors and other stakeholders at policy, planning and implementation levels. It is seen as a strong contributing partner by government, the UN and other stakeholders. The HIV programme addresses key areas of the ZNASP II and the more recent (2013) Combination HIV Prevention implementation approach and related thematic guidance, having been actively involved in their development. The CO works from its areas of comparative advantage with critical population groups for social and behaviour change communication and demand generation for services, as well as strengthening HIV-related service provision, to both of which outputs it has made significant contributions. Overall these are working well. The integration of HIV with wider sexual and reproductive health and with rights (primarily around GBV and for female sex workers and young people), is a strategic approach for investment that UNFPA is pursuing as its main orientation in line with international thinking.

5.3.2 Efficiency

While donors and IPs reflected positively on several areas of achievement for HIV prevention, they noted inefficiencies in the CO, partly to do with the substantial expansion of funding and insufficient office capacity to handle the greatly increased work load, and leading to, for example, late procurement and delays in training material development that, in turn, delayed MoHSS staff, peer educator and BCF training schedules. Also, the heavy work load includes complex demands for coordination and the managerial and administrative requirements of fund management while direct government funding is not feasible. The budget and programme scale up during the 6th CP have greatly expanded, testimony to donor confidence in the strategic positioning of UNFPA and recognition of the high level of need in Zimbabwe; but office capacity has not expanded at the same rate. Programme roll out was slow during 2012 but has gained ground in 2013 and 2014, however, and implementation rates are coming on track. Limitations to M&E are one concern with the rapid expansion and need to be strengthened to measure better the efficiency and effectiveness of resource use. Recommendations elsewhere in the report to strengthen M&E and management apply also with respect to HIV prevention. See also 5.1 regarding resource use.

The theory of change logic in the CPAP for HIV prevention is fairly strong but CPAP indicators are insufficient to measure contributions to meaningful outcome results, particularly for social and behaviour change and demand generation.

5.3.3 Effectiveness

The focus of UNFPA on increased coverage of SBCC and of improved demand for and provision of HIV prevention services remain highly relevant for the next CP, and contributions to the outcome level require a stronger RRF and results chain logic (as noted earlier).

By mid 2014 UNFPA has substantially achieved its targets for HIV prevention activities in CPAP Outputs 4 and 5, exceeding them in some areas, or on track to achieve targets by end of 2015. An area of performance below expectation was support for male circumcision roll out.

The largest part of UNFPA programme expenditures was support from the Integrated Support Programme, a well-conceived integrated programme for SRHR/HIV based on prior research. This is well targeted, addressing the populations of female sex workers, adolescents and young people, and women and men of reproductive age through home visits and other approaches. The full effectiveness

of UNFPA's programmes for HIV prevention for social and behaviour change and demand generation is a challenge to assess, however, and more qualitative analysis is both needed and planned. Nonetheless, there is clear evidence of increased demand amongst sex workers as a key population, and some limited evidence from the door to door home visits.

Regarding specific programme areas:

- The Sisters with a Voice FSW has scaled up with ISP funding through a strong implementing and research partner collaborating closely with MoHCC, and demonstrating significant results in numbers of FSW reached and taking up HTC, STI treatment, condom use and family planning. Beneficiary feedback is positive, with sex workers feeling empowered and valued. The programme includes strategic operations research to measure outcomes resulting from HTC, and for impacts on new HIV infection and treatment uptake**,** supported by UNFPA. It also includes an innovative programme to address GBV and the human rights of FSW. It is acknowledged internationally as good/best practice that UNFPA should continue to support.
- The innovative strategy in the ISP of door to door home visits to raise demand for services has achieved fairly high coverage in the 26 roll out districts, but how far it translates into access to and uptake of comprehensive SRH and HIV prevention services is unclear. There is a risk that if a one-size-fits-all approach continues regardless of the actual availability of different services, the approach will generate high unmet demand and lose credibility; and one-off visits may not be ideal to achieve results.
- Regarding increased availability of HIV prevention services, the evidence shows: strengthened service provision through procurement and improvement of facilities, despite delays; expanded UNFPA-supported health provider training for integration of SRHR/HIV, the new STI syndromic management guidelines and condom programming; and provision of HTC in almost all facilities to which UNFPA contributed test kits as well as increasing demand through home visits and the FSW project in particular. Quality service guidelines and tools have been developed, eight VMMC sites were supported, and VMMC research was supported to guide the way forward. UNFPA-supported research by CeSHHAR related to sex workers (including for ART access and uptake) will influence policy and service provisions.
- Piggy backing nurse training for integrated services on to existing STI training and CCP training is logical and efficient and needs better evaluation regarding improved practice
- UNFPA and UNICEF are supporting strategy development for eMTCT, and the strategy should be in place by early 2015 enabling UNFPA greatly to strengthen its currently insufficient support for Prongs 1 and 2.

In addition, although UNFPA does not have a mandate for HIV treatment, there need to be close links between HTC demand generation and availability of and uptake of treatment services, and it is important that UNFPA coordinate effectively with other partners supporting the MoHCC in treatment delivery and monitoring of treatment adherence for opportunistic infections and ART.

In particular, detailed operations research has not yet been taken of the patient/client flow through integrated service delivery, of waiting times, of the allocation of tasks and job descriptions, and of the efficiency and effectiveness of the integrated sites, from basic facility level through to the Linkages centres of excellence. This means that there could be scope for substantial improvements, for both beneficiaries and for the service providers. Some inefficiencies in the existing systems were observed at one centre: e.g. mismatch between poor and crowded facilities for heavily utilized services (e.g. FP) while better facilities were available for underutilized services (e.g. ASRH), and mismatch between the level of staffing available, equipment and private space for consultations (e.g. for HTC in an ANC setting, or regarding VIAC).

5.4. Gender

The UNFPA Gender Equality Programme has been the mainstay of efforts to end GBV in Zimbabwe, providing essential added value to this key area. The UNFPA mandate of interventions up and down stream is critical. The GE programme is highly relevant and has been effective.

To enhance effectiveness, efficiency and sustainability of interventions, the evaluation concludes that UNFPA will need to support coordination at different levels. There is need to trigger and support purposive co-ordination at policy level of the Ministries Health and Child Welfare, Home Affairs (Police) and Justice and Parliamentary Affairs and MWAGCD. GBV is a public health issue and UNFPA has a mandate to strengthen the capacity of the health sector to respond. The evaluation notes the existence of likeminded coordination mechanisms in the same Ministries spearheaded by the Judiciary Service Commission. UNFPA would do well to ascertain the existence of similar coordination mechanisms at community levels, namely ward, district and provincial levels and involving community, traditional and local level leaders, religious leaders, youth and other gate keepers and opinion leaders to capacitate them to estalbish movements to end GBV.

Zimbabwe finds itself in a peculiar situation, where because of the governance challenges faced in the recent past, development funding has been channelled through CSOs that have gained strength and temporarily partly taken over government roles. However, this space offers UNFPA an opportunity to support and capacitate the National Machinery for Women's Advancement and key ministries within the multi-sectoral response with requisite skills to lead and champion efforts to end GBV. UNFPA has the mandate and authority to support high level policy dialogue for enhanced GBV programming.

The other conclusion drawn is that whereas the work of UNFPA partners is appreciated and answers practical and strategic needs of communities, they have not been fully exploiting the consortium of IPs. The evaluation did not find targeted and strategic release of the partners into the communities. The entry was not coordinated, nor did it work within the comparative advantage offered by the partners. The weak IP coordination meant that they could not benefit from peer review and joint assessment and review of their work. It also means that they cannot easily discern and collectively deal with emerging issues and share information on effective programming strategies and approaches. In addition, they are not able to build on and harness the gains that the other partners are making, thereby maximising impact.

The evaluation noted the value added in UNFPA's support for ZIMSTAT to generate and analyse population and other issues. Greater partner coordination would ride on this comparative advantage and provide a coordinated platform for deepening evidence based programming and enhance responsiveness in dealing with new and emerging SRH and GBV related issues. This same conclusion applies in dealing with the UN family. UNFPA has the mandate to ensure a coordinated UN system response to GBV and in relating to GoZ and other partners. GBV is the UNCT's flagship programme and UNFPA can leverage this to enhance coordination.

Within UNFPA too, internal integration can be improved. The evaluation team did not find that the different programmes work optimally together. The UNFPA GBV Strategy refers to addressing GBV through UNFPA supported SRH programmes as the minimum standard to which all UNFPA operations should be held accountable[106]. Efforts by the organisation to support entry level training for cadres in the health and police sectors in dealing with GBV is laudable and should be escalated in the 7th country programme. It is imperative that in the next country programme UNFPA strengthen the SRH and GBV link in its programming.

The evaluation concludes that M&E needs to be strengthened within the UNFPA Gender Programme and among IPs. Up until recently, the programme has used quantitative indicators, yet the changes sought are both quantitative and qualitative, and therefore require an additional set of measures. In addition to developing both qualitative and quantitative indices, there is a need for a paradigm shift in the way RBM is viewed away from perceiving it as a donor requirement, but more an act of accountability to UNFPA, IPs and communities served. IPs have weak M&E frameworks that are by and large activity driven. UNFPA needs to invest in supporting a results-based culture, balanced with the exigencies of sustainability. Respondents in the field expressed surprise at the evaluation, noting that they were hardly followed in the field by UNFPA.

[106]UNFPA Strategy and Framework for Addressing GBV

Whereas UNFPA holds itself accountable to values of promoting gender equality and gender mainstreaming in all its programmes and projects, the GE Programme has limited staff. While acknowledging that this programme is wholly nationally executed, there is need for additional high level gender equality expertise.

The UNFPA GE Programme areas are for prevention and response to incidents of GBV. Whereas a range of interventions for response to GBV have been supported such as offering health services, psychosocial support, legal aid, sheltering and material support, the prevention side is not as strong. The current programme boasts a weak link between SRH and GBV and humanitarian interventions. It is critical to elevate prevention strategies within a clearly articulated long term plan to end GBV riding on the comparative advantage of UNFPA in SRH and as UN team leader for responding to GBV in humanitarian settings.

UNFPA needs to enhance its support for the leadership and standard setting role of the National Machinery for Women's Advancement and also support its capacities for GBV programming at local levels. Furthermore, capacity strengthening should be extended to competent traditional and community leaders, religious leaders, gate keepers and community based structures including young women and men.

Finally, the evaluation concludes that there is a lack of regional balance in the selection of IPs and for the next country programme, this must be rectified.

5.5 Population and Development

UNFPA has made significant contributions to the availability of data in Zimbabwe through support for the 2012 Census, 2010 ZDHS and other surveys, and these data are now collated in ZIMDAT. However, KI interviews and reports showed a still-outstanding need to transform data into information usable for planning purposes. This affects data from censuses, surveys and research reports, and presents a major challenge to Government and UNFPA.

UNFPA has supported the national statistical agency, ZIMSTAT to address the skills gap through on-the job training for key staff members, and recruitment of experienced consultants for ZIMSTAT. These approaches have achieved important results, the main one being the 2012 Census, but ZIMSTAT remains in need of further capacity development given the continuing brain drain.

The support for activities to enhance the integration of population into development, addressing the ICPD PoA agenda, has been minimal during the 6th CP, however, unlike in the previous CP. It was unclear in the evaluation why UNFPA had reduced support to the Population Development Unit in the Ministry of Economic Planning that has the mandate for these activities. Possibly this reflected that the institution coordinating these efforts lacked the necessary skills and knowledge in integration and would need capacity building. The PDU is poorly resourced and its participation at the DfDWG is inconsistent despite its mandate to play a central role. KI interviews indicated that it is not clear whether UNFPA is not fully supporting it because it is weak, or it is weak because of insufficient UNFPA support.

Finally, UNFPA P&D Unit has underutilized potential to undertake relevant operations research; it also has comparative advantage to support GoZ for stronger integration of population issues into Zim Asset, the economic blue print for development, which currently lacks a strong population focus.

Chapter 6. Recommendations

6.1 Strategic Positioning, Management and Monitoring and Evaluation

Although UNFPA is strategically positioned, the agency needs to:

i) prioritise more effectively, and strengthen its internal and external coordination including for IPs and other stakeholders to improve efficiencies, and finalise key recruitment
ii) measure programme effectiveness and efficiency to assess intended results and demonstrate value for money through a more robust and coherent RRF and results chain logic across all programme components
iii) review and ensure capacity, particularly in the M&E Unit to deliver on operations research and evaluation at the level required in light of the greatly increased monitoring work load
iv) explore mechanisms to streamline work flow, acknowledge bottlenecks and strengthen inter-unit collaboration and communication to achieve greater synergies within the CO
v) regarding M&E of IPs, standardize criteria for approving quarterly and annual reports.

6.2 Reproductive Health

6.2.1 Strategic Focus

The key areas of focus on reproductive health for the remainder of the 6th CP and the 7th CP should remain largely the same,, but UNFPA should:

i. ensure tighter prioritization of high impact, evidence-informed strategies, and focus the most attention on districts and populations where needs are known to be highest prior to national scale up
ii. rapidly complete the full RH typology in 2015.

6.2.2 Integrated Support Programme (ISP)

UNFPA should (also see HIV component below)*:*

i. expand ISP supported work in the 26 districts, initially intensifying coverage for results rather than expanding more widely geographically, seeking further funding resources as needed
ii. maintain the emphasis on integrated services, with HIV prevention, family planning, condom programming and STI treatment remaining core areas for UNFPA support
iii. engage with MoHCC and other stakeholders on modalities to maximize patient treatment for cervical cancer and avoid generating demand that cannot be effectively addressed.

6.2.3 Reducing Maternal and Infant Mortality: (H4+, EmONC, Maternity Waiting Homes) and other MoHCC support

In the remainder of the 6th CP and into the next CP UNFPA should:

i. utilize the findings from the H4+ project and maternal deaths surveillance and response assessment greatly to strengthen support around maternal and infant morbidity and mortality
ii. support provincial hospitals to meet the seven signal functions of WHO, with essential drugs and commodities and skilled staff, as well as continue to strengthen district and lower level facilities
iii. support regional training centres, to reduce reliance on central facilities, including support for nursing and midwifery schools jointly with UNICEF
iv. consider EmONC training expanding into a mentoring mode on the job to ensure quality of service provision and sustained benefits of training
v. Raise MWH refurbishment to meet minimum standards and strengthen health education for mothers at MWHs as a feasible, low cost contribution to maternal and neonatal health and well-being.

