GOVERNMENT OF ZIMBABWE/ UNITED NATIONS POPULATION FUND

5th COUNTRY PROGRAMME (2007 – 2011)
Final Independent Evaluation Report

By

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<tr>
<td>ADVC</td>
<td>Anti-Domestic Violence Council</td>
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<tr>
<td>ARC</td>
<td>Adult Rape Clinic</td>
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<td>ARO</td>
<td>Africa Regional Office</td>
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<td>ASRH</td>
<td>Adolescent Sexual Reproductive Health</td>
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<td>BCF</td>
<td>Behaviour Change Facilitator</td>
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<td>CARRMa</td>
<td>Campaign for the Accelerated Reduction of Maternal Mortality</td>
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<td>CBD</td>
<td>Community-Based Distributor</td>
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<td>CEDAW</td>
<td>Convention for the Elimination of All forms of Discrimination Against Women</td>
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<td>CIDA</td>
<td>Canadian International Development Assistance</td>
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<td>COARS</td>
<td>Country Office Annual Reports</td>
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<td>CP</td>
<td>Country Programme</td>
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<td>CPAP</td>
<td>Country Programme Action Plan</td>
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<td>CPD</td>
<td>Country Programme Document</td>
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<td>CPR</td>
<td>Contraceptive Prevalence Rate</td>
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<td>CSO</td>
<td>Central Statistical Office</td>
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<td>DfDWG</td>
<td>Data for Development Working Group</td>
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<td>DFID</td>
<td>Department for International Development</td>
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<td>DHS</td>
<td>Demographic Health Survey</td>
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<td>DV</td>
<td>Domestic Violence</td>
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<td>DVA</td>
<td>Domestic Violence Act</td>
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<td>EA</td>
<td>Enumeration Area</td>
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<td>EmONC</td>
<td>Emergency Obstetric and Neonatal Care</td>
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<td>ESP</td>
<td>Expanded Support Programme</td>
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<td>Family AIDS Caring Trust</td>
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<td>GBV</td>
<td>Gender Based Violence</td>
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<td>Health Management Information System</td>
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<td>IMIS</td>
<td>Integrated Management Information System</td>
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<tr>
<td>L &amp; R</td>
<td>Love and Respect</td>
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<td>MAC</td>
<td>Matebeleland AIDS Council</td>
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<td>MC</td>
<td>Male Circumcision</td>
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<td>MASO</td>
<td>Midlands AIDS Service Organisation</td>
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<td>MDGs</td>
<td>Millenium Development Goals</td>
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<td>Acronym</td>
<td>Description</td>
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<td>MIMS</td>
<td>Multiple Indicators Survey</td>
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<td>Management Information Systems</td>
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<td>MNH</td>
<td>Maternal and Neonatal Health</td>
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<td>MOED</td>
<td>Ministry of Economic Development</td>
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<td>MOEPIP</td>
<td>Ministry of Economic Planning and Investment Promotion</td>
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<tr>
<td>MOWAG&amp;CD</td>
<td>Ministry of Women’s Affairs, Gender and Community Development</td>
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<td>MSF</td>
<td>Medecins Sans Frontieres</td>
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<td>MTE</td>
<td>Mid-term Evaluation</td>
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<td>MTP</td>
<td>Medium Term Plan</td>
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<td>MVA</td>
<td>Post abortion care Equipment</td>
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<td>MWH</td>
<td>Mothers Waiting Homes</td>
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<td>NAC</td>
<td>National AIDS Council</td>
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<td>NHIS</td>
<td>National Health Information System</td>
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<td>NPP</td>
<td>National Population Policy</td>
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<td>P&amp;D</td>
<td>Population and Development</td>
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<td>PASS</td>
<td>Poverty Assessment Study Survey</td>
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<td>RH</td>
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<td>SIDA</td>
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<td>SPR</td>
<td>Standard Progress Report</td>
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<td>STERP</td>
<td>Short-Term Economic Recovery Programme</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<td>UNDG</td>
<td>United Nations Development Group</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>UNIFEM</td>
<td>UN Fund for Women</td>
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<tr>
<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
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<td>VFU</td>
<td>Victim Friendly Unit</td>
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<td>WFP</td>
<td>World Food Programme</td>
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<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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<td>ZAPSO</td>
<td>Zimbabwe AIDS Programme Support Organisation</td>
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<tr>
<td>ZEDS</td>
<td>Zimbabwe Economic Development Strategy</td>
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<tr>
<td>ZIMDAT</td>
<td>Zimbabwe Data Base</td>
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<td>ZIMSTAT</td>
<td>Zimbabwe Statistical Office</td>
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<td>ZMPMS</td>
<td>Zimbabwe Maternal and Perinatal Mortality Study</td>
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<td>ZNFPC</td>
<td>Zimbabwe Family Planning Council</td>
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<td>ZUNDAF</td>
<td>Zimbabwe United Nations Development Assistance Framework</td>
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<td>ZWLA</td>
<td>Zimbabwe Women Lawyers Association</td>
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ACKNOWLEDGEMENTS

The Evaluation Team was led by Mr. Lalan Mubiala, an independent consultant and a former Monitoring and Evaluation Officer at the then UNFPA Technical and Evaluation Division (TED), UNFPA/New York. In the context of this evaluation, Mr. Mubiala covered the Population and Development component. Other members of the Evaluation Team were Dr. Tsitsi Magure, obstetrician and gynaecologist, responsible for the Reproductive Health component, Mr. Leonard Maveneka, a Consultant on HIV and AIDS, and Mr. Pindai Sithole, a Consultant on Gender.

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Without the cooperation and willingness of everyone to assist in every way possible and to provide information, this report would not have been completed at the time it did.
EXECUTIVE SUMMARY

The UNFPA-Government of Zimbabwe 5th Country Programme (CP) for the period 2007-2011 seeks to contribute to the improvement of people’s quality of life by addressing: (i) high maternal mortality through improving reproductive health; (ii) high HIV and AIDS prevalence through HIV prevention; (iii) ensuring gender equality; and (iv) improving the utilization of data for development and the integration of population, reproductive health, gender and HIV concerns into national and sub-national development planning.

UNFPA commissioned an end of programme evaluation to assess the impact of the interventions it supports in improving the quality of life of the people of Zimbabwe. The evaluation also analysed factors that facilitated or hindered achievements and documented lessons learnt to provide input into the 6th Country Programme.

The methodology used for the evaluation combined both quantitative and qualitative approaches, including interviews, focus group discussions and a desk review of a wide range of documents. Field visits were also organized to the provinces of Manicaland, Midlands and Matebeleland to validate desk review findings as well as to gather on-the-ground information from stakeholders. Two debriefing sessions were held first with UNFPA Country Office (CO) and then with Government and civil society implementing partners to present findings, clarify observations and fill gaps.

The main thrust of the evaluation was based on the planned outcomes of the 5th Country Programme. These are described as follows:

1. A policy environment that promotes reproductive health and rights
2. Increased utilization of comprehensive, gender-sensitive reproductive health services
3. Increased adoption and maintenance of safer sexual behaviors as well as increased utilization of HIV-prevention services
4. Improved utilization of population and development-related data disaggregated by age and sex
5. National, sub-national and sectoral policies, plans and strategies take into account population and development linkages
6. Strengthening institutional mechanisms and socio-cultural practices that promote and protect the rights of women and girls and advance gender equity.

During 2007 and 2008, Zimbabwe experienced an extremely difficult socio-economic, financial and political environment characterized by an unprecedented hyperinflation, a cholera epidemic, the collapse of the public health system and a massive brain drain. Progress towards achieving programme objectives was hampered due, among other things, to the closing of most public health institutions, the lack of human resources, drugs and equipment. UNFPA showed unusual flexibility and creativity to respond to the crisis. In the reproductive area, the CO provided emergency obstetric care assistance and supported payment of allowances for health professionals to facilitate the reopening of health centres. The CP target of increasing the availability of comprehensive gender-sensitive RH services, including EmONC was severely
compromised as emphasis shifted to emergency assistance. The programme was nevertheless still able to provide a number of key interventions that were instrumental in keeping the health system afloat. The interventions included the refurbishing of Mothers’ Waiting Homes (MWH), the provision of prepaid blood coupons for pregnant women who could not afford the cost of blood transfusion and support for key management staff positions in the Ministry of Health and Child Welfare’s (MOHCW) head office and at provincial levels. This particular intervention proved crucial in maintaining the Ministry’s capacity to formulate, implement, monitor and evaluate programmes that promote increased access to reproductive health and HIV prevention services.

In spite of the difficult environment, several RH policies, strategies and guidelines were formulated and several studies and surveys were conducted. District and provincial Health Management Information Systems (HMIS) were strengthened to facilitate evidence-based planning and programming. Looking forward to the next programme, (i) the provision of EmONC services will remain a priority as will, (ii) support to key management positions in MOHCW. Other priorities include: (iii) promoting institutional deliveries and (iv) strengthening joint programming between MOHCW, UNFPA, WHO, UNICEF and other partners.

The HIV prevention programme has been a major success. It has achieved broad geographical coverage as it is now covering the whole country. The programme has begun to record positive changes in behavior in areas such as Voluntary Counseling and Testing (VCT) and condom uptake as well as in the reduction of stigma and discrimination. It will be necessary, in the context of the next CP: (i) to consolidate the gains that have been made by ensuring the retention of BC facilitators and by increasing male and youth participation; (ii) attention will also need to be paid to speeding up disbursement of funds to reduce delays in programme implementation that have characterized the current phase; (iii) more effort will also need to go into raising awareness about male circumcision in anticipation of the national roll out following the success of the pilot phase.

The youth friendly and the peer education components of the Adolescent Sexual and Reproductive Health (ASRH) programme continued to face problems with high attrition rates of nurses and peer educators. The programme also failed to expand to the 30 additional districts as originally envisaged and has not performed well in the districts in which it was meant to consolidate. This could be the reason why the EC has not renewed funding. There is a serious need: (i) to reconceptualise the programme and; (ii) to analyse the reasons for its failure to make the impact it should have over the years. While some of the problems might be due to the external environment, serious consideration should be given to whether current implementing modalities are likely to achieve the desired results.

The marked improvement in data collection, processing and reporting has been the major achievement in Population and Development (P&D). Of the six household surveys conducted, all but one had been processed, analyzed and published. In comparison to 2005 when only 60% of the household surveys had their reports printed on time, the proportion was close to 100% at the time of the evaluation. The completion of those surveys together with the annual updating of ZIMDAT have contributed to increasing the availability of sex and age-disaggregated population and development data at national and sub-national levels. By the end of 2009, most MDG, ICPD and CEDAW indicators had been incorporated into ZIMDAT. Compared to 2005 when only 40% of the indicators were included, at least 75% of all the indicators have
now been incorporated. The establishment of the Population and Development Unit (PDU) and the revision of the National Population Policy (NPP) went a long way in restoring the appreciation for population issues in the country after a six year hiatus. As a result, the draft Medium Term Plan (MTP) includes a chapter on population and development linkages while other key population issues are mainstreamed in the rest of the document. There was no evidence however that a deliberate effort had been made to integrate population factors in development planning at sub-national levels. Nevertheless the P&D component of the 5th CP was able to achieve by and large its two outcomes of improved utilization of population and development-related data as well as the integration of population factors into development planning. Priorities during the next programme include: (i) support to the 2012 Population Census; (ii) the establishment of a Population Commission; (iii) training of PDU officers and planners in line ministries and at sub-national levels in integrating population into development planning.

In the area of Gender, new institutions were established specifically to address domestic and gender-based violence. These include the Anti-Domestic Violence Council, the Victim Friendly Units, the One-Stop Centres and the Adult Rape Clinic. Capacities have been built in the Ministry of Women Affairs, Gender and Community Development (MOWAG & CD) and other key line ministries. Improved technical and resource support by UNFPA has contributed to an increased number of civil society organizations involved in implementation of domestic and GBV activities. At individual and community levels, some of the key achievements include awareness raising; increased men and boys' involvement in gender issues and improved service provision to the survivors of GBV.

The priorities for the next CP include: (i) development of a national GBV strategy; (ii) establishment of a national GBV database; (iii) scaling up one-stop centres nationwide and, (iv) a comprehensive analysis framework on cultural practices, norms, and beliefs with a special focus to also identify those that can be used to address GBV in Zimbabwe.
CHAPTER ONE

INTRODUCTION

1.0 Background

In accordance with UNFPA policies and procedures on monitoring and evaluation, UNFPA Country Office (CO) in Zimbabwe commissioned an end of programme evaluation of the country’s Fifth Country Programme (CP) covering the period 2007-2011. The Terms of reference for the evaluation were developed by the CO in close collaboration with the Government of Zimbabwe. They were finalized after extensive review by and discussion with Africa Regional Office (ARO) in Johannesburg, South Africa.

The evaluation team was led by a former UNFPA staff, a demographer, with extensive experience in evaluations and comprised one Medical Doctor, with expertise in obstetrics and gynaecology, and two seasoned professional evaluators with expertise in international development, HIV and AIDS, and Gender. The evaluation was conducted during the period 25 October-2 December 2010.

1.1 Purpose and Scope

The goal of Zimbabwe 5th Country Programme is to contribute to the Government’s aim of improving the quality of life of the people of Zimbabwe. This is to be achieved through the implementation of projects and activities under the three programme components, namely Reproductive Health (RH), including maternal health, adolescent reproductive health (ASRH), HIV and AIDS, and fistula; Population and Development (P&D) and, Gender. The problems addressed by the programme are high maternal mortality, high HIV and AIDS prevalence, widespread concerns with domestic and gender-based violence and the dearth of current data for development planning and monitoring.

The specific objectives of the evaluation were to:

- Determine the extent to which planned activities were completed
- Assess the achievement of expected results in the three programme areas of Reproductive Health, Gender and Population and Development
- Gauge the alignment of the 5th CP strategies with current and emerging national priorities
- Assess the relevance, effectiveness and efficiency, impact and sustainability of UNFPA’s 5th Country Programme for Zimbabwe
- Assess the coordination, the leadership and management of the CP5, including human resources, financial resources, systems
- Identify the challenges, strengths, weaknesses and gaps that can be addressed in the 6th Country Programme
- Draw lessons learnt and good practices

The evaluation covered the period January 2007 to August 2010 and assessed programme implementation in the three thematic areas throughout the whole country. As per UNFPA’s Monitoring and Evaluation Policy, the main thrust of the evaluation was on the expected six outcomes of the CP as follows:

- **Reproductive Health:** (i) A policy environment that promotes reproductive health and rights; (ii) Increased utilization of comprehensive, gender-sensitive reproductive health services; (iii)
Increased adoption and maintenance of safer sexual behaviors as well as increased utilization of HIV prevention services.

- **Population and Development**: (iv) Improved utilization of age and sex-disaggregated population and development related data; (v) National, sub-national and sectoral policies, plans and strategies take into account population and development linkages.

- **Gender**: (vi) Strengthening institutional mechanisms and socio-cultural practices that promote and protect the rights of women and girls and advance gender equity.

### 1.2 Methodology

#### 1.2.1 Data Collection and Analysis Methods

The methodology used for the evaluation is in line with the specifications highlighted in the UNFPA Evaluation Policy and Procedures and in the TORs for this evaluation. Both quantitative and qualitative approaches were used to allow for comprehensive analysis of the 5\(^{th}\) CP. These are detailed below:

- **Briefings** by CO staff on topics ranging from the operating environment to the implementation, monitoring and evaluation of the programme and its component projects, including achievements, challenges and constraints.
- **Desk review** of a wide range of documents related to the programme, including the United Nations Development Assistance Framework (UNDAF), the Country Programme Document (CPD), the CPAP, the Standard Progress Reports (SPRs), Country Office Annual Reports (COARs), the National Reproductive Health Policy, Zimbabwe National Population Policy, the National Gender Policy and successive Millennium Development Goals (MDGs) Progress Reports, literature and web searches, to name only a few.
- **Interviews** with UNFPA programme managers, UN cooperating agencies, Government officials, Non-governmental organizations (NGOs) counterparts, key informants and other key stakeholders, including traditional and religious leaders.
- **Focus group discussion** mainly with RH and HIV and AIDS services beneficiaries.
- **Field visits** to three provinces -- Manicaland, Midlands and Matebeleland.
- **Report writing**. The analyzed data was compiled into a comprehensive report covering the three thematic areas and including recommendations that will inform the development of the sixth CP. The draft report was presented to UNFPA first, then to the Government and other stakeholders.

#### 1.2.2 Evaluation criteria

The evaluation questions were formulated and administered according to the following criteria:

- a) **Strategic direction**: Relates to the way in which UNFPA has positioned itself within the overall country development context;
- b) **Effectiveness**: The extent to which planned results were being achieved, or were likely to be achieved at the level of the outcomes;
- c) **Efficiency**: The extent to which UNFPA used the most cost efficient ways of programme delivery;
- d) **Relevance**: The extent to which an activity reflected national needs and priorities;
e) Impact: The extent to which a difference has been made in the quality of life of the beneficiaries as a result of interventions supported by UNFPA;
f) Sustainability: The extent to which the Government of Zimbabwe and other stakeholder can continue implementing current interventions without UNFPA support.

1.2.3 Limitations
The evaluation team was not complete until days into the process of data collection and document review, which somehow delayed the familiarization stage and the start of the evaluation. Other constraints stemmed from insufficient data, in particular the lack of baseline data in some thematic areas. From an organizational point of view, the timing of the evaluation, which coincided with an audit evaluation of UNFPA Zimbabwe Country Office, was not ideal. The staff was continuously pulled from all sides and could not give the CP evaluation team the undivided attention they required. Furthermore, due to travel schedules and prior commitments, some implementing partners could not meet with the evaluation team.

