COUNTRY BRIEF

FOR

MID-TERM REVIEW (MTR) OF THE UNFPA 3rd COUNTRY PROGRAMME OF ASSISTANCE TO THE GOVERNMENT OF SOUTH AFRICA (2007-2010)

DRAFT

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ACRONYMS AND ABBREVIATIONS

AIDS  Acquired Immunodeficiency Syndrome
AU   African Union
AWP  Annual Work Plan
CA   Country Analysis
CDP&D Chief Directorate Population and Development
CO   Country Office
CP   Country Program
CPAP Country Programme Action Plan
CSO  Civil Society Organization
CST  UNFPA Country Support Team
DHS  Demographic and Health Survey
DMC  Disaster Management Committee
FAO  Food and Agriculture Organization
FP   Family Planning
GDP  Gross Domestic Product
GBV  Gender Based Violence
HIV  Human Immuno Deficiency Virus
HIV  Human Immunodeficiency Virus
IDP  Internally Displaced Person
MDG  Millennium Development Goals
DSD  Department of Social Development
DOH  Department of Health
M&E  Monitoring and Evaluation
MOU  Memorandum of Understanding
MTR  Mid-Term Review
PD   Population and Development
RH   Reproductive health
RO   Regional Office
SADC Southern African Development Community
StatsSA Statistics South Africa
STIs  Sexually Transmitted Infections
TFR  Total Fertility Rate
TOT  Training of trainers
UN   United Nations
UNCT United Nations Country Team
UNDAF United Nations Development Assistance Framework
UNDP United Nations Development Programme
UNFPA United Nations Population Fund
UNICEF United Nations Children Fund
WHO  World Health Organization
1. Introduction

The objectives of the MTR are: a) to assess progress made in the implementation of the CP, with reference to the three programme components: RH, PD and Gender; b) to examine the extent to which advocacy in support of specific issues was mainstreamed into each programme component; c) the focus the components had on youth development, gender concerns in RH, HIV/AIDS prevention and management, sectoral use of population data, and research methodologies.

This Mid-Term Review (MTR) brief is based mainly on the analysis of periodic office reports on the components of the RSA/UNFPA 3rd Country Programme (CP) prepared by programme officers and related documents. Information from the Country Office (CO) records was supplemented by interviews with programme component implementers at national and provincial levels and UNFPA Programme Officers. The three components of the CP reviewed are Reproductive Health (RH), Population and Development (PD), and Gender, as well as the overall Management of the CP. The preliminary findings of the field work and office data collection were discussed with the managements of UNFPA CO and Chief Director, Population and Development from the Department of Social Development before the preparation of this brief.

The immediate objectives of the MTR are: a) to assess progress made in the implementation of the CP, with reference to the three programme components: RH, PD and Gender; b) to examine the extent to which advocacy in support of specific issues was mainstreamed into each programme component; c) the focus the components had on youth development, gender concerns in RH, HIV/AIDS prevention and management, sectoral use of population data, and research methodologies;

The focus of programme components regarding youth, gender, RH, HIV and AIDS prevention, use of population data and research for planning, is mainstreamed into the report. This allows a balanced view of the status of specific issues such as RH, in relation to youth and gender. Where necessary, youth or gender is treated as a topic under a heading, but in general, consideration is given to both youth and gender under each thematic area of UNFPA.

The MTR was also designed to examine management issues, particularly those relating to the effectiveness of programme coordination and collaboration with concerned Government Departments, international agencies and Non-Government Organizations (NGOs).

2. National Context

The current CP was formulated in 2006 under social, economic and demographic conditions that have experienced notable developments since
then. However, it is important to recall some of these features because of their relevance to this review.

**Social**

Since 1994, South Africa has made remarkable progress towards providing its population with access to basic social services, including water, health, education and housing. In 1994 only 61.7% of households had access to basic water services and this figure has increased to 87.2% of households in 2007. As of 2006 there were approximately 3.3 million people with no access to water and a further 4.9 million people with access to water below RDP levels. This indicator is important as it indicates population growth within South Africa as well as provides an indication of whether access to basic water has improved within the country. Target 10 of Goal 7 of the Millennium Development Goals requires a halving of the proportion of households without sustainable access to safe drinking water and basic sanitation.

Since 1994 education policies have focused on redressing the inequalities of the past by, inter alia, making education accessible. Access to education has grown substantially since the early 1990s with school enrolment increasing by 16.6% between 1991 and 2005. Most of this growth has been due to the rapid expansion of secondary education, which increased by 53.4% over this period, while the further education and training band (Grades 10, 11 and 12) alone, grew by almost 70%. The policy on universal access to primary health care, introduced in 1994, paved the way for effective health care delivery programmes that have had a major impact on the South African population.

**Economic**

Since 1994, South Africa has made remarkable progress towards providing its population with access to basic water supply infrastructure equal to or above RDP levels. In 1994 only 61.7% of households had access to basic water services and this figure has increased to 87.2% of households in 2007. As of 2006 there were approximately 3.3 million people with no access to water and a further 4.9 million people with access to water below RDP levels. This indicator is important as it visually indicates population growth within South Africa as well as provides an indication of whether access to basic water has improved within the country. Target 10 of Goal 7 of the Millennium Development Goals requires a halving of the proportion of households without sustainable access to safe drinking water and basic sanitation.

South Africa is ranked as a Middle-income country but poverty remains pervasive. In 2000, 11% of people in South Africa lived on less than US$1 a day and 34% survived on less than US$ 2 a day. Based on Income and Expenditure Survey of 1995 and 2005/06, it is reported that household poverty, as measured by the proportion of households falling below a poverty line of R322 per month (in 2000 prices) declined by five percentage points between 1995 and 2005/06. Similarly, the headcount rate at the lower poverty line of R174 per month decreased from about 31% to just below 23%. However, South Africa continues to be a highly unequal society, with the wealthiest 10% of the
population earning more than 50% of total household income. Poverty in South Africa also remains a disproportionately female phenomenon as can be seen from the consistently higher headcount rates for female-headed households.

Demographic

In 2006, when the 3rd CP was being formulated, South Africa had a population of 47 million, with youth (those aged 15 to 28) comprising about 37% of the total population. In the decade before 1994, the country had a steady population growth of about 2.1% annually; but growth rates have slowed down since 2000 due to the effect of AIDS. The sex composition of the population has remained steady with more females than males, estimated at 51% females and 49% males of the population.

Modern contraceptive prevalence in the country was estimated at 60% in 1994, up from 55% in 1990. Current contraceptive use remained constant at around 50% for all women between 1998 and 2003, but among married women, the proportion currently using any modern method increased from 55.1% in 1998 to 60.3% in 2003. These prevalence levels are highly correlated with education, place of residence and economic status of women.

The total fertility rate in South Africa was estimated at 2.9 in 1998, with considerable differentials between the four population groups but a similar downward trend of fertility decline since 1960. Declining fertility is due partly to social and economic trends, including economic growth in South Africa, urbanization, social mobility, and migration. Empowerment of women in terms of education, family planning, and access to jobs has contributed to driving fertility down. In 1998, South African women had an average of 2.9 children. There was a notable difference between urban and rural populations, with urban women having an average of 2.3 children each, and rural women averaging 3.9 children each. Fertility declined to an average of 2.7 children per woman in 2006. (Statistics South Africa report 2007) The average South African women would have approximately 2 children by the end of her reproductive age. Of those, according to the survey in 2003, approximately 1.6 was reported to be wanted fertility. (DHS 2003)

Before the AIDS epidemic, South Africa had been enjoying a drop in mortality, resulting in an increase in life expectancy. However, as a result of AIDS, the average life expectancy dropped from 63.3 years in 1990 to 55.6 years in 2000, and 50 years in 2006. Between 2001 and 2003, there was a steady but modest decline in the levels of mortality among children. This decline in mortality has been attributed in part to the government's programme of preventing mother-to-child infection of HIV. Maternal mortality ratio (adjusted for under-registration) stood at 56.5 per 100,000 live births in 1998 but increased to 78 in 2001; the upward trend is attributed to HIV/AIDS complications affecting mostly young women.
HIV/AIDS
The Government of South Africa has recognized HIV and AIDS as one of the main health and development challenges facing the country. Approximately 5.5 million people were estimated to be living with HIV in South Africa in 2005, with about 18.8% of the adult population (15-49) affected. Women are disproportionately affected and account for more than 50% of people living with HIV in the country. Women aged 25-29 are the most affected with prevalence rate of about 40% (Department of Health, 2006). For men, the peak is reached at older ages (30-39), with an estimated 23.3%. HIV prevalence among women 20 years and younger seem to be stabilizing at about 16% (Department of Health, 2005). It was also estimated that 96 228 babies were infected during 2003.

HIV/AIDS remains the greatest threat to improvement in the reproductive health status of the population of South Africa. Contributing drivers of HIV/AIDS in South Africa include male attitudes and behaviours, intergenerational sex, gender and sexual violence, stigma, untreated sexually transmitted infections, lack of consistent condom use in multiple and concurrent partnerships and mother-to-child HIV transmission. These drivers of HIV/AIDS are worsened by underlying social and structural factors such as high population mobility, poverty, inequalities of wealth, cultural factors and gender inequality that render young women particularly at risk of HIV infection, in addition to their greater biological vulnerability.

In response to the HIV and AIDS endemic, the government of committed to a multi-sectoral HIV & AIDS and STI Strategic Plan for South Africa 2007-2011 (NSP) aiming to reduce number of new infections by 50% and provision of treatment care and support to 80% of people diagnosed with HIV. The NSP is driven by the South African National AIDS Council (SANAC) under the leadership of the Deputy President.

Policy
The Population Policy for South Africa 1998 notes that gender issues constitute a significant challenge to programmes of social and economic development in the country. Incidence of violence against women is high, with an estimated average of one rape every 83 seconds. Childbearing levels for South African adolescents do not appear to be changing and is still significantly high, with one-third of women having experienced at least one pregnancy before the age of 20. Teenage pregnancies are also more prevalent among coloured and rural African girls, and those with little or no education. Women are the most affected with HIV/AIDS among the total population of South Africa, with young women more likely to be infected than men. Regarding education, at primary school level, the ratio of girls to boys has remained consistently close to 1 from 1999 to 2006. This suggests that more boys than girls are enrolled at this level of the education system. At secondary school level, the picture is reversed. More girls than boys are enrolled at this level throughout the years 1999 to 2006. The share of women in wage employment in the non-agricultural sector has increased between 1995 and 2000. Nevertheless, significant challenges remain in redressing gender imbalances in the country: the majority of the poor are, disproportionately, women; the level of women’s participation in the economy is
woefully low - as employees in most skills categories, as managers and as entrepreneurs.

It was against the above background that the 3rd CP was designed in 2006.

2.2 CP design and resources

The design of the 3rd CP was done within the context of the United Nations Development Assistance Framework for South Africa (UNDAF), 2007-2010, which was jointly agreed by the Government and the UN system in South Africa. The UNDAF took into account broad social and economic transformation outcomes, as detailed in the Reconstruction and Development Programme (RDP) of South Africa, and incorporated the “five big ideas” as outlined by Government in Vision 2014, with a view to achieving these fundamental objectives: Meeting basic needs; Building the economy; Democratizing the State and society; Developing human resources; and Nation building. The CP was also aligned with the MDGs, the ICPD Programme of Action, the Maputo Declaration on Continental Policy Framework on Sexual and Reproductive Health and Rights, and the UNFPA Mid-Term Strategic Plan.

The support of UNFPA to the 3rd CP in South Africa was approved (23 August 2006) in the sum of $13 million: $7.6 million from regular resources and $5.4 million through co-financing modalities and/or other, including regular, resources. In accordance with UNFPA mandate, the CP was designed to address three focal areas; namely, Reproductive Health, Population and Development, and Gender. Also based on the Fund’s priorities, the approved total fund of US$13 million was distributed among the three programme components as follows: RH (US$ 6.0million); PD (US$3.0 million); and Gender (US$ 3.4); while the balance of US$ 0.6 million goes to Programme coordination and assistance.

