End of Program Evaluation of the
UNFPA Namibia

FINAL REPORT

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<tr>
<td>AFHS</td>
<td>Adolescent Friendly Health Services</td>
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<td>AIDS</td>
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<td>ANC</td>
<td>Ante- Natal Care</td>
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<td>AWP</td>
<td>Annual Work Plan</td>
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<td>CCA</td>
<td>Common Country Assessment</td>
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<td>Council of Churches in Namibia</td>
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<td>CEDAW</td>
<td>Convention for the Elimination of Discrimination Against Women</td>
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<td>COMBI</td>
<td>Communication for Behavioural Impact</td>
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<td>CO</td>
<td>Country Office</td>
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<td>CP</td>
<td>Country Program</td>
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<td>DHS</td>
<td>Demographic and Health Survey</td>
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<td>EmONC</td>
<td>Emergency Obstetric and Neonatal Care</td>
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<td>Food and Agriculture Organization</td>
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<td>GFP</td>
<td>Gender Focal Point</td>
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<td>GMP:</td>
<td>Gender Mainstreaming Policy</td>
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<td>GRN/UN:</td>
<td>Government of the Republic of Namibia/United Nations</td>
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<td>HIV</td>
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<td>IEC</td>
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<td>MISA</td>
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<td>M&amp;E</td>
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<td>Mid -Term Review</td>
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<td>National Health Training Center</td>
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<td>Acronym</td>
<td>Full Form</td>
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<td>NDP</td>
<td>National Development Plan</td>
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<td>NGO</td>
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<td>PMTCT</td>
<td>Prevention of Mother –to –Child Transmission</td>
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<td>P&amp;D</td>
<td>Population and Development</td>
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<td>PPA</td>
<td>Participatory Poverty Assessment</td>
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<td>PoN</td>
<td>Polytechnic of Namibia</td>
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<td>OAM</td>
<td>Operation, Administration and Maintenance</td>
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<td>Ombetja Yehinga Organization</td>
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<td>Reproductive Rights</td>
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<td>Result Based Management</td>
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<td>Southern Africa Development Community</td>
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<td>Sexually Transmitted Infections</td>
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<td>TFR</td>
<td>Total Fertility Rate</td>
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<td>TOT</td>
<td>Training of Trainers</td>
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<td>United Nations</td>
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<td>UNICEF</td>
<td>United Nations Children Fund</td>
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<td>VCT</td>
<td>Voluntary Counseling and Testing</td>
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<td>World Health Organization</td>
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<td>Fig. 3: Gender Financial implementation</td>
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EXECUTIVE SUMMARY

1. Purpose, scope and clients of evaluation
This is an independent end-of the 4th GRN/UNFPA programme cycle evaluation designed to assess the achievement of the results, the factors that facilitated/hindered achievement, and to compile lessons learned so as to inform development of the next country programme cycle that begins in 2013. The evaluation has covered the period of the programme cycle, as amended, i.e. 2006 – 2012; and being a national programme, the evaluation covered the whole country, with a focus on the four regions in which specific projects are being supported; namely, Caprivi, Oshikoto and, more recently, Ohangwena. The audience for this evaluation comprises the implementers and the beneficiaries of the CP, including UNFPA, Government departments, civil society organizations, tertiary institutions and other relevant stakeholders who are expected to use the results for decision-making and to inform the planning, programme, budgeting, implementation processes.

2. Objectives and Brief description of intervention
GRN and UNFPA agreed to implement the 4th CP (2006-2012), which addresses national priorities in line with the Millennium Development Goals (MDGs) and the Programme of Action of the International Conference on Population and Development (ICPD). It reflects the 2004 CCA and the 2006-2012 United Nations Development Assistance Framework (UNDAF) and addresses key national priorities and development challenges outlined in the second and third National Development Plans and Vision 2030. The goal of the 4th CP is to contribute to the Government’s aim of improving the quality of life of the people of Namibia through: (i) improving reproductive health; (ii) reducing the spread of HIV; (iii) ensuring gender equality; and improving the utilization of data for development and the integration of demographic, reproductive health, gender equality and HIV variables into national programming. The 4th CP has three related components: Reproductive Health; Population and Development and; Gender. The programme was also designed to address certain cross-cutting issues: the human rights based approach, gender mainstreaming, emergencies and humanitarian response. The RH component of the 4th CP focuses on HIV prevention, impact mitigation and the provision of high-quality reproductive health services, including essential obstetric care in selected intervention areas. UNFPA interventions paid particular attention to 18 health facilities in the three selected regions. Caprivi, which is one of the participating Regions, also has the highest adult HIV prevalence rate (40%) in the country. The component has also been supporting national and regional youth networks on population and development, particularly for advocacy to prevent HIV. The P&D strategies include a) helping the national planning commission secretariat, in collaboration with UNDP, to undertake and complete regional poverty profiles for 10 regions by the end of 2008; b) introducing, by the end of 2007, in collaboration with UNDP and UNICEF, the DevInfo database; and c) strengthening national capacities to collect, analyze, disseminate and utilize population-related data for policy and decision-making. The Gender Component was designed to address gender inequalities that contribute to the spread of HIV/AIDS. A key thrust of the Gender programme is to address structural, economic and cultural barriers to equality and empowerment through the promotion and enforcement of gender equality in laws, practices, policies, value systems to improve women’s capacities, opportunities and decision making.

3. Methodology
Based on the relevance of their background qualifications and professional experience, the CO employed the services of three consultants to undertake this independent evaluation. The
evaluation employed a combination of qualitative and quantitative methods to collect data for answering the evaluation questions which address progress, performance and relevance of the 4th GRN/UNFPA CP, including the three components and crosscutting issues. The process of data collection and validation of report was inclusive, involving a broad range of partners and stakeholders, including an Evaluation Management Team constituted by project management for quality assurance and inclusive participation. The consultancy was carried out between 24 October and 25 November 2011. The limited time allowed for field visit and data collection from publications and their analysis imposed a constraint on impact assessment, particularly as it relates to programme beneficiaries scattered all over the vast territory of Namibia. Nevertheless, the evaluators supplemented the information from primary sources by a myriad of CO reports, project reports, workshop reports and related documents from CO, Government and other sources. Therefore, the reliability of the data and information collected as well as the conventional analytical methods employed for data tabulation and analysis, should assure the integrity of this evaluation report.

4. Main Conclusions

In terms of programme design, the goals, outcomes and outputs of the three components of the 4th CP for Namibia has been clearly defined. Considering the population and socio-economic development challenges faced by GRN as efforts are being made to prepare NDP4, the interventions provided by UNFPA in the areas of RH, P&D and Gender under the 4th CP still remain relevant. The entire programme has been anchored on building sustainable and relevant capacity at national and regional levels for addressing SRH issues, including Family Planning and reduction in the spread of HIV/AIDS and teenage pregnancies; generation and utilization of population data and analysis for integration of population issues into development policies and plans; and addressing gender disparities. Support was provided by CO for community mobilization activities targeting community leaders and males in order to improve decision making on health care seeking behavior and eventually increase utilization of EmOC services; this has stimulated community preparedness and support system for improving referral of cases from community to first level of health care system. The provision of high quality RH services specifically, improved maternal health and essential obstetric care services, is an important undertaking under the 4th CP. RH interventions also strengthened capacity for the management and monitoring of adolescent friendly reproductive health services at the regional and district levels, and is directly linked to the achievement of UNDAF outcomes 1 and 3: the HIV/AIDS response is strengthened.

Support to statistical services has been effectively delivered by CO through investments in capacity building of implementers and beneficiaries, technical and financial inputs for the production and publication of output reports and their dissemination, and through acquisition of equipment, programme monitoring and evaluation. With the support by CO, Government successfully implemented the Participatory Poverty Assessments (PPAs) project; undertook and published the 2006/2007 National Demographic and Health Survey and the 2006 National Intercensal Demographic Survey. Equally important, the 2011 Population and Housing Census project has recently completed the head count and plans are in place for in-depth analysis of data and preparation of thematic reports. Notably, CO in partnership with UNDP and UNICEF, supported the introduction and establishment of the use of NamInfo/DevInfo (demographic &socio-economic database). In the light of the achievements and shortcomings of past capacity-building activities, emphasis has been placed during the past five years on enhancement of capacities of institutions implementing the 4th CP, including MoHSS, DDP and CBS in NPCS, MGECW, the 13 Regional Offices, and UNAM. Such capacity building interventions would henceforth be better focused on the new Namibia Statistical Authority which replaces CBS.

Regarding gender, UNFPA support to the achievements of gender outputs consisted of capacity building, research/ assessment, advocacy and community mobilization interventions. Among
others, significant achievements included the empowerment of women through trainings and sensitizations to ensure protection of their reproductive rights in Caprivi region, particularly in Singalamwe, Makaravani and Mubiza communities. Ministry of Gender Equality and Child Welfare and key line Ministries and NGOs were capacitated in gender mainstreaming using the SADC gender mainstreaming tool; paralegals empowered with knowledge and skills on various gender laws to further sensitize their respective communities. The capacity building of implementers and beneficiaries by CO, among others, have led to a better understanding of the linkages between population dynamics, poverty, and the demographic and socio-economic causes and consequences of the HIV/AIDS epidemic in the project areas. The results reveal that major strides were made in the implementation of the program and that overall, the program was effectively implemented. Gender equality issues were adequately considered in the formulation of the 3rd National Development Plan (NDP3) of the Government of Namibia. Financial resource disbursement and implementation rates met most of the expectations of the stakeholders.

5. Recommendations
The following recommendations are made based on the major conclusions and challenges faced by the programme implementation processes. Although debatable, the recommendations are arranged by programme component in order of priority.

5.1 General
a) GRN and UNFPA should involve all relevant programme managers, coordinators and implementers when output indicators, baselines and targets are being set in CPAP, so that the whole team has a common understanding of the implications and in order to assure ownership.