1.2.4 Report outline
Chapter One is the introduction. Chapter Two are the evaluation findings. Chapter Three deals with Programme Management issues. Chapter Four assesses UNFPA’s 5th CP against the evaluation criteria while recommendations constitute Chapter Five. The Terms of reference for the evaluation, the Evaluation Report Outline, the list of persons met and the list of documents reviewed constitute Annexes 1, 2, 3 and 4 respectively.
CHAPTER TWO

EVALUATION FINDINGS AND CONCLUSIONS

2.1 Reproductive Health

2.1.1 Introduction

The reproductive health component of the Country Programme (CP) planned to address national priorities in reproductive health in line with the Millennium Development Goals (MDGs). The national priority was to reduce Maternal Mortality through:

- Increased skilled birth attendants at delivery
- Increased Contraceptive Coverage Rate (CPR)
- Strengthening the referral system
- Improving the Commodity security
- Strengthening the capacity to plan, monitor and evaluate RH programmes, with special focus on strengthening the National Health Information System

The MoHCW through the RH unit coordinated the implementation of the RH programme components. The reproductive health component had two outcomes and two outputs. The outcomes for the 5th CP were: i) A policy environment that promotes reproductive health and rights; ii) Increased utilization of comprehensive, gender sensitive reproductive health services. The two RH outputs were: i) Enhanced national capacity to formulate, implement, monitor and evaluate policies that promote increased access to reproductive health and HIV-prevention services; ii) Increased availability of comprehensive, gender sensitive reproductive health services, including essential obstetric care and family planning.

The planned key activities to achieve output 1 included: supporting MoHCW in evidence-based development of policies, strategies and guidelines; supporting the conducting of studies and surveys; and strengthening of provincial/district capacity to plan, monitor and evaluate their RH programme activities; supporting staff positions in MoHCW's head office and provincial levels; strengthening of the district and provincial Health Management Information System (HMIS) to facilitate data collection for planning, monitoring and evaluation of programs. The strategies that had been set out for the successful implementation of output 2 include: the provision of EmONC drugs, equipment, supplies and contraception; training of skilled attendants in EmONC, post abortal care; contraceptive implants insertion skills; and infrastructure refurbishment. These strategies were in line with the MNH Road Map Four Pillars of Safe Motherhood concept and were aimed at addressing the three delays in women accessing RH services.

The main implementing partners for the Reproductive Health (RH) component of the CP are the Ministry of Health and Child Welfare, Zimbabwe National Family Planning Council (ZNFPC), UNFPA, UNICEF and WHO.
2.1.2 **Progress and Achievements**

Progress of the RH component of the CP is assessed against two outcomes and two outputs as indicated in Table 1 below. The output indicators, the strategies and the achievements have been summarised in the table below for easy assimilation.
**Table 1: Summary of Achievements in RH by CP Outputs, Indicators and Strategies**

**ZUNDAF Outcomes:**
Maternal and child mortality and morbidity rates reduced, health sector rehabilitated and disease burden reduced

**CP RH Outcomes:**
1. Policy environment that promotes reproductive health and rights
2. Increased utilization of comprehensive gender sensitive reproductive health services

<table>
<thead>
<tr>
<th>CP Output and Indicators</th>
<th>Strategies and activities</th>
<th>Achievements and Progress so far</th>
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| **Output 1:** Enhanced capacity to formulate, implement, monitor and evaluate policies that promote increased access to reproductive health and HIV prevention services | Technical and financial support to MoHCW RH unit to develop RH policies; strategies; guidelines; conduct of studies and surveys; and strengthening of the district and provincial HMIS | **Policies developed:**
1. Reproductive health policy **Strategies formulated**
1. Maternal and newborn health road map
2. ASRH strategy
3. National Health Management Information System
**Guidelines developed**
1. Evidence based revision of STI guidelines
2. Evidence based revision of FP guidelines
3. Waiting Mothers Homes guidelines
**Studies and surveys Conducted:**
1. Maternal and Perinatal Mortality study
2. Fistula needs assessment
3. Male circumcision feasibility study
4. Adolescent and sexual and reproductive health assessment
5. National Reproductive health services assessment
6. Maternity waiting homes study
**Strengthening of the district and provincial HMIS**
- CO strengthened the district and provincial HMIS through training and installation of HMIS software in the institutions.
- Mashonaland Central was the pilot province where all district and mission hospitals have the DHIS software installed and in use.
- Details of some activities carried out in fulfillment of the MNH Road Map are
described under CP Output 2 below. The distribution of the revised guidelines has been done and the guidelines are currently being used for the management of the conditions. The MWH guidelines are currently being used to guide the support to the MWH refurbishment.

| Output 2: Increase availability of comprehensive gender sensitive RH services, including essential obstetric care | The activities carried out to achieve CP output 2 include:  
- Training of doctors and midwives  
- Provision of RH commodities  
- Infrastructure Refurbishment  
- Staff retention scheme through salary support with incentives | Status of the output 2 indicator: The RH assessment in March 2010 showed that: 
- The majority of primary health care facilities were not providing many of the EmONC signal functions. 
- Only 38% of the assessed district hospitals were offering comprehensive EmONC signal functions. 
- The least commonly provided signal functions were; assisted vaginal deliveries, MVA and blood transfusion. 
- The set target of 25% of primary care facilities offering basic EmONC has not been met due to various reasons, chief among them being the shortage of skilled staff. |

**Output indicator:** Proportion of institutions offering basic and comprehensive RH services including FP, MHC & EmOCN

**Target:** 25% by 2011

**Baseline:** 0% for primary health care facilities in 2005

1. Training  
- Support the training of doctors and midwives in EmONC, PMTCT, MVA, Jadelle implants  
- Since 2005, 3000 Doctors and midwives were trained in EmONC

**Status:** Most of those who were trained are no longer in service. 
- According to the RH assessment done in March 2010, of all the doctors in post, 10% were trained in EmONC, 4% in MVA and 4% ASRH, and 17% in implant insertion. Of the midwives in post 13% were trained in EmONC, 7% in implant insertion and 4% in ASRH. 
- Some of the reasons that could have contributed to this low number of people trained in post include:  
  - High staff attrition  
  - Trained staff being moved to work in other departments not offering RH services  
  - Staff promotion

2. Provision of RH commodities

2.1 Essential EmONC drugs, equipment and supplies  

**Status:** EmONC drugs, equipment and supplies were distributed to all levels of health facilities from central hospitals to primary health care clinics. 

**Achievements:** The RH services assessment done in March 2010 showed some general improvement in the status of RH services compared to the situation in 2007-2008. Variations in the availability of drugs were observed across the board with pronounced deficit at the primary level. Secondary and tertiary health institutions have managed to
achieve above 80% availability of EmONC drugs and supplies. The shortages in supplies and equipment were most pronounced at the primary and secondary levels.

### 2.1 Contraception
A total of 337 Community Based Distributors (CBD) and 60 group leaders were supported with allowances, uniforms and job aids (bicycles, motor cycles, fuel, and stationary)
- Doctors and midwives were trained to insert Jadelle implants

**Status:** CPR went up from 60% in 2005/2006 to 65% in 2009. Unmet need at 13% in 2005/6 and more in special groups like the adolescent and sexually unmarried women. The target for unmet need had been 10% by 2011. Status to be determined in the next DHS.

**Achievements:** The target of having attained a CPR of 65% by 2011 was achieved in 2009.
- Within the public sector, all service delivery points, including central, provincial and district hospitals, clinics and ZNFPC CBD and depot holders provide at least 3 modern methods of contraception.
- The increase in access of contraception in rural areas due to the training of CBDs and the increased variety of contraception through the training of doctors and midwives in Jadelle implants insertion are some of the factors that contributed to these achievements.

### 2.3 Manual Vacuum Aspiration (MVA)
- Doctors and midwives were trained in post abortion care, including MVA.
- 57 district and provincial hospitals received MVA kits

**Status:** There has been a low uptake of MVA by district hospitals despite the availability of the equipment.
According to the MWH study, only 40% of district hospitals were offering MVA as EmONC signal function. Some of the reasons for this low uptake include:
- Lack of skilled personnel in the MVA procedure
- Resistance to change from the conventional method of curettage to the MVA method

### 2.4 Blood transfusion coupons
- Blood vouchers for pregnant women introduced in 22 health institutions
- Plans underway to increase the national coverage.

**Status:** The RH services access barrier due to user fees was partly addressed by this intervention

**Achievement:** An initial assessment of the blood coupon system in 6 pilot institutions in 2009-2010 showed a reduction in maternal mortality due to obstetric hemorrhage. The intervention has since been expanded to 22 institutions across the country.
### 2.5 Mother Waiting Homes (MWH) Refurbishment

**Ambulance Refurbishment**

- 22 MWH at district hospitals were refurbished
- Garages were engaged to refurbish ambulances in the 22 districts selected for MWH Project.

Accessories like car batteries and tyres were procured for the ambulances.

**Status:** ANC coverage decreased from 94.3% in 2006 to 93% in 2009 against a target of 100% by 2011.

Institutional deliveries decreased from 72% in 2004 to 60% in 2009.

**Achievements:**
- The refurbishment of MWH has had a significant impact on increasing ANC coverage, institutional deliveries and PNC for both mother and babies.
- The refurbishment of the MWH saw an increase in utilisation of these homes and an associated increase in the number of women delivering in these institutions.
- MWH admissions have increased from an average of 23 to 58 pregnant mothers with some having floor beds, thereby surpassing the target of 50.
- In order to address the second delay, the refurbishment of the ambulances has improved the timely referral of obstetric and neonatal emergencies.

### 2.6 Cervical Cancer Screening and Treatment Equipment

- 24 Cryotherapy machines were procured
- Doctors and midwives trained in Visual Inspection with Acetic acid

**Status:** Cervical cancer remains the leading cause of cancer deaths in women in Zimbabwe.

Zimbabwe has one of the highest prevalence rates (54-62/100,000wy).

**Achievements:**
- 2 centers have started carrying out cervical cancer screening using VIA and treatment with cryotherapy

### 3 Human Resources Retention Scheme

- Salary incentives scheme

**Status:** Skilled birth at delivery declined from 73% in 1999 to 69% in 2006.

**Achievements:**
- Doctors, midwives and support staff working in maternity units have benefited from UNFPA supported salary top ups.
- This intervention helped to open 2 of the major maternity units at central hospitals in Harare during the health crisis.
2.1.2 Facilitating factors

Factors that have contributed to the positive results achieved in the RH component of the 5th CP include:

- The socio-economic and political environment has had a major bearing on implementation of programmes. With the formation of the Unity Government, the introduction of the multicurrency and the stabilization of the economy, the RH programme has been able to achieve significant progress in its programme implementation within a short period as indicated by the recently conducted RH services assessment. If the situation continues, the 6th CP should see major strides toward the attainment of the MDGs.
- The existence of the RH policy document before the commencement of the programme and the development of the other strategic and guideline documents have helped to create a clear working environment for all partners in the RH sector.
- The holding of regular quarterly RH Steering Committee meetings helped in ensuring strong coordination among UN agencies and the implementing partners.
- Increased awareness of the magnitude of the burden of maternal and newborn morbidity and mortality by the government through massive media coverage on MNH issues and advocacy.
- The Campaign for the Accelerated Reduction in Maternal Mortality (CARMMa) spearheaded by the Deputy Prime Minister, has helped in increasing public appreciation of maternal health issues and has helped in mobilizing resources for the RH sector.

2.1.3 Constraining factors

Constraints to RH programme performance include:

- The economic difficulties that Zimbabwe experienced, which escalated in 2007-8 resulted in a sharp decline in health provision due to poor facilities and equipment, rising costs and staff shortages and in the closing down of major hospitals.
- Political environment during the pre and post election period from March to September 2008 severely restricted NGOs from carrying out community activities and some of the activities such as the RH Steering Committee meetings were put on hold
- High staff attrition rate in health institutions due to poor remuneration coupled with massive staff exodus to neighboring countries and abroad
- Difficulty in mobilizing extra-budgetary resources due to donor fatigue.
- Poor transport and communication made the implementation of most interventions difficult. Most government vehicles broke down because of lack of maintenance.

2.1.4 Lessons learnt

- **CP Support:** Flexibility in modifying strategies and implementing modalities is important in responding to extraordinary circumstances like the one that prevailed in Zimbabwe during the life the 5th CP. For example the CO had to apply for waiver to enable it to support salaries for health workers in order to keep health institutions open, while the hyperinflationary environment made the procurement of goods and services from outside the country more cost effective.
2.1.5 Conclusion

Despite a favorable policy and strategic framework for provision RH services, the deteriorating socio-economic and political situation during the period 2007-8 which led to the total collapse of the health sector severely compromised the ability of UNFPA to fully achieve its target of supporting the MoHCW in reducing maternal mortality through increasing the availability of comprehensive gender sensitive RH services. During this period, the Country Office (CO) had to respond to emerging needs through resource mobilization to assist in meeting the bare minimum package for maternal and newborn health service provision. Hence the country is off track on its main goal of reducing maternal mortality and increasing access to skilled birth attendants at delivery.

The training of doctors and midwives in EmONC, though an effective intervention to improve response to maternal and newborn emergencies, found its impact compromised by the high staff attrition rate. With the stabilization of the health sector, UNFPA should strengthen pre-service training of doctors and midwives in the EmONC life saving skills as an efficient and cost effective way to ensure that skills are imparted on a large number of health personnel in a shorter period of time.

Despite the challenges, the CP successfully supported the MoHCW to formulate the MNH Road Map and other strategic documents like the ASRH strategy and HIMS strategy, which provided strategic framework to implement interventions to meet the CP outputs. Although the road map has provided the strategic framework for implementing evidenced based high impact interventions, there is currently no implementation, monitoring and evaluation plan for the Road Map activities. The exercise of conducting surveys and assessments before implementing some interventions, for example the WMH assessment, were helpful in formulating evidence-based activities and targets to be achieved.

2.2 HIV and AIDS

2.2.1 Introduction

Despite a decline in HIV seroprevalence from 24.6 percent in 2003 to 14.6 percent in 2009, Zimbabwe remains one of the hardest hit countries, with an estimated 3 200 AIDS related deaths a week and 160 000 new infections in 2005. The 5th CP sought to address national priorities in line with the Millennium Development Goals and was based on consultations with the Government of Zimbabwe and took into account crucial analysis of the HIV situation and the 2004 MDG progress report which identified areas for priority intervention. The outcome for HIV and AIDS was increased adoption and maintenance of safer sexual behaviours as well as increased utilization of HIV prevention services. The output was effective behavioral change promotion across sectors and at district as well as at community level targeting most at risk groups.

The bulk of UNFPA support in the 5th CP has gone towards HIV prevention and reproductive health, which between them take up a total of $19 million out of the total CO’s budget of $40 million. The Behaviour Change (BC) component is being implemented by eight partners in the country’s eight provinces -- Family AIDS Caring Trust (FACT) Mutare, ZICHIRe, Zimbabwe AIDS Prevention Service Organisation (ZAPSO), Batsirai Group, Regai Dzive Shiri, Matebeleland AIDS Council (MAC), World Vision and Midlands AIDS Service Organisation (MASO).
The major source of funding for the program was UNFPA and the Expanded Support Programme, the European Commission (EC), and the Global Fund Round 8. The National AIDS Council was responsible for the overall programme coordination while the programming partners were the Ministry of Health and Child Welfare (MOHCW), UNFPA and UNAIDS.

The National BC Strategy was developed in 2006 to guide interventions aimed at behavior change promotion in the country. The main areas of intervention include addressing multiple concurrent sexual relationships, inter-generational sex and incorrect and inconsistent condom use. In 2009, UNFPA supported the implementation of a behavior change programme in 26 districts. Since April 2010, the programme has been scaled up with support from the Global Fund, to cover an additional 35 districts, thus ensuring national coverage (see table).

Other HIV prevention programme components were condom promotion, male circumcision and the STI/HIV control programme targeting sex workers. On male circumcision, UNFPA provided technical and financial support to the Ministry of Health and Child Welfare (MOHCW) for the development of a MC policy, setting up a MC training centre at ZNFPC and establishing four pilot sites offering male circumcision.