2.3 Programme goal, outcomes and outputs

In arriving at the CP goal, outcomes and outputs, the UNFPA Office in Pretoria worked closely with the Department of Social Development, its principal partner on population matters, as well as with the Provincial Population Units in the identified four priority provinces; namely, Limpopo, Eastern Cape, KwaZulu Natal and Free State. Consultations were also held with the component programme implementers, including the Departments of Education, Health, Labour, Local Government, the Presidency, selected universities and training institutes, NGOs and community-based organizations (CBOs). It is noteworthy that the leadership role played by DOH and The Presidency in the definition of respective sub-programmes (RH & Gender) would need to be improved for the next CP.

The stated goal of the country programme under review is to improve the quality of life of South Africans by helping to reverse the spread of HIV, reduce gender inequities, and enhance the centrality of population issues in development policies and programmes. By its design, each of the three programme components is expected to contribute to the achievement of relevant
UNDAF outcome(s), and in that way, the CP addresses all the five UNDAF outcomes, and through them the overall national development goals to: (a) eradicate poverty; (b) accelerate the growth of the economy and development for the benefit of all; (c) strengthen South African and sub-regional institutions to consolidate the African Agenda and promote global governance and South-South cooperation; and (d) strengthen the efforts of the Government to promote justice, peace, safety and security. The CP Results and Resources Matrix for South Africa which is annexed to the CP document (2006) shows the relationship between the CP outcome(s) and outputs for each component and related UNDAF outcome.

**Reproductive Health**

RH component has two stated outcomes: i) strengthened capacity of the Government to implement the comprehensive HIV/AIDS plan; and ii) improved and expanded capacity of the national health system to deliver high-quality services. In order to address the two outcomes, the following outputs were planned:

a) Strengthened capacity of the Government, non-governmental organizations (NGOs) and civil society to prevent HIV infection, especially among youth.

b) The Government is supported in achieving universal access to HIV/AIDS prevention, treatment, care and support services.

c) Strengthened capacity of health-care workers to deliver reproductive health services, including high-quality family planning and services to prevent and manage gender-based violence and avoid unwanted and teenage pregnancies.

d) Accelerated and increased use of female condoms.

e) A strengthened national monitoring and evaluation framework, especially with regard to the compilation and analysis of HIV/AIDS data and reporting on reproductive health commodities.

**Population and development component**

The outcomes for the PD component are: (a) strengthened national macroeconomic capacity for policy formulation, implementation and coordination; and (b) strengthened government ability to develop and implement coordinated interventions to address economic and employment inequalities within the economy. The following three outputs were identified to address the PD outcomes:

a) Strengthened government capacity to integrate population, gender, environment and HIV/AIDS issues into development.

b) Strengthened government capacity to develop and implement policies and programmes on employment and training.

c) Strengthened government capacity to generate, analyse and disseminate policy-relevant data, including Millennium Development Goal-related indicators.
Gender component
The only outcome for the Gender component is: enhanced structures and capacities to prevent and respond to violence against women. In this regard, the CP defines the outputs as follows:

a) Increased community capacity to prevent and respond to gender-based violence.

b) Strengthened capacity of different sectors of government and other relevant institutions in gender auditing, gender budgeting and gender mainstreaming.

c) Strengthened provision of comprehensive services for female victims of gender-based violence and abuse.

d) Strengthened capacity of national, provincial and local authorities and law enforcement agencies to implement human rights-based policies and programmes to prevent gender-based violence.

2.4 Programme implementation strategy
In order to achieve maximum impact with the limited resources, the CP was designed to be strategic in its interventions. The programme supports the Department of Social Development, Department of Health, SANAC and the Ministry of Women, Children & Persons with Disabilities at the national level, and selected provinces of Eastern Cape, Kwa-Zulu Natal, Limpopo and the Free State, based on their poor socio-economic indicators and large population. It was determined that strengthening the capacity of the two UNFPA sub-offices (KwaZulu-Natal and Eastern Cape) and extending sub-offices to the Free State and Limpopo would result in improved programme delivery.

At the design stage, the Department of Social Development made an alternative proposal to UNFPA CO, suggesting that the aim of the CP should be to have reached all nine provinces by 2010 through a “phased approach... from the current 10 rural districts in three provinces (Limpopo, KwaZulu Natal and Eastern Cape), to all 21 rural and urban development nodes, and ultimately to all 53 districts/metros in all nine provinces” (Chief Director, CDP&D: 22 August 2006). Due to financial and human capacity constraints, UNFPA does not have the capacity to cover as many districts; therefore, Government is supported to increase efforts in expansion of the population programme. The phased expansion has not materialised, and support to the four provinces has been inconsistent and, in the case of the Free State, virtually on paper only.

The Department of Social Development (DSD) is the national coordinating Government agency for the population programme in South Africa (Population Policy, 1998). The CP acknowledges this role with reference only to the national level. Coordination of the CP at provincial and district levels is jointly by the Department of Social Development, and the offices of the provincial premiers. In operational terms, the autonomous status of the provincial governments in the country puts the UNFPA in an uneasy middle position between national government in Pretoria and the provincial governments, especially in reaching out to government implementing partners (Departments of Education, Health, Labour, Local Government and the Gender Commission). Walking the thin line of authority structures between national and provincial Departments has remained a politically sensitive and administratively difficult operation; but
recent developments whereby all the implementers have a common forum to discuss programme matters is a promising solution to a tangled management problem.

Indeed, the 3rd CP suggests such a development at the higher levels of governance: (a) establishing a national coordinating committee on population and development; and (b) setting up similar coordination arrangements at the provincial level. While efforts at establishing a national coordinating committee on population and development are fairly recent (first National Population Forum meeting was held on 25 November 2009, and a follow-up meeting on 03 February 2010), it will take a while for such a coordinating body to be established and effective in the four focal provinces and the country at large. It is also important to note that the establishment of a coordinating committee for South Africa’s population programme (as opposed to UNFPA/GoSA CP) is the mechanism proposed in the Population Policy (1998), with the National Population Unit serving as the Secretariat for the committee in facilitating the coordination of the national population programme (or Action Plan for Population Policy Implementation), which is yet to be developed.

It should be noted that the coordination forum mentioned here discusses only UNFPA CP as it relates to the 3 thematic areas it is not a forum that discusses Government population and development business in which UNFPA support is one agenda item. This is an opportunity that Government could take advantage of to meet as a collective to discuss and agree on issues related to the implementation of the National Population Policy rather than just UNFPA support. The Forum is best titled “National Coordination Forum on UNFPA Support to the Government of South Africa”.

3.0 MTR design

3.1 Methodology

The Terms of Reference (TOR) for this MTR evaluation places the responsibility for a design of approach on the Consultant (see Annex 1 of this report). It requires the Consultant to “prepare MTR design proposal, including: a) proposed evaluation methodology, b) sample sizes, c) evaluation questions, d) questionnaires, e) work plan". At the start of the exercise, it became clear that there was only one consultant and that the assignment should be completed within 11 working days. The actual contract allows the consultant days of stay within the country, and the MTR report drafted elsewhere at home station. The draft MTR report will be made available for presentation of findings at the next National Coordination Forum for feedback and validation by partners, resulting in the final MTR report.

3.2 Data sources and limitations

The UNFPA CO prepared a roster of persons and agencies to visit during the data collection period. Based on the schedule, the consultant collected data and information from CO records, held interviews and meetings with UNFPA staff at national and sub-regional offices and programme implementers at national and
provincial levels. In order to maximize the utilization of time, most of the interviews and discussions were held with implementers over the telephone.

Interviews were held with the following implementers, representing UNFPA, Government and Non-Governmental Organizations in accordance with the work plans for the period of review.

**Partners**

Jacques van Zuydam  
Zoliswa Tshiki  
Dr. Eddie Mhlanga  
Dr. Nathaniel Khaole  
Ranji Reddy  
Alex Nyago  
Sanele Bhengu  
Siphiwe Maseko  
Makhosazana Nxumalo  
Momvula Kwadjo  
Khawula Mrs

Chief Director, Social Development, Pretoria  
Chief Director, Social Development, Bisho  
Cluster Manager, Maternal, Child and Women’s Health, Department of Health, Pretoria  
Director, Women’s Health and Genetics Dept of Health, Pretoria  
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Director, SPW, East London  
PPU, KZN Province, Social Development  
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One major problem from the data collection process, was the virtual absence of institutional memory in the CO for a greater part of the review period (2007-2009). Out of the 12 management and professional staff members in the UNFPA CO Pretoria in 2007, only one National PO and one Programme Associate remained by the end 2009. Some of the same category of staff serving in 2008 had left by the end of 2009, worsened by leadership (UNFPA Representative) vacuum. In the circumstance, reliance had to be placed largely on office records, without much opportunity to clear with programme officers or management certain professional issues about implementation challenges and proffered solutions.

Analysis of data collected through the records and interviews formed the basis of this report. It is expected that further clarifications on specific programme implementation issues would be provided at the planned stakeholders’ workshop to be scheduled by the CO. The final report of the MTR Brief would benefit from the workshop.
Presentation of this report relied on UNFPA Guidelines for MTR reporting.

4.0 Analysis of Programme Performance

4.1 Continued relevance of programme objectives and strategies
The stated goal of the programme is to improve the quality of life of South Africans by helping to reverse the spread of HIV, reduce gender inequities, and enhance the centrality of population issues in development policies and programmes. The overall strategy of the CP has been to focus on three thematic areas; namely, RH, PD and Gender, with concentration of programme interventions at national level and in the poorest four provinces indentified by Government (Limpopo, Kwa-Zulu Natal, Eastern Cape and Free Sate). By such a strategy the CP supports the Government efforts to eradicate poverty, improve the reproductive status of men and women, including prevention of HIV/AIDS, to enhance the capacity of planners at all levels to integrate population issues into policies and programmes, and to promote gender mainstreaming.

Regarding poverty, the ICPD + 15 review report shows that South Africa continues to be a highly unequal society, with the wealthiest 10% of the population earning more that 50% of total household income; the proportion of the rural population living in poverty increased from 45% to 46% on a $2 per day poverty line between 1996 and 2001; but despite the relatively large declines in the proportion of Africans living in poverty, Africans (who make up 79% of the total population) constitute a disproportionate share of the poor.

While South Africa has made tremendous achievements in addressing RH issues since 1994, particularly at the policy level, by 2009 significant challenges still remained. HIV and AIDS remains the greatest threat to improvement in the reproductive health status of the population of South Africa; the drivers of HIV and AIDS are worsened by underlying social and structural factors such as high population mobility, inequalities of wealth, cultural factors and gender inequality that render young women particularly at risk of HIV infection, in addition to their greater biological vulnerability. Women bear the brunt of the epidemic in that they account for 55% of people living with HIV and AIDS in South Africa. This phenomenon is more pronounced in the age groups 20-24 and 25-29 years.

Overall, South Africa has the necessary political will, legislative framework and broad societal commitment that has allowed for practice measures to affirm the rights of women in critical areas and advance the women empowerment agenda. In pursuit of its constitutional imperatives on violence against women, the SADC Addendum; the Beijing Platform for Action; CEDAW and other relevant international human rights norms and instruments, South Africa has implemented a comprehensive law reform process to strengthen the integrated response to violence against women in the country. Despite these concerted efforts on policy, legislative and programmatic levels; harmful practices against women and children, on grounds of gender and sexuality, remain common.
The recent CEDAW country report confirms that South Africa has amongst the world’s highest levels of reported sexual and domestic violence. Research conducted by the Medical Research Council in 2004 shows that “a woman is killed by her intimate partner in South Africa every six hours.” The South African Police Services (SAPS) have also reported that the country has experienced a rise in the number of (reported) sexual offences, for example from 133.4 per 100 000 in 2007/08 to 144.6 per 100 000 in 2008/09. Published by The Presidency in 2008, the Towards a Fifteen Year Review Synthesis Report notes that the incidence of reported rape increased from 1994, then fell back to 1994 levels by 2002 and has since fallen lower (76 per 100 000 in 2007/08 compared with 115 in 1994/95). However, the SAPS Annual Report 2007/2008, Crime Situation in South Africa revealed that as a proportion of overall violence against persons, crimes against women and children have not, however, shown significant change. Over half of common assaults and half of assaults with grievous bodily harm are against women and children.