5.2 Reproductive Health
b) Although programme delivery at intervention areas proved to be effective, at national level, despite several years of interventions in safe motherhood in the country, maternal mortality has increased from 271 to 449/100,000 live births between 2000 and 2007. There is a great need to continue the UNFPA support to RH in terms of capacity building, monitoring of RH trends, maternal audits and other aspects of data collection, analysis and dissemination.

c) National data is showing a downward trend in teenage pregnancy rate, there is still a concern at the regional level. Of all three intervention areas, only one is below the national figure only with 1% (Oshikoto: 14%), UNFPA could probably venture in the general educational curriculum and strengthen the life skills education from earlier stages (10years). This could probably help them if they understand their body. This could be coupled with strong community advocacy groups to strengthen the parent-children communication on sexual issues.

d) Family Planning is another source of concern, while Namibia is a youthful society, FP services are widely available and accessible but the rates remain low. Although there is an upward trend in the intervention regions, all three are still below their national targets. Ministry should seriously look into their current strategies, (strengths, weaknesses and opportunities) and strengthen this very important RH service.

e) There is a need for IEC materials to be developed in local languages and real life issues in the communities be illustrated; the use of cartoons should be minimized to enable the communities to identify with the real issues in their midst.

f) Issue of stock-outs of condoms is a serious concern in the era of HIV/AIDS and need should be addressed promptly; the discrepancy in condom distribution from the national level to the regions and within the regions is a peculiar one that needs an urgent investigation, given that the regions are experiencing stock-outs for as long as 3-4 months.

g) GRN and UNFPA should continue to support SRH interventions nationally, and should encourage the regions should not lose the focus on the ongoing HIV/AIDS prevention strategies.

h) Male involvement in sexual and reproductive health should be encouraged by the line ministries, not only for intervention areas, but such groups need to be established in all 13 regions of the country to support RH in general and maternal health in particular.
5.3 Population and Development
   a) The NDP4 formulation process by Government should endeavour to integrate population issues (population dynamics, SRH, gender, youth, environment, etc.) into the Plan.
   b) GRN and UNFPA should continue to support the on-going census project and capacity building for data utilization for policies and plans, with focus on both NPCS and the newly approved institution, the Namibia Statistical Authority.
   c) NPCS, with the support of UNFPA, should strengthen the population staff capacity of DDP; including training of the staff in post, recruitment of two or more Demographers in order to enhance the Directorate’s capacity for coordinating population activities in the country.
   d) The ongoing revision of the National Population Policy should be concluded by Government as soon as possible, and strategy for its implementation put in place.
   e) Given that UNFPA has been the lead agency in supporting statistical services in Namibia since independence and because of the Fund’s comparative advantage in population and related statistical data collection and analysis, support to Government in strengthening the civil registration and vital statistics, the next CP should provide intervention in this area and possibly collaborate with UNICEF again as has been successfully demonstrated with the NamInfo project.
   f) Research and training in population in support of development policies and plans at both national and regional levels should be encouraged; this should provide an opportunity for strengthening the capacity of the Statistics Department at UNAM to train more statisticians and demographers in support of statistical services and population programme implementation in the country.
   g) Government should revive the activities of the Advisory Committee on Population as well as its technical arm, the Inter-Agency Technical Committee on Population and Development, in order to be able to design and implement a comprehensive and coherent programme of population/RH/Gender policy implementation at national and regional levels.

5.4 Gender
   a) Gender mainstreaming through sector-based analysis should be supported and greater coordination between the MGE CW and key line Ministries such as Health, Education, Finance and Agriculture which will enable sectors justify for gender responsive budgeting based on gaps identified in the assessment.
   b) Technical and system support for strengthening coordination and gender management system. In regard to geographical focus of UNFPA Namibia, UNFPA should consider concentrating gender interventions on two-to-three regions and dedicate its resources comprehensively in those regions based on criteria.
   c) An integrated approach and increased research to understand root causes of GBV should be undertaken by the MGE CW with support from UNFPA.
   d) In recognition of the fact that the majority of the population of Namibia is young, increased support for youth-focused projects on GBV, SRH and HIV/AIDS should be intensified and coordinated by MGE CW and implemented with relevant stakeholders.
   e) More support to be provided for the One Stop Centre approach for addressing violence against women and also support MGE CW for the establishment of networks with various key partners for effective service delivery.
1. Introduction

This is the report of the ‘End of Program Evaluation of the 4th GRN/UNFPA Country Programme (2006 – 2012)’. The 4th Country Programme (CP) was originally designed to cover the period from 2006 to 2010 but was later extended to 2012 in order to align the 5th CP with the forthcoming National Development Plan (NDP4) and related development frameworks in the country. As a matter of policy, UNFPA requires that a summative evaluation is conducted at the end of each programme cycle in order to determine the impact of the interventions.

1.1 Purpose and objectives of the evaluation

The purpose of this independent evaluation is to assess the achievement of the results, the factors that facilitated/hindered achievement, and to compile lessons learned so as to inform development of the next country programme cycle that begins in 2013. The report of this evaluation is expected to be shared among the implementers and the beneficiaries of the CP, including the UNFPA itself, government departments, civil society, tertiary institutions and other relevant stakeholders who are expected to use the results for decision-making to inform the planning, programming, budgeting, and implementation; the report should also inform the up-coming UNDAF process.

According to the TOR prepared for this exercise by the CO (see Annex 5 of this report), the objectives of the 4th GRN/UNFPA Country Programme evaluation are as follows:

i) To provide an independent evaluation of the achievement or lack thereof, towards the expected outcomes and outputs envisaged in the 4th GRN/UNFPA CP. Where appropriate, the evaluation will also highlight unexpected results (positive or negative) and missed opportunities;

ii) To provide an analysis of how relevant the 4th CP was in response to national needs/priorities and changes in the national development context;

iii) To assess UNFPA CO resources (e.g. coordination, organizational, leadership and management, human resources, financial resources) and capacity to deliver on the country programme outcomes and outputs;

iv) To look at cross cutting aspects such as the human rights based approach, gender mainstreaming, emergencies and humanitarian assistance, special attention to marginalized populations, coordination and partnership in a Delivering as One Country.

v) To present key findings, draw key lessons, and provide a set of clear and forward looking options leading to strategic and actionable recommendations for the next Programming cycle.

1.2 Scope of evaluation

This evaluation has covered the period of the programme cycle, as amended, i.e. 2006 – 2012. Being a national programme, the evaluation covered the whole country, with a focus on the four regions in which specific RH and Gender projects are being supported; namely, Caprivi, Ohangwena, Otjozondjupa, Oshikoto. The evaluation also covered the three programme components as approved by the Executive Board of UNDP and UNFPA, comprising Reproductive Health, Population and Development, and Gender.
addition to the thematic coverage, the evaluation examined cross cutting issues such as the human rights based approach, population communication and gender mainstreaming. In addition, attention has been given to programme management issues such as coordination and partnerships, as well as the role of UNFPA in addressing the UN ‘Delivering as One’ initiative through joint programmes.

In order to assess the effectiveness, efficiency, relevance and impact of UNFPA 4th Country programme in contributing to the improvement in the lives of the people of Namibia, certain key questions were addressed in the course of collecting and analyzing data and information on programme implementation. Data and information collected were analyzed such that the report identifies challenges and strategies for future interventions. The CO in collaboration with the Evaluation Management Team already suggested for the consideration of the evaluation team certain ‘indicative evaluation questions’, to guide the evaluation process. The evaluation team modified these questions as deemed appropriate.

The questions allowed the evaluators to address the evaluation criteria considered critical to the integrity of this type of evaluation by UNFPA; namely, strategic direction for the programme; effectiveness of the programme; efficiency in the management of resources (human, financial and material resources); relevance and strategic fit of the programme and strategies; impact orientation and sustainability of programme activities in the absence of UNFPA interventions. The evaluation questions guided the formulation of the questionnaires designed by the evaluators for collecting data and information from programme implementers and beneficiaries during the field work, and also in identifying for review relevant documents and materials.

Issues of effectiveness of programme implementation relate to whether UNFPA Country office (CO) in Namibia implemented and supported programmes using the most effective means, the extent to which the programmes and activities supported by UNFPA Namibia were targeted at the right beneficiaries, and to what extent the expected results were achieved. Finally, what could UNFPA Namibia and its partners have done better to improve programme delivery?

Regarding efficiency, the key evaluation questions concern efficiency in the deployment and utilization of resources (human, material and financial) to effect programme delivery; whether programme inputs and service delivery were timely and result-oriented; and the extent to which service delivery met minimum standards of quality for the beneficiaries. Finally, what could UNFPA Namibia have done better to improve the efficiency of programme delivery?

On relevance, one critical question is whether the 4th CP that UNFPA Namibia has been supporting is still relevant to the needs of the population and the development challenges faced by the country. And whether the strategic actions, outputs and indictors of the 4th

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1 The experts for each of the components designed questionnaires for data collection in collaboration with the respective NPOs, and validated by the Evaluation Management team. See Annex 7 of this report for the final schedule for each component.
CP have been contributing to the strategic priorities of the Namibia national development plan as well as the UNDAF.

Questions about programme impact are critical to determining the future orientation of the programme, whether there is need for a change of strategy or resource combinations, or to abandon a particular output altogether. Regarding RH, for example, what reproductive health impacts were made as a result of interventions supported by UNFPA Namibia? Through UNFPA’s interventions in supporting the availability of data on population, has Government improved its evidence-based policy formulation and programme design capability both nationally and across the sectors? What gender related impacts were made a result of supported interventions? What HIV related impacts did the fifth country programme contribute to? What impacts did UNFPA make through its support on the availability of data for development plans and policy formulation?

Regarding sustainability, one standard evaluation question is whether the Government of Namibia and other stakeholders can continue implementing current interventions without UNFPA support. Inclusive participation is also key: were partners, including the Government of Namibia, involved in the design, planning, implementation, monitoring and evaluation of the 4th CP? If not, how could the implementers continue the process without the intervention of UNFPA? Are UNFPA programme indicators included in partners’ strategic plans for the implementation of P&D, RH, Gender and HIV related programmes? Valid answers to these questions allow the evaluation to determine the sustainability of programme activities.

2. Methodology and Approach

2.1 Data collection
The CO employed the services of three consultants to undertake this independent evaluation. These are: Prof. Oladele O. Arowolo (P&D Specialist & Team Leader); Dr. Kathe Hofnie-//Hoebes (RH Specialist); and Dr Kenneth K. Matengu (Gender Specialist). The selection was based on the CO criteria which included relevance of background qualifications and professional experience, and familiarity with the social, economic, population and environmental conditions of the country and the development challenges faced by Namibia.

Firstly, the recruited experts were briefed by UNFPA CO at the inception of this assignment; and also a special briefing meeting was held with the UNFPA representative at the start of the evaluation. The consultants were taken through the Terms of Reference (TOR) already made available to them by email before signing their respective contracts for this assignment. The briefing also examined the detailed work plan for the exercise, which was discussed and modified by consensus.

Secondly, the consultants prepared an inception report and presented it to the Evaluation Management Team as scheduled. Thereafter, the consultants worked closely with their respective NPOs to finalize their questionnaires before the commencement of field visits.
Concurrently, the evaluators identified for review UNFPA and GRN documents and publications relevant to the 4th CP in general and the three components in particular. Additional materials were collected from the UNFPA and GRN websites and from the implementing agencies (NPCS, CBS, MoHSS, MGECW, MoYNSSC, etc.) during the field work (see Annex 1 for Bibliography).