6.2.4 Adolescent Sexual and Reproductive Health

UNFPA should, in the remainder of the 6th CP and into the 7th CP:

i. take bold steps to reconceptualise ASRH services regarding modalities and implementing partners, with strong operations research to assess compliance with international guidelines for youth friendly services, and to identify and overcome barriers to access and uptake by females and males; learn from international experience; and carefully evaluate results of integrating ASRH into adult health services
ii. explore with partners effective ways to implement community based peer education progammes and other modalities with young people that can be effectively supported and monitored, including community sensitization and education for community leadership and health providers.
iii. continue work with youth networks to strengthen young people as rights bearers
iv. expand peer education at teacher-training colleges nationwide and strengthen the linkages between this programme and support for comprehensive sexuality education (CSE) in schools
v. contribute to CSE in schools through advocating and supporting curriculum revision, pre- and in-school teacher training to deliver the curriculum effectively and making the subject examinable, in line with international guidelines.

6.3 HIV Prevention

6.3.1 Strategic focus and CO management for HIV Prevention

In the 7th CP UNFPA should:

i. maintain the current strategic focus for HIV prevention, except that the linkage of HIV prevention and treatment needs to evolve in line with emerging opportunities and evidence
ii. stay abreast of new evidence for the effectiveness or otherwise of HIV prevention strategies with both key vulnerable groups and mainstream populations to ensure optimal investments, guided by the Combination HIV Prevention Approach
iii. strengthen support for integrated SRH and HIV services, remaining abreast of new evidence for efficiencies and effectiveness of results, intensifying support in existing regions and prioritise later expansion according to identified need
iv. strengthen its coordination role with other key stakeholders (e.g. with UNICEF in relation to adolescents) to achieve an effective division of labour for national coverage of quality programming for integrated HIV prevention at national level and also at programmatic level on the ground, with effective IP coordination to achieve synergy, complementarity and greater efficiencies in programming

6.3.2 Linkages Project

With regards the Linkages Project centres of excellence for integrated services, UNFPA should:

i. through a consultative and participatory process, cascade the Linkages Project to lower level facilities in the 7th CP, ensuring strong M&E to measure results; and learn lessons from the project's six partner countries and from other integration strategies in place in Zimbabwe
ii. consider supporting time and motion studies in all three centres of excellence to determine bottlenecks in patient flow through the integrated systems for eMTCT/ANC and for SRH services and HIV prevention and treatment; use findings to inform work allocation and job descriptions, and participatory mechanisms for scale up.

6.3.3 Demand Generation, Door to Door Home Visits, Sista2sista Clubs

The following recommendations are made for UNFPA: the agency should:

i. develop more robust mechanisms to track increased demand and service uptake arising from behaviour change facilitator (BCF) visits and other demand generation efforts, e.g. through peer educators, and assess the relative benefits of different modalities for home visits
ii. assess how far BCFs emphasise abstinence-only messaging, and ensure they address male and female condoms, HTC, supporting girls who are HIV positive and reducing stigma, with appropriate approaches for sexually active and non-sexually active members

iii. expand links with MoHCC, Africaid's Zvandiri Programme and other partners in the field to boost mentors' support for HIV positive adolescents, including the trained mentors for the Sista2sista groups

iv. support the Positive Health Dignity and Prevention agenda, not just for adolescents but throughout the HIV programming to a greater extent than apparent during the evaluation

v. review roles of other community cadres e.g. village health workers, in relation to BCFs regarding potential synergies and complementarities

vi. monitor the extent to which demand may be outpacing service provision in light of the continued threats to health service capacity to deliver, and to sustain standards, and modify the present strategy as needed and/or reconsider its role in health system strengthening in conjunction with key stakeholders and the UN division of labour; consider tailoring demand creation through BCFs to the services available in a given area, given that these vary considerably, rather than routine blanket needs assessment and referral; ensure BCFs know what services are available where, of challenges in access, and that they identify gaps.

6.3.4 The Sex Work Programme, Sisters with a Voice

UNFPA should:

i. continue financial and technical support for both the implementation programme and its research programme, and take into account the increasing administrative burden on the implementing partner as the programme expands

ii. contribute to advocacy for the rights of sex workers to full SRHR and HIV services, including FSW empowerment to challenge GBV

iii. ensure clinic staff in outreach sites are sex worker friendly (as well as adolescent friendly).

6.3.5 eMTCT

UNFPA should:

i. adopt the combined eMTCT strategy currently being developed to guide and greatly strengthen UNFPA support for Prongs 1 and 2

ii. support time and motion studies in pilot sites for integrated ANC/eMTCT facilities to increase efficiency and effectiveness (as recommended for the Linkages Project).

6.3.6 HTC

UNFPA should:

i. continue to support HTC demand creation, particularly among FSW, adolescents and in couples

ii. support operations research to assess its impact on HIV prevention and treatment uptake in different settings (such as the FSW programme) where it is evaluable.

6.3.7 Voluntary Medical Male Circumcision

In relation to VMMC UNFPA should:

i. continue support at policy level, in the TWG and for coordination staff in government

ii. continue funding strategic research to strengthen programming, including for demand generation

iii. explore with MoHCC the way forward to optimise long-term benefits of MC.

6.4 Gender

The following recommendations are made, in priority order, for the GE Programme.

i. Given Zimbabwe's multisectoral and coordinated strategy and policy position for ending GBV, UNFPA should support MWAGCD to convene policy dialogue with key GoZ ministries and departments on the critical pathway for handling GBV cases with increased policy commitment and collective actions to end GBV. In addition, UNFPA should support decentralised coordination at ward, district and provincial levels with a view to supporting community capacity building and actions to end GBV.

ii. UNFPA should coordinate with IPs, the UN family and with GoZ to enhance GE and GBV programming, targeted at enhancing the work of partners, creating an information sharing and planning platform, and facilitating peer review for enhanced GBV programming. In addition, UNFPA should play a stronger leaderhip role to coordinate partners and maximise the consortium by harnessing its comparative advantage, that of IPs and the leadership and standard setting role of MWAGCD.

iii. In the context of limited funding support for GBV programming and that UNFPA's GE programme is 90 percent donor funded, UNFPA should use its comparative advantage within the UN family to align the 7th CP to its corporate policy approach of addressing GBV through SRH programmes as a minimum standard to which its operations are held accountable.

iv. UNFPA should use its knowledge, comparative advantage and mandated leadership role to support the GoZ and IPs to develop mechanisms and capacity to address GBV in humanitarian settings.

v. UNFPA should invest in partner consultation to explore wider strategies to prevent GBV within an evidence based strategic framework that clearly defines UNFPA's role as thought leader, advocate, technical expert and capacity builder for efforts to end GBV.

vi. Given the findings of weak results based programme management (RBM), UNFPA should invest in capacity building for RBM for the GE Programme and partners premised on clear theories of change for UNFPA and partner organisations.

vii. UNFPA should commission a gender review/audit of its country programme to guide and strengthen support for gender mainstreaming in the organisation and in support to IPs.

viii. UNFPA should explore new funding mechanisms, including use of core funds for GE, in light of heavy donor dependence.

ix. UNFPA should take into account regional balance in the selection of CSO IPs for the next country programme, redressing the current sole representation of Harare.

6.5 Population and Development

For the P&D component, recommendations are made for three main activities: generation of relevant population data needed for development planning, mainly through support to ZIMSTAT; integration of population issues in development planning for the ICPD PoA agenda through support to the Population Development Unit in the Ministry of Finance and Economic Development; and further support for population integration into development.

6.5.1 UNFPA Support to ZIMSTAT

The following recommendations, ranked by their order of importance are made for UNFPA support to ZIMSTAT to promote utilization for evidence-based research, policy and programming of the wealth of data produced with UNFPA support.

i. As well as supporting data capture and analysis, UNFPA should support regular workshops for producers and users at national, provincial and district levels to strengthen use of quality data with which ZIMDAT is regularly populated through the Census and other surveys.

ii. Given the skills shortage at ZIMSTAT, UNFPA should continue to provide capacity building for ZIMSTAT staff and co-develop a replacement plan to mitigate the current brain drain of trained personnel. A cost-effective approach for continuity might be to design a mentoring scheme using retired and experienced statisticians, demographers and economists in Zimbabwe to work with recent graduates at ZIMSTAT on specific tasks.

iii. While the use of consultants supported by UNFPA to undertake various tasks to fill the skills gaps at ZIMSTAT is unavoidable, UNFPA should make it mandatory that any consultant seconded to ZIMSTAT has an understudy officer to promote skills transfer.

6.5.2 UNFPA Support to the Population and Development Unit

The following are recommendations, in order of priority, for UNFPA on support to the Population and Development Unit (PDU):

i. In view of minimal and intermittent assistance for the PDU, UNFPA should intensify support to strengthen the PDU regarding the ICPD PoA. UNFPA should work with the PDU to develop a strategic plan to assist ministries to integrate population issues in their plans.
ii. UNFPA should help the PDU develop its work plans around the ICPD PoA, including setting up an inter-ministerial committee for implementation and review, given the multisectoral nature of the ICPD PoA. The PDU mandate needs to be more clearly defined but should prioritise the need for implementing and monitoring ICPD PoA.
iii. UNFPA has assisted various countries to set up capacity-building institutions in population and development to support implementation of ICPD PoA. UNFPA should develop the capacity of institutions to provide an in-service skills training programme on population and development to enable government planners to integrate population into development planning and policy in various sectors. Experience in South Africa shows that this is cost-effective and, in the long-run, self-financing if other stakeholders like NGOs and the private sector come on board when they realize the utility of the skills for their own organizations. In Zimbabwe, the course could be introduced at the Centre for Population Studies, where review shows that relevant skills are available. Such institutions are sustainable because they use local staff and are established in an institution as an academic programme.

6.5.3 UNFPA Support for Population and Development Integration

i. The UNFPA P&D Unit is well placed for operations research. The wealth of data produced with UNFPA support needs to be utilized for evidence- based research.
ii. The omission of population issues in the current economic development blueprint, Zim Asset needs to be addressed. UNFPA needs actively to engage GoZ policy makers on the importance of integrating population issues in the action plans that will be developed for ZIM Asset, through policy dialogue meetings on development and population issues.

Annex 1: Terms of Reference

TORs for End of the UNFPA/GoZ 6th Country Programme (2012-2015) Evaluation

1. Introduction

The Government of Zimbabwe (GoZ)/United Nations Population Fund (UNFPA) 6th Country Programme Document (CPD) and Country Programme Action Plan (CPAP) (2012-2015) focuses on improving reproductive health, preventing HIV, promoting gender equality and women's empowerment, and improving the availability and utilization of data for development.

The goal of the sixth country programme is to contribute to the improvement of the quality of life of the people of Zimbabwe, especially among women and young people, through promoting universal access to Sexual and Reproductive Health and Rights. In particular, the programme seeks to reduce maternal mortality, the unmet need for family planning, new HIV infections and gender based violence, informed by a better understanding of population dynamics, and using rights-based and gender-sensitive approaches. The 6th country program aimed at scaling up advocacy efforts for an enabling policy and programming environment towards the achievement of MDG's in particular MDG 5 and the ICPD agenda.

The UNFPA Evaluation Policy (DP/FPA/2009/4), states that every country programme must be evaluated at least once in a programme cycle. The Evaluation policy defines the overarching framework of the UNFPA evaluation function and spell out the roles and responsibilities of the different UNFPA units. The Evaluation guidelines reiterate that end of country programme evaluations and final evaluations of demonstration projects are mandatory, and must be conducted in time to inform the development of the subsequent programme/projects.

The primary users of the evaluation are the decision-makers within UNFPA and the Executive Board, Government counterparts in Zimbabwe and other development partners are also seen as part of the audience of the report.

2. Context

The GoZ/ UNFPA 6th Country programme is expected to contribute to the 7 outcomes of the global UNFPA development results as articulated in the revised strategic plan 2008-2013. It also contributes to the national priorities through five of the eighteen 2012-2015 Zimbabwe United Nations Development Assistance Framework (ZUNDAF) outcomes
2.1: Enhanced Economic Management and Pro-Poor Development Policies and Strategies
2.3: Improved Generation and Utilisation of Data for Policy and Programme Development and Implementation by Government and Other Partners;
5.2 Increased Access to and Utilisation of Quality Basic Health and Nutrition Services
6.1 Improved Access To (and Uptake of) HIV Prevention Services
7.1. Laws and Policies Established, Reviewed and Implemented to Ensure Gender Equality and Empowerment of Women and Girls.

The expected outcomes of the 6th country programme were:-

- Increased utilization of comprehensive gender-sensitive and youth-friendly RH services.
- Increased adoption of safer sexual behaviour and use of HIV prevention services.
- Increased availability and utilization of disaggregated data at national and subnational levels.
- Improved policy and legal environment for gender equality and increased utilization of gender-based violence services.

In the 6th Country programme, UNFPA Zimbabwe is working with various partners namely Ministry of Health and Child Care, Ministry of Women affairs, Gender and Community Development, Zimbabwe Statistical Agency (ZIMSTAT), National AIDS Council, Zimbabwe National Family Planning Council, Musasa Project, PADARE, SAYWHAT, Zimbabwe Youth Council., Women Action Group(WAG) Midlands AIDS Support Organisation (MASO). Family AIDS Caring Trust(FACT), ZICHIRE, ZAPSO, Regai Dzive Shiri (RDS), World Vision, Matabeleland AIDS Council(MAC) and Zimbabwe Women Lawyers Association(ZWLA)

3. Scope and Objectives of the evaluation

3.1 Purpose of CPE

The main purpose of the end of CP evaluation is to assess the progress of the 6th CP towards achieving the CPAP outputs and outcomes.. The evaluation will also analyse factors that facilitated or hindered achievement and document lessons learned to provide input to the 7th Country Programme.

3.2 Scope of the CPE

The end of the CP evaluation will cover the period 1st January 2012 to 30 June 2014.

- ***Time period.*** The evaluation will cover the activities that were carried out in the entire country programme from 1st January 2012 to 30 June 2014.

- ***Geographical coverage.*** The evaluation will cover all the districts and provinces where UNFPA funded projects.

- ***Programme aspects.*** The evaluation will look at the four technical areas of the country programme (Population and Development, Reproductive Health, HIV/AIDS and Gender). In addition for each thematic area, the evaluation will look at cross cutting aspects such as human rights based approach, gender mainstreaming, coordination and partnerships.
- ***Evaluation criteria.*** The evaluation will use the following criteria, relevance, effectiveness, efficiency, impact, sustainability, management systems (human resources, financial resources, systems).

The specific objectives will be:

a) To provide an independent assessment of the progress of the 6th CP towards the expected outputs and outcomes set forth in the results framework of the country programme with special focus on:-

   i. Determining whether planned activities were carried out as planned and whether targets were met

   ii. Examine programme management effectiveness and efficiency in achieving expected results

   iii. Assess the relevancy, effectiveness, efficiency, impact and sustainability of the 6th CP

b) To provide an assessment of the country office (CO) positioning within the developing community and national partners, in view of its ability to respond to national needs while adding value to the country development results and assess the coordination, leadership and management of the CP

c) Identify challenges and draw lessons and good practices that can be used to develop the 7th CP.