The RH component of the CP is made even more relevant by recent information. According to the Strategic priorities for the National Health System, 2004-2009, while the overall HIV prevalence is stabilizing and its prevalence among young women was decreasing, there remains the challenge of implementing the Comprehensive Plan for Treatment, Management and Care of HIV and AIDS, and this includes safe provision and use of ARV to the patients that qualify to be in the programme. Also, a big challenge in HIV and AIDS activities is achieving behavioural change through practicing safe sex, particularly condom use. This is where the continued intervention of UNFPA as the lead agency among the UN family in HIV prevention within UNDAF remains critical.

In recognition of the significance of the challenges posed by HIV/AIDS to governance and development in the country, the South African government introduced two important policies on HIV and AIDS since 2000: i) the HIV, AIDS and STI Strategic Plan for South Africa (2007-11) which set the basis for South Africa’s response to the growing challenge of HIV infection; and ii) the Comprehensive HIV and AIDS Prevention, Care, Management and Treatment Plan for South Africa which was adopted in November 2003. The two policies combine prevention, support, care and treatment for HIV and AIDS, and associated conditions. The size of South Africa’s HIV and AIDS programme is evident from its financing, which has increased from ZAR 342 million in 1994 to a projected ZAR 3,600 million (approximately USD 600 million) in the 2005/6 financial year, making it one of the largest domestic HIV and AIDS programmes in the world. The programme has a strong prevention focus and is built upon the principle of strengthening health services. This has meant that users of the public health system have experienced increased access to care in general, better access to the treatment of opportunistic infections, better quality of care and more comprehensive care for HIV and AIDS in particular. More than 131 216 persons with HIV and AIDS have benefited from nutrition interventions through food parcels and nutritional supplements.

There are PD-related challenges identified in the ICPD @ 15 review for South Africa which also continue to make the 3rd CP relevant to the country’s
development. It is noted that population and demographic skills and expertise required to implement the Population Policy remain a major challenge and constraint at national and sub-national levels. The report suggests that there is need to i) enhance the technical capacity of technical planning staff in pertinent government institutions at all levels and in all sectors with regard to the methodologies for integrated population, development and gender-sensitive planning and programming; ii) expand opportunities for training in Demography and Population studies; iii) establish and/or strengthen mechanisms for inter-sectoral consultation, collaboration and coordination. On population research, the report points at the need to strengthen commitment to and enhance national capacities and mechanisms for the collection, analysis interpretation and dissemination of population data and information, including data and information on all aspects of human development, and the use of such data and information to inform policy making and development planning. The Population Policy indicates that an action plan will be drawn to facilitate the process of policy implementation and coordination; the 2009 report notes that this action remains a gap and should be filled in order to synchronize Government investments with the efforts of Non-Government agencies and development partners. The absence of the national population action plan with a clear division of labour amongst Government depts. is still problematic; as this has direct bearing development of UNFPA CP and further engagement with other Government partners. The absence of the national population action plan with a clear division of labour amongst Government depts. is still problematic; as this has a direct bearing on the development of UNFPA CP and further engagement with other Government partners.

The National Policy Framework outlines the structure and functions of the facilitative components of the National Gender Machinery, each of which are located strategically at the highest level of government, within Parliament and amongst statutory bodies. However, the country has been challenged by the lack of a more clearly defined institutional framework necessary to coordinate and drive the vision of gender equality. In addition, the country’s Beijing+15 Review Report indicates that this challenge was exacerbated by lack of enforceable mechanisms towards increasing the accountability of the senior management in the Public Service for the increased recruitment of women into management positions to meet the goal of gender parity and in promoting a more enabling environment for empowerment of women. Furthermore, the envisaged coordination framework outlined in the Policy Framework in bringing together the private sector, business, local government level and the trade union movement, has not yet fully materialized, with the results being that partnerships and collaboration between different stakeholders have become piecemeal and mostly ad hoc in nature.

Within the context of these challenges, the 3rd CP of UNFPA is relevant to provide the necessary technical assistance and support in the process of developing a more clearly defined institutional framework necessary to coordinate and drive the vision of gender equality, as recommended in the country’s recent CEDAW report. Building on this work, the 3rd CP should specifically focus on strengthening the Government’s capacity to create
increasing opportunities for mainstreaming gender and equality goals into national agenda-setting processes and transformation priorities.

In so doing, the program will strengthen national women’s empowerment strategies that will lead to real gender equality and women’s greater participation in the country’s democratic processes. One of the key strategic interventions should be to strengthen the technical capacity of the newly-established Ministry of Women, Children and Persons with Disabilities, which is meant to achieve better alignment between structures, the electoral mandate and the developmental challenges that need to receive immediate attention from the government and the different sectors of the society. The Ministry remains a critical role-player in the achievement of the Government’s 12 identified strategic outcomes in the current Medium Term Strategic Framework.

On the overall UNFPA CP continues to be relevant in the context of the socio-economic development and health challenges facing the country.

4.2 Progress made in achieving results of CP at all levels
The coordination of programme monitoring and evaluation requires a framework, which defines the outcomes and outputs and their indicators, together with baselines and targets for each outcome/ output indicator. In the case of UNFPA CP, this is the CPAP which is an elaboration of the CP Results and Resources Matrix, to be done jointly by the CO and the programme implementers. The elaboration of the CP Results and Resources Framework has not been adequately implemented, particularly the determination of baselines and targets for the identified programme outputs, and this makes it difficult to critically analyse programme performance in terms achievement of objectives (outputs) and determination of the efficiency and effectiveness in the deployment of programme resources (money, equipment, materials) during the review period.

4.2.1 Reproductive Health
RH component has two immediate objectives; namely, to strengthen the capacity of the Government to implement the comprehensive HIV and AIDS plan, and to improve and expand the capacity of the national health system to deliver high-quality services.

In order to address the above immediate objectives of the RH component, CO in collaboration with the Department of Health (DOH) drafted SRH Work plans in 2007 and 2008). Unfortunately, both workplans were not signed. However, during the same periods, 2006 to 2008, Cervical Cancer Screening work-plans were signed and implemented as formulated by UNFPA with the Department of Health. UNFPA appointed a Technical Adviser, who was based at NDOH to support the implementation of this project. In 2009 and 2010, SRH work plan was developed and signed by both UNFPA and NDoH. The implementation of both work plans was undertaken jointly by UNFPA and NDoH. Deriving from the stated objectives of the RH component, this section will focus on i) capacity strengthening of the Government and implementing partners to implement the comprehensive HIV/AIDS plan; ii) CP support to the capacity of the health
system for the delivery of high-quality health services, during the review period (2007-2009) and; CP support to HIV/AIDS programme in the country.

1) Capacity strengthening

One of the initial projects on SRH capacity strengthening carried out by CO is the Religious Leaders Project (RLP), which focuses on Faith Based Organizations in the country. The RLP was designed to strengthen the capacity of Religious Leaders to advocate for the prevention of HIV and Gender Based Violence (GBV) and the promotion of Sexual and Reproductive Health (SRH) services. Jointly being implemented by UNFPA and CDP&D, the project was approved for implementation over a period of eighteen (18) months from 2005; but actual work on the project started only began May 2007 to 2009. Implementation was undertaken in collaboration with the following Faith Based Organizations: Soshanguve Ministers Fellowship (SMF) in Gauteng; South African Council of Churches – Limpopo, KwaZulu Natal Christian Council, Eastern Cape Council of Churches, and Congress of South African Churches (COSACHU) in the North West. A recent evaluation report on RLP performance (2009) identifies the following major achievements of the project in the targeted provinces: a) religious leaders bought into the project and opened their church doors for community mobilization and sensitization efforts to be done; b) improved capacity of the religious leaders to disseminate messages in advancing the prevention of HIV and AIDS, GBV and SRH services through their sermons and regular church activities. As evidence of its relevance, beyond the initially targeted nodal areas, there were requests for replication of project activities across all implementing provinces. In order to assure sustainability, the evaluation report recommends the strengthening of project activities on a number of levels, including systemic/organizational, programmatic, technical support and administration.

In 2008 and 2009, UNFPA in partnership with WHO, supported the Department of Health (DoH) in efforts towards promoting increased use of family planning services. Use of modern contraceptive method according to 2003 DHS is 64.7%. Dropping fertility is due partly to social and economic trends, including economic growth in South Africa, urbanization, social mobility, and migration. In 1998, South African women had an average of 2.9 children. There was a notable difference between urban and rural populations, with urban women having an average of 2.3 children each, and rural women averaging 3.9 children each. Fertility declined to an average of 2.7 children per woman in 2006. (Statistics South Africa report 2007). The average South African women would have approximately 2 children by the end of her reproductive age. Of those, according to the survey in 2003 approximately 1.6 was reported to be wanted fertility. (DHS 2003).

The support was geared towards promoting access to contraception including male and female condoms, as well as emergency contraception, with involvement of young people, based on culturally sensitive approaches and men’s engagement. The activity included technical assistance to DoH in two areas: a) in conducting an update training on Family Planning for SRH trainers, Primary Health Care managers, and School of nursing tutors; and b) in the
promotion of use of contraceptive use with male or female condoms. UNFPA CO also worked with DoH and WHO and trained 84 participants from 8 provinces, as Master trainers with specific focus on repositioning of Family Planning and promoting use of the services; cervical cancer screening and management, advocacy for prevention of GBV and HIV and AIDS, , with special emphasis on promotion of use of dual protection. As part of the cervical cancer screening programme, UNFPA also supported training of 27 Doctors from all nine provinces on use of Colposcopy in 2008 and 2009. Training was undertaken by University of Pretoria, Obstetrics and Gynaecology Unit. In an effort to improve institutional capacity in rendering SRH services, UNFPA in 2009 supported participation of two NDoH senior staff members in regional training workshops on Monitoring and Evaluation of Maternal Health programmes in Tanzania, and Human Resource development for Maternal Health, Task Shifting in Ethiopia.

In addition, CO supported SPW in the Eastern Cape to establish Youth Action Groups in rural communities, and training of Peer Educators who in turn conducted sessions specifically on condom use every month, including promotion of family planning services. Technical assistance was again provided to DOH through workshops focusing on issues of prevention of HIV/AIDS; early sexual activity and teenage pregnancy; and protection against unwanted/unplanned pregnancy and disease.

With the support of UNFPA, the Department of Social Development (DSD) implemented a training course for senior managers and planner across the government departments on HIV/AIDS and Integrated Development. UNFPA also supported DSD, through a service provider, in carrying out an evaluation of the training programme and the impact of the training on the 294 government officials who participated, as well as institutionalization of the training results within government. These are practical examples of UNFPA interventions that Government found to be strategic and very effective.