The fourth step was collection of data from primary sources (implementers and beneficiaries) through the administration of interview schedules prepared in collaboration with the NPOs (RH, P&D, Gender and HIV&AIDS), as approved by UNFPA CO. Reproductive Health and related data and information were collected from the Ministry of Health and Social Services (MoHSS); the four regions (Caprivi, Oshikoto, Otjozondjupa and Ohangwena), as well as training institutions (UNAM and NHTC) and three non-governmental/civil society organizations (NRCS, NAPPA and CCN). Those who were directly involved and/or were in charge of the specific four components of RH [Communication for Behavioural Change (COMBI), Maternal Health, Integrated sexual and Reproductive Health (ISRH) and RH in Emergency settings] were purposefully included for the interviews.

The institutions contacted for P&D related data and information included the following:
National Planning Commission: Director, DDP; Deputy Director, DDP; Deputy Director, CBS; Chief Info Officer, Census, CBS; Chief Statistician, CBS; Chief Public Relation Officer, CBS; Chief Technical Advisor, Census, CBS; and Head, Statistics Department, UNAM; 1 Lecturer, Statistics Department, UNAM.

On gender, the Ministry of Gender Equality and Child Welfare (MGECW) provided data and information through interview and discussions, particularly with the Deputy Director, Research; Deputy Director, Gender Mainstreaming. Also, interviews extended to UNAM - Dean, School of Nursing and Public Health; UNAM Course Coordinator and Lecturer, School of Nursing and Public Health. At the regional level, evaluators visited and collected data from Katima Mulilo Rural Constituency, Mubiza Community, Garden Project; Katima Mulilo Urban Constituency, Makaravani, San Community, Project members; Parliament of Namibia, National Assembly, Gender and Family Affairs Committee members; Namibia Planned Parenthood Association, Executive Director, and Gender Program Officer. In addition to the above data sources, the evaluators also searched the UNFPA website for related data and information².

Following the data collection phase, a variety of methods were adopted to ensure that the data collection procedure adopted and analytical techniques employed were valid. The statistical techniques used include the relevant measures of central tendency and dispersion, with graphic illustrations for visual acuity. In essence, the evaluation employed a combination of qualitative and quantitative methods to answer the questions that were developed to assess progress, performance and relevance of the 4th GRN/UNFPA CP, including the three components and crosscutting issues. The

² See Annex 3 of this report for List of persons met and sites visited; and Annex 6 for the Detailed Work Plan for this evaluation
triangulation approach allowed for more confident interpretations of data from official sources and those derived from programme reports, against those generated from field investigation.

2.2 Stakeholders’ Involvement
The process of data collection and validation of report was inclusive, involving a broad range of partners and stakeholders, in fulfillment of the human rights clause of the programme. These stakeholders included representatives from the Government, civil-society organizations, the private-sector, UN organizations, other multilateral organizations, bilateral donors, and most importantly, the beneficiaries of the programme. The evaluators worked closely with the UNFPA CO staff, including the NPOs (RH, P&D, Gender, HIV&AIDS and the M&E Officer) as well as the CP Evaluation Management Committee (CPEMC). The Consultant(s) have worked in line with the terms of reference (see Annex 5 of this report) under the overall supervision of the CP Evaluation management Committee (CPEMC), as defined in the Annex 2 of this report. The evaluation was managed by the UNFPA M & E Officer who was responsible for convening, coordinating and supporting the (CPEMC) meetings and consultants on behalf of the UNFPA Representative.

The CPEMC was made up of evaluation and programme experts from UNFPA, National Planning Commission (NPC) and other government agencies and Civil Society partners has been set-up for quality assurance purposes. The team was responsible for approval of the Consultants’ inception report, and for monitoring progress and quality of evaluation activities, including the Evaluators’ field mission report. As part of progress monitoring and quality assurance, CO invited the evaluation team to present the preliminary report of this evaluation at the GRN/UNFPA Annual Review and Planning meeting of the 4th CP held in Ondangwa (15-17 November 2011). The CO gave the evaluation team a slot at the Annual Review and Planning meeting to make presentation on the preliminary evaluation findings during the morning session on 17 November 2011. Members of the CPEMC were present in the validation workshop of 17 November 2011, which was attended by 62 participants representing the implementing partners at national and regional levels. At the validation workshop, the evaluation team made presentations and received comments from the participants, which have been reflected in this report to the extent possible.

Following the validation workshop, the evaluation team prepared a report of the workshop, including the presentations and comments received, and submitted to the report to the UNFPA Representative, in accordance with the TOR.

Lastly, the Team Leader for the evaluation prepared the overall evaluation report, based on the TOR, and submitted to CO for comments. The comments received were incorporated, to the extent possible, into the final evaluation report submitted to the UNFPA representative as scheduled.

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3 See the Annex 2 of this report for list of CPEMP members.
4 See Annex (e) of the Validation Workshop Report for the List of Workshop participants.
2.3 Limitations
The consultancy was carried out between 24 October and 25 November 2011. The breakdown of days is shown in Annex 4 of this report. Time is always a limiting factor in such a study as this; the limited time allowed for field visits and data collection from publications and their analysis imposed a constraint on impact assessment, particularly as it relates to programme beneficiaries scattered all over the vast territory of Namibia. Although the M&E Programme Officer tried her best to send the questionnaires by mail before the commencement of the field visits, the response to the questionnaire was generally not encouraging. However, face-to-face interviews proved to be more effective, provided the officials were available for appointment and for interview.

Nevertheless, the evaluators supplemented the information from primary sources by a myriad of CO reports, including project reports, workshop reports and related CO documents, Government and other sources. The internet search by the consultants also provided valuable additional information. Therefore, the integrity of the data and information collected as well as the analytical methods employed for data tabulation and analysis, should assure the integrity of this evaluation report.

2.4 Structure of the evaluation report
Guided by the TOR for this evaluation, the report is presented in six sections. Section 1 is ‘Introduction’, in which the 4th CP being evaluated is described, including the problems being addressed by the interventions. This section also contains a summary of the evaluation purpose, objectives, and key evaluation questions; the methodology employed to conduct the evaluation; the team involved in conducting the evaluation and their respective roles and responsibilities. Section 2 is on ‘Methodology’; justification for the method and approach adopted and the constraints and limitations. Section 3 focuses on the context for the design of the 4th CP. The ‘Findings/Analysis’, are presented in section 4, specific to each programme component, (a summary based on Logical Framework, is presented in Annex 4 of this report). The analysis of findings in section 4 addresses, among others, the critical evaluation questions based on the evaluation criteria: adequacy of programme design, effectiveness of programme interventions, efficiency, relevance, impact orientation, and sustainability. This is followed by ‘Future direction’ in section 5, and by ‘Conclusions’ in Section 6: based on the findings and consistent with the data collected, in relation to the evaluation objectives and answers to the evaluation questions. Section 7 is on ‘Lessons learned’ in the course of programme implementation. Section 8 is the final section in the report; it contains the ‘Recommendations’; these are based on the evidence gathered, conclusions made and lessons learned. The report also has Annexes and Bibliography sections following section 8.

3. Context

3.1 Development challenges
The 4th CP was designed to assist the Government of Namibia in addressing the pressing population and related socio-economic challenges facing the country as assessed in 2005. Despite the middle-income status of the country, large segments of the population receive low wages and are engaged in subsistence agriculture. By 2005, research survey indicated
that 40 per cent of Namibians were living below the poverty line. Namibia has made progress towards several Millennium Development Goals (MDGs), including universal access to primary school education. However, the high HIV prevalence rate (22 per cent in 2002), which was responsible for a growing number of vulnerable and orphaned children, undermined such achievements. As the 2004 common country assessment (CCA) indicates, the combination of HIV/AIDS, food insecurity and weakened institutional capacity constitutes a triple threat within the humanitarian crisis in Southern Africa, including Namibia.

**Population dynamics and development**

The analysis carried out in 2005, which served as inputs into the formulation of the 4th CP, revealed important social, economic and demographic indicators for Namibia: national population total was estimated at 1.8 million; annual average population growth 2.6% (1991-2001); the total fertility rate (TFR) 4.1 births per woman; and the contraceptive prevalence rate, 37.8 per cent.

Government anticipated an annual population growth rate of 3 percent by 2006; but average annual population growth rate for the period 1991-2001 was 2.6 percent, in part due to the effect of concerted Reproductive Health (RH) efforts including the implementation of the Reproductive Health Policy by the Government in collaboration with the private sector, non-governmental organizations and international development partners. It is acknowledged that the delivery of reproductive services to the communities has not only resulted in a reduction in the population growth but has also led to improved general health and sexual and reproductive health (NDP3, 2008). The 2007-2007 DHS results show that the Total Fertility Rate has declined from 5.4 (1990-1992) to 4.2 (1998-2000) and 3.6 (2006-2007).

In 2006, the Central Bureau of Statistics (CBS) issued the results of population projections for Namibia (2001-2031), also indicative of improvements in demographic indicators; the Medium variant of the projections were based on based on the following demographic assumptions: TFR 4.1 (2001), 3.5 (2016), 3.0 (2026), and 2.4 (2031). Regarding mortality, approximated by Life Expectancy at birth for both sexes, it was assumed that Life Expectancy would increase during the projection cycle as follows: Females from 50 years (2001) to 60 years (2021), and 65 years (2031); while for Males from 48 years (2001) to 58 years (2021) and 63 years (2031).

The population of Namibia is predominantly youthful: young people below the age of 15 make up more than 39 per cent of the population. Six per cent of females and 12 per cent of males are sexually active before the age of 15, and almost all Namibians are sexually active before the age of 20. Although the teenage pregnancy rate has dropped, 39 per cent of 19 year olds are mothers or are pregnant. Youth unemployment may be as high as 60

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5 According to the results of the 1993/94 and 2003/2004 Namibia Household Income and Expenditure Surveys (NHIES), the incidence of poverty (defined as those devoting 60 percent or more of their total expenditure to food) among households declined from 38 percent in 1993/94 to 28 percent in 2003/04, or by 26 percent during the decade.
per cent, which could lead to alcohol abuse, an increased sense of hopelessness and risky sexual behaviour. Large parts of the country are subject to recurring natural disasters such as droughts and floods.

The integration of population issues (including gender, reproductive health, HIV/AIDS) into policies and plans at all levels remains a challenge. The treatment of population dynamics and the associated factors in the NDP3 shows a significant deviation from the past (see NDP2 and Vision 2030) in which the centrality of population as the objective of development was demonstrated. The Population Policy (1997) is being reviewed but the capacity to implement its programme has remained a challenge.