3.3 Evaluation criteria and evaluation questions

The following questions under each evaluation criteria will guide the evaluation.

3.3.1 Relevance

- How did the 6th country program address the needs of the population of Zimbabwe in relation to reproductive health, HIV/AIDS Prevention, Population and development and Gender based violence service provision?
- Are the strategic actions, outputs and indicators of the 6th CP contributing to the strategic priorities of the Zimbabwe national development plan and the UNDAF?

3.3.2 Effectiveness

- To what extent were the program objectives, expected results and targets met under the 6th CP?
- What factors influenced the success and effectiveness or failure of the program?
- What impact did the 6th country program have on the lives of people of Zimbabwe in terms of reproductive health, HIV/AIDS prevention; Gender based violence and Population and development issues?

3.3.3 Efficiency

- Could the program have been implemented with fewer resources without compromising on the quality and quantity of the results?
- What measures were taken during planning and implementation to ensure that the resources are efficiently used?

3.3.4 Sustainability

- Can the Government of Zimbabwe and other stakeholders continue implementing current interventions without UNFPA support?
- How did the country program promote sustainability of activities that are being supported in the community?

3.3.5 UNFPA contribution to UNCT coordination

- How effective did programme staff coordinate with other relevant agencies e.g. UNCT or other UN agencies, NGOs or CBOs in the programme areas?
- To what extent did UNFPA country programme align with the UN strategy (UNDAF) in the country.

4. Methodology and approach

The end of program evaluation will employ a combination of qualitative and quantitative methods to answer the questions that will be developed to assess progress, performance and relevance of the 6th CP in addressing the reproductive health, HIV/AIDS, gender and population and development needs

of the people of Zimbabwe. More specifically, the consultant(s) shall include the following methods in their assessment.

- Desk review of key programme documents and reports
- Interviews with programme managers of UNFPA and implementing partners of the 6th CP.
- Interviews and focus group discussions with beneficiaries of the 6th CP; and
- Project site visits, where appropriate to validate findings from other sources.

4.1 Data Collection

The evaluation will use a multiple-method approach including desk review of relevant documents, group and individual interviews, focus group discussions and field visits as appropriate.

4.2 Validation mechanisms

The Evaluation Team will use a variety of methods to ensure the validity of the data collected. Systematic triangulation of data sources and data collection methods and tools, will be conducted to validate the data. Regular exchanges with the CO programme managers will also be done to ensure data quality.

4.3 Stakeholders participation

The evaluation will adopt an inclusive approach, involving a broad range of partners and stakeholders. The evaluation team will select and justify a strategy for stakeholders mapping. This will enable selection of both UNFPA direct and indirect stakeholders (i.e., partners who do not work directly with UNFPA and yet play a key role in a relevant outcome or thematic area in the national context) . An Evaluation Reference Group (ERG) will be established. The group will aide as a peer review mechanism for ensuring the quality of the evaluation and, to enhance country participation and ownership. The group will be constituted from a broad range of constituents, including government, academicians, and civil organizations that are familiar with UNFPA mandate and with the country context.

5. Evaluation process

The evaluation will unfold in three phases, each of them including several steps as explained below.

5.1 Design phase

This phase will include:

- A desk review of all relevant documents available at UNFPA HQ and CO levels regarding the country programme for the period being examined;
- A stakeholder mapping – The evaluation team will prepare a mapping of stakeholders relevant to the evaluation. The mapping exercise will include state and civil-society stakeholders and will indicate the relationships between different sets of stakeholders;
- An analysis of the intervention logic of the programme, - i.e., the theory of change meant to lead from planned activities to the intended results of the programme;
- The finalization of the list of evaluation questions;
- The development of a data collection and analysis strategy as well as a concrete workplan for the field phase.

At the end of the design phase, the evaluation team will produce a **design report**, displaying the results of the above-listed steps and tasks.

5.2 Field phase

After the design phase, the evaluation team will undertake a three-week in-country mission to collect and analyze the data required in order to answer the evaluation questions final list consolidated at the design phase.

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

5.3 Synthesis phase

During this phase, the evaluation team will continue the analytical work initiated during the field phase and prepare a first draft of the final evaluation report, taking into account comments made by the CO at the debriefing meeting.

This **first draft final report** will be submitted to the evaluation reference group for comments (in writing). Comments made by the reference group and consolidated by the evaluation manager will then allow the evaluation team to prepare a **second draft of the final evaluation report**.

This **second draft final report** will form the basis for an **in-country dissemination seminar**, which should be attended by the CO as well as all the key programme stakeholders (including key national counterparts).

The **final report** will be drafted shortly after the seminar, taking into account comments made by the participants.

5.4 Use of evaluation results

The results will be used by National stakeholders, UNFPA management and staff, UNFPA donors and any other partner organizations. The main use of the evaluation results should be to inform and improve on-going programmes and to feed into the development of the 7th country programme.

6. Expected outputs/ deliverables

The evaluation team will produce the following deliverables:

- A design report including (as a minimum):
  a) a stakeholder map
  b) the evaluation matrix (including the final list of evaluation questions and indicators)
  c) the overall evaluation design and methodology, with a detailed description of the data collection plan for the field phase
  The design report should be less than 70 pages.
- A debriefing presentation document (Power Point) synthesizing the main preliminary findings, conclusions and recommendations of the evaluation, to be presented and discussed with the CO during the debriefing meeting foreseen at the end of the field phase;
- A draft final evaluation report (potentially followed by a second draft, taking into account potential comments from the evaluation reference group);
- A Power point presentation of the results of the evaluation for the dissemination seminar to be held in Harare

- A final report, based on comments expressed during the dissemination seminar.

All deliverables including the Power point presentation for the dissemination seminar and the final report will be drafted and presented in English.

7. Work plan/ Indicative timeframe

The selection and hiring of the consultants is expected to be completed by end of June 2014 and approval of the evaluation by the Evaluation Unit of headquarters is expected at the end of June. The evaluation process is expected to be completed by end of September 2014.

The table below shows the revised proposed activity schedule of consultants.

Activities	**No. of Days**	**Dates**
1. Advertise for consultants		6 June 2014
2. Establish Evaluation Reference Group		30 May 2014
3. Recruitment of consultants		23 July 2014
4. Consultants start work		4 Aug 2014
5. Prepare and submit evaluation inception report ; -Review of documents, program officers consultation and Development of evaluation data collection tools including stakeholder mapping	9	4 - 14 Aug 2014
6. Finalise desk review and consultations in the CO; Prepare for inception report presentation	1	15Aug 2014
7. Present Evaluation Inception/ Design Report (Evaluation Reference Group) (10am-12pm)	1	18 Aug 2014
8. Data Collection – Harare key stakeholders and finalising the data collection tools	4	19-22Aug 2014
9. Data collection (including field visits to key stakeholders in selected project sites)	7	24-30Aug 2014
10. Data analysis including Preparations for preliminary findings presentation	4	1-4 Sept 2014
11. Writing draft report and sharing with ERG	6	5, 6, 8-11 Sept 2014
12. Present to UNFPA CO	1	12 Sept 2014
13. Incorporate comments from UNFPA	4	13,15,16,17 Sept 14
14. Document Review and Key informants (RH)	5	18, 19, 20, 29, 30 Sept 2014
15. Analysis and Report Writing (RH)	4	1-4 Oct 2014
16. Peer Review whole report	1	6 Oct 2014
17. Submit to UNFPA and prepare for presentation. Share report with ERG	1	7 Oct 2014
18. Present preliminary findings to ERG (11am-1pm)	1	8 Oct 2014
19. Incorporation of comments from ERG and Preparation for presentation	1	9 Oct 2014
20. Presentations to stakeholders for validation (IPs, UN agencies, Govt, NGOs) –(10am -1pm)	1	10 Oct2014
21. Final report writing incorporating comments (Consultants finish in-country);	1	11 Oct 2014

22. Submit Final Report to RO and HQ		13 Oct 2014
23. Comments received from RO and HQ		27 Oct 2014
24. Incorporate comments and finalise		28 - 31 Oct 2014
25. Submit final report to RO and HQ		7 Nov 2014

8. Composition of the evaluation team

The evaluation team will consist of four members, a team leader who will be responsible for conducting the evaluation of the reproductive health component of the programme and consolidating the report and three others who are specialised in population and development, HIV/AIDS and gender. The following are the brief responsibilities of the team members:-

- Team leader will have the overall responsibility for the production of the draft and final evaluation reports. She/he will lead and coordinate the work of the evaluation team and will also be responsible for the quality assurance of all evaluation deliverables. The team leader should have a good knowledge of the national development context and be fluent in English. At the synthesis phase, she/he will be responsible for putting together the first comprehensive drafts of the Inception Report, an evaluation design methodology, data collection tools and the final evaluation report, based on inputs from other evaluation team members. In addition to these responsibilities, the team leader will also be responsible for one of the thematic areas.
- The other team members should have expertise in the following areas, HIV and AIDS, Gender and Population and Development. The consultant of each thematic area will take part in the data collection and analysis work during the design and field phases. She/he will be responsible for drafting key parts of the design report and of the final evaluation report, including (but not limited to) sections relating to reproductive health and rights, HIV and AIDS, Gender and Population and Development as applicable.
- Where other national native languages other than English will be used, the team will be assisted by an interpreter, during the field phase, for the conduct of focus group discussions with final beneficiaries.

The work of the evaluation team will be guided by the Norms and Standards established by the United Nations Evaluation Group (UNEG). Team members will adhere to the Ethical Guidelines for Evaluators in the UN system and the Code of Conduct, also established by UNEG. The evaluators will be requested to sign the Code of Conduct prior to engaging in the evaluation exercise.

9. Management and conduct of the evaluation

9.1 Management of the evaluation

The evaluation will be managed by the evaluation manager with support from the evaluation reference group. The **evaluation manager** will support the team in designing the evaluation; will provide ongoing feedback for quality assurance during the preparation of the design report and the final report. She/he will be supported by the RO M&E adviser.

An evaluation reference group will be formed to oversee the evaluation. This will be composed of The UNFPA Deputy Representative, The UNFPA Assistant Representative, UNFPA M&E analysts, representatives from Ministry of Health and Child Care, National AIDS Council, Ministry of Women's Affairs, Gender and Community Development, Ministry of Finance, ZIMSTAT and a representative from of implementing partners. The group will report to the UNFPA representative and will get technical support from the UNFPA regional office and relevant departments in headquarters.

The main functions of the reference group will be:

- to discuss the terms of reference drawn up by the evaluation manager;
- to provide the evaluation team with relevant information and documentation on the programme;
- to facilitate the access of the evaluation team to key informants during the field phase;
- to discuss the reports produced by the evaluation team;
- to advise on the quality of the work done by the evaluation team;
- to assist in feedback of the findings, conclusions and recommendations from the evaluation into future programme design and implementation.

9.2 Quality Assurance Process

The evaluation process will be monitored closely to ensure that the evaluation is of the highest quality. The terms of reference of the evaluation will be peer reviewed by the members of the Evaluation reference group, the Regional M&E adviser and the Evaluation unit at UNFPA head office. The Evaluation reference group will be involved in the selection of the consultants to ensure that the evaluation is impartial. The Regional M&E adviser will review the final report using the EQA grid.

10. Remuneration

The consultants will be paid an agreed daily rate within the UN consultants scales based on qualification and experience.

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

- Upon submission of a satisfactory inception report: 20%
- Upon submission of a satisfactory draft evaluation report: 50%
- Upon submission of a satisfactory final evaluation report: 30%

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

11. Qualifications of the evaluation team

11.1 Team leader

- An advanced medical degree and specialization in public health;
- Substantive knowledge of reproductive health/maternal health, including knowledge of themes/issues relevant to: Family planning, human resources in the health sector, emergency obstetric and newborn care, adolescent reproductive health, HIV and AIDS;
- Proven experience in evaluation of sexual and reproductive health programmes. Experience in evaluation of Population and development, HIV/AIDS and Gender would be an added advantage
- Familiarity with UNFPA or UN operations;
- Experience working in the SADC region and in Zimbabwe
- Evaluation methods, data collection and analysis skills
- Experience in carrying out Country Program evaluations
- Process management skills
- Ability to work in a team.

11.2 Other Team members in the evaluation team

- Knowledge of area of specialty: Population and development, HIV/AIDS and Gender Experience working in the SADC region and in Zimbabwe
- Evaluation methods, data collection and analysis skills
- Experience in carrying out Country Program evaluations
- Process management skills
- Ability to work in a team

Bibliography and resources

The following documents will be provided to the consultants at the beginning of the evaluation:-

- 6th Country Programme Document (CPD) and Country Programme Action Plan (CPAP)
- Country Office Annual Report (COAR)
- Zimbabwe United Nations Development Assistance Framework (2012 – 2015)
- Standard progress reports
- AWP progress reports
- Donor reports such as the ISP Report
- Project evaluations conducted during the 6th CP

Annexes

- Ethical Code of Conduct for UNEG/UNFPA Evaluations
- List of Atlas projects for the period under evaluation
- Information on main stakeholders by areas of intervention
- Short outlines of the design and final evaluation reports
- Evaluation Quality Assessment template and explanatory note
- Management response template

Ethical Code of Conduct for UNEG/UNFPA Evaluations

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

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

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

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

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

stakeholders, evaluators should conduct the evaluation and communicate its purpose and results in a way that clearly respects the stakeholders' dignity and self-worth.

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

For details on the ethics and independence in evaluation, please see UNEG Ethical Guidelines and Norms for Evaluation in the UN System
http://www.unevaluation.org/search/index.jsp?q=UNEG+Ethical+Guidelines
http://www.unevaluation.org/papersandpubs/documentdetail.jsp?doc_id=21

_____	_____	_____
Name of Lead Consultant	Signature	Date

_____	_____	_____
UNFPA Representative	Signature	Date

Annex 2: Indicator Matrix

Results	CP output indicators and baselines	Annual Targets and achievements								Means of verification	M&E activities	Timing/ frequency of M&E activities	Persons/ units responsible for M&E activities	Resources available for M&E activities	Comments
		2012		2013		2014		2015							
		AnnualTarget	Achievements	Annual Target	Achievements	Annual Target	Mid Year Achievements	Annual Target	Cummulative Target						
SP outcome 2: Increased access to and utilization of quality maternal and newborn health services															
UNDAF outcome 5.2: Increased access to and utilization of quality basic health services															
CP Output 1: Strengthened capacity of Government and civil society partners to coordinate and deliver reproductive health services	Number of district, provincial and district hospitals supported to offer comprehensive EmONC services (Cumulative) Baseline: 0	6	6	31	31	46	46	65	148	Program reports	Routine monitoring through program reports	Quarterly	RH Units of MOHCW and UNFPA.	23,236 for indicators under output 2	
	Number of hospitals supported to offer cervical cancer screening using VIAC Baseline: 5	6	9	19	16	26	17	20	71	Program reports	Routine monitoring through program reports	Quarterly	RH Units of MOHCW and UNFPA.		