2.2.2 Progress and Achievements

The table below outlines the CP programme outputs, the indicators used to measure progress, the activities that were undertaken as well as the progress and achievements made in the three HIV Prevention programme components -- Behaviour Change, Male Circumcision, Condom Promotion, STI/HIV Control and RH Programme for Sex Workers and the Adolescent Sexual and Reproductive Health programme.
| Table 2: Summary of Achievements in HIV and AIDS by CP Outputs, Indicators and Strategies |
|---------------------------------------------|-----------------|-----------------|---------------------------------------------|
| **ZUNDAF OUTCOME 4: Reduced number of HIV infections** | **County Programme Outcome:** Increased adoption and maintenance of safer sexual behavior as well as increased utilisation of HIV prevention services | **Outcome/Output** | **Indicator** | **Strategies/activities** | **Progress to date** |
| | | Country programme Outcome: Increased adoption and maintenance of safer sexual behavior as well as increased utilisation of HIV prevention services | The percentage of men and women reporting more than one sexual partner in the past 12 months Baseline: men 28.4%; women 9% Target: men 21.3%; women 6.8% | Training of IP staff Sensitizing people on BC Training of community leaders Development and implementation of district level action plans Strengthening leadership in behavioural change promotion | The percentage of men and women reporting more than one sexual partner in the past 12 months reduced from 28.4% to 20.9% and from 6.8% to 3.2%, for men and women respectively. |
| | | Effective behavioural change promotion across sectors and at district as well as community level targeting most at risk groups | Number of persons reached through IPC on HIV prevention behavior change (person exposures): Baseline: 0 in 2007 Target: 9,750,000 by end of 2011 | Through UNFPA’s support to the BC programme, 8.2 million inter-personal communication exposures were recorded by community BC facilitators in 16 districts.  
- recruitment and training of 190 staff positions and 84 interns.  
- Sensitization of 430,694 persons on BC by end of September 2010  
- Sensitization of 9,922 community leaders on BC by end of September  
- Development and implementation of 924 community action plans by end of September 2010 | |
<p>| | | Number of men accessing male circumcision services Baseline: 0 in 2007 Target: 1.2 million by 2015 | Carrying out of situation/response analysis Development of a national MC policy on MC carried | Through support to the establishment of 5 MC sites, 1102 clients were circumcised by Sept 2010. |</p>
<table>
<thead>
<tr>
<th>Establishing MC pilot sites</th>
<th>Training service providers in MC</th>
<th>Carrying out of male circumcisions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>a situation/response analysis on male circumcision was carried.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>a MC policy was developed.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>XX health service providers were trained in MC</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of sex workers provided with STI/HIV services</th>
<th>Establishment of referral and outreach centres for sex workers</th>
<th>Through UNFPA's support for the STI/HIV control program, 1 800 sex workers were provided with STI/HIV information and treatment services.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline: 0 in 2007</td>
<td>Training of peer educators to mobilize sex workers</td>
<td>2 referral sites and 16 outreach centres for STI/HIV control program for sex workers were established.</td>
</tr>
<tr>
<td>Target: to be decided based on size of estimates</td>
<td>Training nurses</td>
<td>31 peer educators were trained</td>
</tr>
<tr>
<td></td>
<td>Provision of health services to sex workers</td>
<td>150 000 Bioline Rapid Syphilis test kits were procured and distributed to the sites and 60 000 RPR test kits for syphilis testing.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>340 nurses were trained on STI management and 240 nurses were trained on rapid syphilis testing.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of condoms distributed</th>
<th>Procurement and distribution of condoms</th>
<th>UNFPA supported the procurement and distribution of 2.7 million female and 57 million male condoms in 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline: 2.1 million FCs in 2006</td>
<td>Training of health service providers and community based distributors</td>
<td>- 164 health service providers and 64 community based distributors in condom promotion activities</td>
</tr>
<tr>
<td>Target: 3.3 million in 2010</td>
<td>Male condoms: 95 million by 2011</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
2.2.3 Facilitating factors

The major facilitating factors for the success of the HIV Prevention programme include:

- Easy access to VCT which was facilitated by the BC implementing partners who made mobile VCT available to those who had gone through the Love and Respect training.
- Training in proper condom use and easy access to condoms encouraged those who were being trained by BCFs and by youth peer educators to use condoms.
- Access to ART encouraged people to go for VCT in the knowledge that if they tested positive they could get treatment.
- Community leaders’ support for the BC programme was a big push factor for, particularly for men who were initially skeptical to join.
- The training that nurses running the Drop in Centres for sex workers and the mobile outreach services received encouraged sex workers to use the facilities as staff was non-judgmental and did not stigmatize them.

2.2.4 Constraining factors

- The BC programme is losing BCFs due to volunteer fatigue and because of the low incentives paid. Volunteers are paid $10 a month, which is too low if one considers the work they do. As the programme expands, volunteers are walking longer distances to run training courses and sometimes have to use public transport at their own expense.
- Although the L&R training has now been reduced to seven weeks, communities feel that this is still too long and that the programme should be further condensed.

2.2.5 Lesson learnt

- When leaders have been trained, it is easier to mobilize people in the community. There is also need for the programme to be sensitive about the periods when they can call meetings. When the farming season starts, people are busy in their fields and so it is not the time to be calling training meetings.

2.2.6 Conclusion

The BC programme has been a major success as it has achieved broad geographical coverage and also because of the positive changes in behavior that are being recorded in VCT and condom uptake as well as in the reduction of stigma and discrimination. The roll of out of the programme in the remaining 35 districts means that the programme is now covering the whole country. Going into the next CP, it will be necessary to consolidate the gains that have been made by ensuring the retention of BCFs and by increasing male and youth participation. Attention will also need to be paid to speeding up disbursement of funds to partners reduce delays in programme implementation that have characterized the current phase. More effort will also need to go into raising awareness about male circumcision in anticipation of the national roll out following the success of the pilot phase.

Male circumcision has proved popular, but the service is currently available in the pilot sites. Plans are now underway for a national roll out of the programme that is targeting to circumcise 1.2 million men by 2015. But to achieve the target there will be need for a national roll out of the programme and for initiatives to raise awareness among men on the importance of circumcision.
There is a high demand for the BC programme in schools, but the L&R manual is not suitable for in-school youths as it mainly targets married couples so there is need to factor this in when taking the manual into schools. There is also little or no linkages between the ASRH programme and the BC programme so there is need to foster linkages between the two as they both aim at HIV prevention and behavior change. The involvement of men remains a challenge in the BC programme. There is need to come up with strategies that will increase male involvement.

What worked well in the BC programme was ZAPSO’s initiative of involving youths in ball games, organizing tournaments and giving them prizes. ZAPSO also hold quiz competitions for the youths. The initiative is very popular with youths, particularly in the rural areas that are starved of entertainment. It is also educative as HIV messages and talks are given before the games. ZAPSO came up with the youth programme after realizing that there is usually only one youth friendly centre in a district, which the majority of youths cannot access.

2.3 Adolescent Sexual and Reproductive Health

2.3.1 Introduction

UNFPA supported ZNFPC and the MOHCW to increase the utilization of youth-friendly sexual and reproductive health (SRH) services at district level. The Adolescent Sexual and Reproductive Health (ASRH) programme was implemented with financial support from EC and focused on the provision of youth friendly services, through youth centres and youth friendly clinics and information dissemination through peer educators in 16 districts.

2.3.2 Progress and Achievements

As initially planned, the programme was supposed to be scaled up to 30 districts. However a mid-term evaluation report carried out in 2007 found that the programme was under-performing and recommended that rather than expanding the programme, it should be consolidate in those 16 districts where it was already operating. Some of the major achievements of the programme include the development of an ASRH strategy, the training of nurses in youth friendly service provision and the training of young people as peer educators. Other achievements are highlighted in Table 3 below.
**Table 3: Summary of Achievements in ASRH by CP Outputs, Indicators and Strategies**

**ZUNDAF Outcome:** Improved access to quality and equitable social services, reduce the spread of infection, improve quality of life of those infected and mitigate the impact of HIV and AIDS

**Country Programme Outcome:** Increased adoption and maintenance of safer sexual behaviours and increased utilization of HIV prevention services

<table>
<thead>
<tr>
<th>Output</th>
<th>Indicator</th>
<th>Strategies/activities</th>
<th>Progress to date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased coverage and utilization of high quality gender-sensitive and youth friendly HIV and STI prevention services</td>
<td>Number of young people reached by peer educators on SRH</td>
<td>• Development of the ASRH strategy</td>
<td>• ASRH strategy developed and launched</td>
</tr>
<tr>
<td></td>
<td>Baseline: 64 882 in 2009; target 74 614</td>
<td>• Support to youth friendly health services</td>
<td>• 309 nurses trained in youth friendly youth friendly service provision by 2009</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Support to peer education programme</td>
<td>• 413 young people trained as peer educators by 2009</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Training of nurses in youth friendly health provision</td>
<td>• Furniture and equipment was distributed to all 215 health facilities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Establishing young people’s networks</td>
<td>• 4 capacity building workshops were held for 188 youths in 16 districts</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Training of peer educators</td>
<td></td>
</tr>
<tr>
<td>Number of health facilities offering youth friendly services</td>
<td>Number of health facilities offering youth friendly services</td>
<td></td>
<td>215 health facilities are offering youth friendly health services</td>
</tr>
<tr>
<td>Category</td>
<td>Baseline/Target</td>
<td>Outcome</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Number of young people accessing youth friendly health facilities</td>
<td>Baseline: 34 396 in 2005; target 15% increase</td>
<td>64 571 young people accessed youth friendly health facilities</td>
<td></td>
</tr>
<tr>
<td>Number of youths treated for STI</td>
<td>Baseline: 5 542; target 15% annual increase</td>
<td>9 339 young people were treated for STIs</td>
<td></td>
</tr>
<tr>
<td>Number of youths accessing VCT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of young people accessing contraceptives</td>
<td>Baseline: 18 735; Target: annual increase of 15%</td>
<td>70 840 young people accessed family planning services (an increase of 278%)</td>
<td></td>
</tr>
<tr>
<td>Number of young people reached by peer educators on SRH and BCC</td>
<td>Baseline: 64 882</td>
<td>301 696 young people were reached by peer educators on SRH and BCC issues</td>
<td></td>
</tr>
</tbody>
</table>
2.3.3 Facilitating factors

- ZNFPC long experience in running peer education programmes
- Training of nurses in youth friendly service provision
- Establishment of young people’s networks

2.3.4 Constraining factors

Because of the economic crisis that prevailed during most of the project implementing period (2006 -- 2009) several challenges were experienced that affected implementation:

- The high attrition of nurses, including those who had been trained in youth friendly services, resulted in youths failing to access services and the need for retraining. For example, in Bulilima and Mangwe, all 32 youth friendly nurses trained in 2005 left the two districts, requiring retraining of nurses. There was also reluctance by nurses to fill in the Management Information Systems (MIS) forms as they argued that it was too cumbersome and they were not paid for it.

- The high inflation rate between 2007-08 sharply reduced the value of the allowances paid to peer educators. This was made worse by late disbursement of the allowances by ZNFPC. This resulted in low morale and in reduced commitment to the programme by the peer educators who were no longer filling in forms. Since the project ended in 2009, the peer educators are no longer getting any allowances and according to ZNFPC, very few of them are still active.

- In 2008, ZNFPC reduced monitoring visits from monthly to quarterly due to resource constraints. As a result, there was little information flowing from the health centres to the provinces and vice versa. Regularity of monitoring visits was also affected by the lack of transport by ZNFPC as they had no vehicles dedicated to the programme.

- As a result of these challenges, the monitoring and MIS systems were weak and inadequate due to non-collection of data and incomplete data being submitted both at provincial and national levels.

- During much of 2008, the hyper-inflationary environment pushed up the costs of hiring training venues. As a result, the project used three times more money for the training than what should have been used. Some of the equipment bought for the project was of poor quality and not durable. For instance, the radios that were procured for the youth centres lasted less than three months. The replacement batteries for the radios were the wrong size and did not fit. The soccer balls bought for the programme were unusable after one or two games, while the chess sets acquired were also not durable.

- Some UNFPA decisions also affected project implementation. While ZNFPC allocated each peer educator a bicycle which they could take home and use to come to the health facility and also for outreach work, UNFPA only provided one bicycle per health centre, which the peer educators could not take home. This meant that some PEs had to walk distances of up to 8kms to fetch the bicycle from the health centre for their field work and return it at the end of the day and walk the other 8kms home. UNFPA also funded two peer educator positions from the four that ZNFPC had been working with. ZNFPC argues that funding less peer educators did not take into account the high attrition rate among the youths and as a result, some centres ended up without peer educators.

- Coordination of the programme was poor. The ASRH Coordination Forum does not seem to be functioning well and meetings have been irregular instead of quarterly as originally envisaged. The poor coordination manifests itself in the poor linkages between ASRH and the lifeskills programmes in schools and between ASRH and the BC programme although they should be complementary.
2.3.5 Lessons learnt
Youth are a highly mobile group as they are starting out in life and are developing their careers. Youth peer education programmes should factor in their mobility and high attrition rates by training them in larger numbers to make up for those who will be lost along the way due to the high mobility.

2.3.6 Conclusion
Although ZNFPC has been running the peer education component of the ASRH programme since its inception and over the years has developed expertise in peer education, it has failed to expand the programme beyond the initial 16 districts. It has also failed to come up with strategies to ensure the sustainability of the programme and as a result attrition of peer educators remains high because of low incentives and the resultant low motivation.

There has been a failure by the programme to think through a more innovative system of incentives for youth peer educators other than the allowances. For instance, consideration could be given to other incentives such as linking the youth to training in life skills (carpentry, radio repair, welding etc) programmes run by other organisations. Other possibilities could be to negotiate preference for tertiary training (nurses, teacher training and vocational training) to youths who would have served as peer educators. This would motivate the youths and obviate the need for financial incentives, which are not sustainable.

ZNFPC has also not managed to put in place robust monitoring and supervision systems for the programme. Currently youth peer educators are supervised by CBD group leaders, who in the majority are elderly and not able to cope. ZNFPC also lacks a presence at district level where the peer education programme operates, making it difficult for them to provide oversight.

Given these problems, UNFPA should consider whether continued support to ZNFPC will achieve the desired results or whether the programme would be better run by NGOs with greater a presence at district level, along the lines of the BC programme, who would be able to provide the necessary supervision and also to come up with more innovative strategies to expand the programme.

2.4 Population and Development

2.4.1 Introduction
The Population and Development (P&D) component relates to ZUNDAF Outcome 2 which calls for the need for enhanced national capacity and ownership of development processes in order to achieve the Millennium Development Goals by 2015. In the context of the 5th CP, the P&D component seeks to improve the utilization of disaggregated data in development planning and to strengthen national capacity to formulate, implement and monitor pro-poor policies. The priority to be addressed is the dearth of current data that has forced policy and decision makers as well as other users of statistics to either use estimates or conduct their own ad hoc rapid assessments. Another problem is limited capacity and skills to formulate, implement and monitor pro-poor policies. In line with its two main objectives, the P & D component is made of two outcomes and four outputs as reflected in Table 4 below. In addition to Outcomes and Outputs, the table also includes strategies used, progress achieved to date and indicator of progress together with baseline data and the target.
The P&D component is being operationalized through two main interventions. The first one: Data for Development addresses Outcome 1 and its corresponding Outputs 1 and 2. Its Implementing partner is the Central Statistical Office (CSO), recently renamed ZIMSTAT. Other national institutions involved in the implementation includes the Ministry of Local Government, Public Works and Urban Development and the Ministry of Labour and Social Welfare. The second intervention: Population Dynamics and Inter-Linkages addresses Outcome 2 and the two remaining Outputs 3 and 4. The Ministry of Economic Planning and Investment Promotion (MOEP&IP), formerly known as Ministry of Economic Development. The P&D component, like the two other CP components, is being implemented nationwide.

2.4.2 Progress and Achievements

Table 4 below provides a summary of progress and achievements in P & D.
Table 4: Summary of Achievements in P & D by CP Outputs, Indicators and Strategies

ZUNDAF Outcome 2: Enhanced national capacity and ownership of development processes towards the attainment of the MDGs by 2015

CP Outcomes:

2.1. Improved utilization of age and sex disaggregated population and developmental related data, and

2.2. National and sub-national and sectoral policies, plans and strategies take into account population and development linkages