Reproductive health issues

It is widely acknowledged that HIV/AIDS poses a serious developmental and human rights challenge to Namibia and Government is determined to combat the epidemic by scaling up the response. Hence, action against HIV/AIDS is identified in NDP3 as a Government priority and considered central to Namibia’s achievement of national goals of poverty reduction, macro-economic growth, sustainable development, and realization of Vision 2030. Reports show that Namibia has a generalized HIV/AIDS epidemic with HIV contracted primarily through heterosexual transmission. The HIV prevalence rate has gone down from 12% in 2000 to 10.2% in 2006 for the age group 15-19 years, and from 20% to 16.4% for the age group 20-24 years (NEPRU, 2008). However the estimate is associated with a high variance, as prevalence is still quite high in some regions and is a source of concern. For example, according to 2006 HIV sentinel surveys among pregnant women, Katima Mulilo, which is one of the intervention areas is topping the list with 39.4%. However, during 2008, the rate dropped to 31.7%, showing 7.7%, decrease. Although it was an encouraging trend, there has been again an increase of 3.9% in 2010, indicating 35.6% which is a source of concern (MoHSS, 2010).

In Namibia, 95% women who had a live birth in the five years preceding the 2006 NDHS survey received antenatal care from health professionals; 16% from a doctor and 79% from a nurse or midwife; only 4% of mothers did not receive any antenatal care. (NDHS, 2006/07). The report also shows that the overall unmet need for family planning among all women in Namibia is 3%, 2% for spacing births and 1% for limiting births. This unmet need varies somewhat by age and residence.

The public health sector ensures that women and children have access to health services, and under the safe motherhood initiative introduced in 1991, maternal and child health services are being supported throughout the health care system. It is indicated that close to 95% of pregnant women receives antenatal care from medical professionals. Despite all the efforts including the UN Support for Basic and Comprehensive EmONC, the country is unable to reduce the number of maternal deaths (MoHSS, 2009). Maternal mortality has been on a rising trend since 2000, when the ratio was 271. Maternal Mortality Rate has doubled and stands at 449 deaths per 100,000 live births (DHS, 2006-2007). At the same time, the proportion of births attended by trained health personnel is steadily increasing and is currently at around 80%. However, this latter positive factor could not compensate for the combined effects of HIV/AIDS, poverty and insufficient
health facilities that are not able to deal with complications during delivery, particularly in some of the regions. Moreover it has become clear from studies conducted that the main determinant of the current high levels of maternal mortality is the inadequate capacity of service providers and facilities to provide key emergency obstetric care services (EmOC), which are critical in saving the lives of mothers with emergencies during birth. The direct causes of maternal death are severe eclampsia (high blood pressure and hyper tension) (33%), haemorrhage (bleeding) (25%), obstructed or prolonged labour (25%), and post-partum sepsis (infections) (8%) (NEPRU, 2008). According to MMR study done in 2007, direct causes of maternal deaths are haemorrhages, eclampsia, obstructive labour and rupture of uterus, unsafe abortion and infections, while indirect causes include HIV/AIDS, malaria and anaemia (MoHSS, 2007).

Improved maternal health is a major concern of the Government. Maternal health services are not consistently available throughout Namibia. Seventy Nine (79%) of health facilities nationwide provide antenatal care, this excludes the sick bays and free-standing VCT facilities. Only 18% of hospitals provide ANC. Only nine (9%) of facilities nationwide can perform Caesarean section (C-section) including eighty percent (80%) of hospitals. In some regions only one or two facilities have the ability to perform a C-section, according to the report of the Health Facility Census (2009). Ensuring birth attendance by skilled health personnel is the most effective way of preventing maternal deaths as it is stressed by the implementation of EmOC and other interventions. This is furthermore important to guarantee that women have access to good pregnancy and after birth care, and are able to time and space their pregnancies using family planning. According to the Poverty Bulletin (NPCS, 2009), the proportion of births attended by trained health personnel is steadily increasing and is currently at around 80%. However, this latest development cannot compensate for the combined effects of limited access to emergency obstetric care, HIV/AIDS as well as poverty on maternal health, which explain the recent rise in the rate of maternal mortality in Namibia. According to NEPRU (2008) evaluation of MDGs, the set targets for maternal mortality as well as for birth attendance by trained personnel are unlikely to be met.

Infant mortality rate is currently 46 deaths per 1,000 live births (NDHS, 2006-2007). Regarding adolescent health, the Namibian National Policy for Reproductive Health states that, "adolescents have the right to all information on sexual and reproductive health, and access to quality adolescent friendly services." In this policy, adolescents are defined as individuals between the ages of 10-19, and youth aged 19-30. The policy promotes the establishment and promotion of adolescent friendly health services at all levels of the health care system (MoHSS, 2001). Adolescent health is currently identified by the Ministry of Health as a priority area for public health. The 2008/9 Annual report of the Ministry of Health and Social services indicate that all thirteen regions are running a comprehensive and active adolescent health services except Caprivi.

Regarding RH in emergency settings, the Government of Namibia (GRN), UN agencies and Non-governmental organizations have made some commendable progress in the protection sector during the ‘preparedness and relief’ phases of 2011 flood cycle.
Regarding coordination, a protection sector approach has been promoted. UNFPA became protection lead agency within United Nations Country Team (UNCT), while GRN has yet to formally designate a lead ministry. United Nations Children Fund (UNICEF) supported by the Ministry of Gender Equality and Child Welfare (MGECW), worked together with UNFPA to set up regional child protection committees and in collaboration with Development Aid from People to People (DAPP) to establish child friendly spaces in camps. UNICEF and UNESCO worked with Ministry of Education (MoE) to produce and test emergency preparedness and response manual for the Education sector. Protection providers such as MoHSS, Ministry of Home Affairs and Immigration (MHA & I), and Namibian Red Cross Society (NRCS) conducted outreach services to varying degrees and coverage and protection actors, including UNFPA, conducted some training and awareness raising workshops on some protection issues in the country (Neels, Packwood & Haitembu, 2011).

**Gender and development challenges**

Although Namibia has one of the most progressive gender laws and policies in place, the persistence of gender inequalities remains a major development concern to the Government of Namibia. The constitution outlaws discrimination based on sex and provides for the implementation of affirmative action and policies that advance women’s socio-economic status and roles within society. The laws and policies in place are the Married Persons Equality Act, Combating of Rape Act, Combating of Domestic Violence Act, Communal Land Reform Act, and many other relevant laws. However, these laws by themselves are not sufficient to address the challenges faced by ordinary women and men in society. Increasingly, many stakeholders point out that emphasis need to be on the implementation of these laws.

Several programmes and policies aimed at addressing aspects of gender inequality in the country have been implemented. Despite these efforts women and girl children remain amongst the most marginalized. Traditional perceptions of manhood and womanhood result in the impoverishment and economic dependency of women on males, where practices of inheritance favor men and boys at the expense of women and girls and often affect their opportunity to enroll and complete formal education, and their conditions are exacerbated at the workplace where they lack competitive advantage and are lowly represented in all spheres of decision making. Negative cultural perceptions lead to a lack of opportunities for women and adolescent girls as reflected in the low representation of girls in subjects that are traditionally considered for males. These perceptions and practices have a negative impact on access to and control over resources, availability of support services and women and girls reproductive health. Women, particularly young women, have the greatest risk of becoming infected with HIV/AIDS. There is also the challenge of gender based violence, including rape, passion killing, baby dumping and domestic violence. The 2002 Namibia Demographic and Health Survey (NDHS), showed that violence against women and girl children increased by one hundred percent from Independence to 2001. According to the 2006/2007 NDHS report, 35 percent of women agree with at least one of the five specified reasons for a husband to beat his wife. In addition, NDHS also show that one in four women say that wife beating is justified if a wife neglects the children, 19 percent say it is justified if the wife goes out without
informing the husband, 16 percent say it is justified if she argues with the husband, and 12 percent each say it is justified if the wife burns the food or refuses to have sex with the husband. Furthermore, although the percentage of women who agree with at least one reason for beating a wife does not vary by the woman’s age, women who are employed but receive no cash earnings are much more likely than women who are paid in cash to agree with at least one reason for wife beating (47 percent and 25 percent, respectively). Additionally, formerly married women are more likely to agree on a reason for wife beating (42 percent) than never-married women or married women (35 percent each). The number of children a woman has influences her perception on wife beating; 44 percent of women with five or more children agree on at least one reason justifying wife beating, compared with 33-35 percent among women with fewer children. These findings have implications on the type of target of the CP and future focus. Due to the vulnerabilities which women and girls are exposed to at the household and public domain they face the greatest risk of contracting HIV/AIDS.

In terms of popular participation in decision making, more recent information shows that definite progress has been achieved; as of 2007, women constituted 45 percent of the members in local authorities; 27 percent in the Parliament; 33 percent of the employed in the public and private sectors, with the percentage of women in wage employment at around 44 percent. Also the number of women employed in the public sector is slightly more than men, but they lag behind their male counterparts when it comes to employment in the private sector (NDPS, 2008). Still more needs to be done by all the concerned sectors to raise the status of women and improve their recognition in the household and in the community. Addressing gender discrimination in the society may hold the promise for behavioural change in reproductive health matters and reduction in the spread of HIV in Namibia.

3.2 Aims and strategies of the programme
GRN and UNFPA agreed to implement the 4th CP, which addresses national priorities in line with the Millennium Development Goals (MDGs) and the Programme of Action of the International Conference on Population and Development (ICPD). It reflects the 2004 CCA and the 2006-2012 United Nations Development Assistance Framework (UNDAF) and addresses key national priorities and development challenges outlined in the second and third National Development Plans and Vision 2030. Namibia is completing the implementation of the 2nd UNDAF (2006-2013). UNCT together with the Government agreed that Namibia would be a self-starter for Delivering as One Country.

The goal of the 4th CP is to contribute to the Government’s aim of improving the quality of life of the people of Namibia. The strategies adopted consist of: (i) improving reproductive health; (ii) reducing the spread of HIV; (iii) ensuring gender equality; and improving the utilization of data for development and the integration of demographic, reproductive health, gender equality and HIV variables into national programming. The 4th CP has three related components: Reproductive Health; Population and Development and; Gender. The programme was also designed to address certain cross-cutting issues: the human rights based approach, gender mainstreaming, emergencies and humanitarian response.
The RH component of the 4th CP focuses on HIV prevention, impact mitigation and the provision of high-quality reproductive health services, including essential obstetric care in selected intervention areas. UNFPA interventions paid particular attention to 18 health facilities in the three selected regions. Caprivi, which is one of the participating Regions, also has the highest adult HIV prevalence rate (40%) in the country. The component has also been supporting national and regional youth networks on population and development, particularly for advocacy to prevent HIV.