Results	CP output indicators and baselines	Annual Targets and achievements								Means of verification	M&E activities	Timing/ frequency of M&E activities	Persons/ units responsible for M&E activities	Resources available for M&E activities	Comments
		2012		2013		2014		2015							
		AnnualTarget	Achievements	Annual Target	Achievements	Annual Target	Mid Year Achievements	Annual Target	Cummulative Target						
	Number of women screened for cervical cancer	5,000	10,791	15,000	29,788	31,000	33,163	64,000	115000	Program reports	Routine monitoring through program reports	Quarterly	ASRH Units of MOHCW and UNFPA.	achieved 73 cumulatively	
	Number of service delivery points supported to offer youth-friendly SRHR services Baseline: 37	45 (including the baseline of 37)	39 (includes the baseline of 37)	10	26	10	8	10	75	Program reports	Routine monitoring through program reports	Quarterly	ASRH Units of MOHCW and UNFPA.		
	Number of RH/HIV reference documents (policies, guidelines, protocols) developed, reviewed and/or revised with program support Baseline: 0	2	4	2	3	2	3	2	8	Program reports	Routine monitoring through program reports	Quarterly	HIV Units of MOHCW and UNFPA.		

Results	CP output indicators and baselines	Annual Targets and achievements								Means of verification	M&E activities	Timing/ frequency of M&E activities	Persons/ units responsible for M&E activities	Resources available for M&E activities	Comments
		2012		2013		2014		2015							
		AnnualTarget	Achievements	Annual Target	Achievements	Annual Target	Mid Year Achievements	Annual Target	Cummulative Target						
CP output 2: Increased availability of reproductive health services and commodities	Number of supported facilities in the public health sector with at least one health care worker trained in FP provision including implant insertion Baseline: 0	0	0	140	40	100	218	60	300	Program reports	Routine monitoring through program reports	Quarterly	RH Unit of MOHCW, ZNFPC and UNFPA.		
	Number of **service providers trained in family** planning provision	0	0	300	340	350	429	200	850	Program reports	Routine monitoring through program reports	Quarterly	RH Unit of MOHCW, ZNFPC and UNFPA.		
	Number of supported district hospitals with functional maternity waiting homes, in line with the minimum requirement as	20	0	30	0	50	63	5	105	Program reports	Routine monitoring through program reports	Quarterly	RH Units of MOHCW and UNFPA.		This indicator only refers to refurbishment support. At present 63 sites have been refurbished.

Results	CP output indicators and baselines	Annual Targets and achievements								Means of verification	M&E activities	Timing/ frequency of M&E activities	Persons/ units responsible for M&E activities	Resources available for M&E activities	Comments
		2012		2013		2014		2015							
		AnnualTarget	Achievements	Annual Target	Achievements	Annual Target	Mid Year Achievements	Annual Target	Cummulative Target						
	specified in the MWH operational guidelines Baseline: 20														
	Number of implant insertions for women aged 16 years and above at UNFPA supported sites	0	0	3,840	2,968	28,800	20,849	17,010	49,650	Program reports	Routine monitoring through program reports	Quarterly	RH Unit of MOHCW, ZNFPC and UNFPA.		
CP Output 3: Increased demand for sexual and reproductive health services at the community level	Number of young people reached through peer education on behavior change in SRH and HIV prevention Baseline: 300000	150,000	52349	150,000	23827	150,000	10613	150,000	600000	Program reports	Routine monitoring through program reports	Quarterly	ASRH Units of MOHCW and UNFPA.	Funds for M&E are reflected under output 1 and 2. Data for indicators for this output will be collected at the same time as those for output 1 and 2.	
CP Output 4: Increased coverage of															

Results	CP output indicators and baselines	Annual Targets and achievements								Means of verification	M&E activities	Timing/ frequency of M&E activities	Persons/ units responsible for M&E activities	Resources available for M&E activities	Comments
		2012		2013		2014		2015							
		AnnualTarget	Achievements	Annual Target	Achievements	Annual Target	Mid Year Achievements	Annual Target	Cummulative Target						
the social and behavior change communication programme															
	Number of person exposures to home visits Baseline: 0	0	0	269,880	267,135	921,600	368,640	921,600	1901600	Program reports	Routine monitoring through program reports	Quarterly	Demand generation partners report		
	Number of (New)households reached through home visits sessions.	0	0	89,960	75,875	307,200	110,690	307,200	704360	Program reports	Routine monitoring through program reports	Quarterly	Demand generation partners report		
	Number of operational research studies conducted	0	0	0	0	1	1	0	1	Research reports	Routine monitoring through program reports	Quarterly			
CP Output 5: Increased availability of HIV prevention services	Availability of national combination HIV prevention strategy Baseline: No strategy in 2011	National combination HIV preveneti on strategy finalized by 2012	Draft strategy was produced in the 4th Quarter of 2012.		Strategy now Available		1		1	Program reports	Routine monitoring through program reports	Quarterly	HIV Units of MOHCW and UNFPA.	35,000 for M&E activities under output 5.	
	Availability of Service Guidelines and tools on	Draft SRH and HIV integration Service	Draft SRH and HIV Integration tools	Final SRH and HIV integration Service	Draft tools have been produced and are	Final SRH and HIV integrati	Tools produced and available			Program reports	Routine monitoring through	Quarterly	HIV Units of MOHCW and		

Results	CP output indicators and baselines	Annual Targets and achievements								Means of verification	M&E activities	Timing/ frequency of M&E activities	Persons/ units responsible for M&E activities	Resources available for M&E activities	Comments
		2012		2013		2014		2015							
		AnnualTarget	Achievements	Annual Target	Achievements	Annual Target	Mid Year Achievements	Annual Target	Cummulative Target						
	provision of integrated SRH and HIV services Baseline: No tools in 2011	guidelines and tools	produced. M&E tools finalized.	guidelines and tools	awaiting printing	on Service guidelines and tools					program reports		UNFPA.		
	Number of MC service delivery points strengthened with UNFPA support Baseline: 0 in 2011	3	0	6	8	0	0	0	9	Program reports	Routine monitoring through program reports	Quarterly	HIV Units of MOHCW and UNFPA.		
	Number of sex workers who accessed programme supported sites for the first time Baseline: 13,329	1,000	749	3,000	3,482	5,000	3,952	5,000	14000						
	Availability on evidence on the safety and effectiveness of alternative adult male circumcision device(s) Baseline: Safety study done in 2011.	Evidence from safety and comparative studies on at least 1 device available in 2012	Research on effectiveness of the Prepex device was concluded and finalized.	Evidence on Cost effectiveness of at least 1 MC device available in 2013	Available. Prepex has been pre-qualified by WHO.					Program reports	Routine monitoring through program reports	Quarterly	HIV Units of MOHCW and UNFPA.		
SP outcome 7: Improved data availability and analysis resulting in evidence-based decision-making and policy formulation around population dynamics, SRH (including family planning), and gender equality															

Results	CP output indicators and baselines	Annual Targets and achievements								Means of verification	M&E activities	Timing/ frequency of M&E activities	Persons/ units responsible for M&E activities	Resources available for M&E activities	Comments
		2012		2013		2014		2015							
		AnnualTarget	Achievements	Annual Target	Achievements	Annual Target	Mid Year Achievements	Annual Target	Cummulative Target						
UNDAF outcome 2.1: Enhanced economic management and pro-poor development policies and strategies															
CP Output 6. Strengthened capacity of relevant Government departments responsible for planning to integrate population issues into development plans and monitor sectoral policies and plans	Number of publications on key population issues (research reports, ICPD at 20), produced with UNFPA support Baseline: 0	1	1	1	1	1	0	1	4	Program reports	Routine monitoring through program reports	Quarterly	UNFPA P&D unit	No resources allocated specifically for M&E activities for outputs 6 to 8.	
	Number of progress reports on selected population programmes and projects articulated in the MTP/ZIMASSET Baseline 0	2	2	2	2	2	0	2	8	Program reports	Routine monitoring through program reports	Quarterly	UNFPA P&D unit		
	Availability of a population monitoring and evaluation database Baseline: No database in place	1	0	0	0	0		0	1	Program reports	Routine monitoring through program reports	Quarterly	UNFPA P&D unit and ZIMSTAT		
UNDAF Outcome 2.3: Improved generation and utilization of data for policy and programme development and implementation by Government and other partners															
CP Output 7:	Number of staff trained in latest	15	30	5	5	5	0	5	30	Program reports	Routine monitori	Quarterly	UNFPA P&D unit		

Results	CP output indicators and baselines	Annual Targets and achievements								Means of verification	M&E activities	Timing/ frequency of M&E activities	Persons/ units responsible for M&E activities	Resources available for M&E activities	Comments
		2012		2013		2014		2015							
		AnnualTarget	Achievements	Annual Target	Achievements	Annual Target	Mid Year Achievements	Annual Target	Cummulative Target						
Strengthened capacity of the Zimbabwe Statistical Agency and line Ministries to produce, analyze, disseminate and promote utilization of population database	data processing techniques (including Web-based database systems) Baseline: 0 in 2011										ng through program reports		and ZIMSTAT		
	Proportion of national census and ZDHS budgets mobilized/leveraged by UNFPA Baseline: 0 in 2011	ZDHS 5 % Census 5%	27% for ZDHS and 30% for census	0	0	50 %	47(ZDHS) 29.2% census	50 %	100%	Program reports	Routine monitoring through program reports	Quarterly	UNFPA P&D unit and ZIMSTAT		
	Number of census and ZDHS thematic/in-depth reports produced with UNFPA support Baseline: 0	0	1	4	3	3	3	1	8	Program reports	Routine monitoring through program reports	Quarterly	UNFPA P&D unit		
CP Output 8: Strengthened capacity of ZIMSTAT to coordinate the national	Number of sectoral statistical committees supported by UNFPA Baseline: 0	15	0	15	0	15	0	15	15	Program reports	Routine monitoring through program reports	Quarterly	UNFPA P&D unit		
	Availability of a publication on standardized	1	1	1	1	1	0	1	1	Program reports	Routine monitoring	Quarterly	UNFPA P&D unit and		

Results	CP output indicators and baselines	Annual Targets and achievements								Means of verification	M&E activities	Timing/ frequency of M&E activities	Persons/ units responsible for M&E activities	Resources available for M&E activities	Comments
		2012		2013		2014		2015							
		AnnualTarget	Achievements	Annual Target	Achievements	Annual Target	Mid Year Achievements	Annual Target	Cummulative Target						
statistical system	concepts, definitions and methods used across the national statistical system produced and distributed. Baseline: 0										through program reports		ZIMSTAT		
	Number of statistical inquiries, consultative meetings and user-producer symposiums on statistics supported by UNFPA	1	0	1	0	2	2	1	5	Program reports	Routine monitoring through program reports	Quarterly	UNFPA P&D unit and ZIMSTAT		
SP Outcome 5: Gender equality and reproductive rights advanced particularly through advocacy and implementation of laws and policy															
UNDAF Outcome 7.1: Laws, policies and frameworks established and implemented to ensure gender equality and empowerment of women and girls															
CP Output: 9 Increased capacity of leaders to address negative social norms and	Number of leaders who have adopted and are reporting implementation of the 4Ps campaign Baseline: 0	800	382	1000	3900	700	0	200	2700	Program reports	Routine monitoring through program reports	Quarterly	UNFPA Gender unit and Ministry of gender	$39,000 for output 9 and 10.	

Results	CP output indicators and baselines	Annual Targets and achievements								Means of verification	M&E activities	Timing/ frequency of M&E activities	Persons/ units responsible for M&E activities	Resources available for M&E activities	Comments
		2012		2013		2014		2015							
		AnnualTarget	Achievements	Annual Target	Achievements	Annual Target	Mid Year Achievements	Annual Target	Cummulative Target						
practices that perpetuate gender inequalities	Number of simplified operational guidelines on gender mainstreaming developed and disseminated Baseline: 0	1	1	1	2	1	0	1	4	Program reports	Routine monitoring through program reports	Quarterly	UNFPA Gender unit and Ministry of gender		
	Availability of evidence on determinant of gender inequalities	1 research conducted	0			1 research conducted	1	0	1	Program reports	Routine monitoring through program reports	Quarterly	UNFPA Gender unit and Ministry of gender		
CP Output 10: Increased availability of services to address gender-based violence	Number of centres supported by UNFPA for quality gender-based violence service provision Baseline: 7	10	3	5	5	3	1	2	20	Program reports	Routine monitoring through program reports	Quarterly	UNFPA Gender unit and Ministry of gender		
	Number of GBV survivors who received services at One stop centres	0	0	0	0	4,080	1,949	1,800	5880	Program reports	Routine monitoring through program reports	Quarterly	UNFPA Gender unit and Ministry of gender		
	Number of GBV survivors provided with legal aid service	0	0	1,652	1,652	4,000	2,005	4,000	9652	Program reports	Routine monitoring through program reports	Quarterly	UNFPA Gender unit and Ministry of gender		

Results	CP output indicators and baselines	Annual Targets and achievements								Means of verification	M&E activities	Timing/ frequency of M&E activities	Persons/ units responsible for M&E activities	Resources available for M&E activities	Comments
		2012		2013		2014		2015							
		AnnualTarget	Achievements	Annual Target	Achievements	Annual Target	Mid Year Achievements	Annual Target	Cummulative Target						
	Number of service providers (legal, health, psychosocial and traditional court officials) trained through UNFPA support in survivor friendly approaches including in humanitarian settings Baseline: 0	3,000	241	3,500	1,786	2,354	1,983	2,354	11208	Program reports	Routine monitoring through program reports	Quarterly	UNFPA Gender unit and Ministry of gender		
	Number of location specific referral pathways developed and printed Baseline: 4	10	3	5	8	3	13	2	20	Program reports	Routine monitoring through program reports	Quarterly	UNFPA Gender unit and Ministry of gender		
CP Output 11: Increased community awareness of gender-responsive laws, mechanism and	Number of person exposures to messages on gender and reproductive rights through community level dialogues. Baseline: 0	0	0	58,500	245,507	67,680	21,546	67,680	193860	Program reports	Routine monitoring through program reports	Quarterly	UNFPA Gender unit and Ministry of gender		