Technical support was provided in National Youth consultative forum of the National AIDS Council promoting male reproductive health including Medical Male Circumcision.

ii) Support to delivery of high-quality health services
In 2008, UNFPA increased its support to young people’s access to SRH, HIV and gender-based violence prevention services, and gender-sensitive life skills-based SRH education through support to: a) the Youth sector of South African National AIDS Council (SANAC) to develop institutional arrangements (National and local levels) to strengthen HIV prevention among youth; b) the Department of Provincial and Local Government in its 16 days of activism campaign of ‘No violence against women and children’; c) the National Department of Education on its Advocacy Campaign for the prevention of sexual violence and sexual harassment in public schools with special emphasis on GBV and HIV
prevention strategies for public schools; d) the SPW in the Eastern Cape to implement a youth programme in rural Eastern Cape; e) communities to establish Youth Action Groups and training of peer educators within the targeted communities. Also, CO supported workshops on issues of prevention of HIV and AIDS; early sexual activity and teenage pregnancy; protection against unwanted/unplanned pregnancy and disease. In partnership with Government and South African Council of Churches, UNFPA provided assistance for the training of Master trainers in 5 Provinces in Advocacy for prevention of GBV and HIV and AIDS, who in turn started to train other FBO leaders on the same, with specific focus on the youth.

In 2008, UNFPA supported Government with 300 Female pelvic models for use in health and community condom distribution points for demonstration of correct use of female condoms, and to promote acceptance and increased use of female condoms. Given that demand for pelvic models is high in the country, and in order to ensure proper demonstration and promotion of female condom use, CO planned to continue this support. A mid-year review report indicates that by June 2009, UNFPA had supported DoH with additional 500 female pelvic models for promoting use of female condoms and life-skills education targeting youth out of school, and also supported the implementation of youth programme in rural areas of Eastern Cape promoting safer sexual practices and youth development.

During the Xenophobic attacks by mid-2008, UNFPA participated actively in the UN Protection Theme Group to support xenophobic violence victims. During that period, implementation of CP slowed down, as more time was taken by the response/support to the xenophobic violence victims.

In response to Government’s request, UNFPA together with UNICEF, UNAIDS and WHO conducted a HIV and AIDS Health Sector review designed to assess the impact and readiness of the health sector to cope with certain policy changes planned by the Department of Health related to HIV and AIDS treatment care and support. CO also provided technical assistance on the development of draft MMC policy and sector consultations and review of the contraception and cervical cancer policies.

In 2009, CO continued to provide support to training on the contraception policy and the repositioning of the Family Planning programme, including condom use in an effort to improve uptake. In addition, support was provided in the development of a national HIV prevention strategy that includes male and female condoms.

The Maternal, Child and Women’s health directorate within the National Department of Health, focuses on women’s health, including reproductive health. This sub-programme was allocated R24.5 million in 2008/09 financial year, up from R16.5 million in the 2004/05 financial year. The increase in budget is or intended to ensure availability of reproductive health and related services (including RH commodities to all people in both urban and rural communities principles of primary health care approach SRH and HIV and AIDS services are linked. Health care facilities provide universal access to SRH
and HIV prevention and care services including contraception, male and female condoms at no cost. Govt. ensures that there is sufficient supply and choice of high quality modern contraceptive methods to every person that need them, including condoms. Male condoms are widely available, but female condoms are still mainly available in health care settings (clinics) and NGOs. Contraception, including Emergency contraception are easily accessible in both the private and public sectors, however uptake though high in comparison to other African countries in the region needs to be increased. There are many women, including very young girls seeking abortion services, with unplanned and unwanted pregnancies.

Institutional support to strengthen capacity to deliver quality SRH services, and to improve access and the quality of SRH health services was also provided through training of 84 SRH programme managers at national level, focusing on acceleration of the implementation of the Cervical cancer screening policy; contraception policy and the repositioning of the Family Planning programme, including condom use. In addition, UNFPA provided support to colposcopy training for 7 medical doctors from all nine provinces in an effort to improve cervical cancer screening programme. Support was also provided to a review of cervical screening, contraception and sexual assault policies, and the development of draft Medical Male Circumcision policy and sector consultations on the draft policy.

CO collaborated with other UN agencies in the finalization of the Maternal, Neonatal, Child and Women’s Health Strategy, and the implementation plan for the operationalization of the strategy. Towards enhancing the capacity of doctors and midwives CO supported training in providing quality care to reduce avoidable maternal and neonatal deaths, including training of doctors and nurses in emergency obstetric care; also, technical support was given to midwives professional society to revitalize the profession.

The CP supported training of midwives and doctors on ‘The Essential Steps in Managing Obstetric Emergencies (ESMOE)’ in an effort to reduce avoidable maternal deaths. This training is delivered by the University of Pretoria. This training course is aimed at improving the quality of emergency obstetric care in sub-district, district and regional hospitals in South Africa. Also, UNFPA supported the participation of Cluster Manager at a regional meeting on Task Shifting for Maternal Health in Ethiopia, and Deputy Director: Maternal Health participation in two week training on Monitoring and Evaluation of Maternal Health programmes. Also, CO supported the technical committee on Confidential Enquiries into Maternal Deaths, and the printing of Saving Mothers Report. These UNFPA interventions make a meaningful contribution towards maternal mortality reduction.

**iii) CP support to HIV & AIDS programme**

CO has been supporting the National Strategic Plan (NSP) on HIV and AIDS and STIs since 2007. At the start of CP implementation, CO provided assistance towards a workshop on male circumcision at SA national AIDS Conference; it undertook mission to 5 provinces with the support of CST, and in collaboration
with WHO and DOH to identify challenges and priorities for inclusion in CPAP. UNFPA CO also supported the SPW to work with youth in rural Eastern Cape Province, leading to the establishment of Youth Resource Centres and Youth Action Committees in targeted communities. These centres have been active in regular distribution of condoms, with peer educators giving advice on use when distributing. In addition, support was provided to FFDC to reach young people with HIV and AIDS information in the Western Cape where 382 young people (including 136 out-of-school youth) became active members of the Youth Action Committee (YAC), 48 of these members attended a leadership training camp, and were regularly involved in positive recreation activities. Project monitoring report shows an increase in young people involved in sport, and reported decline in the number of young people drinking liquor daily in the targeted communities.

In 2008, CO’s contribution to demand, access to and utilization of quality HIV and STI prevention services, especially for women, young people, and other vulnerable groups, including populations of humanitarian concern increased through support to i) the Youth sector of South African National AIDS Council (SANAC) to develop institutional arrangements at national and provincial levels to strengthen HIV prevention among youth ii) three of the nine provinces to develop an operational plan for youth based on the National HIV/AIDS strategy; iii) the National Department of Education on its Advocacy Campaign for the prevention of sexual violence and sexual harassment in public schools with special emphasis on GBV and HIV Prevention strategies for public schools; iv) SPW in the Eastern Cape to establish Youth Action Groups, and training of Peer Educators in rural communities, who in turn would conduct sessions specifically on condom use, prevention of early sexual activity and teenage pregnancy; protection against unwanted/unplanned pregnancy and disease; and v) strengthen capacity of youth and women within FBO organizations in five provinces on advocacy for HIV prevention.

In continuation of its targeted support, UNFPA in 2009 provided support to two youth organizations in South Africa to address issues of knowledge and awareness on HIV and AIDS and also to build the capacity of youth leaders to lead the response to HIV and AIDS among their peers. UNFPA supported a Youth Lekgotla prior to the 4th South African AIDS Conference to strengthen the capacity of young people to effectively participate in the conference, to establish trends on the level of youth participation at the SA AIDS conferences, to share knowledge and skills on HIV and AIDS programming for and with young people and to develop a network of young people to act as mentors and ground breakers for future HIV and AIDS interventions. Ninety young people aged between 15 and 24 participated in the Lekgotla. Convening the Lekgotla in itself was a success for the young people and organizations involved and participation in the Lekgotla increased the knowledge for young people who participated in the Lekgotla.

In the Eastern Cape province, one of the provinces hardest hit by the HIV and AIDS epidemic in South Africa, young people were supported on HIV and AIDS prevention through youth lead awareness and development activities such as peer education workshop, sports for development programmes,
entrepreneurship and skills training programme. In 2009 with the support of SPW many workshops and events were held to promote awareness on HIV and AIDS and develop the skills of young people to reduce their vulnerability HIV and AIDS and poverty.

UNFPA worked with the UNCT in South Africa, to conduct a High-Level Health Sector Review of HIV/AIDS / TB / RH to, among others, assess the implementation of the health sector HIV and AIDS programme. The review was led by UNFPA in terms of HIV prevention and sexual reproductive health services; CO also provided inputs to the report on significant gaps and highlighted the opportunity for the integration of HIV prevention and sexual reproductive health services at facility and community level. According to the CO records, the success of the health sector review highlighted the ability of the UN in South Africa to be strategic partner to Government and illustrated the UN’s role in technical support and advice to Government in a timely manner. This include, among others, the brief developed by UNFPA on international good practices for SRH and HIV integration after the Health Sector Review.

On HIV prevention, UNFPA worked in collaboration with other UN agencies in supporting the Youth Risk Behaviour Study that would inform designing of appropriate programmes to reduce the risky behaviours that lead to HIV infections and teenage pregnancies. In 2009, the CO partnered with the Sex Worker Advocacy Task Force (SWEAT) to organize a consultation on HIV/AIDS, Sex Work and the FIFA World Cup 2010. In addition, CO supported Limpopo DoH in the training of youth peer educators working in rural clinics, targeting youth with information on prevention of HIV, teenage pregnancy and drug/alcohol abuse through: a) Sexual Reproductive Health (SRH) update training for SRH programme managers, trainers and nurse tutors focusing mainly on Family Planning and Cervical Cancer screening and management programmes; b) training of Medical Doctors on the use of colposcopes for cervical cancer screening; c) capacity building DoH personnel; and d) UNFPA role as lead in HIV prevention and Chair of HIV prevention cluster in the Joint Team on AIDS.

4.2.2 Population & Development
The outcomes for the PD component are: ‘strengthened national macroeconomic capacity for policy formulation, implementation and coordination; and strengthened government ability to develop and implement coordinated interventions to address economic and employment inequities within the economy’. Evaluation of PD performance will be based on two of the three outputs of PD, which focus on: i) Population and development integration; and ii) Generation, analysis and dissemination of policy-relevant data. In addition to the stated outputs, CP also supported population and development activities at regional and continental levels. However, CO did not develop any specific activities to address the output on policies and programmes on employment and training.

i) Capacity building for population and development integration
During the review period, UNFPA provided technical support to the development of a *Training Manual on Integration of Population Issues into Development Policies and Plans*. Government has already adopted the Manual for training at all levels on the subject of population and development planning, including policy formulation and the integration of population, gender and HIV & AIDS issues into policies and plans. The *Manual* includes aspects of data on population and dynamics, gender, youth, SRH, including HIV/AIDS. Aspects of the manual have been incorporated into the Modules being used for the Applied Population Sciences Training and Research (APSTAR) training programme, which is being supported by UNFPA at the University of KwaZulu-Natal, Durban. Pilot training on the *Manual* has been done through a number of provincial workshops facilitated by UNFPA, the results of which showed that local capacity should continue to be built so as to effectively utilize the manual for training at all levels. In order to promote its widespread adoption and relevance, DSD has taken the *Manual* through the Government accreditation process; and final efforts are being made for its publication and dissemination. The manual is yet to be adopted and integrated into continuous training by provincial government is being done with own finances.

Training in population and development integration has also been promoted by UNFPA through support to two universities; namely, University of Kwa-Zulu Natal, Durban and Northwest University, Mafikeng. CO collaborated with the University of KwaZulu-Natal on the Applied Population Sciences Training and Research (APSTAR) programme. This training programme targets practitioners in the field of population and development who are in employed largely within the public service. Upon successful completion of the programme, applicants are better able to work on population integration issues in their respective offices, and if they choose, they are eligible for admission to the Masters Programme in Development Studies of the university. The Country Office also worked with the Northwest University in partnership with the Government to develop curriculum for Postgraduate Diploma and a Masters Degree in Population Research, Policy and Programme Nexus and undergraduate programme in Population Studies and Demography, and provided support to the establishment of an information and computer centre for demography students, including the supply of computers and related equipment. Government considers both capacity strengthening efforts at university level very strategic and effective.