The overall objective of the P&D component is ‘to contribute to the poverty reduction goals of the NDP2 and the promotion of gender equality and equity.’ The component is directly linked to the achievement of two UNDAF outcomes (Outcomes 2 and 3): UNDAF Outcome 2: The capacity of Government and civil society institutions is strengthened to deliver and monitor essential/critical health and education services; and UNDAF Outcome 3: Livelihood and food security among most vulnerable groups are improved in highly affected locations.

The Gender Component was designed to address gender inequalities that contribute to the spread of HIV/AIDS. A key thrust of the programme is to address structural, economic and cultural barriers to equality and empowerment through the promotion and enforcement of gender equality in laws, practices, policies, value systems to improve women’s capacities, opportunities and decision making.

In terms of resources, the Executive Board of UNDP and UNFPA (New York) approved the proposed UNFPA assistance to the Government of Namibia on population programme in the amount of US$5.5 million (US$3.5 million from regular and US$2.0 million from other resources) covering the period of 5 years from 2006 to 2010. Based on the UNFPA Multi-Year Funding Framework, 2004-2007, the approved programme consists of three main components: Reproductive Health (RH), Population and Development (P&D), and Gender. (Table 1 shows a detailed breakdown of the composition of the UNFPA support to population activities 2006-2010, as approved by the Board).

<table>
<thead>
<tr>
<th>Programme Area</th>
<th>Regular resources</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reproductive health</td>
<td>1.9</td>
<td>1</td>
<td>2.9</td>
</tr>
<tr>
<td>Population and development</td>
<td>0.5</td>
<td>-</td>
<td>0.5</td>
</tr>
<tr>
<td>Gender</td>
<td>0.8</td>
<td>1</td>
<td>1.8</td>
</tr>
<tr>
<td>Programme coordination and assistance</td>
<td>0.3</td>
<td>-</td>
<td>0.3</td>
</tr>
<tr>
<td>Total</td>
<td>3.5</td>
<td>2</td>
<td>5.5</td>
</tr>
</tbody>
</table>

*Figures in US$ millions
In addition, the programme allocated funds for addressing cross-cutting issues through its Programme Coordinating and Assistance (PCA) component, which involves advocacy, inter-agency coordination and collaboration activities.

The level of assistance to the current programme represents a decline from the amount of US$12.5 million approved for the country under the third country programme. However, Namibia has been re-classified by UNFPA in July 2007 as a Group A country from Group B when it was considered a ‘Middle-Income’ country. Now in the Group A countries, Namibia expected additional UNFPA support to its population programme.

4. Findings/Analysis

The summary of achievements is presented for each of the programme components (RH, P&D and Gender) in the Annex Tables 2.1, 2.2 and 2.3 in a Logical Framework, with reference to their outputs, and indicators, their baselines and targets, achievements made in programme implementations and remarks.

In this section, the analysis of findings is presented by programme component, in relation to the evaluation criteria and provides answers to the identified ‘key evaluation questions’: the extent to which progress has been achieved on each of the programme outputs and assessment of programme performance based on the criteria of adequacy of programme design, relevance, effectiveness, efficiency, and impact orientation and sustainability. The presentation is made on this basis for each component in order to avoid possible confusion of means, efficiency, effectiveness and impact across the components of the programme.

4.1 Reproductive Health (RH)

Progress made in achieving the outputs of the RH component is summarized in the Annex Table 3. Indicators are defined for each of the four outputs, and against each indicator, baseline and targets are operationalized as basis for performance or progress evaluation. The last column of the Annex Table 3 contains the evaluation’s observations on means employed and possible impact on RH programme activities.

a) Adequacy of design

The RH component has four outcomes and four outputs to facilitate desired objectives, and these are:

- Outcome 1: Reduced high-risk behavior among vulnerable groups through interventions that address underlying causes. The output for this outcome is defined as: Young people participate in and have access to HIV/AIDS information, life skills and opportunities in 24 health districts;
- Outcome 2: Increased access, utilization and provision of comprehensive, high-quality reproductive health services, including HIV prevention, treatment and care, and VCT, with its Output stated as: Increased availability of comprehensive,
high-quality HIV prevention and youth-friendly health services and care, including VCT and sexual and reproductive health services

- Outcome 3: Strengthened national and regional capacity for humanitarian and emergency response management and its output is defined as: *Strengthened capacity to address reproductive health needs in emergency settings*

- Outcome 4: Strengthened institutional and community capacity for effective delivery and utilization of critical services in health and education. The output is: *Increased availability of high-quality maternal health care services, including essential obstetric care in two thirds of intervention areas.*

A key strategy adopted was community education and mobilization to create a demand for high-quality reproductive health services and to promote healthy reproductive behavior, as a human right. Social mobilization efforts targeted all segments of the population, including political and religious leaders, elders, parents and young people. Community education and mobilization initiatives focused on young people and their health needs, in order to achieve behavioural change results.

**b) Effectiveness of programme**

One basic strategy which proved effective was the focus on capacity building by UNFPA. This involved human capacity development of programme managers, implementers, coordinators, as well as direct beneficiaries of the implemented programmes in the selected regions. Financial and technical assistance was also provided for production of IEC materials, development of training manuals, development or revision of guidelines and policies. However, there has been a request that IEC materials are printed in local languages and cartoons done away with and real life situations in the communities put on posters for education.

As a result of community mobilization activities by LAs in Caprivi, the region reported significant increase in partner referral from 737 in 2008 to 1149 in 2010. Also the enrollment of clients for ARV has increased to an average of 40 clients per week compared to 20-30 in the past. CO collaborated with partners that include the UN agencies, government Ministries, NGOs and Faith-based organizations, and training institutions to implement the RH component of the 4th CP through joint programmes. Interventions provided under this joint programme have been reported showing positive results in the intervention areas.

Different programmes of RH benefitted the target population (men and women, particularly the youth) in unique ways, according to their respective needs. UNFPA advocated for meaningful participation of young people in the COMBI project for HIV/AIDS which aimed at behavioural change. The support provided by CO facilitated social mobilization, community education and advocacy regarding HIV/AIDS. The participation of young people in HIV/AIDS prevention has been a way to enhance effectiveness of interventions targeted to this group.

The direct beneficiaries in the regions also found this programme very useful. The community youth group members responsible for mobilization and advocacy activities of COMBI programme indicated personal gains from the programme. Remarks such as this...
were made: ‘…I have sort of rose from zero to hero, because I discovered myself now. I was mixing things before, but now I am in control of my life’.

The Maternal Health component seems to have benefited the most compared with the other components. New skills were built in Emergency Obstetric Care in different health workers in response to the needs assessment. CO also supported a maternal waiting home (community shelter) that accommodate pregnant women who live far from health facilities. Tuyakula maternal shelter was renovated and fridges, additional beds and mattresses were procured.

Numerous equipment and supplies such as ambulances, delivery beds, delivery packs were provided to increase the availability of high-quality maternal health care services. Health workers were trained in how to conduct Maternal and Neonatal Death Reviews and National MPNDR Committee was instituted to review the deaths and provide meaningful direction to the country. After the capacity of MNPDR was built in 2009, the maternal and neonatal deaths were more accurately recorded, thus in 2010 there was a significant upwards trend in all intervention areas, particularly in the numbers of maternal deaths. However, due to various efforts provided by CO, there has been a downward trend since then in the intervention areas.

Some other interventions provided under this joint programme have been reported showing also positive results in the intervention areas. For example, in Ohangwena, the enrolment in the maternity waiting shelters increased from 231 in 2009 to 750 in October 2011. This increase in enrolment has also generated upwards trends in hospital deliveries in Eenhana from 1,700 in 2009 to 3,909 in September 2011. However, it is evident that among all these strategies to reduce maternal and neonatal deaths, male engagement is still lacking. The only visible male engagement group in Caprivi indicated that the group’s activities were stopped in 2010, due to issues still to be communicated to them.

There is a significant trend in increased uptake of family planning in the intervention areas among young people. The significant increase in utilization of all RH services is more evident in the two NAPPA youth friendly clinics (Katima and Khomas) that cater mostly for the young people. NAPPA reported annual increases in all their services and due to the high demand from the young people to have such many more of youth friendly clinics, one was inaugurated on the 11 November 2011 in Outapi, with some others in the pipeline for Karas in Keetmanshoop, Erongo in Walvis Bay and for Ohangwena in Eenhana. However, there is a need to give consideration to some other RH services that are ever declining such as Pap smear screening in the intervention areas. The participants reported shortage of such screening equipments in the regions.

Capacity of local NGOs and faith-based organizations in the region were developed to publicize the VCT services, reduce stigma and emphasis VCT as an entry point for a continuum of care for HIV infection. Government officials and health staff were sensitized on reproductive health issues in emergency settings. UNFPA together with GRN developed a first contingency draft, which never existed before; and UNFPA also
took action during the 2011 floods as a lead protection agency, in the absence of any lead Government ministry for RH emergency response.

c) Efficiency of programme management
RH human capital was built during 4th CP which shows positive results in awareness level of beneficiaries and through what they described as personal benefits they gained from the support provided for RH programme. UNFPA provided technical support to strengthen capacity of health providers, especially in AFHS (400 nurses), FP (32 providers), and EOC (344 providers). Three regional programme coordinators were recruited and deployed to the three main intervention areas i.e. Caprivi, Oshikoto and Otjonzondjupa to promote and implement RH programmes in their respective regions, and their work has proved to be effective.

UNFPA provided financial and technical support to MoHSS for development and launching of the roadmap to accelerate reduction of maternal and neonatal mortality and morbidity. Furthermore, UNFPA provided financial and technical support for the costing of the roadmap. In line with Maputo Declaration, technical and financial support was also provided for the revision of RH policy to integrate FP and HIV. Financial support was deployed to the implementers in reasonable time. RH received US$ 1.9 million from regular sources, while extra US$ 1 million is from other resources. Table 2 indicates the annual implementation rates for RH; 2006-2011 (see Figure 1). The programme demonstrates a steady increase in the implementation rate from 2006 (over 70%), reaching 98% in 2009 and over 100% in 2010. Already by the end of October RH implementation rate had reached 85%, suggesting that by the end of 2011, the rate is likely to be close to 99%.