<table>
<thead>
<tr>
<th>Output</th>
<th>Indicator</th>
<th>Strategies</th>
<th>Progress to date</th>
</tr>
</thead>
</table>
| 1. Increased availability of sex and age disaggregated data at national and sub-national levels | Percentage of household surveys conducted by CSO for which reports are produced on time (Baseline: 60% 2005 Target: 75% by 2007 and 100% by 2008) | - Developing and implementing a 10-year data collection plan  
- Conducting the 2010 DHS  
- Preparing for the 2012 national population census  
- Strengthening of the national Health Information System  
- Establishment of an Integrated Management Information System (IMIS) at CSO which feeds into ZIMDAT | - Marked improvement in data collection, processing, analysis & reporting with nearly 100% proportion of timely reporting.  
- Processing, analysis & report 2005/6 ZDHS completed  
- Processing, analysis & report 2008 ICDS completed.  
- Processing, analysis & report 2009 MIMS completed  
- ZIMDAT updated & maintained annual basis  
- Establishment IMIS national data base  
- 2010 ZDHS & 2012 Population Census ongoing |
<table>
<thead>
<tr>
<th>Output</th>
<th>Indicator</th>
<th>Strategies</th>
<th>Progress to date</th>
</tr>
</thead>
</table>
| 2. Enhanced national capacity to monitor progress towards the MDGs,  | Percentage of MDGs, ICPD and CEDAW indicators which are included in ZIMDAT | • Strengthening national capacity to facilitate availability & utilization of relevant data at the national and sub-national levels including through the maintenance, updating and dissemination of ZIMDAT| • By 2009, at least 75% of all indicators combined included in ZIMDAT  
• Greatly increased skills of 50 CSO staff through in GIS, REDATAM, M&E, sampling techniques, census data processing, etc.. Updating IMIS &ZIMDAT  
• Rollout ZIMDAT to provinces  
• Backlog on recording cause of death cleared  |
|                       ICPD, CEDAW, and national development frameworks              | (Baseline: 40% included 2005)                                              |                                                                                                                                            |                                                                                                                                                                                                             |
| 3. Improved national capacity to integrate gender, population and    | Proportion of national and sub-national policies, strategies and plans that | • Supporting national trainings to strengthen the capacity of personnel to integrate population, RH & gender issues, including training in gender responsive budgeting into the development planning processAdvocacy for integration of P&D factors across multiple sectors | • At national level, inclusion HIV and AIDS, gender, poverty and human right; but not at sub-national levels  
• Establishment PDU  
• Training PDU officers in population issues  
• Study tours for PDU officers & senior officials to Ghana and Mauritius  
• The 1998 Population Policy revised  
• Draft MTP includes chapter on Population and development linkages.  
• Active part by UNFPA in ZEDS formulation; STERP includes RH, MM &IM concerns as well as HIV and AIDS  |
<p>|                       development issues into national and sectoral          | reflect HIV/AIDS, gender, human rights and poverty                         | • Support for the strengthening                                                                                                           |                                                                                                                                                                                                             |
|                       development policies and strategies                   |                                                                           |                                                                                                                                              |                                                                                                                                                                                                             |</p>
<table>
<thead>
<tr>
<th>Output</th>
<th>Indicator</th>
<th>Strategies</th>
<th>Progress to date</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Increased political support for the incorporation of key population and development factors in poverty alleviation strategies</td>
<td>National poverty strategy includes all major ICPD and MDG targets</td>
<td>• Advocacy for integration of P&amp;D factors across multiple sectors</td>
<td>• Increased political support noted, however NPP yet to be adopted</td>
</tr>
<tr>
<td></td>
<td><em>(Baseline: National poverty reduction strategy no yet in place)</em></td>
<td>• Support for the strengthening of networks of parliamentarians and media on P&amp;D</td>
<td>• MTP adopted the nationally agreed MDG targets</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Draft revised NPP also revised its targets to be consistent with the MDG targets</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• ICPD @15 Report 2009</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Establishment PDU</td>
</tr>
</tbody>
</table>
As reflected in the table, all key activities planned in relation to output 1 were completed, except for the 2010 ZDHS that is due for completion in December 2010 and the preparations for the 2012 Census that will continue in 2011. UNFPA worked in collaboration with UNICEF, UNDP and CSO to continue to update, maintain and disseminate ZIMDAT on an annual basis. The data from the 2005/6 DHS, the first formal joint UN programme in Zimbabwe between UNFPA, UNICEF and UNDP provided not only updated age and sex-disaggregated statistics on health indicators, but also included HIV and AIDS for the first time. Coming right after were more updated sex and age- disaggregated data in the context of the 2008 ICDS. During the period under review, ZIMSTAT conducted altogether a total of six surveys. They were all processed, analyzed and published on time, thus contributing to increasing availability of age and sex-disaggregated data at national and sub-national levels and to progress toward Outcome 1. UNFPA contributed financial and technical resources to the 2005/6 ZDHS, the 2008 ICDS and the 2010 ZDHS, but in different ways to all the other surveys through its leadership of the Working Group on Data for Development, one of the most effective Working Group whose achievements include the two only UN joint programmes in Zimbabwe. It is worth noting that one of those programmes, the 2005/6 ZDHS, was selected by UNDG among forty other joint programmes evaluated as best practice within the UN system.

In relation to Output 2, strengthened staff capability at ZIMSTAT has by far been the greatest achievement, for it made possible not only the updating of ZIMDAT and IMIS, but also the national rollout of the National Health Information System (NHIS) well as the rollout of ZIMDAT to provinces resulting in greater awareness of the data base and its usefulness for monitoring development indicators. The incorporation of most MDG, ICPD and CEDAW indicators into the data base made the monitoring and reporting of these indicators easier. UNFPA financial and material support to ZIMSTAT for coding the cause of death was significant in that it enabled ZIMSTAT to clear the backlog in coding for the years 2002-2006. But ZIMSTAT has fallen back again, being up to date only to the year 2007. Even though already mentioned, it needs repeating that UNFPA collaborated with other UN agencies, particularly UNICEF and UNDP, in implementing the data for development programme. This was achieved through the implementation of a joint annual work plan which was developed, implemented and reviewed jointly. The ultimate expression of this collaboration has been the two only UN joint programmes in Zimbabwe, namely the 2005/6 ZDHS and the 2010 ZDHS.

The activities related to Output 3 were also completed resulting, as reflected in the table, in the establishment of the Population and Development Unit (PDU). This was a significant achievement, in view of the fact that, following the merger of the National Economic Commission (NEPC) with the Ministry of Finance in 2000, population were sidelined as focus shifted to macroeconomic stabilization issues. No other institution was entrusted with the coordination and monitoring of population issues. Although the 1998 National Population Policy (NPP) was updated and a revised version was produced in November 2009, it has not yet been adopted by Cabinet. For this reason all awareness raising activities hinging on the approval of the revised NPP have not been implemented. Technical support was provided by UNFPA through consultants who supported the Ministry of Economic Planning in reviewing and in validating the NPP.
During the 5th CP period three major policy frameworks were formulated: The “Zimbabwe Economic Development Strategy” (ZEDS) (2008), The Short Term Emergency Recovery Programme (STERP) (February 2009-December 2009) and the Mid Term Plan (MTP) (2010-2015). UNFPA took an active part in the ZEDS development process to ensure that key population issues were incorporated into the plan. However ZEDS was never finalized nor implemented. STERP did include gender and HIV and AIDS concerns while the draft Mid Term Plan devoted a chapter on Population and Development, in addition to dealing with gender, HIV and AIDS and poverty. While these issues have been integrated in development frameworks at the national level, the evaluation team found no evidence that the same effort was made at the sub-national level.

The key activities planned to achieve Output 4 relate to the Revised National Population Policy and are concerned with disseminating the Policy, raising awareness on population issues, capacity building by supporting the four PDU officers to attend relevant population courses, workshops and study tours and participating in Regional meetings on population issues. While the NPP has been revised, the delay in its adoption by Cabinet has meant that activities linked to its adoption, namely the dissemination of the Policy and awareness raising about population issues, have not taken place. Nevertheless thanks to enhanced capacity building of the PDU staff, the integration of population factors into the draft MTP was made possible. It is worth noting that not only did the MTP integrate population issues, it also adopted the nationally agreed MDG targets as did the draft revised NPP.

2.4.3 Facilitating factors
A number of factors have contributed to the overall positive results achieved in the P&D programme. The most important include the following:

- The increased capacity of ZIMSTAT to effectively carry out statistical duties;
- The use of the scanning technology to capture data, resulting in greatly reduced data processing time;
- Timely availability of key demographic and health data;
- Regular quarterly review meetings between UNFPA and Implementing partners;
- Strong coordination among UN agencies and some bilateral through the Working Group on Data for Development;

2.4.4 Constraining factors
Constraints that have affected the implementation of the P&D programme included the following:

- A resource- constrained environment, leading to inadequate financial resources to support the programme, in particular the 2012 Population Census;
- High staff turnover and delays in replacing them;
- Inadequate sensitization of the public about the 2010 ZHDS and the 2012 Population Census.
2.4.5 Lessons learnt

- Continuous capacity building efforts involving a large number of trainees in the various areas of an intervention is an antidote in an environment of high staff turnover.
- Coordination of interventions by donors combined with the implementation of joint programmes has proven to be an effective strategy to deliver assistance.
- Integration of population factors in sub-national planning frameworks does not automatically occur because it has taken place at the national or central level. A deliberate effort to that effect is required with provincial and district Planning Committees.
- In order to be effective sensitization of the public on data collection interventions, including mapping and enumeration, must be carried out over a reasonably long period of time using multiple channels, including, as appropriate, neighboring countries TV stations.
- The inability of UNFPA and Government to mobilize sufficient resources for pre-enumeration activities for the 2012 Population Census, in particular the lack of vehicles is constraining mapping operations.
- The annual updating of ZIMDAT with recent data and increasing number of indicators for MDGs, ICPD and CEDAW had made easier monitoring and reporting on these indicators.

2.4.6 Conclusion

A major achievement of the 5th CP in the P&D component has been the marked improvement in data collection, processing and reporting. In comparison to 2005 when only 60% of the household surveys had their reports produced on time, the proportion was nearly 100% at the time of the evaluation. By the end of 2009, most of the MDG, ICPD and CEDAW indicators in Zimbabwe had been incorporated into ZIMDAT. While in 2005 only 40% of them were included, at least 75% of MDG, ICPD and CEDAW indicators combined had been incorporated by the time of the evaluation.

Both national frameworks, STERP and MTP, formulated during the 5th CP, included HIV and AIDS, gender and poverty concerns. At the provincial and district levels, there was no evidence that a deliberate effort had been made to integrate population factors into development planning. This is due to the fact that capacity building in integration of population factors into development planning focused only at the central level with only one institution at the expenses of sub-national levels. Even then the beneficiaries of the training confessed to the evaluation team that their training had been less than satisfactory, as they still felt lacking in integration skills.

After an eight-year period during which population issues were sidelined, the establishment of the PDU, the revision of the NPP and capacity building for PDU staff went a long way in restoring appreciation for population issues. At the time of the evaluation, there was still no national poverty strategy to gauge the inclusion of “all major ICPD and MDG targets” which is the indicator for Output 4. There is no denying
however that all the activities implemented in connection with the PDU and the revised NPP helped keep population issues in the mainstream of development. However the momentum generated by the establishment of the PDU seems to have been lost. More than one year after the it was validated by stakeholders; the revised NPP is yet to be adopted by Cabinet. This may be a reflection of the lack of a strong institutional framework for coordination and implementation of population programmes.

Once the NPP and the MTP have been adopted, their effective operationalization will require the availability of trained personnel in sectoral integration. Some years ago, UNFPA and the African Development Bank (ADB) had developed a manual on population integration in development planning. The CO may wish to avail itself of that manual. Training in integration will also be needed for planners at sub-national levels if the CP objective of enhanced national capacity to monitor development progress and to utilize relevant data at sub-national levels is to become a reality.

The evaluation mission found that coordination within the UN system was at its best when agencies did not only have joint planning exercises, but had also actual joint programmes. The examples of the two only joint programmes in Zimbabwe, the 2005/6 and the 2010 ZDHS, should be followed by more joint programmes in other thematic areas.

In conclusion, it can be said that, through the implementation of the P&D component, the 5th CP made good progress towards the achievement of its two outcomes of improved utilization of population and development-related data disaggregated by age and sex as well as that of integrating population and development factors in national planning frameworks. With regard to the latter, the integration took place only at national level, but not at sub-national level.

2.5 Gender

2.5.1 Introduction

The Gender programme was designed to address nationwide problems of domestic and gender-based violence (GBV). To illustrate the magnitude of GBV in the country, the Zimbabwe Development Health Survey (2005-2006) states that women and girls are 99% victims of GBV, 47% of women have experienced either physical or sexual violence or both, and 25% of women have been sexually abused. The key focus area of the gender programme in the 5th CP was the implementation of Domestic Violence Act (DVA) which was enacted in February 2007 as an overall strategy to address gender-based violence in the country. The GBV programme was implemented in the framework of international, regional, and local conventions, legislations, and policies that aim to promote and protect the rights of women and girls for improved quality of life.

Some of these include the Convention on the Elimination of all forms of Discrimination against Women (CEDAW, 1991), MDGs particularly MDG 3 (Improve gender equality and empower women), Beijing Platform of Action, Protocol to the African Charter on Human and People’s Rights on the Rights of Women in Africa (2008), the African Union Convention for the protection and assistance of the internally displaced persons in Africa (2009), Domestic Violence Act (Zimbabwe, 2007), and Zimbabwe National Gender Policy.
Implementation was through a multi-sectoral approach which involved the Ministry of Women Affairs, Gender and Community Development (MOWAG&CD) that played a coordinating/facilitative role as well as various civil society organizations that implemented activities at community level. GBV programme had greater coverage in urban and peri-urban areas than in rural/remote areas and the most common explanation which was given for this disparity is the limited resources available that constrained reaching out to all provinces, districts, wards, and villages.

2.5.2 Progress and Achievements

The table below provides progress status on outcome and achievements of the two GBV programme outputs.
Table 5: Summary of Achievements in Gender by CP Outputs, Indicators and Strategies

<table>
<thead>
<tr>
<th>ZUNDAF Outcome 4: Reduced negative social, economic, political, cultural and religious practices that sustain gender disparity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Country Programme Outcome: Strengthened institutional mechanisms and socio-cultural practices that promote and protect the rights of women and girls and advance gender equity</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CP Outcome level</th>
<th>Indicators</th>
<th>Strategies/activities</th>
<th>Progress to date</th>
</tr>
</thead>
</table>
| Strengthened institutional mechanisms and socio-cultural practices that promote and protect the rights of women and girls and advance gender equity. | National and sub-national mechanisms in place and effectively implemented to monitor and reduce gender-based violence and advance gender equity. 
*Baseline:* Gender Policy in place 
No national GBV database | UNFPA provided support to strengthen Ministry of Women Affairs, Gender and Community Development | Institutional capacities remain limited, efforts to date demonstrate that if the momentum is maintained, the outcome will be achieved in few years to come.  
- MOWAG & CD with support from UNFPA and others partially (in terms of national coverage) coordinated GBV activities in the country  
- UNFPA supported establishment of National Anti-domestic Violence Council but has been partially functional |

Country Programme Outputs

| Output 1: Enhanced institutional and technical capacity to formulate, | National GBV Database in place. Domestic Violence Bill passed. Number of cases processed using the GBV law. Number of | Strengthening data collection and utilization as well as referral systems and support services for | Commendable work has been done to improve response services and continued strengthening is still required. National GBV database is still not in place.  
- MOWAG & CD received technical capacity support to influence the formulation of pro-women and girls legislation and policies as well as to scale up implementation, monitoring and evaluation of GBV programmes. |
implement, monitor, and evaluate policies and programmes to combat GBV.

<table>
<thead>
<tr>
<th>CP Outputs</th>
<th>Indicators</th>
<th>Strategies/activities</th>
<th>Achievements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Output 2:</td>
<td>Number of interventions undertaken to strengthen the gender analysis skills for members of Parliament on UNFPA areas of work. Percentage of women in Parliament Baseline: Two</td>
<td>Community sensitization/advocacy work. Involvement and participation of community leaders, religious leaders, women, girls, men and boys. Strengthening media partnerships</td>
<td>Great job has been done to raise awareness. Overall, GBV interventions are still at foundational level. Resource capacity of local NGOs is still limited to fully rollout GBV programme.</td>
</tr>
</tbody>
</table>
|            |                                                                           |                                                                                      | • Over 200 NGOs identified which are working on GBV programmes nationwide
|            |                                                                           |                                                                                      | • UNFPA provided technical, financial and resources support to IPs to enable them respond to GBV meaningfully; provision of vehicles, computers, printers, budgetary support to staff salaries
|            |                                                                           |                                                                                      | • Interventions have been carried but not consistently 3 every year.
|            |                                                                           |                                                                                      | • Of members of Parliament and Senate, 16% and 36% are women respectively.  |

Interventions undertaken to promote the implementation of the law and GBV prevention.

Baseline: No national GBV database. Existing laws do not adequately address GBV.

- Since 2005, UNFPA supported campaigns for and subsequent enactment of Domestic Violence Act
- Law reform process started (e.g. Inheritance laws, Marriages Act, sexual offences Act)
- UNFPA supported establishment of Anti-Domestic Violence in 2008 but it has remained partially functional
- Support for capacity strengthening of Victim Friendly Units (VFUs) through training of police officers to ensure domestic and GBV issues are handled well at police stations
- UNFPA supported the development of standard guidelines as part of the strategy to address GBV. For instance, Guide for Survivors of Rape and Sexual Assault as well as Police Handbook on Managing GBV
- UNFPA supported setting up of three one-stop centres in three districts as an attempt to address difficulties most women and girls face in accessing services (health, legal aid, psychosocial support, and judiciary) by bringing the services under one roof at district level
- Through support from UNFPA and other partners, in 2009 MOHCW established Adult Rape Clinic (ARC) at Parirenyatwa Hospital in Harare and the services are still confined to Harare and Chitungwiza.
and the media to advocate for the empowerment of women and girls.

| Interventions carried out on the Domestic Violence Bill | and network of women ministers and parliamentarians on advocating for attitude change and pro-women legal and policy environment. | - Through UNFPA support, IPs sensitized and raised awareness on services available to survivors of GBV (health, legal aid, judiciary, psycho-social support, security) – led to improved access
- An upward trend in reporting on GBV by women in programme areas
- Attitude towards women and girls is reported to be changing due to relatively more men and religious leaders involvement in communities
- UNFPA supported guidelines and training modules for GBV service delivery
- GBV knowledge base established through training of trainers of District Development Officers, Community Development Officers, Provincial Gender Focal Persons, and Community-Based Counselors
- DVA translated into vernacular for improved comprehension and reaching a wider audience nationwide
- UN family improved joint programming for GBV programming – this could also be done at implementing partners’ level. |

**Target:** Percentage of women in Parliament 50% by 2011

**Target:** 3 interventions annually with Parliamentarians on RH, HIV, and Gender
2.5.3 Facilitating factors

Based on the information obtained from past reports, Government officials, implementing partners, community leaders, men, boys, and survivors of GBV, the following are believed to have been the key facilitating factors for the achievements realized to date on gender activities:

- Improved socio-economic and political environment
- Coordination by the Ministry of Women Affairs, Gender and Community Development and other Government line ministries
- An improved national legal and policy environment (Domestic Violence Act, National Gender Policy, National Behaviour Change Strategy, Health Management Guidelines, National AIDS Policy, Sexual Offences Act)
- The existing international and regional conventions on women and girls
- Joint programming/thematic approach employed by UN agencies on GBV response
- Leveraging among implementing partners in the implementation particularly the synergy between women’s and men’s organization in working together on DV and GBV interventions
- Acceptance by local authorities throughout the country which made it possible to work in communities
- Involvement/participation and buy-in by community leaders including traditional and religious leaders – as community opinion leaders, helped to influence change of attitude among community members.
- Prioritization of MDG3 (Improve gender equality and empower women) by the government
- Improved involvement of men and boys (though no baseline information for comparison purposes) in gender issues through participation of men’s organizations – attributed to an approach whereby they are taken as partners rather perpetrators
- Use of local languages and some recognition of positive cultural practice gave the GBV programme a local context/outlook people could identify with

2.5.4 Constraining factors

- **Service provision:** Availability and access to services remain limited throughout the country particularly health, legal aid, judiciary, and security.