Results	CP output indicators and baselines	Annual Targets and achievements								Means of verification	M&E activities	Timing/ frequency of M&E activities	Persons/ units responsible for M&E activities	Resources available for M&E activities	Comments
		2012		2013		2014		2015							
		AnnualTarget	Achievements	Annual Target	Achievements	Annual Target	Mid Year Achievements	Annual Target	Cummulative Target						
services	Number of multi-media campaigns on gender and reproductive rights conducted Baseline: 0	1	1	1	4	1	0	1	4	Program reports	Routine monitoring through program reports	Quarterly	UNFPA Gender unit and Ministry of gender		
	Number of community based cadres trained in counseling and paralegal services Baseline: 0	500	687	1,000	780	1,000	540	500	3000	Program reports	Routine monitoring through program reports	Quarterly	UNFPA Gender unit and Ministry of gender		

Annex 3:Evaluation Matrix

Evaluation Criteria	Key Questions from TOR	What to Check/Performance Indicators	Data Sources	Collection Method
Analysis by Focus Areas				
Relevance				
RH, HIV, Gender, P&D	EQ1: How did the 6th CP address the needs of the population of Zimbabwe in relation to reproductive health, HIV prevention, population and development and GBV service provision?	Degree of concurrence of CPAP with sentinel indicators for target populations and national strategies	National policy documents; Needs assessments; evaluations; situation analysis, ZDHS, MICS and other available data for key indicators	Key stakeholder and beneficiary interviews; document review.
RH, HIV, Gender, P&D	EQ2: How are the strategic actions, outputs and indicators of the 6th CP contributing to the strategic priorities of the Zimbabwe national development plan and ZUNDAF?	Degree of concurrence with UNFPA SP and goals stated in the CPAP; degree of concurrence with country priorities.	National strategic plans, programme policies, Needs assessments, Baseline studies; Project valuation reports; Pertinent national level strategy documents. Regional statements; strategic briefs; DHS; MICS; CPD, CPAP; AWPs; Zimbabwe CCA; ZUNDAF; Needs assessments, evaluations, situation analysis	Document review, key stakeholder interviews, beneficiary interviews, UNFPA SP.
Effectiveness				
RH, HIV, Gender, P&D	EQ 3: To what extent were the programme objectives, expected results and targets met under the 6th CP?	Status of indicators and targets as of 2012–2014; Check the level of achievements focusing on CPAP targets, identify delays in implementation, challenges and obstacles affecting implementation	Focus groups with health providers + beneficiaries; Semi-structured interviews; Review of documents; CPAP ; Progress reports; training reports and progress reports; needs assessments; M&E reports; Supervision tools MOH/PHC; National Statistics	Key stakeholders interviews; document reviews; Site visits;
	EQ 4: What factors influenced the success and effectiveness	Check the level of achievements focusing on	CPAP Tracking Tool Quarterly monitoring	Document review: semi-structured interviews; SWOT

Evaluation Criteria	Key Questions from TOR	What to Check/Performance Indicators	Data Sources	Collection Method
	or failure of the programme?	CPAP targets, identify delays in implementation, challenges and obstacles affecting implementation; Extent to which country situation analysis and ZUNDAF in reflected in CPAP; SWOT analysis Extent to which the analysis led to appropriate planning of programme	tools, annual reports, field monitoring visits reports and other progress reports Annual programme Review reports Implementing partners	analysis KI interviews, semi-structured schedules
RH, HIV, Gender, P&D	EQ 5: What impact did the 6th CP have on the lives of people of Zimbabwe in terms of reproductive health, HIV prevention; GBV and population and development issues?	Extent to which CP outputs for RH, HIV, Gender, P&D programming were on track to contribute to outcomes; Extent to which CP outputs were coordinated with other stakeholders to contribute effectively to outcomes in coordination with other partners; Extent to which UNFPA CO worked in close collaboration with other key stakeholders and partners to achieve outcomes	CPAP ZUNDAF ZNASP COARs Country assessment Zimbabwe country report to UNAIDS AWPs Evaluation reports IP reports UNFPA CO National and UN partners IPs Beneficiaries	KI interviews, semi-structured schedules FGDs with beneficiaries Field visits Observation Significant change stories
Efficiency				
	EQ6: Could the programme have been implemented with fewer resources without compromising the quality and quantity of the results?	- Extent to which UNFPA resources were efficiently utilized for HIV prevention - Extent to which UNFPA resource allocation was proportionate to the achievement of outputs and contribution to outcome results	Financial and administrative reports on budgeting and expenditures CPAP AWPs and budgets COARs ZUNDAF UNFPA CO staff Donors	Document review KI interviews with semi-structured schedules

Evaluation Criteria	Key Questions from TOR	What to Check/Performance Indicators	Data Sources	Collection Method
			IPs	
	EQ7: What measures were taken during planning and implementation to ensure that the resources are efficiently used?	Robust and comprehensive financial and management reports are available; Resource and financial measurement against achievement of outputs and outcomes; Effective actions taken to remedy findings of inappropriate or inefficient resource use	UNFPA financial and management reports; Atlas; IP reports; financial and administrative managers, Assistant or Deputy Representative, POs National policy makers	Document review KI interviews, semi-structured schedules Beneficiary FGDs and personal significant change stories
Sustainability				
RH, HIV, Gender, P&D	EQ8: Can the Government of Zimbabwe and other stakeholders continue implementing current interventions without UNFPA support?	Measures of capacity building, especially . training activities. Patterns of staffing and budgeting over time Evidence of continued economic and political challenges; evidence of funding and/or technical capacity gaps	National policy documents ZUNDAF Zimbabwe country assessment IPs UNFPA CO Donors	Document review. Donor and other stakeholder interviews; Budget review; site visits to implementing agencies; training follow-up interviews.
	EQ9: How did the CP promote sustainability of activities that are being supported in the community?	Exit strategies incorporated in planning of interventions supported/funded by UNFPA and are followed through; Implementers and beneficiaries have become owners of the programmes, interventions and outputs produced by these; Lessons learned from previous evaluations integrated into policies, strategic and operational planning at Nat'l and significant changes in national	CPAP, AWPs, Project/interventions' design/programming documents Policies/programmes/projects' evaluation reports; Previous UNFPA Zimbabwe evaluations; UNFPA reports; beneficiaries	Review documents to identify management strategies of risks and opportunities e.g. SWOT analysis and exit strategies; Interviews with beneficiaries thru focus groups and semi-direct interviews

Evaluation Criteria	Key Questions from TOR	What to Check/Performance Indicators	Data Sources	Collection Method
		development context. Evidence of shifts in programme focus over time within the CPAP		
Evaluation Criteria	**Key Questions**	**What to Check**	**Data Sources**	**Collection Method**
Analysis of Strategic Positioning				
Strategic Alignment P & D	EQ10: To what extent did UNFPA anticipate and respond to significant changes in the national development context within its focus area on Population and Development? How is the UNFPA CO aligned with the UN strategic framework (ZUNDAF)?	CO capacity to monitor significant changes in the national development context in order to plan effectively for change - CO capacity to reorient/adjust the objectives of the CPAP and the AWPs if needed - Extent to which the response was adapted to emerging needs, demands and national priorities Extent to which the reallocation of funds towards new activities is justified - Extent to which the CO has managed to ensure continuity in the pursuit of the initial objectives of the CPAP while responding to emerging needs and demands; Check whether: a) The CPD/CPAP is in line with the UNDAF; b) The UNDAF reflects the interests, priorities and mandate of UNFPA; c) Degree of coordination between UNFPA and other UN agencies.	UNFPA strategic Plan (CPAP AWP COARs Country office staff National partners UN Project Management Team Final users of population data 2008-2011); Revised Strategy (2012-2013) ICPD & MDG reports CP, CPAP, AWPs, MOF,	Document review KI and group interviews, semi-structured schedules FGDs, FGD schedules UN Stakeholders. UNDAF documents. UNDAF evaluation. UNFPA CO CPAP, AWPs, project Activities; budget review
	EQ11: How has UNFPA been effectively working together with other UN partners?	Assess perspectives: within UN, among other donors and from non -UN	UN Stakeholders. Non UN Implementing partner stakeholders.	Document review, stakeholder interviews, meetings

Evaluation Criteria	Key Questions from TOR	What to Check/Performance Indicators	Data Sources	Collection Method
		IPs and beneficiaries Extent of collaboration collaboration between UNFPA and other UN agencies' activities and interventions. Perception of UNFPA interventions by UN and Non UN stakeholders including donors.	UNDAF documents. UNDAF evaluation. UNFPA CO CPAP, AWPs, project activities and budget.	with the Resident Coordinator, the UNCT, UN agencies and national government; budget review
	EQ12: How effectively did programme staff coordinate with other relevant agencies e.g. UNCT or other UN agencies, NGOs or CBOs in the programme areas?	Check the linkage of the CPAP with the UN involvement of UNFPA in the UNCT, joint programmes and programming, leading UN theme groups and coordination with other UN agencies, i.e. UNCICEF, UN Women, WHO, etc.	UNCT documents Minutes of meetings Relevant UN agencies Resident Coordinator Programme documents Project proposals	Key informant interviews with UNCT members; interviews with CO staff; UNFPA Rep.; Minutes of theme groups meetings and UNCT meetings, joint programmes documents; general desk review
Responsiveness **RH, HIV, Gender, P&D**	EQ13: To what extent did UNFPA anticipate and respond to significant changes in the national development context within its four core focus areas?	Evidence of shifts in program focus over time within UNFPA CPAP; Identification of significant changes in national development context	Evaluation reports. Initial and revised CPAP Framework. AWPs and COARs. Atlas budget information. Stakeholders, data for key indicators.	Document review, stakeholder interviews, budget review.
	EQ14: What were the missed opportunities in UNFPA programming?	Assess for all four focus areas; Gaps in programming if/as identified by stakeholders and review of project documents and contextual data	Evaluation reports. Initial and revised CPAP Framework. AWPs and COARs. Budget information. Stakeholders, data for key indicators.	Document review, stakeholder interviews, budget review.

Evaluation Criteria	Key Questions from TOR	What to Check/Performance Indicators	Data Sources	Collection Method
Added Value	EQ15: How far did the CP add value to what would have resulted from other development actors' interventions without UNFPA?	All agencies and orgs. that involved in RH, HIV, Gender, P&D at national, provincial, district, ward levels: the GOZ, NGOs, CSOs, donors, etc.,	UNDAF evaluation; COARs; GOZ stakeholders; Donors; CSOs; national and international NGOs, other UN agencies, etc. Evaluation reports and thematic reviews	Document review. Stakeholder interviews.
Analysis of Programme Results Framework and M&E				
	EQ16: How has the quality of the CP design, focused on results and the M&E framework?	Quality of indicators, baselines, targets; appropriateness of results chain; systematic reporting, data generating; knowledge and evidence based CP monitoring	CP/CPAP/AWPs CPAP Tracking Tool CPAP M&E calendar Baseline assessments M&E quarterly Tools Progress reports	Desk review

Annex 4: Key Informant Interviews and Focus Group Discussions

Name	Designation	Organization
Basile Tambashe	Representative	UNFPA
Yu Yu	Deputy Representative	UNFPA
Abbigail Masemburi	Assistant Representative	UNFPA
Paison Mlambo	Programme Specialist: Population and Development	UNFPA
Dagmar Hanisch	Technical Specialist HIV Prevention and SRH	UNFPA
Edwin Mpeta	Programme Specialist Reproductive Health	
Daisy Nyamukapa	SRH and HIV Linkages	UNFPA
Rudo Mhonde	Planning Monitoring and Evaluation and Research Officer	UNFPA
Sunday Munyenya	Planning Monitoring and Evaluation Officer	UNFPA
Choice Damiso	Gender Equality Specialist	UNFPA
Samson Chidiya	ISP Sex Work Programme Officer	UNFPA
Tendai Katsande	ISP Demand Generation Programme Officer	UNFPA
Vibhavendra Raghuvanshi	Technical Specialist Maternal Health and Family Planning	UNFPA
Edwin Mpeta	Programme Specialist Reproductive Health	UNFPA
Agnes Makoni	Programme Analyst	UNFPA
Tamisayi Chinhengo	Programme Specialist ASRH	UNFPA
Verena Donatella Bruno Ms.	Gender/GBV UN Fellow	UNFPA
Farai Guvakuva	Operations Manager	UNFPA
Anthony Daly	Health, Nutrition and HIV Adviser	Department for International Development
Paolo Barduagni	Attache: Social Sectors	Delegation of the European Union
Lena Forsgren	First Secretary: Development Cooperation	Embassy of Sweden
Revai Makanje	Deputy Country Representative	UN Women
Fatima Mhuriro	Coordinator for SRHR and HIV Linkages Programme;	MoHCC AIDS & TB Unit
Sino Xaba	Coordinator for Male Circumcision Programme	MoHCC AIDS & TB Unit
Anna Machiha	Coordinator for CCP and STIs	MoHCC
Margaret Nyandoro	Deputy Director Family Health Department, Reproductive Health Unit	MoHCC, RH Unit
Lucia Tavakwa	Coordinator for H4+	MoHCC, RH Unit
Mucha Mandara	Coordinator for VIAC and FP	MoHCC, RH Unit
Dr Edmore Munongo	Director of Technical Services	ZNFPC
Michael Bartos	UNAIDS Country Coordinator	UNAIDS
Lia Tavadze	Human Rights and Gender Equality Adviser	UNAIDS
Joyce Mphaya	Programme Officer HIV/AIDS	UNICEF
Lovemore Magwere,	HIV/AIDS Specialist	UNICEF
Lucas Halimani	National Programme Officer HIV & AIDS	UNESCO
Trevor Kanyowa	National Programme Officer Child and Adolescent Health	WHO