End of cycle evaluation concurs with the efficiency of 4th CP, but participants pointed out some areas where UNFPA could have done better. Realistic indicators, baselines and targets need to be agreed upon and regularly monitored. There was only one male engagement group operating in Caprivi, but this group also was discontinued during

Table 2: RH Financial Implementation Rates

<table>
<thead>
<tr>
<th>Year</th>
<th>Budget*</th>
<th>Expenditure*</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>389636</td>
<td>285142.41</td>
<td>73.2</td>
</tr>
<tr>
<td>2007</td>
<td>1538933.4</td>
<td>1192934.4</td>
<td>77.5</td>
</tr>
<tr>
<td>2008</td>
<td>1459420</td>
<td>1135541</td>
<td>77.8</td>
</tr>
<tr>
<td>2009</td>
<td>1,913,419.0</td>
<td>1,884,978.00</td>
<td>98.5</td>
</tr>
<tr>
<td>2010</td>
<td>1,983,831.0</td>
<td>2,016,807.00</td>
<td>101.6</td>
</tr>
<tr>
<td>2011</td>
<td>1,559,244.1</td>
<td>1,322,422.77</td>
<td>84.8</td>
</tr>
<tr>
<td>Total</td>
<td>8844483.56</td>
<td>7837825.58</td>
<td>88.6</td>
</tr>
</tbody>
</table>

* Figures in NS. Source: Country Office files: 2011
2010, but according to them, no feedback was provided. Another area for improvement was on the issue of timely disbursements of budgeted funds. The funds were not disbursed timely, resulting in delaying some programme activities.

d) Relevance in the 4th CP
The 4th CP was designed to contribute to the goals of the National Strategic Plan on HIV/AIDS (Medium Term Plan II) particularly that of ‘reducing the incidence of HIV infections to below epidemic threshold’ and combating the spread of HIV/AIDS through multi-sectoral approaches’ (NDPII). Similarly, the component focused on improving maternal health services and provision of EoC to contribute to the reduction of maternal mortality (MDG 5). Strengthened management and monitoring of adolescent friendly RH services respond to community demands for improved quality of service provision at the health facilities.

The RH component focused on HIV prevention and impact mitigation through behavior change interventions and expansion of Voluntary Counselling and Testing (VCT) services in selected regions. The provision of high quality RH services specifically, improved maternal health and essential obstetric care services, is an important undertaking under the 2006-2010 CP. Reproductive health component also strengthened capacity for the management and monitoring of adolescent friendly reproductive health services at the regional and district levels. The RH component is directly linked to the achievement of UNDAF outcomes one and three to achieve by 2010: the HIV/AIDS response is strengthened through (Country Programme Action Plan, 2006-2010)

The strategies in RH are relevant in that they address the various interventions that contribute to improvement of RH indicators. The youth group members who newly joined find door-to-door approach very useful as it enabled them to open up in one on one discussion. Drama plays which are followed up by questions and answers were also hailed as relevant, as the audience pay more attention to what they are viewing, unlike an ordinary talk.

e) Sustainability
UNFPA provided financial and technical support for capacity development and capacity was built, particularly new skills around EmOC and MNPD reviews for sustainability. Similarly, UNFPA facilitated integration of AFHS into the curricula of institutions of higher learning.

The TOT trainings of health workers and training of LAs in their respective regions and districts, as well as the youth clubs also contributed to sustainability. The Namibian government has also adopted a Roadmap which could be used for funding of some essential activities such as those aimed at reduction of maternal and neonatal mortality and morbidity.

Support was provided for community mobilization activities in order to improve decision making on health care seeking behavior and eventually increase utilization of EmOC services. These community mobilization activities target community leaders and males
for stimulating community preparedness and support system for improving referral of cases from the community to the first level of health care system.

**f) Impact**
The term impact could be used in different ways. It is a broad, long-term effect of specific work, or the institutional changes that result from interventions. In the current evaluation we consider impact to be the outcomes achieved in the 4th CP as measured by data from beneficiaries as well as implementing partners. As impact is a long-term effect, it is not always possible that certain intervention alone can be responsible for such an outcome. Different interventions could sometimes be needed before such impact could be measured.

However, in some cases, direct impact could be measured. For example, certain health facility used to refer most of their patients for surgery because of lack of anaestheticians; but after doctors received necessary training in anaesthesia through UNFPA intervention, regional hospitals were able to conduct caesarean sections, without transferring uncomplicated cases.

CO also supported community shelter for pregnant women whose distance could not allow them to access health facilities. Tuyakula maternal shelter was renovated and fridges, additional beds and mattresses were procured. This support has increased the enrollment to the shelter and contributed to a rising trend in deliveries attended by skilled attendants in Eenhana district health facility. This implies that as a result of government and UNFPAs contribution, there has been a reported increased awareness of the community on matters related to household health seeking behaviour.

Two government officials and two parliamentarians were supported to attend Reproductive Health Commodity security (RHCS) Advocacy capacity Building workshop in Gaborone (2007). After the workshop, the Parliamentarians have taken initiatives to advocate for RHCS through meeting RHCS coordination mechanism and sensitized other Parliamentarians.

Utilization of LAs in conducting house to house visits have contributed to the increase in demand and utilization of both condoms and RH services, by increasing accessibility of condoms, especially after hours. UNFPA supported 3 week in-country training on FP. A group of national TOTs was established through this activity. Community mobilization activities were conducted to promote condoms. Three thousand two hundred eighteen (3218) members i.e. youth, women and men were reached during these activities. However, STIs were ever increasing in all intervention areas.

UNFPA in collaboration with UNICEF advocated for inclusion of young people into HIV/AIDS policies and programmes at national, regional and grassroots levels through orientation and training of health workers to recognize the uniqueness and complex health needs of adolescents and to offer comprehensive response health services including HIV counseling. The UNFPA worked with RACOCS in 3 regions on HIV prevention. The UNFPA also advocated for integration of SRH and HIV/AIDS through
organizing platforms to discuss modalities in integration and presentations of possible models of HIV/SRH integration.

A target of 20% increase in consistent condom usage among men aged 15-39 years was set for COMBI in 2007. To achieve this target, TOT on COMBI was conducted for 34 participants from Caprivi, Otjozondjupa and Oshikoto regions. Participants were drawn from MoHSS, RACOC, Ministry of Education, Faith based organization and NHTC. The aim was to orientate the stakeholders on COMBI approach for better and effective implementation of COMBI project and to facilitate the training of LAs. One thousand (1000) LAs were trained in three UNFPA/GRN focused regions, to do house to house visits during the campaign, each LA has been allocated 100 households to visit during the year.

Six medical officers were trained in one of the intervention sites in administering anaesthesia with the objective of increasing caesarean section coverage and to improve maternal and neonatal health in the region. As a result of this intervention, meeting the need for EmONC has improved as 100% of women estimated to have major direct obstetric complications were treated in BEmONC and the CEmONC. All the 4 district hospitals with population of less than 500,000 were providing CEmOC compared to previous years, an increase from 50% to 100%. This intervention is also benefiting other districts in neighbouring regions as several cases were reported to have been referred from other districts for further CEmOC management as a result of anaesthesia training. Referrals of maternal nature to other hospitals (national referral hospital-distance of more than 240km) have also been reduced drastically as all the district hospitals were providing CEmOC.

Regarding suggestions of national priorities for the next country programme, no completely new national priorities were suggested; but rather, a continuation of current activities in the 4th CP, with the possibility of extending the activities to the other regions that were not covered.

4.2 Population and Development (P&D)

a) Adequacy of design
The outcome of the P&D component is: strengthened national statistical system to ensure effective development and application of tools for evidence-based policy making, planning, implementation, monitoring and evaluation. This outcome was expected to contribute to the above UNDAF outcomes by facilitating the formulation and implementation of national policies and programmes aimed at mitigating the consequences of the HIV/AIDS epidemic, alleviating poverty and bringing about gender equality and equity, in response to the objectives ICPD PoA and MDGs.

Output/Indicators
The P&D component has only one output to achieve the above CP outcome: Improved availability and utilization of age- and sex-disaggregated data for the formulation of national plans and policies and for planning, implementation, monitoring and evaluation
Achievement of this output was to be determined by the following five indicators defined the 4th CP’s Results and Resources Matrix:

- Indicator 1: Regional poverty profiles for 10 regions available by the end of 2008.
- Indicator 2: reproductive health and gender issues in the context of HIV/AIDS integrated into poverty monitoring and analysis.
- Indicator 4: increased number of users and organizations accessing data from the Central Bureau of Statistics.
- Indicator 5: Increased availability of disaggregated population data for policy & planning.

Given these indicators and in order to achieved the P&D output, the programme has the following three stated strategies: a) helping the national planning commission secretariat, in collaboration with UNDP, to undertake and complete regional poverty profiles for 10 regions by the end of 2008; b) introducing, by the end of 2007, in collaboration with UNDP and UNICEF, the DevInfo database; and c) strengthening national capacities to collect, analyze, disseminate and utilize population-related data for policy and decision-making. Through Annual Work Plans and based on the output indicators and strategies outlined above, a number of related activities were identified and carried out under the P&D component. In order to address the cross-cutting issues of gender and human rights, emphasis was placed on collection, analysis and use of gender disaggregated data for planning.

One limitation of the output definition for P&D is the absence of any output or strategy for the population coordination sector for which the National Planning Commission has an institutional responsibility as clearly defined in the National Population Policy 1997. The Mid-Term Review (MTR) of the 4th CP carried out in 2008 noted that the P&D strategies and the range of supporting activities would suggest that the single output defined for the component did not adequately cover the actual activities being carried out under the P&D component. However, CO has not adopted the suggestion concerning possible second P&D output during this programme cycle.

b) Effectiveness of programme.

In terms of means of delivering support, during the current programme cycle, CO supported P&D activities through investments in capacity building of implementers and beneficiaries, and financial inputs for the production and publication of project reports and their dissemination, acquisition of equipment, programme monitoring and evaluation. The specific areas in which such support were provided included the following:

i) NPCS supported to implement the Participatory Poverty Assessments (PPAs) project;
ii) NPCS supported to undertake a joint 2006/2007 National Inter Censal Demographic Survey;
iii) NPCS supported to carry out the 2006 National Demographic and Health Survey;
iv) Supported the NPCS in implementing the 2011 Population and Housing Census project;
v) In partnership with UNDP and UNICEF, supported the introduction of, and established the use of NamInfo (demographic &socio-economic database);
vi) Supported to MoHSS to strengthen HIS capacity in collection, analysis and interpretation of sex-age-disaggregated data;

vii) Provided financial support to the Statistics Department UNAM to conduct research on Youth Migration;

viii) Provided to NPCS in organizing training workshops for Parliamentarians, media practitioners and senior policy makers, on population & development issues;

ix) Support to NPCS for the revision of the National Population Policy (1997), and preparation of the ICPD @ 15 Report;

x) Support to NPCS for the training of Regional Managers and Planners in the utilization of sex-age-disaggregated data (Census, NIDS, DHS, PPA) for planning;

xi) Provided support to the train TOTs in RBM and P&D integration;

xii) Supported the MOHSS to conduct an Essential Indicator Capacity workshop for staff from all 13 regions.