- **Coordination mechanisms:** GBV efforts both at UN agencies’ and implementing partners' levels are fragmented contributing to resources being stretched thin resulting in less than meaningful results (coverage, quantity and quality) and duplication is inevitable.

- **Funding:** Current funding for GBV interventions is insufficient and short-term in nature. UNFPA should provide long-term funding as the impact of the interventions can only be achieved over a long period. Substantial and long-term funding would also enable broadening the geographical coverage nationwide and depth of programme activities. This is cognizance of the fact that the
government is experiencing budgetary constraints, shortages of skilled personnel, equipment and supplies.

- **Shifting focus of support:** The implementing partners cited that UN agencies (including UNFPA) tend to shift focus of projects they support sometimes midway or on the eve of project completion. This is reported to have resulted in some projects to be partially completed – thus creating demand but not committed to meet it; thereby frustrating current and potential beneficiaries.

- **Impunity:** It is sometimes not easy to implicate some influential people in communities when they commit GBV-related cases and others have interpreted this as condoning GBV. Consequently, efforts to address GBV have been severely regressed in the communities where this has happened.

- **Processing of applications and court cases:** Application of GBV cases is currently costly for an ordinary woman and girl. In addition, there are high levels of backlogs of cases in the courts. For instance, out of 280 cases reported in Harare in the month of October 2010, only 58 managed to go through to courts. In Zvishavane Magistrates’ courts, out of the total 44 cases received in the period January to 16 November 2010, only 20 have been completed.

- **Withdrawal of applications/cases:** It is reported that between 60-80% of applications or cases are withdrawn by applicants. Some of the reasons are that the perpetrator (husband or partner) is the breadwinner, pressure put on the survivor of GBV by relatives of her husband/partner, no safe houses for survivors of GBV, and stigma associated with being known in the community that one is a survivor of GBV especially sexual abuse.

2.5.5 Lessons learnt

- **Community Opinion Leaders:** Attitude change also requires one to hear the issues from people of respect and authority in the community. The community opinion leaders approach has contributed remarkably to influence men and boys to change their attitudes towards women and girls in respect of GBV.

- **Coordination mechanism:** If gender programme efforts are fragmented, very little can be achieved. It is critical to strengthen joint programming and joint programmes at donors’ and implementing partners’ levels.

- **Economic empowerment:** Economic empowerment for women and girls can not in any way be considered as an absolute solution to GBV because even women who are economically independent and have high positions in organizations do experience GBV. Therefore, other aspects should be considered to complement economic empowerment aspect towards a holistic and sustainable solution to GBV in Zimbabwe.

- **Broad-based solution provision:** If GBV solution is narrowly defined, not much can be achieved. A broad-based approach in finding solutions to end GBV is necessary such as strengthening analysis on the social support systems, spiritual, criminal, and economic dimensions as key elements to combat GBV.

- **Care for the survivors of GBV and perpetrators:** Due to the crisis nature of GBV in the country, current services are designed to care more for survivors of GBV than the perpetrators – a balance is needed. Some perpetrators have become more violent after going through police interrogations and court proceedings. If perpetrators are left with minimum or no support for them to reform, it will take a long time for men and boys to change attitude towards women and girls.
- **Reporting GBV-related case**: There are widespread reports that some survivors of GBV are victimized even worse emotionally by relatives of the perpetrators when it has become known they have reported the perpetrator. If the extended-family social support systems are not extensively analyzed and specific interventions instituted, this backlash would continue on survivors of GBV who report their cases or even discourage others from reporting.

### 2.5.6 Conclusion

The GBV programme has raised awareness on domestic and gender-based violence especially in communities where it has been introduced; multi-sectoral approach that was used remains a highly commendable strategy. Involvement of community leaders (including traditional and religious leaders) contributed remarkably to knowledge on GBV in the communities as well as the rights of women and girls and now people appreciate the importance of maintaining peace in the home, community, and in the country as whole. Male involvement in gender issues remains a key component to effectively address GBV.

While efforts to address domestic and gender-based violence are highly commendable, there are still gaps which, if addressed, can further enhance the strategies towards a holistic solution to GBV. The non-availability of safe houses has contributed significantly to survivors of GBV to withdraw their cases/applications because they end up with no option but to go back to the same home where they experienced abuse. The high prevalence of GBV cases has led to unprecedented backlogs in the courts as there is no court system to deal specifically with domestic and gender-based violence cases. Social support systems play vital role (positively or negatively) in addressing GBV in communities and not much has been done to establish how these can be used to promote and protect the rights of women and girls.

Formulation of outcome, outputs, indicators, and targets could have been more results-based including making them more specific to allow for focused programming and to effectively inform UNFPA resource mobilization strategies. The 5th CP on Gender had limited baseline information to enlighten formulation of indicators and targets. More strategic partners at national and sub-national levels are required for a comprehensive GBV programme design.
CHAPTER THREE

PROGRAMME MANAGEMENT

3.1 Introduction
The sections below provide an overall assessment of the management of the 5th CP including such aspects as resource management, personnel and coordination.

3.2 Resources Management and Expenditure
The 5th CP was approved by the Executive Board in the amount of $40,500,000, of which $13,500,000 from regular resources and 27,000,000 through co-financing modalities and/or other, including regular resources. At the time of the evaluation, the CO had mobilized a total of $43,230,198 out of which $15,089,264 from core resources and $28,140,934 from other sources. This is a remarkable achievement. The combined distribution of budget per programme component is $36,024,671 for RH including HIV; $2,721,356 for P&D; and $4,484,171 for Gender. Due to the difficulty of isolating expenditure per year for donors’ funds, the tables below present allocations and expenditure per year for core resources only. This is in order to avoid double counting as donors’ funds mobilized in a given year and recorded as such, may be spent years later, even though they may have been recorded as an allocation during the year they were mobilized. As of 22 November 2010, UNFPA had allocated from core resources $9,841,120 to Reproductive Health; $2,297,920 to Population and Development and, $2,950,224 to Gender for a total of $15,089,264. The tables below show for the CP and each programme component the allocations, expenditure and implementation rate per year.

Table 3.1 shows the allocations and expenditures of the CP made per year and the implementation rates. The overall implementation rate of the programme over the four years it has been operational is 97.07%, including programme coordination costs.

<table>
<thead>
<tr>
<th>Year</th>
<th>Allocations</th>
<th>Expenditure</th>
<th>Imp. Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>3,024,998</td>
<td>2,956,709</td>
<td>97.74%</td>
</tr>
<tr>
<td>2008</td>
<td>4,802,224</td>
<td>4,687,314</td>
<td>97.61%</td>
</tr>
<tr>
<td>2009</td>
<td>4,133,000</td>
<td>4,094,732</td>
<td>99.07%</td>
</tr>
<tr>
<td>2010</td>
<td>3,129,042</td>
<td>2,907,761</td>
<td>92.93%</td>
</tr>
<tr>
<td>Total</td>
<td>15,089,264</td>
<td>14,646,517</td>
<td>97.07%</td>
</tr>
</tbody>
</table>
Table 3.1a below shows the implementation rate of the Reproductive Health component to be 98.11%. Given the health sector crisis highlighted in the document, this rate is more than likely, especially considering the fact that the programme had to fund activities not originally planned for, such as the payment of salaries and incentives.

<table>
<thead>
<tr>
<th>Year</th>
<th>Allocations</th>
<th>Expenditure</th>
<th>Imp. Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>1,602,078</td>
<td>1,579,011</td>
<td>98.56%</td>
</tr>
<tr>
<td>2008</td>
<td>3,390,000</td>
<td>3,335,352</td>
<td>98.39%</td>
</tr>
<tr>
<td>2009</td>
<td>2,659,000.00</td>
<td>2,632404</td>
<td>99.00%</td>
</tr>
<tr>
<td>2010</td>
<td>2,190,042.00</td>
<td>2,108,589</td>
<td>96.28%</td>
</tr>
<tr>
<td>Total</td>
<td>9,841,120</td>
<td>9,655,356</td>
<td>98.11%</td>
</tr>
</tbody>
</table>

Table 3.1b shows the Population and Development implementation rate which stands at 95.10%. The rate may be a reflection, among other things, of the marked improvement observed at ZIMSTAT in data collection, processing, analysis and reporting.

<table>
<thead>
<tr>
<th>Year</th>
<th>Allocations</th>
<th>Expenditure</th>
<th>Imp. Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>522,920</td>
<td>494,566</td>
<td>94.58%</td>
</tr>
<tr>
<td>2008</td>
<td>605,000</td>
<td>550,073</td>
<td>90.92%</td>
</tr>
<tr>
<td>2009</td>
<td>810,000</td>
<td>802,255</td>
<td>99.04%</td>
</tr>
<tr>
<td>2010</td>
<td>360,000</td>
<td>338,477</td>
<td>94.02%</td>
</tr>
<tr>
<td>Total</td>
<td>2,297,920</td>
<td>2,185,371</td>
<td>95.10%</td>
</tr>
</tbody>
</table>

Table 3.1c below shows the Gender component implementation rate at 95.10%. This is more than likely given the crisis situation discussed throughout this report.

<table>
<thead>
<tr>
<th>Year</th>
<th>Allocations</th>
<th>Expenditure</th>
<th>Imp. Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>900,000</td>
<td>883,133</td>
<td>98.13%</td>
</tr>
<tr>
<td>2008</td>
<td>807,224</td>
<td>801,889</td>
<td>99.34%</td>
</tr>
<tr>
<td>2009</td>
<td>664,000</td>
<td>660,073</td>
<td>79.57%</td>
</tr>
<tr>
<td>2010</td>
<td>579,000.00</td>
<td>481,983.00</td>
<td>83.24%</td>
</tr>
<tr>
<td>Total</td>
<td>2,950,224</td>
<td>2,805,790</td>
<td>95.10%</td>
</tr>
</tbody>
</table>
In conclusion, with an overall implementation rate of over 90% for the CP and each programme component, it would appear that the CO used effectively the funds at their disposal. However delays in disbursement were reported by some implementing partners, in particular those in the BC programme. As recommended elsewhere in the report, the CO should pay attention to speeding up disbursement of funds in order to reduce delays in programme implementation that have characterized the current phase.

3.3 Programme Coordination

The Ministry of Finance has in principle the overall responsibility for coordinating the CP. As such the Acting Permanent Secretary of the Ministry of Finance signed the CPAP together with the UNFPA Representative. In practice however, the implementation of the programme is coordinated by the MOEP&IP, through the PDU. At the implementation level, the Ministry of Health and Child Welfare, through the RH unit, AIDS and TB unit, the Zimbabwe National Family Planning Council and the National AIDS Council are responsible for the RH and HIV and AIDS programmes. The Ministry of Women’s Affairs, Gender and Community Development coordinated the implementation of the gender programme, while the Ministry of Finance through the Zimbabwe Statistics Agency and the Ministry of Economic Planning &Investment Promotion through the PDU, coordinated and managed Population Data and Population and Development Inter-linkages. A number of non governmental organizations and civil society, including Padare and Musasa are also involved in the implementation of particular aspects of the programme related to gender and HIV and AIDS. The various implementing partners were selected by UNFPA through a competitive capacity assessment process that focused on sound management systems, past experience in implementing related activities, and potential to contribute to the CP outcomes and outputs. Except for the setback caused by the brain drain that affected many an agency or department, the evaluation found the selection of implementing partners to have been sound. At the grass-root level, implementing partners should consider working more through Community-Based Organizations (CBOs) to increase coverage and ensure sustainability of interventions.

3.4 Country Programme Alignment with Current and Emerging National Priorities

The 5th Programme was formulated on the basis of extensive consultations with the Government of Zimbabwe, United Nations agencies, donors and key partners in the civil society. It is fully synchronized with Zimbabwe United Nations Development Assistance Framework (ZUNDAF) for the period 2007-2011. In turn UNFPA Country Programme was articulated within the context of national priorities aimed at improving maternal health, combating HIV and AIDS, ensuring better utilization of population data disaggregated by age and sex and their integration in development planning, as well as promoting gender equality and empowering women. UNFPA-funded interventions during the period under review have remained consistent with those priorities. During the last decade most health indicators have deteriorated, making it difficult, if not impossible for Zimbabwe to achieve most of its health targets including the MDGs and those that have been set for ZUNDAF 2007-2011. While gender disparity can be eliminated at all levels of education, women still face daunting challenges to meet the goal of 50-50 representation in
decision-making positions and statistics on gender-based violence are on the increase. Furthermore, the current economic and financial crisis has made it difficult for the government to fund core statistical activities including the 2012 Population Census. All these constitute national priorities for which the next CP will need to intensify its interventions.

3.5 Partnerships/Leadership

Mindful that its interventions alone, however significant, will do little to alter the population and reproductive landscape in Zimbabwe, UNFPA has been particularly active during the review period, in strengthening partnerships not only with the Government and the civil society, but also with the UN system and donors alike. Cases in point include the strategic partnership between UNFPA and WHO which resulted in the development of guidelines for FP and STIs; the partnership between UNICEF, WHO and UNFPA which resulted in the development and launch of the Maternal and Neonatal Health (MNH) road map; the partnership with the donor community and civil society that enabled to mobilize resources to support sexual behavior changes initiatives. In the same context, UNFPA worked with UNAIDS, UNICEF and the National AIDS Council to support eight NGO partners who are implementing the HIV Behavior Change Strategy. Several key sectoral data sets including ZIMDAT are being updated on an annual basis in collaboration with UNICEF and ZIMSTAT. Last but not least, UNFPA’s partnership with the Ministry of Women’s Affairs, Gender and Community Development and the civil society resulted in the passing of the Domestic Violence Act, and the establishment of the Domestic Violence Council responsible for monitoring the implementation of the Domestic Violence Act. UNFPA leads the Working Group on Data for Development, whose achievements include the formulation and implementation of the only two joint programmes in Zimbabwe, namely the 2005/6 and the 2010 ZHDS. Within UNCT, UNFPA chairs the UN inter-agency Task Force for the ZUNDAF 2012-2015 rollout. The overall objective of the Task Force is to assist the Resident Coordinator’s (RCO) in coordinating and facilitating the ZUNDAF process, to provide advice and technical support to the thematic groups and to the UN Country Team on the development of ZUNDAF, and to act as advocates and champions for the ZUNDAF, including in their respective agencies.

3.6 Human Resources Management

The country office in Zimbabwe consists of the Representative, five Programme Managers, four National Programme Officers, one Operations Manager, three Programme Associates and four Administrative Support Staff and six Transport Assistants. Although a post of Assistant Representative is provided for in the manning table, it was vacant at the time of the evaluation, following the resignation of the incumbent. From the evaluation team’s discussion with staff, there appeared not to be an urgent need for additional personnel, at least as far as programme implementation is concerned. However the lack of a Deputy post in the manning table combined with the vacancy of the Assistant Representative post, puts extreme pressure on the CO as it strives to meet representational obligations and to ensure programme implementation that is most cost-effective and results-oriented. The evaluation team has made a number of recommendations calling for the scaling up of a number of current interventions. These include Maternity Waiting Homes, the One Stop Centers, greater involvement of men and boys in the campaign against GBV, provision of shelters for GBV survivors, male circumcision and STI/HIV control for sex workers. Should the new CP
take these on board, the existing personnel may not be adequate. One other consideration for the CO has to do with providing leadership in the area of maternal health which is the main focus of UNFPA assistance in Zimbabwe. It would seem appropriate that the CO speaks with a strong and authoritative voice when dealing with donors and the government alike. It would be extremely useful to have one or two international advisers in maternal health in the country office, in addition to the existing national staff. As the CO considers the formulation of the next CP and in light of the recent decision by UNFPA to lift the 25% limit for resources earmarked for staffing, there may be need to revisit the current manning table for Zimbabwe field office with a view to providing for a Deputy Representative post and recruiting additional project personnel, including internationals to give the CO a stronger voice and to strengthen programme implementation.

3.7 Monitoring and Evaluation

In accordance with UNFPA guidelines on Monitoring and Evaluation, the CO has developed an elaborate system of planning, regular and periodic reviews whose purpose is to ensure that programme implementation remain on track. At the planning level, the process involves the joint development of the ZUNDAF by all UN agencies, government and the civil society; development of the Country Programme Document (CPD); development of the Country Management Plan (COMP) at the beginning of every year; and the Annual Work Plan (AWP) with partners every year. Also developed every year for each individual staff member is a Performance Appraisal and Development (PAD) plan. Programme monitoring consists of regular review of the COMP and the AWP; quarterly field monitoring visits with implementing partners; quarterly review meetings with implementing partners; fortnightly CO programme meetings; the annual Standard Progress Report; and the Country Office Annual Report (COAR). Key evaluation activities include mid-term project reviews; regular surveys and impact assessments, and annual and end of programme evaluations.