Frances Cowan	Director	CeSHHAR
Sibongile Mtetwa	ISP Programme Coordinator	CeSHHAR
Thomas Kazonda	Behaviour Change Programme Manager (and Acting Director)	ZAPSO
Mapeta W	Director of Census	ZIMSTAT
Mr Matsinde	Census manager	ZIMSTAT
Mr Murinda	Director: Youth Development	Ministry of Youth
Dr P Mafaune	Provincial Medical Director	MoHCC
Dr Mashizha	MCH Officer	MoHCC
Group Interview	Matron, Sister in Charge, FCH X 2, Family Planning Nurse	Mutare Provincial Hospital
Mvududu S	RGN/SRM	Chipinge District Hospital
Chikurira E	RGN/YFSP	Chipinge District Hospital
Mai Nyaradzo Chikwanda	Beneficiary	Chipinge District Hospital FCH
Mai Message Masapa	Beneficiary	Chipinge District Hospital FCH
Husband visiting wife	Relative of beneficiary	Karoi District Hospital MWH
Nengomasha P	Matron	Rusape Hospital
Chiluvanyanga S	RGN	Rusape Hospital
Chingawo	Journalist	Freelance
Mamhunze	ZRP Victim Friendly Unit	Rusape One Stop Centre
Doloba	ZRP Victim Friendly Unit	Rusape One Stop Centre
Chivasa E.	Counsellor	Rusape One Stop Centre
Chihono E	District Head	Ministry of Women Affairs
Mdianyama F	RGN/RM	Chinhoyi Hospital
Chitomba F	RGN/RM	Chinhoyi Hospital
Shumba G.	Programme Director	FACT Mutare
Magada E	Support Officer	FACT Mutare
Kanyenze P	Program Officer	FACT Mutare
Tengende L.	Student Intern	FACT Mutare
Mukwekezeke L.	Support Officer	FACT Mutare
Ndebele P	ISP IBC Manager	FACT Mutare
Mandoga J	ISP Progamme Officer	FACT Mutare
Musimwa T	Support Officer	FACT Mutare
Ngolo B.A.	Student Intern	FACT Mutare
Muganzi SM	Registered General Nurse	St Peters Hospital: Checheche
Mabvuu L	Midwife Nurse	St Peters Hospital: Checheche
Thomas A	RGN	St Peters Hospital: Checheche
Dzawanda R	RGN	St Peters Hospital: Checheche
Kuonza T	Nurse Aid	St Peters Hospital: Checheche
Sithole C	Nurse Aid	St Peters Hospital: Checheche
Tandaanguni P	PCN	St Peters Hospital: Checheche
Chiwanguwangu A	RGN	St Peters Hospital: Checheche
Sithole J	PCN	St Peters Hospital: Checheche
Sithole T	Peer Educator	St Peters Hospital: Checheche
Garutsa B	Hospital Administrator	St Peters Hospital: Checheche
Abigail Mudege	PMTCT Focal Person for Linkages Project	United Bulawayo Hospitals
Group KI Interview: Linkages clinic heads for PMTCT, VIAC, STI, HIV		UBH
Group KI Interview: Youth corner staff		UBH
Tinashe Nnaki	VIAC clinic sister	UBH
Nothando Nkono	VIAC clinic sister	UBH
Veronica Nhemachena	CEO	MASO
Jabulani Mapingier	Programme Manager	MASO
Group KI Interview with 4 district officers and 3 support officers		MASO
Group KI Interview: clinic heads from PMTCT, VIAC, FP, OI/ART		Gweru Provincial Hospital
Male beneficiary	OI/ART clinic	Gweru Provincial Hospital
3 individual beneficiary interviews at home from MASO BCF door to door		Gweru urban
Group KI Interview: VIAC, ANC/FP, OI, GBV, and youth corner staff		Gweru District Hospital

Matron Bushu	Matron	Gweru District Hospital
Mr Muzenda	Personal Asst to Med Superintendent	Gweru District Hospital
Viola George	Director/CEO	MAC
Group KI Interview: 3 Programme Officers, 2 Support Officers, 1 intern		MAC
Sikhatele Matambo	Director	Emthonjeni Women's Forum
Caroline Matizha	Director, Gender	MOWAGCD
Nomthandazo Jones	Regional Manager	Musasa Project Bulawayo
Lungile Mlilo	Shelter Matron	Musasa Project
Ziphongezipho Ndebele	Programme Officer	Padare
Sister Magwera	RH Officer, Midlands Province	MoHCC
Mkhulisi Ntini	Prison Officer	Zimbabwe Police Services
Netty Musanhu	Director	Musasa Project
Paul Shoko	District Head, Gender, Midlands	Ministry of Gender

Focus Group Discussions with Primary and Secondary Beneficiaries and Behaviour Change Facilitators

- Behaviour Change Facilitators (BCFs) for demand generation and sista2sista clubs (Lupane, MAC)
- Hillside Teachers Training College Peer Educators
- Two female sex worker groups and peer educators, Lupane Outeach and Gweru Static Site
- Four sista2sista clubs, Gweru, Lupane, Mutare rural, Magunje
- Expecting mothers at Chipinge and Hurungwe District Hospitals
- Trained community leaders: MASO (mainly ward counsellors)
- BCFs for demand generation: MASO
- Adolescents in youth friendly corners: Gweru District Hospital
- Peer educators in adolescent programme, FACT-supported site at Karoi

In addition, for all field work, courtesy calls on Provincial Medical Directors, Hospital Superintendents and others as required.

Annex 5: Documents Reviewed

The following documents were common to all thematic areas:

1. GoZ/UNFPA 6th Country Programme Action Plan (CPAP) 2012-2015
2. GoZ/UNFPA 6th Country Programme Document (CPD) 2012-2015
3. GoZ/UNFPA 5th Country Programme (2007-2011) Final Independent Evaluation Report, December 2010
4. GoZ/UNFPA 5th Country Programme (2007-2011) EQA
5. UNFPA Strategic Plan 2008-2011
6. Midterm Review of the UNFPA Strategic Plan, 2008-2013
7. UNFPA Strategic Plan 2014-2017
8. UNFPA Country Office Annual Work Plans 2012, 2013, 2014
9. UNFPA Country Office Annual Reviews 2012, 2013, and mid-year 2014 CPAP review
10. UNFPA Programme and Financial Monitoring and Reporting Standard Progress Reports for SRH for Jan-Dec 2012, Jan-Dec 2013
11. UNFPA Zimbabwe, Updated Planning Matrix for Monitoring and Evaluation: April 2013 Update, UNFPA
12. Consolidated UNCT Programme Funding Summary at December 2013, June 2014, UN Zimbabwe
13. Zimbabwe Demographic and Health Survey, 2010-2011, March 2012, ZIMSTAT
14. Multiple AWPs and Quarterly and Annual Reports from Implementing Partners

Reproductive Health and Rights Component, including RH and HIV

15. Mid Year Review July 2014, GoZ/UNFPA: HIV Prevention Services
16. Mid Year Review July 2014, GoZ/UNFPA: HIV Combination Prevention
17. Combination HIV Prevention implementation approach, 2013, NAC and MoHCW
18. National Male Circumcision Policy, Oct 2009, Republic of Zimbabwe
19. National Female Condom Strategy 2006-2010, MoHCW
20. Zimbabwe National Rapid Assessment on SRH and HIV Integration and Linkages, 2011, MoHCW
21. Baseline Survey for three learning sites/centres of excellence for the delivery of integrated SRH and HIV services: Assessment Report, August 2013, MoHCC
22. Interim Annual Reports, (2012, 2014), UNAIDS/UNFPA joint project on 'Linking HIV and Sexual and Reproductive Health and Rights in Southern Africa'
23. Zimbabwe National HIV and AIDS Strategic Plan (ZNASP II) 2011-2015, October 2011, NAC
24. Zimbabwe National HIV and AIDS Strategic Plan 2011-2015 Medium Term Review October 2013, NAC
25. Global AIDS Response Progress Report 2012, Zimbabwe Country Report Jan 2010 – December 2011, NAC
26. Global AIDS Response Country Progress Report Zimbabwe, 2014, NAC
27. Basic Emergency Obstetric and Newborn Care, 2014, Facilitator's Manual, Participants' Manual, Reproductive Health Unit, MoHCW.
28. National Cancer Prevention and Control Strategy for Zimbabwe 2014-2018, Epidemiological and Disease Control Non Communicable Disease Unit, MoHCC
29. Domestic Funding of the National Response to HIV and AIDS, (undated) Zimbabwe National AIDS Trust Fund/NAC
30. Zimbabwe 2012 Millennium Development Goals Progress Report, GoZ, UN Zimbabwe
31. Zimbabwe Sexual and Reproductive Health Programme (Integrated Support Programme – ISP) Annual Reviews July 2013, March 2014, DfID
32. Multiple Indicator Cluster Survey 2014, Key Findings Report, ZIMSTAT
33. Review of Male and Female Condom Programme, December 2012, MoHCC, UNFPA

34. Management of Sexually Transmitted Infections and Reproductive Tract Infections in Zimbabwe" A guide to Essential Practice. December 2012. AIDS & TB Unit, MoHCW
35. Advocacy Package for Integration of SRHR and HIV Prevention Services, 2014, MoHCC
36. SRHR and HIV Linkages Training Curricula for 1) Health Service Managers; 2) Health Service Providers; 3) Community Based Health Workers, MoHCC
37. Service Guidelines on Integrated SRHR and HIV Programmes and Services, August 2013, MoHCC
38. Sexual and Reproductive Health and Rights (SRHR) and HIV Linkages Manual, 2014, MoHCC
39. Demand Generation Home Visit Guide: Integrated HIV, SRH and GBV Support Programme, November 2012, MOHCC
40. Sexuality Education: A ten-country review of school curricula in East and southern Africa, 2012, UNESCO, UNFPA
41. Young People Today, Time to Act Now: Why adolescents and young people need comprehensive sexuality education and sexual and reproductive health services in Eastern and Southern Africa, 2013, UNESCO
42. Ministerial Commitment on comprehensive sexuality education and sexual and reproductive health services for adolescents and young people in Eastern and Southern Africa (ESA), 7 December 2013. Young People Today, Time to Act Now.
43. 'Protection of the sex worker: dialogue with Samson WChihule-hule', 12 November 2013, P6, article in Newsday, Zimbabwe
44. Accelerating Progress Towards Maternal, Neonatal and Child Morbidity and Mortality Reduction (MDGs 4,5,6), Joint Funding Proposal Submitted to the Canadian International Development Agency. WHO, UNICEF, UNFPA, World Bank, UNAIDS and MoHCW, July 2011
45. Accelerating Progress Towards Maternal, Neonatal and Child Morbidity and Mortality Reduction (MDGs 4 and 5), Joint Funding Proposal Submitted to the Swedish International Development Cooperation Agency. WHO, UNICEF, UNFPA, UNAIDS, UN Women and MoHCW, August 2013
46. Emergency Obstetric and Neonatal Care Service Needs Assessment for the H4+ Sida/CIDA Supported Districts. MoHCC. April 2014
47. Mid-term and end line evaluations of the CIDA supported H4+ program in Burkina Faso, DRC, Sierra Leone, Zambia and Zimbabwe, Inception Report. Ipact and Institute of Tropical Medicine, Antwerp. August 2013.
48. H4+ Canada supported activities: mid-term review in Zimbabwe, Country Report for 2012-2013. Ipact and Institute of Tropical Medicine, Antwerp. April 2014
49. Zimbabwe H4+ Sida Intermediary Report May 2014.
50. Selected stakeholder Annual Work Plans, quarterly and annual Progress Reports and records drawn between 2012 and June 2014 from: GoZ: MoHCC AIDS & TB Unit, NAC Gweru Provincial Hospital, Gweru District Hospital Integrated Support Programme for SRH, HIV prevention and GBV CeSHHAR (female sex worker programme) Linkages Project, United Bulawayo Hospitals NGO IPs

Gender Equality

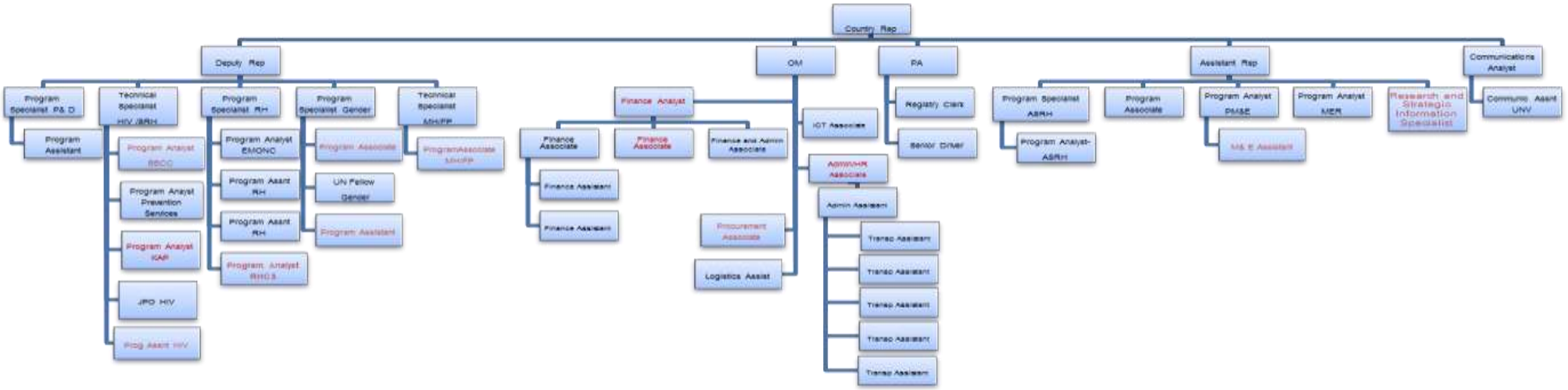
51. Annual Work Plans
52. The Constitution of Zimbabwe, 2013
53. Integrated Support Programme for Sexual and reproductive Health and HIV prevention in Zimbabwe (ISP) 2012-2015
54. UNFPA Strategy and Framework for Action to Addressing Gender-based Violence: 2008-2011
55. Evaluation Report The relevance, Effectiveness, efficiency and Sustainability of GBV Survivors Friendly Services in Zimbabwe, March 2012
56. The National Gender Policy, The Republic of Zimbabwe(2013-2017)
57. Domestic Violence Act (CHAPTER5:16)
58. Zimbabwe National Gender Based Violence Strategy, 2012-2015
59. Joint Programme for Gender Equality Proposal (JPGE) 2013-2015
60. Concluding observations of the Committee on the Elimination of All Forms of Discrimination against Women, Zimbabwe. Fifty First session 13 February- 2 March 2012

61. Zimbabwe Sexual and reproductive Health Programme(Integrated Support Programme) Annual Review, May 2014 Zimbabwe Sexual and reproductive Health Programme(Integrated Support Programme) Annual Review, May 2014
62. Sexual and Reproductive Health and HIV Prevention in Zimbabwe Annual Review, July 2013
63. SADC Gender protocol 2013 Barometer Zimbabwe
64. Minutes of the Gender Theme Group,2012-2014
65. Various Reports on the 4 Ps Campaign, 2012-2013
66. Beijing Declaration and Platform for Action, 1995
67. Beijing +20 Review Draft Report, 2014
68. Zimbabwe UN Development Assistance Framework 2021-2015
69. Zimbabwe Statistical Agency(ZIMSTAT), United Nations Children's Fund(UNICEF) and Collaborating Centre for research and Evaluation(CCORE), 2013, National Baseline Survey on Life Experiences of Adolescents,2011
70. SADC Protocol on Gender and Development,2008
71. Zimbabwe 2012 Millennium Development Goals Progress Report, GoZ/UN Zimbabwe
72. 2012-2015 AWPs for MWAGCD, ZWLA, WAG, WLSA, PADARE, ARC and Musasa Project.