The initial support to NPCS to P&D during the programme cycle was mainly to the PPA project and for capacity strengthening of the NPCS; but the support structure expanded to data collection, analysis and integration matters as the programme advanced. CO provided technical assistance (TA) to NPCS for the Participatory Poverty Assessments (PPAs) project, focusing on Gender and Reproductive Health issues in all 13 regions; and later provided financial support for the production of videos and printing of reports; and financial support for organizing the dissemination workshops across the country. The PPA project was anchored on poverty forums created to provide feedback to the residence of the regions on the PPA process and to have financial inputs into the development of Poverty Profiles for the regions. The project was completed in all the 13 regions. The CO made inputs into the PPA process to ensure that population, RH, Gender and HIV/AIDS issues were reflected in the reports and in the video. In the end, the PPS reports as well as the final version of the Poverty Video were well received by the communities and their leaders; additionally, the exercise strengthened the capacity at NPCS to plan and monitor the implementation of poverty reduction programmes under NDP3.

With regard to increased availability and use of gender and age disaggregated population data for policy and planning, CO supported the NPCS in implementing the 2011 Population and Housing Census project, specifically a) in the development of the census project document; b) training of statisticians and information technology (IT) staff of line ministries at UNAM and PON in the use of scanning technology; c) provision of technical assistance (in partnership with UNDP) to facilitate two follow-up training (phases two and three) in scanning technology and data processing procedures where 33 statisticians and IT persons from the government O/A/M and UNAM and PON were trained. UNFPA has also supported the position of a Chief Technical Advisor (CTA) for the Census; the CTA is currently assisting with data capture and plans to continue with other post-enumeration activities for which a scheme of work has already been developed. Apart from the overall capacity building output of the CO’s support, the concrete results of the census, as in the past, should prove to be invaluable to
government, private sector and the UN system in planning, policies and programme management.

In partnership with UNDP and UNICEF, CO supported the introduction and establishment of the use of NamInfo (Namian version of Dev-Info); provided technical assistance to CBS for the timely utilization of sex-age-disaggregated data; supported the conduct of training workshops for Regional Planners in the utilization of sex-age-disaggregated statistical data of (Census, NIDS, DHS, PPA, etc.) for evidence-based planning and project proposal writing and the use of tools like NamInfo. Apart from officials from the various sectors empowered to use NamInfo, it was estimated that 80 % of Parliamentarians, and all senior policy makers and planners used DevInfo and age-sex disaggregated statistical data. Also, CO provided financial and technical support in organizing training workshops for Parliamentarians, media practitioners and senior policy makers, on the use and interpretation and on reporting population dynamics, poverty and HIV/AIDS, and related socio-economic statistics for evidence-based policies and programmes, in the context of the formulation of NDP3.

CO also provided technical and financial support to MoHSS to strengthen the Health Information System (HIS) capacity in the collection, analysis and interpretation of sex-age-disaggregated data especially on RH; provided TA to NPCS and the Ministry of Health and Social Services to undertake a joint 2006 National Inter Censal Demographic Survey (NIDS) and the 2006/2007 National Demographic and Health Survey (NIDHS) respectively, which were invaluable in updating the existing population and development indicators. In addition, CO supported data analysis and publication of the report both the NIDS and NDHS; and supported the MoHSS to conduct an Essential Indicator Capacity workshop for staff from all 13 regions that were trained to analyze raw data from the District Health Information System, producing regional and national Statistical Abstracts to be used by regional planners and managers.

During the evaluation period, CO provided financial support to the Statistics Department UNAM to conduct research on Youth Migration; supported publication of preliminary report of the study; and provided financial support to UNAM for the publication of Students’ Research Report (2009 & 2010). All these inputs have contributed to strengthening research and training capacity in population at UNAM, and should eventually feed the national and regional population sector for integrated population and development planning.

In the area of population policy and programming, CO provided technical and financial support to NPCS for the revision of the National Population Policy (1997), and preparation of the ICPD @ 15 Report. The Draft Review of the National Population Policy is awaiting the availability of the new (2011) census figures to update the data and target indicators before finalization. The Programme for Population Policy Implementation, although hardly used, was planned to run till 2014 but now outdated in view of policy review. Future support in this area should target NDP4 now being considered, to ensure that population issues receive due attention as in NDP1 and NDP2.
On integration and related matters, CO provided technical and financial support through training of Regional Managers and Planners in the utilization of sex-age-disaggregated data (Census, NIDS, DHS, and PPA) for planning. In addition, CO supported the training of TOTs in RBM and P&D integration.

There is one particular area where CO’s intervention, though critical, was almost lacking. This has to do with policy implementation and coordination of population activities in the country. The Population Policy (1997) made adequate provision for both a technical committee and a higher level policy advisory Council to promote the coordination of policy implementation, with the then Population Unit in NPCS as the Secretariat of the two institutions. Specifically, these include i) National Advisory Committee to advise Cabinet and the President on policy issues; ii) Inter-Agency Technical Committee on Population (IATCP) to coordinate the implementation of population policy; iii) Population Unit (now a sub-Division in the Division of Poverty Reduction and Human Resource Planning in NPCS), to serve as Secretariat to IATCP. These institutions were supported in their functions by the National Action Plan for Population Policy Implementation drafted in 1999 and later finalized, to run from 2004 to 2014.

The mid-term review (MTR) of the current CP (October 2008) noted that apart from fragments of what used to be Population Unit in NPCS, none of the established institutional structures for policy implementation, and hence, coordination of population activities, was active. This leaves a huge gap in P&D activities in Namibia, which NPCS plans to consider in the ongoing re-structuring of the institution.

The 2008 MTR further noted that in the absence of relevant institutional structures for population policy implementation coupled with a weakened Population sub-Division in NPCS (has only one Statistical officer with undergraduate training in Population/Demography), coordination of population activities in the country has been ineffective since 2006. This has also affected the orientation of P&D support to population activities during the review period: the focus has been on statistical issues on poverty analysis and related population indicators and, to some extent, generation of population data. The role of facilitating the coordination of population activities by the Population sub-Division has been largely dormant. The MTR recommended that rest of the programme cycle could be used to address this shortcoming by reviving the dormant institutions, supporting the process of population policy review and re-drafting the Action Plan. However, limited progress has been recorded. The next programme cycle should consider the coordination of population policy implementation as a priority area within the context the new UNFPA MRF (2011).

c) Efficiency in resource utilization

Human resource deployment – Technical Assistance

Under P&D, CO appointed a National Programme Officer who serves as the link between CO on the one hand and Government and other implementers on the other. The NPO has been effective in developing appropriate annual work plans for the component in collaboration with the implementers, and efficient delivery of programme activities has been promoted through attendance at meetings and workshops and periodic evaluation of
the inputs into the component programme. The series of field mission reports by the NPO also attest to efficiency in programme monitoring.

The strategy of providing technical support to implementing partners has also yielded expected returns to investment in terms of capacity building and actual production of defined outputs. Particularly in the generation and analysis of gender disaggregated data for policy and planning, CO intervention through deployment of technical personnel, both local where possible and international where local capacity is lacking, has proved to be productive and efficient. For example, CO recruited three international consultants (Demographer, Cartographer and Data processor) with the assistance of Sub-regional Office to assist the Central Bureau of statistics (CBS) to assess its capacity to implement the 2011 Census project and to produce the 2011 census project document with implementation plan as well as the budget. The Census project document was ready in time and the CBS conducted a pilot census in August 2010. The CO provided technical and financial support to CBS to conduct user producer workshops with national and regional leaders to inform them of the importance of the upcoming 2011 Namibia Population and Housing Census (2011 NPHC); as result regional and national inputs were received on the Pilot Census Questionnaire which included key national and regional priorities to better track national and regional and ICPD/MDG indicators. Through UNFPA technical and financial support CBS established a Census Technical Committee consisting of technical staff from all key stakeholders and convene meetings to give technical inputs on the 2011 NPHC planning process and ensure better stakeholders' participation. All these interventions combined to make the census a successful operation.

A local consultant from UNAM was recruited to work with CBS staff as counterparts in the cleaning of the raw data sets, producing the required tabulations and to compile the 2006 Namibia Inter-Censal Demographic Survey (NIDS) report. A report writing workshop conducted in November 2009 brought together 18 participants from different GRN agencies/ministries, research and training institutions and UN agencies and this enhanced sectoral capacity in this area.

Such technical interventions led to the successful execution of the 2006 National Inter-Censal Demographic Survey (NIDS), the 2006/2007 National Demographic and Health Survey (NDHS); and the ongoing 2011 Population and Housing Census project. While the sample surveys benefited from short-term technical interventions (in workshops and related training activities, questionnaire formulation, data analysis, etc.), the census project has been supported by a resident CTA for a longer term. Both the sample surveys have been completed and their reports published and disseminated. The census is still ongoing and a scheme for a more elaborate analysis of data and production thematic reports, unlike in the past, has been developed with the support of the CTA.

Similar support was provided to NPCS for the revision of the National Population Policy (1997), and preparation of the ICPD @ 15 Report; both reports necessitated the intervention of international consultants and should be seen as efficiency in resource utilization given their quality and timeliness of delivery.
Local capacity in population research and training has also been supported by CO. In an effort to encourage the use of raw data collected by GRN, through surveys and census, the CO supported UNAM final year population and development (P&D) B.Sc. students to produce final year projects using raw data from government data; the output has been printed: University of Namibia, Research Projects 2009, Department of Statistics. In support of staff capacity for research, CO provided financial support to the Statistics Department UNAM to conduct research on Youth Migration; the research has been completed and the preliminary finding published and disseminated. The 2011 census data being captured for processing and analysis should provide a fertile ground for further research and production of a variety of reports on aspects of the population of Namibia. CO should make deliberate effort to invest in such research works during the next CP.

In order to ensure an efficient utilization of resources through synergy, CO collaborated with UNDP and UNICEF in the introduction of, and establishment and use of NamInfo (demographic & socio-economic database). Through that collaborative effort, the capacity of planners, implementers and even parliamentarians was built; the national database was established and is being used by all. The project in partnership with UNDP and UNICEF continued to roll out NamInfo, used for sensitizing key stakeholders from the MOHSS (DSP/HIV), Office of the Prime minister (Emergency Management Unit) and for conducting regional training activities for Omusati, Oshana and Ohangwena Regions. About 40 participants were trained in the User Module of NamInfo, basic indicators identification and in the Administrator module, resulting in all the 13 Regions establishing NamInfo focal points. NamInfo database is continuously been updated and all MDG and NDP3 indicators have been included in the NamInfo database.