Research on population and development is critical to successful integration of population issues into development policies and plans. In this regard, UNFPA supported a number of research activities under the PD component during the review period. Important research activities carried out under PD include a study of the youth demographic dividend; evaluation of population and development advocacy programme; desk study of teenage pregnancy in KwaZulu Natal; assessment of Population Policy awareness and implementation in KZN, etc. Some of the research works are inconclusive and the extent to which preliminary findings have been used is not on record.

UNFPA also supported DSD in the International Poster Competition being implemented through national and provincial population units across the
country, aimed at enhancing life-skills and promoting learners’ awareness on Sexual and Reproductive Health, HIV prevention and population and development issues.

Apart from the above achievements, in 2009 UNFPA supported the implementation of certain activities included in the provincial work plans, including the following:

- PD sensitization workshops in KZN, Limpopo and Eastern Cape;
- Youth sensitization on population issues in KZN;
- Support to development of the State of the Province Population Report in KZN;
- National Poster Competition under the theme “Plan your family, plan your future”

**iii) Generation, analysis and dissemination of data**
The CO supported Statistics South Africa (Stats SA) towards the preparation for the 2011 Census has been priority in 2009. This includes engagement of a Census Specialist for the Post Enumeration Survey, capacity building in the areas of data analysis and the use of technologies such as REDATAM, CSPro for census processes. CO also supported StatsSA in 2009 with capacity-building for managers on Census operations and management issues.

**iv) Regional population activities**
The Department of Social Development and Leadership for Environment and Development (LEAD) Southern Africa have been collaborating with local universities to conduct training on the relationship between population, environment and development challenges facing Southern Africa and the world. Beneficiaries of the programme include trainees drawn from SADC countries. During the review period, UNFPA continued to support the participation of key national partners responsible for the implementation of the national population policy in this programme. An international training session is planned for November 2010.

UNFPA (CO and RO) also provided technical and financial support to the Government of South Africa, as Chair of Southern Africa Development Community (SADC), to develop the SADC ICPD+15 Regional Report, which provides a comparative analysis of progress made in ICPD implementation and brings out specific SADC issues in relation to the ICPD agenda. The technical support to the regional review culminated in a Technical Experts Meeting (13-15 July) and SADC Ministers' Meeting on ICPD+15 (17 July) at which SADC leaders adopted a set of resolutions committing themselves to accelerated ICPD implementation in the remaining years of the ICPD PoA.

CO partnered with the DSD to coordinate and undertake the national and regional launch of the 2009 SWOP with theme on Population, Climate Change and Women.

### 4.2.3 Gender
The only outcome for the Gender component is: "enhanced structures and capacities to prevent and respond to violence against women". The CP addresses this outcome through four outputs that focus on capacity strengthening of community and government, to prevent and respond to gender-based violence (GBV); provision of comprehensive services for female victims of GBV and abuse and; strengthened capacity at all levels to implement human rights-based policies and programmes to prevent GBV.

**Work plan development**
Like other components, CO could not develop a comprehensive national work plan of any sort by which the different implementers could collaborate with UNFPA in addressing the outputs of the gender component until 2009. For the first year of the programme, CO did not appoint a Gender Programme Officer; one was appointed in 2008 but resigned after one year. The result is that gender was largely a floating component and lacked focus until 2009 when a work plan was developed. Activities related to gender were inserted into aspects of RH and PD until a Gender NPO was appointed; but then, no framework was established by CO for gender programme monitoring during the review period. (A Gender NPO has recently been appointed by CO).

Some gender related programming support was also given to selected NGOs. UNFPA supported Women In Partnership Against AIDS (an NGO) to incorporate the need of young women and girls into their 5-year strategic plan. The UNFPA project on Capacity building of Religious Leaders include advocacy on discrimination against women.

In August 2009, UNFPA held its first consultation with the Director General of the Ministry of Women, Children and Persons with Disabilities, where both parties agreed on initial areas of collaboration. This laid a solid foundation for the UNFPA / Women’s Ministry further collaboration in the future. CO has acknowledged that it is important that UNFPA continues strategic engagements with the newly established Ministry of Women’s Affairs, Children and Persons with Disabilities in advancing support to the Government in the area of gender mainstreaming.

**Advocacy**
In 2008, UNFPA supported the National Department of Education on its Advocacy Campaign for the prevention of sexual violence. Support was also provided to the Department of Education’s Gender Equity Directorate on conceptualizing its advocacy campaign in the preparation of their guidelines for the management and prevention of sexual violence and harassment in public schools. UNFPA also provided technical assistance to the Department of Education to develop its strategy to prevent and manage sexual violence and harassment in public schools.

**Capacity building**
UNFPA conducted training on Gender and Human Rights for national gender focal points in the Department of Education, Department of Provincial and Local Government (DPLG) and Department of Social development. Also to DPLG, the UNFPA provided technical assistance in developing its programme
for the 2008 campaign on 16 days of Activism of *No Violence against Women and Children*.

In 2009, CO supported DCGTA on the 10-Year Review of the 16 Days of Non-Violence Against Women and Children, and in collaboration with DSD, UNFPA and government trained traditional leaders on prevention and redress of GBV. Traditional leaders were equipped with the knowledge on legal enforcement and new legislation on GBV and provided with support to address the GBV related challenges in their communities. UNFPA influenced the inclusion of issues of Gender and Gender based violence among girls and young women into the HIV strategic plan for the women sector. UNFPA commissioned a study on "GBV, knowledge attitudes and practices" to provide government with information on their impact on GBV and, to inform them of the gaps and silences in policy and services related to GBV. The study informed government’s GBV policies, responses, and prevention interventions at district level. The study also revealed the gaps in knowledge and skills among traditional leaders in terms of existing legislations, policies and drivers of GBV. UNFPA made input into provincial strategic plans on HIV/AIDS placing particular emphasis on GBV and the vulnerabilities of women and children.

Support to gender activities was also provided through projects at the provincial level, mostly in KZN and EC. In KZN, UNFPA supported research work on teenage pregnancy to inform Government on the vulnerabilities of young girls to unwanted pregnancies and HIV infection. The idea was to incorporate the findings of this study into a national study on teenage pregnancy to be commissioned by the National Department of Education in 2009. UNFPA trained Health care workers in the Departments of Health (KZN) on family planning with special emphasis on gender issues in the use of contraception. The intention was to equip women and girls with the skills and knowledge to make informed decisions about their reproductive rights. The training opened the space for critical dialogue on the responsiveness of government’s national policy and provided the impetus for its review. In the Eastern Cape, UNFPA supported the development of a Manual on Gender-Based Violence (including forced and early marriage), prepared together with the Commission on Gender Equality. The Manual has been finalized but yet to be published and disseminated.

For the current term of Government, (2009-2014), the Executive has decided to apply the outcomes approach in achieving the objectives of the Medium Term Strategic Framework. Generally and given the UNFPA’s mandate and technical expertise, the 12 identified strategic outcomes of Government will give the 3rd CP an increased opportunity to strategically engage the government and strengthen government’s capacity, specifically because of the following opportunities:

- Increased focus on service delivery and policy implementation;
- Strengthening government accountability systems and Monitoring & Evaluation
- Changed/reorganized and enhanced institutional arrangements – e.g. Ministry of Women, Children and Persons with Disabilities
• Improved South to South collaboration

5.0 CP Management Issues

The important management issues addressed in this evaluation include staff capacity; programme coordination; collaboration, finance; office management; and humanitarian response.

5.1 Staff capacity

When the CP strategies were being designed, the UNFPA Country Office (CO) had a Representative, an assistant representative, two national programme officers and several support staff. Apart from the specific CP outputs, in recognition of the leadership role that South Africa has in the region and to support its goals on regional integration, the CP is also expected to help with implement regional population and development agendas. Even with occasional CST support and the projection of an additional programme officer to be recruited, the CO professional staff strength was too thin to effectively manage the implementation of the numerous outputs at national level and in the four selected provinces, as well as support at regional level. As the implementation of the CP progressed, it became obvious that the outputs were ambitious in the context of lean professional staff complement.

In 2007, CO had a Representative, but the AR was reassigned the same year; there were two NPOs (RH and Population), and one Programme Associate (PA) who were on Fixed-Term contracts. The remaining 6 professional staff in the CO Pretoria were placed either on Service Contract or one of its derivatives, because their appointments were project-based. Also, the only two Provincial POs were on Service Contract, even though they were not project-based. The implied lack of job security in a service contract also extended to most of the support staff: only 3 out 8 had a fixed-term contract.

Among the professional staff, 2008 was a year of rapid staff attrition: both the NPO-SRH and the SRH/HIV/AIDS Advisor resigned; service contracts which ended fairly early in the year but not renewed included those of one PO (RLF), the Procurement Officer, and the Eastern Cape PO. Even the Representative was reassigned in November 2008 leaving the position on acting arrangements to date.

Year 2009 also witnessed considerable staff attrition: both the newly appointed NPO-HIV/AIDS and NPO-HIV/AIDS Gender (a rather clumsy job title) resigned in the year and no replacements were made as these posts had been funded from trust funds which had already expired. A Deputy Representative commenced duty in April 2009. Then came a succession of three Acting Representatives following the departure of the Representative. At May 2010 when this review was carried out, the CO was headed by the Deputy Representative.
In context of the revised Country Office Typology (approved July 2009) aimed at strengthening human resource capacity to effectively support implementation of the CP, a Monitoring and Evaluation Officer post has been created and filled. This post aims to strengthen the role of UNFPA as chair of UNDAF M&E Group and CO’s capacity for effective country programme delivery, including capacity-building efforts among sub-offices and national partners. M&E responsibilities have been covered by the Assistant Representative and the Deputy Representative. The revised typology also established post of Gender Officer, to covene UNFPA’s role among the UN Gender Task Team.

As already noted, the post of a substantive Representative has been vacant since November 2008 and should be filled. Moreover, the key position of Operations Manager was vacant for several years, until filled for the first time in July 2010. In the 2009 interim and pending recruitment processes, the Deputy Representative is currently assuming responsibilities of these functions, with support of existing CO staff. The revised typology (July 2009) has been implemented in full and this is expected to enhance programme delivery going forth.

A strategic objective of the UNFPA Country Office management is to increase staff confidence through capacity building initiatives and staff learning. To this end, staff members have been exposed to capacity building initiatives both nationally and regionally. Knowledge sharing amongst staff members has been institutionalized through learning sessions. In addition the office supports training of implementing partners with the view to strengthen their capacity to deliver services to target communities and beneficiaries in South Africa.

5.2 Planning, Monitoring and Evaluation

5.2.1 CO Coordination

In terms of CO programme monitoring and evaluation, the CP proposes that programme implementation will be monitored through the UNDAF monitoring and evaluation (M&E) framework. While UNFPA is Chair of the UNDAF M&E Working Group, efforts to develop a coherent M&E tool for the Group remains a challenge. Possibly in anticipation of an ineffective UNDAF M&E framework, UNFPA CO informed DSD Director-General of the work in progress with the Department “to prepare the Country Programme Action Plan (CPAP) and Annual Work plans that will provide more detail guidance for implementation of the Country Programme” (UNFPA Communication, 14 December 2006). Such an action is necessary to elaborate the CP Results and Resources Matrix, and through consultations with implementers agree on the modality for resource allocation between programme components, outputs and projects. The implementation of the CPAP seems to have been taken over by formulation of numerous projects and development of Annual Work plans with the selected provinces almost on ad hoc basis.

This lapse also leaves a gap in the CO’s M&E capacity; contrary to indications from the CP Results and Resources Matrix, there are no agreed baselines and targets for the CP outcomes and outputs against which progress could be monitored and evaluated; nor has there been established by the CO an objective basis for financial allocation to specific projects and/or activities. The situation
poses a dilemma for the MTR, which relies on office records, with limited institutional memory and scanty means of corroboration, in analyzing the effectiveness and efficiency of CP performance.