Population and Development

73. Annual Work Plans for P&D
74. Minutes of the Data for Development Working Group Meeting Held on 19 February and 2 July 2014
75. Minutes of the Data for Development Working Group Meeting Held on 14 February , 9 July and 12 November 2013
76. Minutes of the Data for Development Working Group Meeting Held on 17 February and 20 November 2012
77. Joint 2013 Data for Development Working Group Annual Work Plan Mid-Year Review – June/July 2013
78. Joint 2014 Data for Development Working Group Annual Work Plan: Mid-Year Review
79. 2012-2015 ZUNDAF Data for Development Working Group 2013 Mid-Year Review Report July 2013 ZUNDAF Priority 2 (ZUNDAF Outcome 2.3)
80. Gaisie SK and Groenewald, CJ (2006) . Building Capacity of Government Officials to Integrate Population Factors into Development Policies, Programmes and Activities: Vols 1-5
81. Gaisie SK Prof CJ Groenewald (2006). Strengthening institutional and technical capacity for implementing population and development programmes: Vols 1-5.
82. GoZ/UN (2012) 2012 ZUNDAF Annual Review Report
83. GoZ/UN (2013) 2013 ZUNDAF Annual Review Report
84. UNFPA P&D (2012) Standard Progress Report for ZIMSTAT
85. UNFPA P&D (2013) Standard Progress Report for ZIMSTAT

Annex 6: Organogram for 2014



Annex 7: Data Collection Tools

UNFPA Country Office – Coordination, Management, Finance

1. Was the overall 6th CP based on National Execution Modalities (NEX)? What worked and what did work? Why? What lessons can be learned for the 6th programme?

2. What level of support did the Country Office extend to the executing agencies?

3. To date, what is the trend (2012 – August 2014) in the Country Office implementation rates (US$) e.g. year, ceiling, total allocation expenditure, implementation rate?

4. How were financial and other non core resources mobilized during the 6th CP?

5. Were the resources allocated for the Country Programme utilized according to budget lines?

6. How effective has the Country Office used its allocated resources? Were these resources used according to AWPs?

7. What coordination and collaboration systems were put in place? What were their strengths and weaknesses? What were lessons learned?

8. How satisfied are you with the Country Office typology? Are there outstanding required posts? What are key activities supported by the four programme components under implementation?

Reproductive Health

Province/District:	Project Area:
Name of Project:	
Programme Focus Area: i. Reproductive Health: ii. HIV Prevention iii. Gender Equality **iv.** Population and Development	 i. UNFPA CO ii. Government Ministries iii. NGO Implementing Partners iv. Other (specify)
Respondent: (If more than one key informant is involved in the interview, please attach the list of names/designation/organization of participants)	

Interview responses should be supported by documentation where possible.

Health Service Providers : Semi-Structured Interview Schedule

Introduction:

My name is _____. I will ask my colleagues to introduce themselves.

We are here to evaluate the joint 6th Country Programme between The Government of Zimbabwe and the United Nations Population Fund (UNFPA) on reproductive health. We would like to ask you a few questions about your involvement in the implementation of this programme. This is not a test; there is no right or wrong answers.

I realize how limited your time is and I greatly appreciate your taking the time to speak with us. Do you have any questions for us before we start?

1. Were you involved in the development of the 6th Country Programme?
2. How were you involved?
3. When did you officially start implementing the annual work plan?
4. When did you start implementing the work plan activities?
5. Do you perceive that you started implementing the work plan activities on time?
6. What are some of the factors that led to the delay?
7. What do you like most about the 6th Country Programme?
8. What are the successes of the 6th CP in your province/district/community?
9. What are the main reasons for these successes?
10. To what extent were you involved in developing the provincial/district work plan that included support from UNFPA?
11. What were the main constraints in implementing the 6th CP?
12. To what extent have the additional resources from UNFPA benefited service provision of reproductive health services in your province/district/community?
13. To what extent have the provincial and district offices integrated the activities in the current 6th CP into their work plans?
14. Can you please share your opinions on coordination and collaboration with UNFPA, Ministry of Youth and ZNFP reproductive health?
15. Which mechanisms in the 6th CP would you like to continue in the 7th and why?
16. Is there anything you would like to improve regarding the financial support from UNFPA?
17. Do you have any recommendations that can strengthen collaboration with UNFPA and other partners on reproductive health?
18. Do you have any recommendations on how UNFPA can improve support for reproductive health services?
19. Do you have recommendations, which you feel can improve the delivery of the 7th CP?
20. Do you have any questions for me?

THANK YOU FOR YOUR TIME

Implementing Partners : GoZ /NGO

1. Did you participate in the development of the 2012 – 2015 Country Programme Action Plan (CPAP)?

2. What major changes have occurred in the RH programme implementation since launching of the CPAP that may have implications for the programme design and performance?

3. What challenges and opportunities have been identified? How have the challenges been addressed? How have the opportunities been addressed?

4. Where can "best practices" be observed?

5. What are your anticipated technical assistance needs of the 6th CP during the remaining of the current programme cycle?

6. How is funding in relation to the adequacy and timeliness of disbursement? How are funding constraints overcome?

7. What other sources of funds (non core) and technical assistance have been mobilized for the 6th CP outside of UNFPA core resources?

8. How has the programme integrated cross-cutting issues of human rights approach, gender mainstream, partnerships and coordination approaches?

9. Are there any changes you would like to see in the output implementation for the remaining of the current programme cycle?

Staff: PO, UNFPA Country Office – Reproductive Health (including ASRH)

1. When was the 2012 – 2015 CPAP launched?

2. What major changes have occurred in the RH programme implementation since launching of the CPAP that may have implications for the programme design and performance?

3. What changes have taken place since the project design (outcome, output indicators) and why have these changes taken place?

4. What challenges and opportunities have been identified? How have the challenges been addressed? How have the opportunities been addressed?

5. What are the procedures for identifying implementing partners (IPs)?

6. Among IPs, who are the "best" performers? Who are the "worst performers"? What factors contribute to these types of performances?

7. Where can "best practices" among implementing partners be observed?

8. What is the situation of "funding" in terms of adequacy and timeliness of disbursement to IPs? What are the challenges/constraints? How can these challenges/constraints be overcome?

9. With regards to the GoZ's support to the 6th Country Programme, what are some examples of positive and negative actions?

10. What would you consider as the major achievements of the RH programme?

11. In terms of relevance, did Reproductive Health focus on the most critical issues related to the ICPD Programme of Action? Did the overall RH design remain relevant to national priorities?

12. In terms of impact-effectiveness, how effective is the RH programme in achieving its objectives? What factors have influenced the effectiveness of the programme?

13. In terms of efficiency, what measures were introduced to improve cost-efficiency? What measures were introduced to improve accountability and transparency?

14. In terms of sustainability, what measures were introduced to ensure sustainability of the interventions?

15. What are your major challenges? What are your strengths? What are your weaknesses?

16. How has the programme integrated cross-cutting issues of human rights approach, gender mainstream, partnerships and coordination approaches?

17. What are your expectations for the near future and for the Seventh Programme?

18. Where could we access the following information?
    - Feedback information from CO staff to IPs on submitted periodic reports
    - Compilation of "Baselines and /or End Lines" conducted and submitted in relation to projects
    - Compilation of "Best Practices" submitted by IPs in relation to specific projects
    - Compilation of "Lessons Learned" submitted by IPs in relation to projects. IPs in relation to projects

Focus Group Discussion, FGD for HIV Prevention (and integration)

Nature of participants
Composition and number
Organisation/programme linkage
Interviewer
Area of analysis
Interviewer code

Beneficiaries: Young people, Sex workers, amend accordingly

Welcome, introductions and explain purpose; invite any questions of clarification. Confirm confidentiality of information shared and encourage open sharing of how they feel, both positive and negative. Say that the aim is to see how the services might be developed to meet their needs better.

1. Can you tell me why you come to the (outreach or fixed clinic) services? (probe about most important services)

2. How easy is to access the services? (is the service provision sufficiently frequent and accessible; user friendly opening times; privacy)

3. How long do you usually have to wait to be seen? Is this a problem?

4. How much time do you have with the nurse/service provider? (Probe is it enough time?)

5. Do you feel able to ask the questions that you want to ask? Probe

6. Are there any gaps in the services in relation to what you need (probe regarding SRH, STI, HIV)?

7. Are there times when you cannot get commodities or services at the service site (probe around condoms, HIV testing, STI treatment, VMMC, other as relevant)

8. How do you feel about the way the staff treat you when you come for services? Probe according to the group of beneficiaries, young men, young women, sex workers

9. Overall, how satisfied or unsatisfied are you with the service provision?

10. How do you think the services could be improved?

11. Is there anything you would like to ask me?

Thank all participants. See if there is the possibility of one or two having a separate interview to explore personal change stories.

Gender Questions for Policy Level Interviews

Relevance:

- In your view, how appropriate is the GE programme within Zimbabwe's efforts to advance gender equality and ending GBV or Violence against Women?
- To what extent do you think that the programme is aligned to national priorities and policies on GBV? Were possible, please indicate the policies you have in mind as you respond.
- In your view, to what extent are the pillars of UNFPA GBV programme dealing with prevention and service provision for survivors necessary and sufficient?
- What else could the GBV programme take on board to increase its relevance?

Effectiveness:

- Has UNFPA's GBV programme contributed towards Zimbabwe's efforts to advance GE and end GBV? To the extent possible, please provide the evidence to demonstrate this point.
- To what extent has UNFPA contributed towards profiling or raising GBV as a national issue?
- In your view are there any unintended impacts of this programme? If any please share your thoughts on what those are and who has been affected positively and negatively by them.

Efficiency:

- Has UNFPA delivered GBV programming in a cost effective manner?
- Could the same quality of programming and results have been achieved with less investment of resources? Please qualify your answers were possible.

Cohesion and Partnership:

- How do you rate UNFPA's commitment to dealing with GBV within national guidelines and structures and, in partnership with likeminded sister agencies and implementing partners?
- How do you rate UNFPA's strength in partnership building and contribution to building a coherent national GBV and GE programming?

Sustainability:

To what extent are UNFPA supported programmes owned by the targeted communities?

Are the UNFPA resource allocations both technical and financial sufficient to support meaningful community initiatives and results?

Value Add:

- In your view could Zimbabwe have made the same advances in promoting GE and ending GBV without UNFPA intervention?

What is UNFPA's added value in the GE sector, especially GBV?

Cross Cutting Issues:

- To what extent do you that UNFPA programmes use a human rights approach, mainstream gender and value partnerships and integrated programming approaches?

Management Issues:

- To what extent do administrative procedures, allocation and fund management facilitate or impede GBV programming?

Soliciting key recommendation:

- This evaluation is looking at the 6th Country Programme and is also soliciting policy guidance and focus for the 7th Country Programme. What are your recommendations to the CO as the strategic focus on GE and GBV for the next programme cycle?

Gender Equality Questionnaire: UNFPA Programme Specialists and IP Programme Officers.

Name of Interviewee……
Position……
Institution/Organization……
Interviewee Stakeholder Type……
Area of Analysis……
Interviewer Code……

Note: This tool will be administered appropriately for UNFPA and IP programme staff.

10. Please give a broad overview of the GE/GBV Programme as given in the 2012 – 2015 Country Programme Action Plan (CPAP)/ your project supported by UNFPA?

11. What have been the most significant achievements of this programme?

12. What have been the challenges and opportunities presented at your level as development/ implementation partner? How have these been addressed?

13. Have there been any significant changes in the programme that may have implications for the programme design and performance?

14. What are your recommendations in responding to these that would inform the last stages of the 6th Country programme as well as inform the next UNFPA country programme?

15. What are the key lessons learnt in programme implementation?

16. What are your anticipated technical assistance needs for the remainder of the 6th CP?

17. How do you characterize the relationship between your organization and UNFPA in relation to adequacy of financial and technical support via a vis your project requirements?

18. In your view, how responsive is UNFPA to changing project and national level needs? Please substantiate your response.

19. GBV is supported by other UN Agencies like UNICEF, UNDP and UNWomen. How well does UNFPA collaborate with these other Agencies? What do you recommend for strengthening of collaboration?

20. What other sources of funds (non-core) and technical assistance have been mobilized for the 6th CP outside of UNFPA core resources?

21. Are there any changes you would like to see in the output implementation for the remainder of the programme cycle?

22. UNFPA programme approaches embed human rights, youth responsiveness and gender mainstreaming, how well has UNFPA done internally in engaging these approaches and also in supporting partners to mainstream these approaches?

23. What is your assessment of the effectiveness of the M&E system within UNFPA/ your organization in tracking the impact of GE programming on the lives of males and females? Please share your views on how the current position can be improved?

24. What would you recommend as the focus for the 7th CP in relation gender equality and GBV?

25. Are there any issues you want to raise that the evaluation has not raised with you?

HIV Prevention KI Schedule: UNFPA Programme Specialists and IP Programme Officers
Name of interviewee
Position
Institution/organization
Stakeholder type
Interviewer
Area of analysis
Interviewer code

Overarching evaluation criteria and core questions to address, developed from the evaluation matrix requirements and relating to achievement of results. The relevant programmes are Integrated HIV, SRH and GBV Services Programme (ISP), social and behaviour change (SBCC) and demand generation for HIV and SRH services; integrated services for sex workers; the Linkages Programme; condom programming; VMMC support. Special beneficiary focus: ASRH, sex workers.
The HIV **Outcome** of the 6th CP for HIV prevention is: *Increased adoption of safer sexual behaviour and use of HIV prevention services* (listed in Combination Prevention Strategy)
CP Output 4*) increased coverage of the SBCC programme;*
CP Output 5) *increased availability of HIV prevention services.*
Outcome indicators: Condom use with non-regular partner; More than one sexual partner in past 12 months; % men 13-49 circumcised by age, urban/rural; SW numbers service access**.**
Throughout, read programme or project as appropriate. Select questions as appropriate to KI level and role, and rephrase as required.

Introductions, explain purpose, thanks for participation and time. Confirm confidentiality.

Schedule:
Please give a broad overview of the HIV prevention programme/project supported by the UNFPA 6th Country Programme Action Plan. Date started. Probe including SRH, gender, youth focus

Please outline the role of UNFPA in supporting this programme/project. Probe re funding, types of technical support

SWOT analysis: include focus on UNFPA contributions

What are the most significant strengths/achievements of this programme?
What do you see as the weaknesses of the programme?
What opportunities are there for future programme development?
What threats might jeopardise successful continuation of the programme to address UNFPA outputs and outcomes? (use appropriate output(s) for programme)

1. How are the weaknesses and threats being addressed within the programme? Probe

2. How essential is UNFPA's continued support for this programme? What other sources of financial or technical support do you have? How sustainable is the programme? Probe

3. How efficient has UNFPA financial support to the programme been during the 6th CP? Probe re timely disbursement of funds, reporting issues.