Planning and monitoring reports made available to the evaluation team, including CPD, CPAP, AWP, the annual Standard Progress Report and the Country Office Annual Report suggest that the CO did by and large adhere to existing guidelines. The quarterly meetings between and UNFPA implementing partners were instrumental in addressing challenges and ensuring a constant track of progress towards achievement of objectives and delivery outputs. The CP mid-term evaluation conducted in 2009 provided assurance that the programme remained relevant, was effective and efficient, and was contributing to the betterment of the quality of life of the people of Zimbabwe. The evaluation team noted that the CO was largely off track in organizing this end of programme evaluation during the last quarter when according to the office work plan, it should have taken place during the second quarter. The evaluation team expressed concern that the delay may adversely affect the development of the new CP, including the amount of time needed to consult with various partners. From discussion with some staff however, it would appear that the delay will have little or no adverse impact on the development of and consultations over the 6th CP as the CO had already initiated such consultations. Be that as it may, whatever may have caused the delay will need to be addressed in the context of the new programme, if only to ensure that planning provisions are adhered to.
CHAPTER FOUR

ASSESSING UNFPA’s 5TH COUNTRY PROGRAMME AGAINST EVALUATION CRITERIA

4.1 Introduction
All the programme interventions implemented under the 5th CP contributed to UNFPA’s goal of improving the quality of life of the people of Zimbabwe through improvement in reproductive health, prevention of HIV, increased gender equality and improved utilization of data for development and integration of demographic, reproductive health as well as HIV variables into national programming.

The following section of the report assesses the specific components of the programme -- Reproductive Health and HIV prevention; Population and Development, and Gender -- for relevance, effectiveness, efficiency and sustainability.

4.2 Strategic Direction

Reproductive health

Most of the activities carried out under the 5th CP RH programme are part of UNFPA’s traditional mandate for which it has comparative advantage and were based on broad based consultations with the MoHCW, other UN agencies and other stakeholders in the RH sector. Going into the next country program, UNFPA CO should focus on fully implementing the planned activities as most of them could not be fully implemented. National roll out of planned interventions should be a priority in to make an impact on RH indicators.

HIV prevention

Going into the next country programme, the most critical HIV prevention interventions will be those that target the biggest drivers of the epidemic, which include multiple concurrency and vertical transmission. Such interventions are likely to yield more long term benefits in the reduction of infections. While some progress has been made in reducing multiple sexual partnerships, this has not been sufficient to make a big dent on new infections. Therefore more needs to be done to achieve results. The STI/HIV control programme for sex workers has met with positive feedback from sex workers. More needs to be done to roll out the programme nationally.

ASRH

The ASRH programme has achieved limited results due to internal and external constraints. But as the CP moves forwards, there is a need for a critical review of the programme to come up with an implementation strategy likely to achieve results. This could include rethinking existing partnerships and implementation modalities.
Gender

The recent draft GBV Strategy provides a road map for future interventions in GBV. Going into the next CP UNFPA should identify interventions that it can support in the strategy and fundraise for them, ensuring that there is coherence with the Secretary General’s Africa Unite campaign to avoid duplication. UNFPA should also be more strategic in partner selection to ensure that it invests in organisations with the potential to expand its programmes.

Population and development

UNFPA Strategic Plan 2008-2011 identifies P&D as one of the three major areas of focus. All the activities carried out under this programme, whether they relate to data collection or policy formulation and implementation are part of the Fund’s traditional mandate, for which it has a comparative advantage. The interventions also address key development challenges and are based on consultations with stakeholders. As such they are strategically relevant. In the context of the next country programme, capacity building of implementing partners, implementation of the revised NPP, including the establishment of a National Population Council, continuous updating of ZIMDAT and IMIS as well as support for the 2012 Population Census should continue to be the main focus of UNFPA interventions. The successful experience of coding of the cause of death by the Registrar’s office should also be considered.

4.3 Relevance

Reproductive health

The Reproductive Health programme was designed to address national priorities in RH in line with the MDGs. The programme addressed specific priorities that had been identified through consultations with the government, UN agencies, donors and civil society. The programme was also in line with the ICPD Programme of Action which calls for the provision of comprehensive and universal access to reproductive health for sustainable development. The contribution of UNFPA to development of major policies and guidelines, especially the MNH Road Map, ensured that UNFPA operated within the context outlined in this strategic document.

HIV prevention programme

UNFPA support was crucial as it focused on interventions addressing some of the critical areas in HIV prevention in Zimbabwe. These include behavior change, condom promotion, increased uptake of VCT and PMTCT, STI control and the ASRH, which is a crucial intervention to prevent HIV infections among the youths, who are the most vulnerable age group. The programme was also in line with the MDG 5 of achieving universal access to reproductive health and Goal 6 of combating HIV and AIDS.

The BC component was relevant as it sought to address the key drivers of HIV and AIDS, which include concurrent sexual relations; inter-generational sex and incorrect and inconsistent condom use. The STI prevention programme targeted sex workers, who are a high risk group and also provides them HIV prevention and RH services. The male circumcision programme builds on scientific evidence which shows a reduction of up to 60% in HIV infection for men who have been circumcised and thus complements other prevention interventions. VCT has been recognized as an effective prevention tool. VCT promotion
therefore complements other prevention initiatives. Short of abstinence, condom promotion programme is the most effective prevention method against contracting HIV.

UNFPA interventions in HIV prevention not only covered the priority areas, but were also complementary as they re-enforced each other at different levels. For instance, the BC programme promoted increased VCT uptake, which in turn made women realize the importance of PMTCT services. Condom use increased among those who had gone through the L&R training, which in turn contributed to STI control. The Drop in Centres and mobile sites for sex workers were effective for STI control and the provision of RH and HIV services to sex workers. The complementarity of the interventions extends to the gender programme, where women’s empowerment and GBV prevention are proven strategies for reducing women’s vulnerability to HIV and AIDS.

Gender

UNFPA’s support to the gender sector mostly went to programmes addressing GBV and was in line with national laws and policies as well as regional and international protocols that aim to promote women rights and equality and to end gender-based violence. Written information as means to communicate GBV information is less relevant to rural communities; thus art, drama, music, and poem is mostly suitable and this needs strengthening.

Population and Development

UNFPA interventions in P&D are in line with national priorities and are consistent with Zimbabwe's need for data to plan and monitor development and ensure the management of population in a manner consistent with the desire for sustainable development. By helping the Government achieve its stated aim of managing population to achieve a balance between population and available resources, UNFPA interventions are contributing to the strategic priorities of the Government as well as the UNDAF.

4.4 Effectiveness

UNFPA interventions in the 5th CP were all effective in addressing the identified national priorities. However their effectiveness was compromised, particularly during 2007 and 2008, by the unstable socio-economic environment. Factors constraining programme effectiveness included the closing down of hospitals due to strikes by health staff, the banning of NGOs from rural areas, the high inflation rate and the high attrition rate for health professionals and youth peer educators.

Reproductive Health

UNFPA support to the RH sector ensured the availability of a basic package of RH commodities to support the provision of RH services during the economic crisis. UNFPA’s flexibility in modifying its delivery modalities enabled it to respond to the humanitarian situation that prevailed during the life of the 5th CP. The provisions of drugs, supplies and equipment helped to keep two of the major referral maternity hospitals (Harare and Parirenyatwa) open to take care of maternal and newborn emergencies. The waiver to allow the UNFPA CO office to support salary top ups helped to keep the few staff Manning the maternity in their posts.
The procurement and distribution of contraception was effectively implemented. The RH Commodity Security Steering Committee was successful in coordinating and implementing the contraceptive commodity security strategy. All service delivery points in the public health sector, including central, provincial and district hospitals, clinics and ZNFPC CBD depot holders provide at least 3 modern methods of contraception. Stock outs of contraceptive commodities have been rare and contraceptive prevalence in Zimbabwe stands at 65%.

HIV prevention

The HIV prevention programme reached out to the various target groups. The BC programme initially was only in 26 districts now covers the whole country with the inclusion of 35 new districts under the Global Fund Round 8. The BC component reached out to community leaders ensuring their buy in. The BC programme is a cost effective intervention as it is community-driven. The programme has also filled critical gaps in information on HIV and AIDS among communities.

The HIV prevention programme was also successful in reaching out to high risk groups, including sex workers through the setting up of the two drop in-centres, that also provide services through 16 mobile sites. The effectiveness of the sex work programme lies in the ease of access to services that it provides to an otherwise neglected group.

The ASRH programme

UNFPA’s collaboration with other partners including UNICEF, NAC, Zimbabwe Youth Council, Ministry of Youth and Employment Creation, improved the effectiveness of the programme and level of programming through joint meetings, sharing of lessons learnt, conducting joint field visits and programme monitoring. Meetings among the partners helped to shape the programme.

While the choice of implementing model in the ASRH programme -- setting up youth friendly corners in clinics and youth centres as well the use of peer educators -- was effective for reaching out to the youth, other factors which include ZNFPC’s operational modalities -- of working with nurses who are MOHCW staff and therefore not accountable to them and with youths at community level when the organization did not have structures at that level to provide constant mentoring and supervision of the youths -- reduced effectiveness. The failure of the programme to scale up to 30 district also reduced its effectiveness as coverage remained limited.

Gender

UNFPA’s support to the gender programme was crucial at the policy level, initially for the enactment of the Domestic Violence Act and for setting up of the Domestic Violence Council and more recently towards the development of the National GBV Strategy. These interventions were critical as they have improved the policy environment for dealing with GBV issues in Zimbabwe.

UNFPA’s support for the establishment of the One-stop centres is also effective in providing a model for integrated service provision for survivors of GBV that can be replicated by the government. Working with community leaders was also an effective intervention strategy as it targeted cultural practices that increase women’s vulnerability to GBV. Using influential and respected people was also an effective way of influencing attitude change. These are sound foundations that have been laid down in the 5th CP and
attitude change which is a key driver to reduce or eliminate GBV has been partially achieved and significant change will take a long time.

*Population and Development*

UNFPA support has been most effective in capacity building at ZIMSTAT and resulted in a marked improvement in the collection, processing, analysis and reporting of survey data. The updating of ZIMDAT and IMIS made it easier to monitor the MDGs. The strategy to train a large number of personnel was sound especially in view of the low staff morale and high staff turnover, so was UNFPA’s initiative to pay salaries or incentives when the Government was unable to do so. The support for the coding of the cause of death was also effective in clearing a six-year backlog. While the process of revising the Population Policy and validating it went smoothly, approval by the Cabinet of the revised Policy is still pending, one whole year after it was produced.

### 4.5 Efficiency

Implementation of the 5th Cp was generally efficient although in cases the operational environment impacted on efficiency particularly in the period 2007 -- 2008 when the country was experiencing shortages across the board.

*Reproductive health*

Joint planning and programming between UNFPA, the MoHCW and other UN agencies, mainly UNICEF and WHO, helped in ensuring coordinated and efficient support to MoHCW during the implementation of the programs. Monitoring and evaluation through thematic groups and quarterly and annual reporting requirements assisted in ensuring the implementation of programme activities within set timelines.

*HIV prevention*

The late disbursement of funds by UNFPA has been a major challenge and has affected efficiency, particularly for the BC Programme. For instance, implementing partners only received the disbursement for the third quarter of 2010 ending in September three weeks before the end of the quarter, which means they had to squeeze all the activities for the period in just three weeks. Partners say this puts pressure on their officers who are sometimes forced to work over weekends to complete the activities. This also compromises the quality of service delivery as the activities are rushed. In many cases partners were unable to pay salaries, which was demoralizing to staff.

*ASRH*

The use of peer educators and health institutions to deliver on the ASRH programme is efficient as the young people can disseminate information among themselves at little cost, while the use of health facilities for the youth friendly corners is also at no extra cost except the training of youth friendly nurses. However, for the system to function more efficiently, there is need to address some of the challenges, which includes the poor quality of the equipment that was procured for use by the youths, such as the bicycles, soccer balls, chess sets and radios that broke down soon after being bought and the failure to factor in the high
attrition rate of youths in planning, which resulted in some health centres not having PEs at all or not regularly, thus reducing the project efficiency.

Gender

Community-based approaches used by partners for GBV interventions were generally efficient as community-based counselors are able to respond quickly to GBV issues since they live in the communities. The one-stop centres improved accessibility of services they are all under one roof. However, UNFPA’s support delivery to MOWAG&CD and IPs was sometimes not on time thereby delaying implementation of certain programme activities.

Population and Development

In so far as UNFPA support to ZIMSTAT resulted in timely reporting of survey data and that ZIMSTAT and IMIS have been regularly updated in spite of staff high turnover and low morale, shows that UNFPA inputs were adequate and timely. The long delay in the approval of the revised Population Policy has however affected efficiency as activities have been put on hold pending cabinet approval.

4.6 Impact

Reproductive health

UNFPA support to policy and guidelines formulation and RH commodities support has enabled the Government to continue to offer RH services. The support to conduct surveys and RH indicators assessments have helped the MoHCW to make evidence based planning and monitoring and evaluation.

The impact of provision of basic and comprehensive EmONC signal functions has been severely compromised by the effect of the socio-economic situation on the health sector. Full service delivery could not be achieved due to the shortages in RH commodities and skilled health personnel. Resource mobilisation for the procurement of drugs, equipment and supplies enabled the health sector to continue to provide the minimal package of EmONC. The impact of training of health personnel in EmONC skills was affected by the high staff turnover with very few of the trained personnel still remaining in the country.

HIV Prevention

Although it is still too early to determine the impact HIV prevention programme, there are some indications that the interventions in the BC programme are having a positive influence on BC. Preliminary data shows that the proportion of men reporting to having more than two sexual partners in 6 districts where the BC programme is being implemented decreased from 25.6 percent for men in 2005 to 20.9 percent in 2010. The decline was even more significant for women from 6.7 percent to 3.2 percent -- a more than 50 percent reduction. The reduction in sexual partners exceeded the targets for both men and women which had been set at 21.3 percent for men and 6.8 percent for women by 2010.

Age at first sex for women below 18 years of age declined from 34.1 percent in 2007 to 28.6 percent in 2009. The number of women with 3-4 lifetime sex partners also declined from 12.1 percent in 2007 to 9.7 percent in 2009. Equally, the number of women with more than two current sex partners declined

Progress was also made in service uptake with significant increases in VCT in the BC districts. In 2007 the percentage of people who had ever been tested for HIV in the districts was 35.9 percent, by 2009 this
figure had risen to 50 percent. UNFPA attributes the increase to BC referrals and says participants undergoing the training on the Love and Respect (L&R) manual were more likely to get tested. Since completing the L&R course, 36 percent of the participants had gone for HIV tests, 30 percent were now faithful to their spouses and 29 percent said discussions with sexual partners had improved, 25 percent had started using condoms while 26 percent were aware of their personal risk to HIV infection.

The male circumcision programme has also taken off well with demand now exceeding supply in some of the pilot sites. So far, more than 11 000 men have been circumcised. However it is still too early to determine the impact of MC in reducing HIV infections

*Population and Development*

The availability of data made possible through UNFPA’s interventions has enabled the Government to plan and monitor development using reliable data. For example in preparing the MDG Reports, the Government has used indicators from ZIMDAT and data from IMIS. The draft MTP used data from recent surveys, including the Inter-Censal Demographic Survey.

*Gender*

The impact of interventions in GBV is difficult to measure at this stage as the program was at foundational level. According to the police, there has been a sharp increase in the number of women reporting domestic violence cases. It is not clear whether this is an indication of an increase in the number of cases or of the increased awareness of women about their rights. However there are some indications that some cultural practices that increase women’s vulnerability to GBV are changing in some communities although it is difficult to attribute the changes to the interventions alone. Among men in communities where the programme was introduced, there is also less tolerance of violence against women. These are only indicators to the impact; but real impact can be evaluated at least in 10 years time. Meanwhile, GBV prevalence is still high across the country.

**4.7 Sustainability**

*Reproductive health*

The partnership between UNFPA and MoHCW which makes the MOHCW the leader in the implementation of activities in the RH sector has increased ownership of programmes by the government, which will contribute to their sustainability. The strengthening of HMIS and staff support to key management posts in the head office and provincial levels will ensure long term leadership of the programmes. Currently the budget support to the health sector is insignificant and as a result, the MoHCW relies heavily on donors to support most of their activities. This situation is not likely going to change in the near future and hence there is need for UNFPA to continue to support the RH activities.

*HIV prevention*

Communities value the new knowledge that they are getting from the BC programme and will pass it on to the next generation e.g. if one is circumcised they are likely to get their children circumcised. People will continue to share information after the NGOs have left and therein lies its sustainability. The BC programme is firmly rooted in communities, which makes it more cost-effective and more sustainable.
However the programme will continue to require external assistance for inputs such as incentives for BCFs, IEC materials and regular monitoring and mentoring of the BCFs. At partner level, the programme will continue to require external funding as coverage is now national, which requires a large staff establishment that partners would be unable to maintain with their own resources. FACT Mutare, for instance has hired 34 people specifically for the BC programme and would not be able to pay them from its own resources.

**ASRH**

The ASRH programme relies on youth volunteers in the community and on youth friendly nurses in health facilities for its sustainability. However, the mobility of youths and their consequent high attrition rate as well as their expectations for allowances threatens its sustainability. The high attrition rate of trained youth friendly nurses is also a threat to the sustainability of the ASRH programme.