In order to make the final evaluation more analytical, the UNFPA CO should consider developing a CP Workplan (a kind of CPAP) together with all the implementers at national and provincial levels, establish output and outcome baselines and set targets, and discuss allocation of resources, even for one year.

5.2.2 Programme coordination
In terms of coordination, CP identifies the Department of Social Development as the lead Government Department that will coordinate programme implementation at the national level. In addition, the Department of Social Development is expected to coordinate the programme at provincial and district levels, together with the offices of the provincial premiers. The CP defines the mechanism for programme implementation: it identifies the Departments of Education, Health, Labour, Local Government and Social Development, the Presidency, selected universities and training institutes, NGOs and community-based organizations as implementers of component projects and activities at national, provincial and district levels.

The approved strategies for programme coordination include: (a) establishing a national coordinating committee on population and development; (b) setting up similar coordination arrangements at the provincial level; and (c) supporting the proposed joint United Nations-government cluster groups to conduct regular reviews of programme implementation. Programme implementation will be monitored through the UNDAF monitoring and evaluation framework.

The point about national coordination of activities in support of implementation of South Africa's Population Policy should be visited; the Policy itself recommends the proposed CP strategy and draws attention to the role of the National Population Policy in facilitating the coordination of the national population programme or Action Plan. In the absence of such a national body, what is proposed in the CP [(a) establishing a national coordinating committee on population and development; and (b) setting up similar coordination arrangements at the provincial level could be a starting point.

In order to strengthen national capacity for programme coordination, the Country Office has held regular meetings with the Department of Social Development (DSD). It is noteworthy that, after many years of trying, CO in collaboration with CDP&D was able to call an inaugural meeting of such a body (National Coordination Forum on UNFPA support to the Government of SA) on 25 November 2009. The meeting deliberated on issues of partnership in regard to the CP, national priorities in population and development, the UNDAF coordination mechanism, coordination of the UNFPA CP, and related matters. Subsequent meeting planned for February 2010 was actually held 3 February, with much broader participation and greater sense of achievement of set objectives. Government should continue to promote this collaboration, move to regularize future meetings of the Forum, and UNFPA should assist the partners
5.3 UNDAF Joint Programming

In collaboration with the UN family in South Africa, the UNFPA CO played a prominent role in the design and implementation of UNDAF during the review period (2007-2009), particularly as Chair of the UNDAF Monitoring and Evaluation (M&E), but not so much as the lead agency for the Gender Group. Apart from the five thematic UNDAF clusters, UNCT formed the M&E Group with UNFPA as Chair, to ensure monitoring and evaluation of the implementation of the UNDAF and, for coordination of cross cutting issues and needs. Since 2007, the M&E cluster developed an annual work plan and met regularly to review progress and discuss related issues. The following achievements (2007-2009) have been recorded:

- As chair of the M&E group, UNFPA together with the RC’s Office, has lead the Annual Review exercise with GoSA on the implementation of the UNDAF.
- The M&E Cluster successfully coordinated the activities of the UNEG Scoping mission in February 2008, the main outcome of which was draft TOR of the evaluation of GoSA-UN partnership.
- Support to the UNDAF 2007-2010 Case Study, to document the UNDAF process in South Africa, as a contribution to the implementation of the UN Reform and the new thinking on Aid Effectiveness.
- Prepared Draft Guidelines for Cluster Management, which was presented at UNCT workshop in the first quarter of 2009.
- Prepared UNDAF reporting templates for cluster activities, endorsed by the UNCT in February 2008.
- Two M&E workshops were held in November and December 2008 to review work done and deepening of UNDAF programming.
- Undertook an analysis of challenges and opportunities in operationalizing UNDAF and UNDAF Clusters was done and shared at the M&E workshop in November 2008.
- Supported the 2008 UNDAF progress evaluation process and implementation of aspects of its recommendations.

The appointment of a UNFPA M&E Programme Officer would strengthen the Fund in responding to its challenging role in the M&E Group; so also, setting aside a special M&E budget would facilitate its role. (M&E Officer was in place during this review).

UNFPA has been the Chair of the UNDAF Gender Task Team since 2007. The Gender Task Team comprises IOM, UNDP, UNAIDS and UNFPA but has been ineffective for most of the time since its inception, largely because the programme for their work is yet to be developed (new Gender Officer was in place during this review). At its meeting of 2 October 2008, the Gender Task Team discussed the modalities to ‘remobilize’ the work of the group. The meeting also shared information on a strategic UN joint programme for the support of
the 365 Days National Plan of Action to end Gender Based Violence. In response to the xenophobic attacks in the country in May 2008, CO requested and received technical assistance on Gender from Headquarters in order to develop its capacity on gender based violence particularly in the context of the humanitarian need created by the xenophobic attacks. Within the UN Protection Working Group CO provided the support to strengthen national capacity in the implementation of Prevention of GBV among Internally Displaced Persons (IDPs) arising from the xenophobic attacks on foreign Nationals by contributing to the creation of help desk. The help desk was officially launched on 16 September 2008. On the Gender task Team it is noteworthy that the recruitment of a dedicated NPO: Gender has led to revitalization of the Task Team and improved engagement with national structures and partners in the Gender Machinery.

Both the UNFPA and UNICEF supported the rapid inter-agency assessment of gender based violence and the xenophobic attacks in the country in 2008 and the report was circulated to the gender team. In addition, CO monitored the vulnerability of women and children to GBV in shelters for the IDPs; trained government officials on IASC guidelines; and provided support to the IDP re-integration strategy. UNFPA has also been active in the economic, social clusters and in the Joint UN TG on AIDS, with which it has developed joint programmes.

However, like the other UN agencies, but more so for the non-ExCom Agencies, UNFPA has been faced with the problem of joint programme implementation, including pooling of resources, allocation of professional time to cluster meetings and cluster work (the 5 Clusters are yet to be institutionalized), and measurement of individual agency’s contribution to CP outcome and outputs.

In October 2009, the Department of Health requested support from the World Health Organization, the Joint United Nations Program on AIDS and the UNFPA to further strengthen the Department's HIV and AIDS programme so as to accelerate current progress in scaling up HIV services towards universal access and attainment of national goals. In response to this request, UNFPA collaborated with a team of technical experts from DOH, SANAC, WHO, UNAIDS, UNICEF, and USG/PEPFAR, in the review of the health sector HIV and AIDS programme that was carried out over a six-week period from mid-October to end of November 2009. The review was aligned to the wider Mid-term review of the National Strategic Plan 2007-2011, which was also being conducted by SANAC around the same time. The Health Sector Review was also intended to contribute to the "State of Readiness Assessment," which was to assess the readiness of health facilities to support a forthcoming national HIV testing campaign launched in the first part of 2010. The review assessed the implementation of the health sector HIV and AIDS programme, and identified gaps, constraints, challenges and opportunities, and made recommendations for strengthening and improving the health sector response to the HIV and AIDS epidemic in South Africa. Government considers this UN collaborative work very strategic and of significance to the health sector.
UNFPA continues to chair the HIV Prevention Technical Task Team within the Joint UN Team on AIDS. The recent accelerated government response to HIV testing and promotion of treatment resulted in regular meetings of the Prevention team to assess agencies’ support to the campaign as per the division of labour.

5.4 Finance
As already noted above, the support of UNFPA to the 3rd CP in South Africa was approved in the sum of $13 million: $7.6 million from regular resources and $5.4 million through co-financing modalities and/or other, including regular, resources. Based on the Fund’s priorities, the approved total fund of US$13 million was distributed among the three programme components as follows: RH (US$ 6.0 million); PD (US$ 3.0 million); and Gender (US$ 3.4); while the balance of US$ 0.6 million goes to Programme coordination and assistance (see Table 1). However, given the way in which the component programmes were executed, it is difficult to monitor and report on implementation rates by component projects. Even if time and information were available, it would be unwieldy to report on financial implementation of each of the numerous project activities at national and provincial levels.

Table 1: UNFPA assistance to South Africa’s 3rd CP

<table>
<thead>
<tr>
<th></th>
<th>Regular resources</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reproductive health</td>
<td>3.0</td>
<td>3.0</td>
<td>6.0</td>
</tr>
<tr>
<td>Population and development</td>
<td>2.0</td>
<td>1.0</td>
<td>3.0</td>
</tr>
<tr>
<td>Gender</td>
<td>2.0</td>
<td>1.4</td>
<td>3.4</td>
</tr>
<tr>
<td>Programme coordination and assistance</td>
<td>0.6</td>
<td></td>
<td>0.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>7.6</strong></td>
<td><strong>5.4</strong></td>
<td><strong>13.0</strong></td>
</tr>
</tbody>
</table>

*Source: UN, Executive Board of the UNDP and UNFPA, Draft country programme document for South Africa, Second regular session 2006.*

Given the limitation of time, the best that this evaluation could do is to take an overall view of programme financial implementation rate. Table 2 shows the pattern of programme financial implementation each year from 2007 to 2009. Overall, the programme implementation rates are quite high; even in 2008 with staff constraints, implementation rate was over 88%.

Table 2: UNFPA CO Budget and Expenditure Patterns, 2007-2009 (Figures in Rand)

<table>
<thead>
<tr>
<th>Programme Component</th>
<th>Budget</th>
<th>Expenditure</th>
<th>Implementation Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Population &amp; Development</td>
<td>454,708.13</td>
<td>453,627.05</td>
<td>99.76</td>
</tr>
<tr>
<td>2. Reproductive Health</td>
<td>587,123.44</td>
<td>585,899.78</td>
<td>99.79</td>
</tr>
<tr>
<td>3. Programme Coordination &amp; Assistance</td>
<td>388,414.94</td>
<td>385,843.65</td>
<td>99.34</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>1,430,000.00</strong></td>
<td><strong>1,425,189.04</strong></td>
<td><strong>99.66</strong></td>
</tr>
<tr>
<td>4.* Gender (RH – HIV Prevention)</td>
<td>50,000.00</td>
<td>49,962.14</td>
<td>99.92</td>
</tr>
<tr>
<td></td>
<td>2008</td>
<td>2007</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>--------------</td>
<td>--------------</td>
<td></td>
</tr>
<tr>
<td>1. Population &amp; Development</td>
<td>368,254.79</td>
<td>300,406.86</td>
<td>81.58</td>
</tr>
<tr>
<td>2. Reproductive Health</td>
<td>650,819.57</td>
<td>598,587.48</td>
<td>91.97</td>
</tr>
<tr>
<td>3. Gender</td>
<td>6,814.00</td>
<td>5,231.80</td>
<td>76.78</td>
</tr>
<tr>
<td>4. Programme Coordination &amp; Assistance</td>
<td>391,221.00</td>
<td>348,937.19</td>
<td>89.19</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>1,417,109.36</strong></td>
<td><strong>1,283,163.33</strong></td>
<td><strong>88.43</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Population &amp; Development</td>
<td>341,527.76</td>
</tr>
<tr>
<td>2. Reproductive Health</td>
<td>345,099.09</td>
</tr>
<tr>
<td>3. Gender</td>
<td>16,411.00</td>
</tr>
<tr>
<td>4. Programme Coordination &amp; Assistance</td>
<td>365,328.15</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>1,068,366.00</strong></td>
</tr>
</tbody>
</table>

5. * Other Funds

Source: UNFPA CO records

Interviews conducted revealed that dissatisfaction with implementers in collaboration with UNFPA had to do mainly with very small project budgets, long delays in releasing approved funds, and arbitrary budget reductions in the course of execution.

Among the major measures which were taken during the period in review to improve financial management of the CP were the following: New Finance Admin Associate recruited, and taken through intensive induction programme by UNFPA ATLAS trainer (Botswana); all work plans were costed, and expenditure resolved in all financial transactions; training of IFS on UNFPA financial procedures undertaken; and CO started implementation of HACT from 2008.