4. How effective has UNFPA technical support been for the programme? Probe.

5. How effectively does UNFPA collaborate with other partners (UN agencies, ministry, other IPs) in relation to your programme? (as relevant)

6. How is the programme monitored and evaluated? Probe

7. Have any significant changes occurred in the programme from January 2012 to date from what was initially planned? Please explain (relates to responsiveness, capacity, challenges)

8. How are human rights issues incorporated in the programme? Probe

9. How does the programme integrate SRH, HIV and gender? (ask if insufficient above)

10. What support for your programme should UNFPA prioritize in the remaining 18 months of the UNFPA 6th CP (to end of 2015)?

11. What would you like to see UNFPA prioritise in relation to your progamme in the next country programme from 2016?

12. Are there any areas/aspects of the programme that UNFPA supports now, that you think UNFPA should not focus on in the next CP? Probe

Open up for any further comments regarding UNFPA support that have not been covered.

NATIONAL POLICY LEVEL, HIV PREVENTION
AIDS and TB Unit: Focus on health aspects and services
NAC: focus on multisectoral response and coordination
Directorate of HIV Prevention Services in MoHCC

Name of interviewee
Position
Institution/organization

Stakeholder type
Interviewer
Area of analysis
Interviewer code

Overarching evaluation criteria and core questions to address, developed from the evaluation matrix. The relevant progammes are Integrated HIV, SRH and GBV Services Programme (ISP), social and behaviour change (SBCC) and demand generation for HIV and SRH services; integrated services for sex workers; the Linkages Programme; condom programming; VMMC support.
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CP Output 4*) increased coverage of the SBCC programme;*
CP Output 5) *increased availability of HIV prevention services.*
Outcome indicators: Condom use with non-regular partner; More than one sexual partner in past 12 months; % men 13-49 circumcised by age, urban/rural; SW numbers service access**.**

Relevance
1. How did the 6th CP address the needs of the population of Zimbabwe in relation to HIV prevention? Probe around key needs and programmes, TA and finance 2. How did UNFPA contribute to the development of the national policy on HIV in Zimbabwe? 3. How are the strategic actions, outputs and indicators of the 6th CP contributing to the strategic priorities of the Zimbabwe national development plan and ZUNDAF? Probe
Effectiveness
4. How effective were UNFPA's contributions to HIV prevention? Probe for different focal areas 5. What factors influenced the success and effectiveness or failure of the programme? Probe regarding different focal areas
Efficiency
6. Are you able to comment on how efficient were UNFPA CO's contributions for HIV prevention (probe on timeliness of funding, technical assistance, reporting) (May not be able to comment)
Sustainability
7. How far do you think the Government of Zimbabwe and other stakeholders can continue implementing current interventions for HIV prevention without UNFPA support? Probe regarding possible alternative sources of funding, fund management, procurement, and technical support 8. How did the CP promote sustainability of activities that are being supported in the community for HIV prevention and integrated services? Probe
Responsiveness
9. To what extent did UNFPA anticipate and respond to significant changes in the national development context of relevance to HIV prevention and integrated services? Probe around funding and technical assistance 10. Do you think there were any missed opportunities in UNFPA programming for HIV prevention and for integration? Probe
Integration
11. How effectively is UNFPA integrating HIV, SRH, ASRH and gender in its planning and programming? Probe
Coordination with UNCT and other partners
12. How effectively has UNFPA been working with other UN partners regarding HIV prevention? 13. How effectively has UNFPA been working with the national policy and coordination bodies for HIV prevention?
Added Value

14. How far did the CP add value to what would have resulted from other development actors' interventions without UNFPA? Include in SWOT
SWOT Analysis: Introduce SWOT and probe
15. **Strengths** including added value and comparative advantage
16. Weaknesses
17. Opportunities
18. Threats
Cross-Cutting Issues
19. To what extent does UNFPA HIV prevention programming integrate a human rights approach?
20. To what extent does UNFPA HIV programming mainstream gender? Only ask if further probing needed after Q 11.
Orientation to next CP
21. What would you recommend that UNFPA prioritise for HIV prevention in the next CP? Probe around priorities and comparative advantage, changing environment and national priorities; current CP outcomes and outputs 22. What would you consider UNFPA should drop or reduce in the next CP?

P&D Capacity Building Beneficiaries at ZIMSTATS
Key Informants
This questionnaire is targeted at ZIMSTATS Officers who were trained on various aspects of the 2012 Census and other activities funded by UNFPA. We would want to get information on the capacity-building activities have enhanced your performance in producing good data. The completion of the questionnaire will take about 15 minutes.

Name of Interviewee……
Position……
Institution/Organization……
Interviewee……
Stakeholder Type……
Area of Analysis……
Interviewer Code……

1. What capacity building courses did you attend which were funded or facilitated by UNFPA?
2. Was the content appropriate for performing your required tasks at ZIMSTATS
3. Did you gain anything from the course?
4. Give me your views about the methods of course delivery.
    a. Were they effective?

    b. Were the trainers knowledgeable in the subject

5. What activities were you able to perform at you work after the training?
6. How useful was the training to you for your professional growth?
7. What were the useful aspects from the training which you have used in performing?

8. What would be your recommendations for further capacity-building initiatives?

POPULATION AND DEVELOPMENT
Policy-Makers & Project Directors

Name of Interviewee……
Position……
Institution/OrganizationInterviewee……
Stakeholder Type……
Area of Analysis……
Interviewer Code……

Introduction
This tool will be used by policy-makers and project directors who are working in collaboration with UNFPA. We would want to get more information about the UNFPA funded projects that are executed your organizations or institutions.

1. Which activities in your institution (department/ministry) were supported by 6th Country Programme?
    a. PROBE: At ZIMSTATS: data & report production (Census, DHS)
    b. PROBE: At Ministry: Population policy, integrating population and development

Relevance (Usefulness and value to stakeholders)
2. Do the objectives for programme interventions supported by the 6th Country Programme:
    a. Address the needs of your organization?
    b. The needs of the institutions and users you serve?

3. How has the programme supported the organization (ministry) to address the needs of your clients (users of population and other data)?
    a. If not, what issues still need to be addressed?
    b. Are the data used in planning? Examples

4. To what extent are the results and benefits from the 6th Country Programme 2012-2015 useful to users of population data?
5. How are UNFPA interventions integrated/ into related government programmes, for example, ZIMASSET?
6. Is UNFPA responsive to government needs in the context of Zimbabwe as a developing country?

Efficiency (Organisational and programmatic efficiency)
7. How appropriately and adequately are the available resources (funding and resources) used to carry out activities for the achievement of the outputs?
8. To what extent were the activities managed in a manner to ensure delivery of high quality outputs and best value for money?
9. Were agreed outputs delivered?
10. Was the programme approach, partner and stakeholder engagement appropriate for results delivery?
11. Which partnerships were more strategic in bringing about results and value-for money?
12. Were institutions adequately equipped to deliver on results-based management/ M& E for the CP?

Effectiveness (Degree of achievements of outputs and outcomes)
13. To what extent did the UNFPA CP contribute to the stated outcomes?

14. Are the outcomes a result of/attributable to CP interventions?
15. Were UNFPA interventions implemented at adequate scale to reach intended outcomes?
16. To what extent did the programme address the needs of the beneficiaries?
17. Were strategic information outputs such as Census Reports and other research reports used to inform policy/planning?
18. To what extent are P&D managers:
    a. Produce and use population statistics?
    b. Influence the use of population data by other government departments and other users
19. Are relevant population reports and demographic data used for planning?
20. What else should be done to make the programmes more effective?
21. Is budget allocation reflective of population demographics and issues?

Sustainability (Continuity of benefits after 6th Country Programme)

22. Are UNFPA interventions integrated into departmental plans?
23. What are plans for sustainability within your organisation?
24. Does your institution have capacity to continue programme interventions without UNFPA or any donor support?

If not, what kind of assistance will be required?

25. To what extent have the capacities been strengthened?

Impact (OUTCOMES) Effects of the CP, intended & unintended, positive & negative

26. What were the intended and unintended effects of the programme interventions (specify) to the institution)?

27. Could the results (outputs and outcomes) have been achieved without UNFPA?
28. To what extent are the changes that occurred during the life span of the programme attributed to the UNFPA CP interventions?
29. What other factors might have contributed to the achievement of outcomes?
30. What factors hindered the achievements of results?
31. What should be done differently if the CP support were to continue?

Concluding Remarks

32. Thank you for this important information. Do you have any questions or comments for me?

Users of Population Data

Key Informants

This questionnaire is targeted at users of demographic or population or health data from ZIMSTATS. The completion of the questionnaire will take about 15 minutes.

Name of Interviewee……
Position……
Institution/Organization……
Interviewee……
Stakeholder Type……
Area of Analysis…….
Interviewer Code……

1. What demographic of population data do you usually use from ZIMSTATS?
2. What do you use the data for?
3. How useful are the data you get from ZIMSTATS
4. Give me your views about data quality.
    a. Assessment of quality?

    b. What problems did you find in the data?

5. Did you NOT able to get population data you needed? What did you not get?
6. How did this handicap what you were trying to do?
7. How can ZIMSTATS respond to your data needs?

8. Any recommendations on improving data use?

Reproductive Health

Province/District:	Project Area:
Name of Project:	
Programme Focus Area: v. Reproductive Health: vi. HIV Prevention vii. Gender Equality **viii.** Population and Development	v. UNFPA CO vi. Government Ministries vii. NGO Implementing Partners viii. Other (specify)
Respondent: (If more than one key informant is involved in the interview, please attach the list of names/designation/organization of participants)	

Interview responses should be supported by documentation where possible.

Health Service Providers : Semi-Structured Interview Schedule

Introduction:

My name is _____. I will ask my colleagues to introduce themselves.

We are here to evaluate the joint 6th Country Programme between The Government of Zimbabwe and the United Nations Population Fund (UNFPA) on reproductive health. We would like to ask you a few questions about your involvement in the implementation of this programme. This is not a test; there is no right or wrong answers.

I realize how limited your time is and I greatly appreciate your taking the time to speak with us. Do you have any questions for us before we start?

21. Were you involved in the development of the 6th Country Programme?

22. How were you involved?

23. When did you officially start implementing the annual work plan?

24. When did you start implementing the work plan activities?

25. Do you perceive that you started implementing the work plan activities on time?

26. What are some of the factors that led to the delay?

27. What do you like most about the 6th Country Programme?

28. What are the successes of the 6th CP in your province/district/community?

29. What are the main reasons for these successes?

30. To what extent were you involved in developing the provincial/district work plan that included support from UNFPA?

31. What were the main constraints in implementing the 6th CP?

32. To what extent have the additional resources from UNFPA benefited service provision of reproductive health services in your province/district/community?

33. To what extent have the provincial and district offices integrated the activities in the current 6th CP into their work plans?

34. Can you please share your opinions on coordination and collaboration with UNFPA, Ministry of Youth and ZNFP reproductive health?

35. Which mechanisms in the 6th CP would you like to continue in the 7th and why?

36. Is there anything you would like to improve regarding the financial support from UNFPA?

37. Do you have any recommendations that can strengthen collaboration with UNFPA and other partners on reproductive health?

38. Do you have any recommendations on how UNFPA can improve support for reproductive health services?

39. Do you have recommendations, which you feel can improve the delivery of the 7th CP?

40. Do you have any questions for me?

THANK YOU FOR YOUR TIME

Implementing Partners : GoZ /NGO

26. Did you participate in the development of the 2012 – 2015 Country Programme Action Plan (CPAP)?

27. What major changes have occurred in the RH programme implementation since launching of the CPAP that may have implications for the programme design and performance?

28. What challenges and opportunities have been identified? How have the challenges been addressed? How have the opportunities been addressed?

29. Where can "best practices" be observed?

30. What are your anticipated technical assistance needs of the 6th CP during the remaining of the current programme cycle?

31. How is funding in relation to the adequacy and timeliness of disbursement? How are funding constraints overcome?

32. What other sources of funds (non core) and technical assistance have been mobilized for the 6th CP outside of UNFPA core resources?

33. How has the programme integrated cross-cutting issues of human rights approach, gender mainstream, partnerships and coordination approaches?

34. Are there any changes you would like to see in the output implementation for the remaining of the current programme cycle?

Staff: PO, UNFPA Country Office – Reproductive Health (including ASRH)

19. When was the 2012 – 2015 CPAP launched?

20. What major changes have occurred in the RH programme implementation since launching of the CPAP that may have implications for the programme design and performance?

21. What changes have taken place since the project design (outcome, output indicators) and why have these changes taken place?

22. What challenges and opportunities have been identified? How have the challenges been addressed? How have the opportunities been addressed?

23. What are the procedures for identifying implementing partners (IPs)?

24. Among IPs, who are the "best" performers? Who are the "worst performers"? What factors contribute to these types of performances?

25. Where can "best practices" among implementing partners be observed?

26. What is the situation of "funding" in terms of adequacy and timeliness of disbursement to IPs? What are the challenges/constraints? How can these challenges/constraints be overcome?

27. With regards to the GoZ's support to the 6th Country Programme, what are some examples of positive and negative actions?

28. What would you consider as the major achievements of the RH programme?

29. In terms of relevance, did Reproductive Health focus on the most critical issues related to the ICPD Programme of Action? Did the overall RH design remain relevant to national priorities?

30. In terms of impact-effectiveness, how effective is the RH programme in achieving its objectives? What factors have influenced the effectiveness of the programme?

31. In terms of efficiency, what measures were introduced to improve cost-efficiency? What measures were introduced to improve accountability and transparency?

32. In terms of sustainability, what measures were introduced to ensure sustainability of the interventions?

33. What are your major challenges? What are your strengths? What are your weaknesses?

34. How has the programme integrated cross-cutting issues of human rights approach, gender mainstream, partnerships and coordination approaches?

35. What are your expectations for the near future and for the Seventh Programme?

36. Where could we access the following information?
    - Feedback information from CO staff to IPs on submitted periodic reports
    - Compilation of "Baselines and /or End Lines" conducted and submitted in relation to projects
    - Compilation of "Best Practices" submitted by IPs in relation to specific projects
    - Compilation of "Lessons Learned" submitted by IPs in relation to projects. IPs in relation to projects

Staff: UNFPA Country Office – Coordination, Management, Finance

9. Was the overall 6th CP based on National Execution Modalities (NEX)? What worked and what did work? Why? What lessons can be learned for the 7th programme?

10. What level of support did the Country Office extend to the executing agencies?

11. To date, what is the trend (2012 – August 2014) in the Country Office implementation rates (US$) e.g. year, ceiling, total allocation expenditure, implementation rate?

12. How were financial and other non core resources mobilized during the 6th CP?

13. Were the resources allocated for the Country Programme utilized according to budget lines?

14. How effective has the Country Office used its allocated resources? Were these resources used according to AWPs?

15. What coordination and collaboration systems were put in place? What were their strengths and weaknesses? What were lessons learned?

16. How satisfied are you with the Country Office typology? Are there outstanding required posts? What are key activities supported by the four programme components under implementation?