**Population and Development**

UNFPA has used policy and strategy development as well as capacity building to ensure sustainability when its assistance is no longer there. Furthermore UNFPA encourages the Government of Zimbabwe to supplement its development assistance with national contribution. Before the current economic and financial crisis, the Government was making significant financial contributions to UNFPA-funded programmes. Zimbabwe’s last two censuses of 1992 and 2002 were largely carried out with Government funding. But while committed to undertaking the 2012 census, the Government will not be able to wholly fund it. This situation prevails across all sectors of the economy and suggests that until the country is back on its feet economically and financially, UNFPA assistance will not only be required, but will need to be intensified to fill the huge gap in government contribution.

**Gender**

UNFPA’s gender programme has been widely accepted by communities and some of the strategies used such as involvement of community leaders, community based counselors and advocacy with men and outreach activities with boys in schools are creating a culture against GBV that can be sustained even without outside assistance. But there is still need for UNFPA support to consolidate the programmes and to broaden coverage. For long term sustainability, it would be critical to incorporate gender into the schools’ curricula and into the training curricula of police, health personnel and judicial officers.

The Government and implementing partners will continue to need UNFPA support to implement GBV interventions. There is need to strengthen efforts to involve all stakeholders in the designing, planning, implementing, monitoring, and evaluation of GBV activities. It was noted UNFPA programme indicators on gender were partially included in some of the partners strategic plans. When UNFPA GBV programme indicators are included in partners’ strategic plans, it contributes significantly to programme sustainability at institutional level.
CHAPTER FIVE

RECOMMENDATIONS
This chapter outlines the recommendations from the analysis carried out in the previous sections of the report. They have been grouped according to the programmatic focus.

5.1 Reproductive Health

5.1.1 Capacity building

The Health delivery system has been weakened in terms of planning, budgeting and management as a result of high attrition rates of experienced health service and programme managers. Also the collapse of the health sector led to the collapse of HIMS at all levels.

Recommendation
Staff support to key management positions in the MoHCW is key to capacitating the MoHCW to plan and manage the RH programme. Strengthening of the Health Management Information System will help in facilitating evidence-based planning and programming. Adequate capturing of details of maternal and perinatal deaths will also make it possible to perform maternal and perinatal mortality audit/ confidential enquires into maternal deaths which is a very vital intervention in improving service delivery in essential obstetric and newborn care.

5.1.2 Training of Skilled birth attendants

The 5th CP mainly focused on in-service training of doctors and midwives in EONC, contraception, PMTCT and post abortal care. With the high staff turnover, most of those trained have left the healthcare system.

Recommendation
The CO should expand its support of midwifery training schools with advocacy for the inclusion of EmONC, contraception, PMTCT and post abortal care skills training in their curriculum to adequately equip midwives to handle these issues by the time they are deployed. A parallel in-service training should continue to cover untrained doctors and midwifes in service. This would be an efficient way of achieving wide coverage of skills training over a short period of time.

5.1.3 Promoting institutional deliveries

Poor transport and communications present a major barrier to women accessing RH services in the rural areas of Zimbabwe where two thirds of the population live.

Recommendation
In line with the MoHCW policy of promoting institutional deliveries (which stand at 68%) to reduce maternal and newborn mortality, more resources should be secured to expand the refurbishment of MWH to the whole country. The intervention could result in a significant reduction in maternal and newborn mortality. To reduce the second delay in the management of maternal complications, UNFPA should increase its support for the refurbishment of equipment, including ambulances to all the district hospitals.
5.1.4 RH Commodity security

Government financial support for the health sector has remained far below expected levels due to the poor economic status of the country. The situation is likely going to remain the same during the implementation of the 6th CP.

Recommendation
The provision of EmONC supplies and equipment should remain a priority for the 6th CP as it will take a long time before the government can fully support these functions. UNFPA should also support the advocacy for the provision of prepaid services for pregnant women to reduce the effect of user fees as a barrier to access to care for pregnant women as demonstrated by the impact of the UNFPA supported blood donor pilot project.

5.2 HIV Prevention
5.2.1 Increasing Male participation

Currently the number of men who are going through the L&R course is much lower than that of women, in some cases by as much as 15 percent.

Recommendation
There is need to come up with strategies that will attract more men to participate in the BC programmes

5.2.2 Delays in disbursement

Partners in the BC programme are experiencing delays in fund disbursements which result in activities being rushed and in staff not getting paid for months at a time.

Recommendation
UNFPA and other funding partners -- the Global Fund, UNDP and NAC -- should seriously analyse the causes for delays in disbursements of funds and deal with them expeditiously as this is seriously impacting on the delivery of the programme.

5.2.3 Reducing burnout and attrition of Behaviour Change Facilitators

There is considerable attrition among behavior change facilitators, some of which can be attributed to the low incentives they are being paid of only $10 a month.

Recommendation
Considering that the BCFs are the linchpin of the BC programme, serious consideration should be given to increasing their incentives to bring them in line with incentives offered by other organisations for similar community work of around $20 a month. Failure to do this will result in higher attrition rates which will retard the progress being made.

5.2.4 Greater focus on the youth

Current initiatives focusing on HIV prevention targeting the youth are not making a significant impact because of lack of funding or because of limited geographical coverage.

Recommendation
The BC programme has the potential to reach more youths, but there would be need to include more issues of relevance to the youth in the L&R manual and also to make a deliberate effort to target the youth.
5.2.5 Allowing for greater flexibility in programme structuring

Although the L&R training has now been reduced to seven weeks, communities feel that this is still too long and that the programme should be further condensed.

Recommendation
There is need for greater flexibility to allow communities to decide how they want to structure the programme to suit their specific needs without compromising on the issues covered.

5.2.6 Raising awareness on Male circumcision

Currently demand for male circumcision remains low at some of the pilot sites because the programme has not been well publicized.

Recommendation
Given the proven efficacy of MC to reducing the spread of HIV, UNFPA should support a more robust awareness campaign, especially in view of the proposed national roll out of the programme.

5.2.7 Getting doctors in private practice to participate in Male circumcision

While some doctors in private practice were also trained in male circumcision, no incentives were put in place to entice them to carry out circumcisions in public hospitals, consequently they have not volunteered to do so.

Recommendation
As the programme moves from the pilot to the full implementation phase, there is need for the National Male Circumcision programme to come up with incentives that will make it attractive for the doctors to participate.

5.2.8 Broadening access to Male circumcision

Currently access to MC is limited to clients in the urban areas because of the need to review the patients within the first seven days.

Recommendation
There is need for the National MC programme to introduce MC at rural health centres so that men in the rural areas can also have access to the programme.

5.3 ASRH
5.3.1 Motivating youths and nurses to work on the ASRH Programme

The ASRH programme has not functioned effectively because of the high attrition rate among both the trained nurses and the youths. While the attrition of nurses has been partly addressed by training Primary Care Nurses, the high attrition rate among the youth peer educators still needs to be addressed.

Recommendation
There is a need to mobilize resources to provide regular incentives to youth peer educators in the programme as failure to do so has resulted in them losing interest in the programme.
5.3.2 Need for regular and consistent funding of the ASRH program

Funding for the ASRH programme has been erratic and inconsistent. This has resulted in lack of continuity and loss of skills and institutional memory among the peer educators, nurses and ZNFPC staff responsible for the programme who left when there was no funding. Access to sexual and reproductive health services for the youth is however critical, particularly for HIV and AIDS prevention as this age group is particularly vulnerable to infection.

Recommendation
There is need to give greater priority to the ASRH programme and to mobilize long-term resources that will ensure programme continuity.

5.3.3 Poor monitoring and evaluation

Collection of MIS data is very poor in most ASRH districts because nurses are unwilling to fill in the forms as they regard this as extra work.

Recommendation
There is need to integrate the MIS data into the routine National Health Information System. This would ensure that nurses fill the forms regularly as this would be part of their job. As the programme moves from the pilot to the full implementation phase, there is need to come up with incentives that will make it attractive for the doctors to participate.

5.4 Population and Development

5.4.1 Capacity building

The continuous training of ZIMDAT personnel in large numbers proved to be a major contributing factor in the marked improvement in data collection, processing and reporting.

Recommendation
In order to ensure an effective implementation of the programme, even in an environment characterized by high turnover of staff, there is need for UNFPA and Implementing partners to engage in the kind of multifaceted and comprehensive training conducted for ZIMDAT staff during the 5th CP implementation.

5.4.2 Adoption of the NPP and Establishing a National Population Commission

Although it was revised more than one year ago, the NPP has not yet been approved by Cabinet. On the other hand, the integration of population factors in development planning has not filtered down to sectoral and sub-national levels, while programme monitoring and implementation could benefit from a stronger institutional framework.

Recommendation
UNFPA and the Implementing partner should intensify their joint advocacy with the Ministry of Economic Planning and Investment Promotion for a quick adoption of the NPP. The objective must be to ensure that the launching and implementation of the MTP go hand in hand with the launching and implementation of the NPP. Furthermore, to ensure a more effective implementation of the NPP and other population issues, the Government may wish to consider establishing a National Population Commission, a structure that in other countries has proven effective in coordinating the implementation of population programmes.
5.4.3 Integration of Population, Gender and HIV and AIDS in national and sub-national plans and strategies.

The MTP includes a whole chapter on population and development while other population factors are mainstreamed throughout the document. There was no evidence that UNFPA’s efforts to integrate population into national frameworks was filtered down to the provincial or district levels, even though the programme design implied such a result.

Recommendation
With a view to making the integration of population into the MTP meaningful, there is need for UNFPA to provide technical assistance to the Government so that integration of population is operationalized through sectoral integration. Moreover, in order to ensure that sub-national plans and strategies take Population, Gender and HIV and AIDS concerns into account, a deliberate plan must be formulated to train members of provincial and district Planning Committees in the skills of sectoral integration. Such an effort will go a long way in making integration at sub-national levels a reality instead of the slogan it is now.

5.4.4 Need for more Joint programmes

UNFPA coordination with other UN agencies has been most effective where joint programmes have been implemented. This has been especially the case in the context of the work of the UN Working Group on Data for Development. Within the UN system, joint programmes are the ultimate expression of “Working as One”.

Recommendation
In the context of the next CP, UNFPA should seek opportunities for joint programmes involving joint programming and joint funding with joint budgets to build synergy, maximize interventions from individual agencies and become more effective.

5.4.5 Funding for the 2012 Population Census

The delay in mobilizing resources for the 2012 Census is adversely affecting pre-enumeration activities, especially the mapping operation.

Recommendation
To ensure that the timeliness and quality of the 2012 Population Census are not compromised, it is recommended that UNFPA, in collaboration with other donors, intensify their resource mobilization efforts.

5.4.6 Coding the cause of death

With UNFPA assistance, ZIMSTAT was successful in clearing the backlog in coding the cause of death for the years 2002-2006. But the coding has fallen back again, being up-to-date only to the year 2007.

Recommendation
There is a need for UNFPA and ZIMSTAT to revisit the strategies used to clear the previous backlog in coding the cause of death to ensure that the existing backlog is not only cleared but that the coding is done on a routine basis as a regular statistical activity.
5.5 Gender

5.5.1 Programme design

While UNFPA and other UN agencies involved in the 5th CP focused on providing support to strengthen institutional capacities of partners, the GBV programme design was not comprehensively formulated and implemented. This is particularly so given that GBV is a national problem that as such requires a multi-sectoral approach with enhanced capacities.

Recommendation

Although UNFPA has been supporting development of National GV Strategy and Implementation Plan since 2005, MOWAG&CD should ensure that it is adopted to guide national GBV programming. This process should also include strengthening and operationalizing of the national GBV database. This can start in 2011.

Recommendation

For sustainability, it is essential for MOWAG&CD to advocate that GBV be incorporated in education curricula (pre-school, primary, high school, colleges and universities). It is also important for the GBV programme to involve youths, people living with disability, and the elderly.

Recommendation

Extensive socio-cultural analyses need to be done nationwide on social support systems (e.g. aunts, uncles, community elders) and cultural practices, norms, and beliefs that exist in the communities with the aim to identify those that can be used/strengthened to address GBV; realizing that Domestic Violence Act and related policies alone are not absolute solutions to GBV.

5.5.2 Capacity strengthening

While UNFPA has done a great job to provide technical and resource support to partners, the Ministry of Women Affairs, Gender and Community Development still has limited capacities to research, design, implement, monitor, and evaluate GBV interventions at national and sub-national levels.

Recommendation

UNFPA should continue capacity strengthening of MOWAG&CD and implementing partners for national coverage and impact of GBV programme.

5.5.3 Service provision

While commendable work has been done in service provision to respond to GBV, it is apparent that these efforts should be scaled up in and in a coordinated manner. This is with the recognition that demand for GBV services is high across the country and that there are over 200 organizations providing services.

Recommendation

UNFPA should scale up establishment of both models of one-stop centres (under one roof and the coordinated response) to achieve national impact and this should be linked to provision of safe houses for survivors of GBV. An evaluation of the existing centers should be done including undertaking study visits in countries where this has been successful before a full scale up.

Recommendation

The costs of reporting GBV cases and the subsequent legal processes are prohibitive for the majority of women and girls particularly in rural areas. There is a need for MOWAG&CD to advocate for a mechanism to make the costs of services affordable to survivors of GBV.
Recommendation
The Ministry of Home Affairs should increase response by ensuring that Victim Friendly Units are adequately staffed, open 24 hours daily, and that there are dedicated vehicles for improved mobility for police officers to handle GBV cases. Furthermore, while VFUs are in every police station in the country, some of these are very far from some people particularly in rural areas; thus posing accessibility challenge.

Recommendation
UN agencies and implementing partners need to strengthen joint programming and joint programmes on GBV interventions for greater impact and elimination of duplication.

5.5.4 Targeting and sensitization

While sensitization activities have been confined to selected rural districts and urban areas, it is essential that these activities are upscaled to cover the whole country and a cross-section of people because GBV is a national problem.

Recommendation
UNFPA should encourage MOWAG&CD to consider targeting mining and resettlement communities as these areas are reported to have high incidences of domestic and gender-based violence.

Recommendation
UNFPA should consider supporting establishment of Youth GBV Dialogues in and out of school youths by creating Youth Dialogues/Padare/Indaba in schools and communities. It is important to link these GBV youth dialogues with already existing youth activities like Young People We Care and Lifeskills (supported by UNICEF and others). It would also be good to explore faith-based groupings at schools like those supported by Scripture Union and other church denominations to avoid creating youth club fatigue in schools and communities.

Recommendation
UNFPA and MOWAG&CD should consider partnering with other key ministries like Ministry of Youth and Development and Ministry of Education, Sports, and Culture as strategic partners for young people.
Annex 1: Terms of reference (ToR)

Background for the evaluation

The United Nations Population Fund (UNFPA) is currently supporting the Fifth Country Programme (5th CP) for the period 2007 to 2011 to assist the Government of Zimbabwe in contributing to the improvement of the quality of life of its population.

The goal of the 5th CP is to contribute to the Government’s aim of improving the quality of life of the people of Zimbabwe through: (i) improving reproductive health; (ii) reducing the spread of HIV; (iii) ensuring gender equality; and improving the utilization of data for development and the integration of demographic, reproductive health, gender equality and HIV variables into national programming. In order to achieve the above objectives, UNFPA supports implementation of joint programmes with other United Nations Agencies and partners in the areas of maternal and neonatal health, adolescent sexual and reproductive health, HIV prevention, gender based violence, and data for development.

Through the framework of a human rights based approach, the 5th CP addresses national priorities in line with the Millennium Development Goals (MDGs) and the Programme of Action of the International Conference on Population and Development (ICPD) following extensive consultations with the Government of Zimbabwe, United Nations agencies, donors and civil society partners.

The 5th CP consists of three programme components, namely:

Reproductive Health programme that contributes to following outcomes: (i) Policy environment that promotes reproductive health and rights; (ii) Increased utilization of comprehensive gender sensitive reproductive health services; and (iii) Increased adoption and maintenance of safer sexual behaviours as well as increased utilization of HIV prevention services.

Population and Development programme that contributes to the following outcomes: (iv) Improved utilization of age and sex disaggregated population and development related data; (v) National, sub-national and sectoral policies, plans and strategies take into account population and development linkages.

Gender programme that contributes to the following outcome: (vi) Strengthened institutional mechanisms and socio-cultural practices that promote and protect the rights of women and girls and advance gender equality.

To the extent possible, the programme is jointly implemented, monitored and evaluated with relevant United Nations agencies such as UNICEF, WHO, UNDP, UNIFEM, IOM, and UNAIDS among others.

The 5th CP was developed in 2006 when the country was experiencing a challenging political, socio-economic and development environment which rapidly deteriorated in 2008. This resulted in the closure of most public schools and health facilities, rampant food shortages and emigration of both professionals and

non-professionals to neighboring countries in large numbers. The official year on year inflation reached an unprecedented figure of 231 million percent. An inclusive Government was established in February 2008 resulting in some improvements on both the political and socio-economic landscape. On the economic front, the country has adopted utilization of multiple currencies leading to the official suspension of the local currency.

It is against this background that UNFPA is commissioning this end of program evaluation to assess the effectiveness, efficiency, relevance, sustainability and impact of UNFPA 5th Country program in contributing to the improvement in the lives of the people of Zimbabwe. The evaluation will cover the 5th CP implementation period from January 2007 to August 2010. The evaluation findings and recommendations will constitute key inputs for the formulation of our next Country Programme.

**Purpose of the evaluation**
The main purpose of the end of program evaluation is to assess the impact of supported interventions in changing the quality of life of people of Zimbabwe. The evaluation will also analyse factors that facilitated or hindered achievement and document lessons learned to provide input to the 6th Country Programme.