It is recommended that:

1) determination of resource allocation to outputs/projects should be discussed in the process of formulating CPAP and Annual CP work Plan;

2) once a project document has been signed by the concerned parties, instances of mid-stream budget cuts should be minimized if not blocked entirely;

3) CO should fill all vacancies and avoid arbitrary use of service contracts to the extent possible;

4) the UNFPA should avoid making promises of financial and/or technical support which it may find difficult to meet for whatever reason and partners to ensure that promises made are adequately covered in new work plans not to prioritise other areas of support if promises are deemed strategic.

5.5 Office management
Equipment
UNFPA CO maintains a regularly up-dated filing system containing records of equipment at the CO and in UNFPA sub-offices, including equipment purchased for projects such as Northwest University, APSTAR, etc. Based on periodic inspection reports, CO has followed standard procedure for disposing of unserviceable items and acquiring new ones as part of its asset management.

UNFPA sub-Offices
The Government directed the UN system in South Africa to focus on four provinces with the worst socio-economic indicators namely: KwaZulu-Natal, Free State, Limpopo and Eastern Cape. In the interest of advancing programme delivery in these provinces the Country Office consulted with the respective Provincial Governments on the possibility of opening Sub Offices, for which approval was granted. During the review period, UNFPA had two Sub Offices operational, namely Eastern Cape and KwaZulu-Natal. The Government approved office space for a UNFPA Sub Office within Limpopo Welfare Complex in 2009. Due to financial constraints, opening of Limpopo and Free State sub-offices will be delayed until such time that adequate resources have been mobilized.

In general, the sub-offices were poorly staffed; efforts should be made to appoint PAs in strategic areas in consultation with the Provincial Governments. Research Assistants were employed during the review period with a poor job description, while programme areas such as RH, PD and Gender were addressed in the Sub-offices by the Programme Officer who also managed office operations. The revised Office Typology established enhanced operational support to sub-offices as Admin Associate and Finance Assistant were established and appointed. To address staff capacity and welfare the sub-office staff contractual modalities have been improved to fixed-term appointments.

Staff welfare
Regarding staff welfare, CO has been implementing the UN Cares Minimum Standards on HIV in the Workplace. Key highlights of UN Cares work in South Africa include the re-launch of the workplace response in Pretoria with the constitution of the Workplace Wellness Team in place at the end of the first half of 2009. This followed designation of Focal Points by all Agencies, including UNFPA. In order to provide UN personnel living with HIV a forum for peer support and guidance on personal management of life with HIV, UN team organized a Wellness Day that brought health and wellness services, including HIV counseling and testing to the UN workplace. The team also mobilized female staff to take part in a women’s day organized by Spar Supermarkets. Also, CO staff joined in the World AIDS Day commemoration; later, PEP Starter Kits were received and deposited with UNDSS for use by UN staff and their families in case of emergency exposure to HIV.

5.6 Humanitarian response
Given the unpredictability of disasters requiring assistance, humanitarian response is not part of the CP Results and Resources Framework. Nevertheless,
CO provided humanitarian assistance in collaboration with other UN agencies to South African townships from May 2008 when they experienced violent xenophobic attacks on foreigners in which 60 people were killed and over three thousand people were displaced.

CO together with the regional Humanitarian Officer adapted Standard Operating Procedures and Guidelines for GBV in Humanitarian Settings for South Africa. In particular, training was provided for government officials and NGOs in the Western Cape. UNFPA also participated in the weekly Protection Working Group meetings and focused on GBV and HIV/AIDS prevention and made input into the development of a reintegration strategy for IDPs. Furthermore, UNFPA provided inputs for the weekly report on the humanitarian crisis.

UNFPA, in partnership with UNICEF, conducted a GBV assessment in the camps of IDPs during the xenophobic attacks in South Africa. The report was made available to government. The CO also provided technical assistance to government’s Disaster Management Committee (DMC) on GBV and HIV prevention. Furthermore, Standard Operating procedures, including the IASC guidelines for GBV Interventions in humanitarian Settings were adapted to a certain extent to the South African context (including laws relating to sexual violence and medical examination etc.), and the Sexual Exploitation and Abuse (SEA) guidelines were provided to the national Department of Social Development and the DMC.

On the down side, UNFPA volunteered to lead the collection and rapid analysis of data on IDPs at the initial stage of the xenophobic attacks. Questionnaire was developed and copies produced and administered to some centres. However, CO had no facility for data capture and analysis (SPSS, or any such software); hence, the process was aborted. In addition, CO procured RH Kits through the Humanitarian Branch UNFPA HQ, - drugs, ARTs, contraceptives, condoms, etc. - but Government refused delivery. The necessary education and consultations were probably missing; and this should serve as a lesson for the future.

Challenges

Some the challenges encountered in the process of implementing the CP include the following:

**Reproductive Health and HIV & AIDS Interventions**

- Arbitrary reduction in allocated budget below projected levels by implementing partner, necessitating reprioritization of activities and in some instances scaling down on intended coverage in view of costs;
- Poor funding for HIV/AIDS projects resulting in small scale, non-strategic programme interventions with limited reach and impact especially around youth issues
• UNFPA leadership on prongs 1 and 2 of PMTCT is weak and require strengthening,
• Since March 2009, the Country Office has not had a devoted programme officer on supporting the HIV and AIDS response, a function until recently, covered by the SRH Programme Officer (HIV/AIDS Officer in place during this review).
• In terms of programme management, the prolonged delays by Government implementing partners in signing the work plan constituted a hindrance to smooth project implementation.

Population and Development Interventions
Implementation of planned activities was severely curtailed by the long delays experienced in getting the Government partners in the four focal provinces (Eastern Cape, KwaZulu-Natal, Free State and Limpopo) to sign the Annual Work Plans. The delay caused almost six months of implementation time in 2008. Learning from experience, UNFPA started to review the 2008 AWPs in December 2008 and begun to prepare for 2009 in order to cut down on the delays experienced in 2008, but not much was accomplished. In 2009 this was partly attributed to leadership changes surrounding the general election and other related political changes in the country. This had delayed programme implementation across the thematic areas.

The challenges noted with regard to the work plan development and approval prior to implementation were caused from both Government and UNFPA sides. For example, in in 2009 UNFPA was not immediately available to commence work plan discussions with partners as all staff members were committed to the Regional Planning meeting of the organization. Following this, Government partners were equally not available and not able to commit to the contents of the work plans due to election processes and subsequent administrative changes. Only after May 2009 were the partners able to discuss and finalize work plans which delayed commencement with implementation. A different approach was adopted with negotiation on 2010 work plan commencing in the last quarter of 2009, the Coordination meetings were very instrumental in reviewing progress and defining 2010 work plans which is an improved mechanism that should be strengthened.

6. Lessons learned

• The effective coordination of programme implementation, including monitoring and evaluation, requires a framework or Country Programme Action Plan (CPAP), which defines the outcomes and outputs and their indicators, together with baselines and targets for each outcome/ output indicator. The CPAP for the CP being evaluated was not finalized, and this makes it difficult to critically analyse programme performance in terms of efficiency and effectiveness in the deployment of programme resources (human, money, equipment, materials) during the review period
• Implementation of planned activities was severely curtailed by the long delays experienced in getting the cooperation of Government partners in the four focal provinces, resulting in delays in signing Provincial Work Plans which caused almost six months of implementation time in 2008. On UNFPA side, lengthy processes in negotiation of workplans discourages partners.

• Given UNFPA's limited financial resources, CO-supported initiatives which address strategic population and development issues (such as development of Manual on Integration, Research on Demographic Dividend, Capacity building for Religious Leaders on HIV/AIDS campaign, the APSTAR project on integration at KZN University, capacity building for research and training in Population at Northwest University, Training on HIV/AIDS, etc.) have generated much of the desired impact on target beneficiaries, as opposed to a large number of operational activities conceived and executed as small projects on moving targets in the country. The HIV/AIDS Health Sector Review, provision of a Technical Expert to the DOH, Training of Doctors on the use of colposcopes for cervical cancer screening and support to the Midwifery Society of SA, are some examples of strategic support that need to be upscaled.

• Lack of capacity in the CO weakens the ability to effectively address CP objectives: in the case of HIV & AIDS since March 2009, the Country Office has not had a devoted programme officer on supporting the HIV and AIDS response, a function until recently (Oct 2009), covered by the SRH Programme Officer. The same goes for Gender. The Gender Subprogramme was covered by Assistant Representative and NFO: HIV Prevention until recent filling of post in April 2010.

• Expanded delivery of high-quality RH services will require increased supply of colposcopes in the provinces for cervical cancer screening.

• Even with occasional CST support and the projection of an additional programme officer to be recruited (CP, 2006), the CO professional staff strength was too thin to effectively manage the implementation of the numerous outputs at national level and in the four selected provinces. As the implementation of the CP progressed, it became obvious that the outputs were ambitious and some activities carried out were substantially non-strategic. Since activities undertaken are mainly in consultation with Government, it is critical that there is mutual understanding on what is "strategic"
Like the other UN agencies, but more so for the non-ExCom Agencies, UNFPA has been faced with the problem of joint programme implementation, including pooling of resources, allocation of professional time to cluster meetings and cluster work, measurement of individual agency’s contribution to CP outcomes and outputs.

Support to Stats SA on preparation for the next round of census, through regional capacity building initiatives, support to the young statisticians programme, and learning exchanges with other middle income countries and support to DSD to promote South-South dialogue and cooperation (through SADC ICPD@15 review, PED training, involvement at AU dialogue on population, etc) has been strategic and effective.

7. Recommendations

Coordination

• CO should continue to work with Government and the other implementers to promote programme coordination through the newly constituted National Coordination Forum on UNFPA Support, move to regularize future meetings of the Forum and UNFPA to assist the partners in formulating a National Action Plan for the implementation of South Africa’s Population Policy, as basis for future UNFPA CPs.

• In order to make the final evaluation more analytical, the UNFPA CO should consider establishing a functional M & E system to track output results, and establishing outcome results trends for this CP

UNDAF Joint Programming

• The capacity of CO to make a meaningful contribution to the “One UN” initiative should be strengthened, particularly by providing human and financial support to the Country Office in playing its role as the lead agency on M&E, and contributing to joint UN HIV/AIDS and Gender.

• UNFPA CO and the Africa Regional Office should continue to provide technical and financial support to GoSA to promote South-South dialogue and cooperation.

CP Implementation

• The Government MTSF 2009 – 2014, 10-Year Review of Population Policy Implementation in South Africa, Annual Government PoAs and related research reports by the DSD, DOH and Ministry of Women could serve as pointers to the areas of future UNFPA/GoSA project focus and location.

CO capacity
All positions in the revised country office typology of July 2009 have been filled; the Regional Office should fast track the appointment of a Representative as this is the only vacant post. UNFPA should find ways to effectively communicate on short term assignments versus fixed term contracts to newly appointed staff as this has been misinterpreted by short term contract holders to imply a full time job, especially in the context of the labour conditions in South Africa.

Finance
- Regarding finance: (*) determination of resource allocation to outputs/projects should be discussed in the process of formulating CPAP and Annual CP work Plan; (*) once a project document has been signed by the concerned parties, instances of mid-stream budget cuts should be minimized if not avoided entirely; (*) determination of resource allocation to outputs/projects should be discussed in the process of formulating CPAP and Annual CP work Plan; (*) partners should ensure that promises made by UNFPA principals are adequately covered during development of annual workplans.
ANNEXES

Annex 1: Terms of Reference for MTR


1.0 Background

The UNFPA Country Programme for South Africa 2007 – 2010 has three components: (a) reproductive health; (b) population and development; and (b) gender. It reflects the national priorities as articulated in Vision 2014, the national development plan. The programme components are aligned with the Millennium Development Goals and the United Nations Development Assistance Framework (UNDAF) 2007 -2010.