**Scope**
The end of program evaluation will cover the period January 2007 up to August 2010.
Geographical regions – The whole country
Programme aspects – The three technical areas of the country programme (Population and Development, Reproductive Health and Gender). In addition for each thematic, the evaluation should look at cross cutting aspects such as human right based approach, gender mainstreaming, coordination and partnership.
Evaluation criteria – Relevance, effectiveness, efficiency, impact, sustainability, management systems (human resources, financial resources, systems).

3.1 Specific objectives of the evaluation are to:
determine the extent to which planned programme activities were completed.
assess the achievement of expected results in the three programme areas of Reproductive Health, Gender and Population and Development.
gauge the alignment of 5th CP strategies with current and emerging national priorities.
examine the programme management effectiveness and efficiency in achieving expected results.
assess the relevance, effectiveness, efficiency, impact and sustainability of the UNFPA 5th Country Programme for Zimbabwe.
assess the coordination, the leadership and management of the CP5, including human resources, financial resources, systems.
identify the challenges, strengths, weaknesses and gaps that can be addressed in the 6th Country Programme (2012 – 2016)
draw lessons learnt and good practices

3.2 Evaluation questions
The following questions under evaluation criteria will guide the evaluation:
Strategic direction
Is UNFPA Zimbabwe currently supporting programs and interventions that it has comparative advantage on? What national priorities can UNFPA Zimbabwe focus on in the next country program?

Effectiveness of program.
Did UNFPA Zimbabwe implement and support programs using the most effective means? Were the programs and activities supported by UNFPA Zimbabwe targeted at the right beneficiaries? To what extent were expected results achieved? What could have UNFPA Zimbabwe and its partners done better to improve program delivery?

Efficiency
Did UNFPA Zimbabwe use the most cost efficient ways of program delivery? Were programme input and service delivery timely and achieved desired results? Did service delivery meet minimum standards of quality for the beneficiary. What could have UNFPA Zimbabwe done better to improve the efficiency of program delivery?

Relevance
Are the programs that UNFPA Zimbabwe supporting still relevant to the needs of the population of Zimbabwe? Are the strategic actions, outputs and indicators of the 5th CP contributing to the strategic priorities of the Zimbabwe national development plan as well as the UNDAF?

Impact
What reproductive health impacts were made as a result of interventions supported by UNFPA Zimbabwe? What gender related impacts were made a result of supported interventions? What HIV related impacts did the fifth country programme contribute to? What impacts did UNFPA make through its support on the availability of data for formulation of development plans and policy formulation?

Sustainability
Can the Government of Zimbabwe and other stakeholders continue implementing current interventions without UNFPA support? Were partners including the government of Zimbabwe involved in design, planning, implementation, monitoring and evaluation of the 5th CP? Are UNFPA programme indicators included in partners strategic plans for the implementation of P&D, RH, Gender and HIV related programmes?

Evaluation Methodology

Methods:
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 5th 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
Extensive consultations with UNFPA and its implementing partners in order to develop relevant evaluation questions and tools.
Interviews with programme managers of UNFPA and implementing partners of the 5th CP.
Interviews and focus group discussions with beneficiaries of the 5th CP; and
Project site visits, where appropriate to validate findings from other sources.

As part of the inception report the evaluator/consultant is expected to produce the following evaluation matrix.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Specific Evaluation Question</th>
<th>Performance Indicator</th>
<th>Data Source</th>
<th>Evaluation design</th>
<th>Sampling Plan</th>
<th>Data collection instruments</th>
<th>Data analysis plan</th>
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**Workplan, Organization and budget**

5.1 *Management and support arrangements*
The Consultant(s) will conduct the task in line with the terms of reference under the overall supervision of the Evaluation Task Force to be composed of UNFPA Country Representative, Assistant Representative, UNFPA and Implementing Partner M & E focal points, technical person for each thematic area (UNFPA and Implementing Partner Staff).

The evaluation will be managed by the UNFPA Assistant Representative who will be responsible for convening, coordinating and supporting the Evaluation Task Force meetings. The other duties include leading the development of TOR and the management response; managing the evaluation budget and ensure logistical and administrative support; and facilitating access to background documents.

The roles of the Evaluation Task Force shall include the following:
- Approving TOR
- Selecting and debriefing Evaluation Team
- Organizing technical support
- Approving inception report
- Monitoring progress and quality of evaluation activities
- Reviewing and commenting on drafts
- Approving evaluation reports
- Disseminating and following up to evaluation findings and recommendations
- Assessing performance and approving payments to evaluators
5.2 Implementation milestones

An inception report (showing the proposed design, methodology, implementation plan, deliverables, and deadlines);
A debrief at the end of field work (covering summary of resources spent and work covered in the field, and preliminary findings); and,
A final report.

The Evaluation task force shall convene a meeting upon achievement of each milestone to review products from the milestone. The inception report and the draft evaluation report will be shared with the Regional Office for quality assurance and clearance.

5.3 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 ongoing as well as future programmes.

5.4 Work plan and Activity Schedule

The following table shows the suggested work plan.

<table>
<thead>
<tr>
<th>Activities</th>
<th>Consulting person days</th>
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</thead>
<tbody>
<tr>
<td>Prepare evaluation inception report</td>
<td>1</td>
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<tr>
<td>Review of documents, stakeholder consultation and development of evaluation data collection tools</td>
<td>3</td>
</tr>
<tr>
<td>Data collection (including field visits to project sites)</td>
<td>5</td>
</tr>
<tr>
<td>Data capture and analysis</td>
<td>3</td>
</tr>
<tr>
<td>Writing draft report</td>
<td>4</td>
</tr>
<tr>
<td>Presentations to a stakeholders meeting</td>
<td>1</td>
</tr>
<tr>
<td>Final report writing incorporating comments</td>
<td>3</td>
</tr>
<tr>
<td>Total consulting person days</td>
<td>20</td>
</tr>
</tbody>
</table>

5.5 Final Report

The consultant is expected to produce a final report that contains the following sections (see Annex 1 for more details).

Title page
Table of contents
Acknowledgements
List of acronyms
Executive summary
Introduction
Findings and conclusions
Lessons learned
Recommendations and use of results
Annexes
Terms of reference
List of person interviewed
Sites visited
List of documents reviewed

Required Qualifications and Competencies
The assignment shall be carried out by a team of two competent consultants, one international and one local. The consultant(s) must have at least a relevant Masters Degree in the Social Sciences, Public Health or Epidemiology with more than ten years experience in carrying out evaluations for national, international and bi-lateral institutions. Previous evaluation experience of UNFPA Country programs or thematic areas, knowledge of UN programming, prior experience of evaluating UN programs, knowledge of current trends in key thematic areas and clear understanding of the TORs will be an added advantage.

In addition to the above qualifications and experience, the international consultant who will act as the team leader should have documented evidence of leading others in conducting large evaluations. The team shall also have strong communication, writing and facilitation skills.

Responsibilities of the Consultant(s)
The Consultant(s) will be responsible for the overall planning and implementation of the evaluation until the production of the final report. The specific responsibilities will include among other things:

Organizing the work and preparing a detailed plan for the assignment;
Conducting briefing and debriefing sessions to update the Evaluation task force on progress and constraints;
Consulting with CO and relevant partners to ensure that TOR are adequately addressed;
Ensuring the draft and final reports are timely prepared in accordance with the Terms of Reference; and
Facilitating the meetings to present the main findings of and recommendations from the evaluation.

Contractual agreements
A Special Service Agreement (SSA) will be signed with the Consultant(s). The evaluation team shall commence the performance of the SSA during the period of October to November, 2010. 20 working days maximum will be required for the Evaluator(s) to complete the assignment. Payment modalities will be as follows:
Upon a satisfactory Inception Report – 30%
Upon successful completion of fieldwork – 20%
Upon a satisfactory final report – the remaining 50%

UNFPA evaluation reports should include all the following elements:

**Title page**
Should contain name of project, programme or theme being evaluated; country/ies of project/programme or theme; name of the organization to which the report is submitted; names and affiliations of the evaluators; and date.

**Table of Contents**

**Acknowledgements**
Identify those who contributed to the evaluation.

**List of acronyms**

**Executive summary**
A self-contained paper of 1-3 pages, summarizing essential information on the subject being evaluated, the purpose and objectives of the evaluation, methods applied and major limitations, the most important findings, conclusions and recommendations in priority order.

**Introduction**
Describe the project/programme/theme being evaluated, including the problems being addressed by the interventions. Summarize the evaluation purpose, objectives, and key questions. Explain the rationale for selection/non selection of evaluation criteria. Describe the methodology employed to conduct the evaluation. Detail who was involved in conducting the evaluation and what were their roles. Describe the structure of the evaluation report.

**Findings and conclusions**
State findings based on the evidence derived from the information collected. To the extent possible measure achievement of results in quantitative and qualitative terms, and analyze the linkages between inputs, activities, outputs, outcomes and, if possible, impact. Discuss the relative contributions of stakeholders to achievement of results. Conclusions should be substantiated by the findings and be consistent with the data collected, and must relate to the evaluation objectives and provide answers to the evaluation questions.

**Lessons learned**
Based on the evaluation findings and drawing from the evaluator(s)' overall experience in other contexts if possible provide lessons learned that may be applicable in other situations as well. Include both positive and negative lessons.

**Recommendations**
Formulate relevant, specific and realistic recommendations that are based on the evidence gathered, conclusions made and lessons learned. List proposals for action to be taken (short and long-term) by the person(s), unit or organization responsible for follow-up in priority order, including suggested time lines and cost estimates (where relevant) for implementation.

**Annexes**
Attach Terms of Reference for the evaluation; list persons interviewed, sites visited; list documents reviewed (reports, publications); data collection instruments (e.g., copies of questionnaires, surveys, etc.); web links.
Annex 3: List of people met

Alex Zinanga  
HIV and AIDS Programme Manager

Alfred Manyengavana  
Village Head, Mutare Rural District

Alice Madendaja  
Mapper

Augustine Zinhumwe  
Provincial Supervisor

B. Gwandiregera  
Senior Economist

Banele Nkala  
Mapper

Bendamin Mukuri  
Driver/Mapper

Bertha Mukome  
Training Capacity Building Officer, for Youth Interventions,

Bhekimpilo Nyoni  
Mapper

Boniface Chitiyo  
Village Head, Mutare Rural District

Brian Nachipo  
Programme Manager, ASRH, ZNFPC

Brian Rufasha  
Provincial BC Coordinator, Mashonaland East, ZICHIRE

Butawu  
ZNFPC

C. Mooko  
Chief Economist

Chipo Mubikoni  
RGN, Mutare General Hospital MC Unit

Christine Gonese  
Provincial BC Coordinator for Harare, ZICHIRE

Clara Mukome  
Coordinator, Teen HIV Prevention Programme, City of Mutare

Clemens Benedikt  
HIV Prevention Manager, HIV Unit, UNFPA

Coherence Mamvura  
General Nurse, Mutare General Hospital MC Unit

Doreen Nyamukapa  
Gender Programme Analyst UNDP

Dr Edwin Mupeta  
Reproductive Health Programme Officer, UNFPA

Dr Owen Mugurungi  
HIV and TB Unit, Ministry of Health and Child Welfare

Dr Trevor Kanyowa  
National Programme Officer for Child and Adolescent Health,

Dr. Ruwona  
Acting Hospital Superintendent Munene Hospital (One-Stop

Edmund Kambarami  
Chief, Mutare Rural

Emilia Muchawa  
Director Zimbabwe Women Lawyers Association

Eunice Chirwa  
Mutare Rural District Councillor

Ewart Masuaure  
Mapper

Felix Chihlaba  
Mapper

Fiona Mwashita  
Executive Director, ZAPSO

G. Nyaguse  
Director, Policy Planning & Coordination

Getrude Shumba  
BC Programme Manager, FACT Mutare

Goodshow Bote  
Programme Assistant – Gender

Grace Chirewa  
Programme Officer – HIV, AIDS & GBV, International

Gwati Gwati  
Planning and Donor Coordination, MOHCW

I. Taramusi

Interview with 3 survivors of GBV, Mberengwa (names withheld for privacy)

Itai Mujaide  
Mapper
<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Role</th>
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<tbody>
<tr>
<td>James Wakiyaga</td>
<td>Economist</td>
</tr>
<tr>
<td>Jekoniah Chitereka</td>
<td>Youth Programme Manager, ZNFPC</td>
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<td>Jekoniah Chitereka</td>
<td>Youth Programme Manager</td>
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<tr>
<td>Jelda Nhliziyo</td>
<td>Gender Programme Officer, UNICEF</td>
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<tr>
<td>Kelvin Hazangwi</td>
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<tr>
<td>Kennedy Makadzange</td>
<td>Village Head, Mutare Rural District</td>
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<tr>
<td>Kenneth Chingono</td>
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<td>Khayetihle Dlodlo</td>
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<tr>
<td>L. Mandishara</td>
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<tr>
<td>Leo Wamwanduka</td>
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<tr>
<td>Luckson Chatora</td>
<td>RGN Mutare General Hospital MC Unit</td>
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<tr>
<td>M. Kurangwa</td>
<td>Clinic Manager, Adult Rape Clinic</td>
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<tr>
<td>Marion Manjoro</td>
<td>RGN Mutare General Hospital MC Unit</td>
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<td>Matron Mundoringisa -</td>
<td>Matron, Mutambara Mission Hospital</td>
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<td>Mercy Mandizvo</td>
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<td>Midlands-Census Mapping</td>
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<td>Mike Mavima</td>
<td>Accountant, ZAPSO</td>
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<tr>
<td>Mildred Matuwi</td>
<td>Magistrate Zvishavane Magistrates Court</td>
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<td>Moleen Zinhumwe</td>
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<td>Moly Madziwa</td>
<td>RGN, Mutare General Hospital MC Unit</td>
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<tr>
<td>Munyaradzi Gwazani</td>
<td>Deputy Team Leader</td>
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<tr>
<td>Netty Musanhu</td>
<td>Director, Musasa</td>
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<tr>
<td>Newenya Harry</td>
<td>Provincial Supervisor</td>
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<tr>
<td>Nkosentsha Mpofu</td>
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<tr>
<td>Nomagugu Ncube</td>
<td>Migration Health Project Officer, IOM</td>
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<td>Nomatter Masauso</td>
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<td>Nosikelelo Ndlovu</td>
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<tr>
<td>Orliata Chisvo</td>
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<tr>
<td>Peter Doroba</td>
<td>Mutare Rural District Councillor</td>
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<tr>
<td>Pregnant women in Mutambara</td>
<td>MWH</td>
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<tr>
<td>Raymond Moonsammy</td>
<td>Driver</td>
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<td>Raymond Tsiga</td>
<td>Mapper</td>
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<td>S. Rushambwa</td>
<td>Magistrate (Zvishavane)</td>
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<tr>
<td>Sarudzai Chimbadzwa</td>
<td>Mapper</td>
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<tr>
<td>Sheila Greenland</td>
<td>Project Manager, ZICHIRE</td>
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<tr>
<td>Shirley Chitsungo</td>
<td>UNICEF</td>
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<tr>
<td>Shumba</td>
<td>Counselor of survivors of GBV, Musasa</td>
</tr>
<tr>
<td>Siniikiwe Miilo</td>
<td>Team Leader</td>
</tr>
<tr>
<td>Slyvia Chirawu</td>
<td>National Coordinator, Women and Law in Southern Africa</td>
</tr>
</tbody>
</table>
Annex 4: List of documents reviewed

Adult Rape Clinic Annual Report (March 2009 - March 2010)
Millennium Development Goals Status Report, Zimbabwe 2010
Multiple Indicator Monitoring Survey Report, 2009, Zimbabwe
The National Gender Policy, Republic of Zimbabwe
Gender Based Violence Service Providers Directory, Republic of Zimbabwe, 2009
Using the Law to Enhance Women’s Presentation and Participation at all Levels of Political Structures in Zimbabwe, 2009
Gender Based Violence Service Providers Atlas, Zimbabwe, 2009
Understanding Gender and Gender Based Violence, Resource Manual for Training Trainers
Understanding Gender and Gender Based Violence, Participant’s Resource Handbook of Handouts
Zimbabwe Anti-Domestic Violence Council, Strategic Plan (2009 – 2011)
MoHCW 2007 Maternal and Newborn Health Road Map
MoHCW 2009 Mothers Waiting Homes Study
MoHCW 2007 Zimbabwe Maternal and Perinatal Mortality study
MoHCW 2010 Reproductive Health Services Assessment
MoHCW 2009 Obstetric fistula assessment
2007 UNFPA country report
2008 UNFPA country report
2009 UNFPA country report
UNFPA country programme for Zimbabwe
UNFPA 2007 Reproductive Health annual work plan
UNIFPA 2008 Reproductive Health Annual work plan
UNFPA 2009 Reproductive Health annual work plan
Mid Term Evaluation of the UNFPA 5th Country Programme
Government of Zimbabwe Country Analysis report for Zimbabwe
UNFPA Reproductive Health Standard Progress Report – 2007
UNFPA Reproductive Health Standard progress Report – 2008
UNFPA Country Office 2009 Final Narrative Report for the EC Delegation to Zimbabwe, ASRH Programme
UNFPA Country office 2009 Interim Progress Report for the EC Delegation in Zimbabwe, ASRH Programme
Government of Zimbabwe 2006 Zimbabwe National HIV and AIDS Strategic Plan 2006-10
MOHCW 2007 Towards Universal Access to HIV Prevention