The goal of the current programme is to: (a) improve the quality of life of South Africans by helping to reverse the spread of HIV; (b) reduce gender inequalities; and (c) enhance the centrality of population issues in development policies and programmes. The programme focuses on the provinces with the least progressive socio-economic indicators, Eastern Cape, KwaZulu-Natal, Limpopo, as well as the Free State province. Central towards achieving the CP goals is strengthening the capacity of the Population Units and the three UNFPA sub-offices as the institutional mechanism for improved programme delivery. In recognition of the leadership role that South Africa has in the region and globally, UNFPA will support this critical role in the area of Population and Development.

Lessons learned from the previous country programme 2002 - 2006 include: (a) an appreciation of the fact that strengthened presence in the provinces is essential to enhance programme delivery; (b) programmes are more sustainable, if support is provided to programmes and activities that already exist in government development plans, rather than formulating separate project documents; (c) it is imperative to highlight gender inequalities in addressing population and development concerns; (d) the provincial growth and development plans, together with the integrated development plans for the districts, offer ample opportunity to integrate population factors into national development; and (e) the coordination of population and development programmes is more effective if they are integrated into socio-economic development planning frameworks at national and subnational levels.

The 3rd Country Programme Document will be the main resource for this review exercise. In assessing progress made in programme implementation, the Review Expert will make extensive use of the Results and Resources Framework contained in the CPD, drawing mostly on predetermined indicators as outlined.

2.0 Objective of Country Programme Midterm Review (MTR)

The main objective of the MTR is to assess progress made in the implementation of the current country programme, with a view to highlighting what has been achieved, what has not been achieved in each of the 3 thematic areas namely, sexual and reproductive health, population and development, gender. The MTR should provide concrete recommendations on how programme delivery could be enhanced in the remaining part of the programme.

The MTR will examine the extent to which advocacy in support of specific issues was mainstreamed into each subprogramme, analyse the focus the subprogrammes had on youth development, gender concerns in reproductive health, HIV/AIDS prevention and management, sectoral use of population data, and research methodologies. Furthermore, the review will examine how the design and execution of the subprogrammes supported national ownership and leadership as well as decentralization.

2.1 Reproductive Health

The outcomes for this component are: (a) strengthened capacity of the Government to implement the comprehensive HIV/AIDS plan; and (b) improved and expanded capacity of the national health system to deliver high-quality services. Programme Outputs geared towards the attainment of outcomes in this thematic area included:
Output 1: Strengthened capacity of the Government, non-governmental organizations (NGOs) and civil society to prevent HIV infection, especially among youth.

The review will assess the extent of UNFPA interventions in the following areas:
(a) Assisting the Government, NGOs and civil society to conduct behaviour change communication and other sensitization activities by using media and advocacy strategies; and
(b) Enlisting the support of religious, traditional, community, business and youth groups.

Output 2: The Government is supported in achieving universal access to HIV/AIDS prevention, treatment, care and support services.

The review should assess UNFPA's role in the UN Joint Programme of Support on HIV/AIDS with a major focus on the role of convening the HIV/AIDS Prevention Task Team, ensuring that gender dimensions of HIV/AIDS are taken into account in programming. This should include qualifying and quantifying gender responsive and HIV/AIDS Prevention strategies employed under the leadership of UNFPA as well as assessing UNFPA’s technical capacity to effectively carry out this role.

Output 3: Strengthened capacity of health-care workers to deliver reproductive health services, including high-quality family planning and services to prevent and manage gender-based violence and avoid unwanted and teenage pregnancies.

The review should assess UNFPA interventions and the effectiveness of such interventions on the following:
(a) Strengthening the capacity of the Government and NGOs in sexual and reproductive health service delivery, including HIV prevention;
(b) Supporting the national adolescent-friendly clinic initiative to enhance delivery of adolescent-friendly sexual and reproductive health services; and
(c) Supporting the management of sexually transmitted infections.

Output 4: Accelerated and increased use of female condoms.

UNFPA initiatives in the following areas should be appraised, including support to Government towards comprehensive female condom programming, as well as contribution in the following:
(a) Supporting behaviour change communication on women's empowerment, male involvement, reproductive rights and protection against STIs and HIV;
(b) Orienting health service providers on female condom use;
(c) Supporting promotional sessions on female condom use;
(d) Encouraging female condom usage among high-risk and vulnerable groups; and (e) ensuring accessibility and monitoring usage.

Output 5: A strengthened national monitoring and evaluation framework, especially with regard to the compilation and analysis of HIV/AIDS data and reporting on reproductive health commodities.

The area of monitoring and evaluation of the Government's SRH programming was identified as requiring extensive UNFPA technical support. The review should assess UNFPA contribution in the following:
(a) Analysing the existing monitoring and evaluation framework for the national sexual and reproductive health programme in order to link it with the national strategic plan on HIV/AIDS;
(b) Addressing identified weaknesses and building capacity for timely reporting on sexual and reproductive health; and
(c) Reviewing and supporting the management information system for reproductive health commodities.

2.2 Population and development strategies

The main objective of the population and development strategies subprogramme is to contribute to an enabling environment for the implementation of the national population policy. The outcomes for this component are: (a) strengthened national macroeconomic capacity for policy formulation, implementation and coordination; and (b) strengthened government ability to develop and implement coordinated interventions to address economic and employment inequities within the economy. To achieve these outcomes, the following specific outputs were identified for UNFPA's strategic intervention:
Output 1: Strengthened government capacity to integrate population, gender, environment and HIV/AIDS issues into development.
The review should determine the extent and effectiveness of UNFPA's support for:
(a) Integrating population concerns into the provincial growth and development plans and the integrated district development plans;
(b) Institutionalizing training programmes in population and development; and
(c) Strengthening training programmes on population to make them more responsive to needs.

Output 2: Strengthened government capacity to develop and implement policies and programmes on employment and training.
The review will assess the extent and effectiveness of UNFPA's interventions and collaboration with the Department of Public Works, Department of Labour and ILO on the following:
(a) Integrating population factors into the training curriculum of the national expanded public works programme;
(b) Incorporating population concerns into the expanded public works programme; and (c) Supporting the review of employment policies to ensure that they respond to population issues.

Output 3: Strengthened government capacity to generate, analyse and disseminate policy-relevant data, including Millennium Development Goal-related indicators.
The review will determine progress made to date in collaboration with Statistics South Africa, the Department of Social Development, universities and other institutions to provide support to target provinces to:
(a) Prepare midyear population projections and population reports;
(b) Prepare district population data;
(c) Build capacity in integrating population data into district development plans;
(d) Disseminate and utilize data on gender-based violence and on the impact of HIV/AIDS on families; and
(e) Strengthen the existing monitoring and evaluation framework.

2.3 Gender
The outcome for this component is: enhanced structures and capacities to prevent and respond to violence against women. The review will assess progress made towards the attainment of this outcome through the following outputs:

Output 1: Increased community capacity to prevent and respond to gender-based violence.
UNFPA contribution to date on the following areas should be determined:
(a) Improved access to legal, health and other social services;
(b) Community-based human rights education and outreach;
(c) Gender advocacy programmes; and
(d) Strengthened partnerships among the Government, NGOs, community-based organizations, religious groups and traditional leaders.

Output 2: Strengthened capacity of different sectors of government and other relevant institutions in gender auditing, gender budgeting and gender mainstreaming.
This area of work entails UNFPA technical assistance and capacity building initiatives towards an enabling environment to achieve gender equality. The review will assess UNFPA interventions to date on the following:
(a) Providing technical expertise to orient policymakers and planners on the role of gender in development;
(b) Capacity-building in gender auditing, gender budgeting and gender mainstreaming; and
(c) Supporting gender auditing, budgeting and mainstreaming for selected development policies and programmes.

Output 3: Strengthened provision of comprehensive services for female victims of gender-based violence and abuse.
The review will assess UNFPA contribution on the following:
(a) Supporting the expansion of and capacity-building in government-run Thutuzela Care Centres; (b) addressing identified capacity gaps;
(c) Supporting the sharing of lessons learned and experiences among different provinces; and
[d) Using service statistics to conduct evidence-based advocacy on gender-based violence and abuse.

26. Output 4: Strengthened capacity of national, provincial and local authorities and law enforcement agencies to implement human rights-based policies and programmes to prevent gender-based violence.

The review exercise will assess UNFPA interventions in strengthening capacities for GBV prevention, articulate progress made in the following areas:

(a) Playing a key role, along with other United Nations agencies, in a joint programme supporting the government programme to halt violence against women;

(b) Orienting law enforcement agencies, NGOs and community-based organizations on the human rights-based approach to gender equity and development;

(c) Building the capacity of Government, NGOs and community-based organizations to prevent and respond to gender-based violence;

(d) Supporting an advocacy programme on preventing gender-based violence and abuse; and

(e) Institutionalizing gender equality and empowerment in identified policies and programmes.

2.4 Programme Management, Monitoring and Evaluation

The review will assess progress made in collaborating with key stakeholders in programme implementation such as the Departments of Education, Health, Labour, Provincial and Local Government and Social Development, The Presidency, selected universities and training institutes, NGOs and community-based organizations.

At national Government level, the review will assess the coordination and leadership role played by the Department of Social Development, Chief Directorate for Population and Development. At Provincial level, the coordination and leadership role played by the Department of Social Development, Provincial Population Units and Premier’s offices will be assessed.

The review will also review progress made in the following:

(a) Establishing a national coordinating committee on population and development;

(b) Setting up similar coordination arrangements at the provincial level; and

(c) Supporting the proposed joint United Nations-government cluster groups to conduct regular reviews of programme implementation.

(d) Programme monitoring mechanisms

3.0 Focal Provinces for the MTR

The evaluation will be national in nature, with a focus on four focal provinces: Limpopo, KwaZulu-Natal, Eastern Cape, Free State.

4.0 Obligations of the Consultant

1. Prospective Consultants should be experienced professionals sufficiently qualified to undertake the assignment.

2. Review various key programme documents.

3. Prepare MTR design proposal, including
   a. proposed evaluation methodology,
   b. sample sizes
   c. evaluation questions
   d. questionnaires
   e. work plan

4. Collect and analyse data to determine progress in programme implementation.

5. Prepare programme midterm review report satisfactory to the UNFPA Country Office, documenting lessons learnt and recommending policy actions to improve implementation in the remaining part of the programme.

5.0 Obligations of the UNFPA Country Office

1. Provide consultant with day to day support required for the success of the MTR exercise.

2. Provide all the relevant background documentation and information.

3. Provide timely inputs and comments on all intermediate and final products to the Consultants.
6.0 Deliverables
- A proposal demonstrating understanding of the assignment, with a detailed account of a suggested methodology that satisfactorily demonstrates how progress made in the implementation of the 3rd CP will be measured and an outline of the indicators to be measured
- A timetable for the MTR exercise
- Proposed Questionnaires, and how these will be administered
- Draft MTR Report for review by Government and UNFPA
- Final MTR Report

7.0 Duration of the assignment
The assignment should be completed within 11 working days.

8.0 Consultant Qualifications
The Consultant will be an experienced development professional with proven skills on the following:
- Development programme management (programme planning, development, implementation, monitoring and evaluation)
- Reproductive health
- Population and development strategies
- Gender Mainstreaming

9.0 Some background documents
- ICPD Programme of Work Document
- UNFPA South Africa 3rd Country Programme Document
- RSA UNDAP Document
- National Population Policy
- Demographic and Health Survey Documents
Annex 2: Documents consulted

- UN, Executive Board of the UNDP and UNFPA, Draft country programme document for South Africa, Second regular session 2006.

- UNFPA, Annual Work Plans for Limpopo, Eastern Cape, Kwa-Zulu Natal and Free State, 2007-2009; UNFPA Files and Documents on programming, Finance and Administration; Workshop Reports; Reports on Forum for Population and Development Coordination (Nov 2009 & Feb. 2010), etc.


- Republic of South Africa. 2008. ICPS @ 15: Review of Implementation of ICPD PoA.

- UNFPA, Project Evaluation Report: Religious Leaders Project (June 2009)


List of Persons Met / Interviewed

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