Namibia has now consolidated the statistical system with the new Statistical Act, as opposed to the decentralized statistical structure in the past in which CBS provided training for its staff and not for other line institutions that also collected data. UNFPA technical and financial support for training on key P&D issues for all key institutions that collect data was provided under the current CP. This has increased collaboration among sister institutions and allowed for improved quality of data, usage and analysis. The result of joint training allowed technical staff from the different line institutions get to interact more fruitfully and better understand the specific data each institution collects and thereby achieve synergy. Under the new centralized statistical services structure of the Namibia Statistical Authority, UNFPA will need to continue its capacity building efforts in order to ensure that the new institution is firmly established and its effective functioning sustained.

In response to the GRN’s adoption of a Results Based Approach (RBA) in implementing the NDP3, CO provided support to the National Planning Commission Secretariat (NPCS) and the Ministry of Finance (MoF) to send nine of their staff to Canada for training as TOT in RBM and mid-term expenditure framework. Other five (5) staff members from the Ministry of Planning were trained in Cape Town, South Africa in Population, Environment and Development, to equip them with skills in integration of these issues into policies and plans. Given that the staff members trained outside the
country have since completed their programmes and returned to their respective offices, it can safely be assumed that the new knowledge acquired should enable them function more effectively at their jobs; therefore, such investments in fellowship training should be regarded as efficient resource utilization.

**Financial Resource**

During the evaluation period, allocations to the P&D component fluctuated from US$46,650 in 2006, to over US$346,000 in 2011. Table 2 shows the trends in allocation, expenditure, and implementation rate for the period. The 4th CP did not anticipate any other resources besides regular, in support of P&D, although the period covers the conduct of NDS, NDHS and preparations for the 2011 Population and Housing Census. This may explain why UNFPA’s input into DHS was limited to comments on the questionnaire; but CO recognized the significance of the NIDS and the 2011 population census and provided much needed technical support.

The implementation of aspects of P&D activities also benefited from the generous support of the Grand-Duchy of Luxemburg Government in the amount of US$250,962 in 2007 and US$69,893 in 2008. Similar support was received through joint implementation of NamInfo institutionalization by UNDP and UNICEF.

In terms of resource utilization on specific P&D activities during the review period, a summary view is presented in the progress evaluation table presented above (see Table 3 and Figure 2). In general, implementation rates for specific activities were quite high, except in 2006 when 2 out of 4 activities could not be implemented largely because CO did not have the NPO in place until October 2006. The delay in implementing P&D activities in 2006 was also due to the long delay in signing the MOU by NPCS, which had to wait till 2007.

<table>
<thead>
<tr>
<th>Year</th>
<th>Allocation (US$)</th>
<th>Expenditure (US$)</th>
<th>Implementation rate (%)</th>
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<tbody>
<tr>
<td>2006</td>
<td>46,650</td>
<td>33,971.00</td>
<td>72.8</td>
</tr>
<tr>
<td>2007</td>
<td>325,000</td>
<td>315,453.51</td>
<td>96.2</td>
</tr>
<tr>
<td>2008</td>
<td>232,680</td>
<td>208,927.58</td>
<td>89.8</td>
</tr>
</tbody>
</table>
Otherwise, with the NPO in place and technical assistance provided whenever needed, implementation of P&D activities progressed smoothly from 2007 till 2011. The highest annual implementation rate was recorded in 2010, reaching 100.7%. The full picture expenditure of expenditure in 2011 is still unfolding, which is why the level as of October was 67%; from all accounts that level will be well over 90% by the close of the books in December 2011.

CO has established a viable accounting system and its application during the 4th CP posed no problem to management. The Accounts section in CO has been efficiently managed by an Operations Manager supported by a Finance/Administrative Assistant, under the able supervision of the accounting office, the UNFPA Representative and professional oversight through annual audits. There are no records of complaints about delay in the transfer of funds by implementers, implying that financial management did not create any problem for programme delivery during the programme period. Programme finances have been subjected to annual auditing as requested and, overall, the reports have been generally satisfactory. The latest Auditors’ Report (May 2011) concluded as follows:

- The Summary Financial Report presents fairly, in all material respects, the actual eligible expenditure incurred for the Project for the period from 1 January to 31 December 2010 in conformity with the applicable Contractual Conditions; and
- The project funding provided by UNFPA has, in all material respects, been used in conformity with the applicable Contractual Conditions).

Nevertheless, the Auditors have made some observations, to which CO promptly responded as required. With reference to P&D activities carried out in 2009, the Auditors expressed some concerns: “We noted that certain activities were not implemented as per the timeframes agreed in the Annual Working plan signed by both parties at the beginning of the year. Funds amounting to N$112,971.04 were on hand as at 31 December 2009 and should have been refunded to UNFPA as required by the letter of understanding or alternatively disclosed as outstanding UNFPA advance in reporting Form D. In response, CO submitted that the sum of money “on hand” had already been committed to printing three approved documents and should be regarded as spent while the printing process was still on but finalization and delivery awaited. Overall, the CO managed the P&D funds in an efficient manner.

Material resources – Project Equipment
Except for the data sever purchased by CO for CBS in support of data processing, P&D interventions was not concentrated in office equipment. The data server proved most useful in the analysis of data sets from the 2006 NIDS and the 2009/2010 Household Income and Expenditure Survey. Its value will appreciate further during the tabulation and analysis of the 2011 census.

d) Relevance of P&D in the 4th CP
One critical question is whether the P&D programme that UNFPA Namibia has been supporting is still relevant to the needs of the population of the country. From the start,

<table>
<thead>
<tr>
<th>Year</th>
<th>Budgeted</th>
<th>Actual</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>316,141.35</td>
<td>277,863.35</td>
<td>87.9</td>
</tr>
<tr>
<td>2010</td>
<td>256291.30</td>
<td>257994.59</td>
<td>100.7</td>
</tr>
<tr>
<td>2011</td>
<td>346737</td>
<td>320992</td>
<td>66.6</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1,421,753</td>
<td>1,325,202.03</td>
<td>93.2</td>
</tr>
</tbody>
</table>

Table 3: P&D Financial implementation
the formulation of the 4th CP, particularly the Population and Development (P&D) component, was informed by the orientation of the 1997 National Population Policy for Sustainable Human Development and the challenges faced in its implementation. In terms of policy and programming, the 4th CP faced the challenges of reviewing the 1997 population policy and its Action Plan. In addition, the Government was poised to update the population database, through the 2006 Demographic Survey, the 2006/2007 Namibia Demographic and Health Survey, and also the conduct of the census of population and housing in 2011, all of which were factored into the design and extension of the 4th CP. Analysis of the 2011 census is yet to be done, and there is the need to go beyond the production of Census Highlights (as done in the past with the 1991 and 2001 censuses) and go a little in-depth to produce thematic reports on selected issues of population and development in the country. Thereafter, there will always be the need to update the available data through NIDS and NDHS before the next round of census in 2021. To that extent, UNFPA’s technical and financial inputs will still be needed in P&D in Namibia for some time to come.

The design of the P&D component of the 4th CP was also cognizant of the 2006-2010 United Nations Development Assistance Framework (UNDAF), the Second National Development Plan (NDP2) and Vision 2030 (Namibia’s long-term development plan). While the country had made progress towards the achievement of several Millennium Development Goals (MDGs), including universal access to primary school education, the high HIV prevalence rate (21.3 per cent in 2003) and AIDS epidemic, constituted a severe drawback on progress and served as a negative force on the demography of the country. Therefore, current efforts to develop capacity for data collection, analysis and integration of RH, HIV and gender issues into policies and development plans will continue to be critical to development in the country.

In terms of linkages between national priority, UNDAF and CP components, the 4th CP addresses national priorities in line with the Millennium Development Goals (MDGs) and the Programme of Action of the International Conference on Population and Development (ICPD). It reflects the 2004 CCA and the 2006-2012 United Nations Development Assistance Framework (UNDAF) and addresses key national priorities and development challenges outlined in the second and third National Development Plans (NDP2 and NDP3) and Vision 2030. Namibia is completing the implementation of the 2nd UNDAF (2006-2013). UNCT together with the Government agreed that Namibia would be a self-starter for ‘Delivering as One’ country. Therefore, P&D inputs will continue to be relevant to development programming in the country in future.

As already noted, the overall objective of the P&D component is ‘to contribute to the poverty reduction goals of the NDP2 and the promotion of gender equality and equity.’ The component is directly linked to the achievement of two UNDAF outcomes (Outcomes 2 and 3): UNDAF Outcome 2: The capacity of Government and civil society institutions is strengthened to deliver and monitor essential/critical health and education services; and UNDAF Outcome 3: Livelihood and food security among most vulnerable groups are improved in highly affected locations.
The outcome of the P&D component is: “Strengthened national statistical system to ensure effective development and application of tools for evidence-based policy making, planning, implementation, monitoring and evaluation”. This outcome will contribute to the above UNDAF outcomes by facilitating the formulation and implementation of national policies and programmes aimed at mitigating the consequences of the HIV/AIDS epidemic, alleviating poverty and bringing about gender equality and equity. Through the generation and analysis of gender disaggregated data on population and reproductive health issues, the P&D component supports the realization of the objectives of both the RH and Gender components of the CP.

While awaiting the formulation of the next UNDAF by UNCT and NDP4 by the Government in which national priorities will be re-defined, recent developments within the government seem to indicate how and in which areas UNFPA could focus future P&D investments. Significant among these is the 2011 census; the enumeration was carried out in August 2011 and should be regarded as an ongoing activity. Only recently, UNFPA hired a Census Consultant to assist CBS in the task of census data collection, analysis and report production. The evaluation has noted that the census management has produced a work plan involving the following critical activities for which UNFPA’s support would be critical:

**Namibia 2011 Census: Schedule of Post-Enumeration Activities**

- Data capture: Ongoing
- Data cleaning and tabulation: February-March 2012
- Preparation of Provisional Report: Nov 2011 – March 2012
- Dissemination/Archiving: Jan. 2014 – Feb 2014

Closely related to census activities is the need to continue to support capacity building for data utilization for policies and plans, with focus on both NPCS and the newly approved institution, the Namibia Statistical Authority under the Statistical Act 2011.

Research and training in population in support of development policies and plans at both national and regional levels should be encouraged; this should provide an opportunity for strengthening the capacity of the Statistics Department at UNAM to train more statisticians and demographers in support of statistical services and population programme implementation in the country.

UNFPA should consider renewing and strengthening its support to population policy implementation now that the National Population Policy 1997 is being reviewed. During the years since its formulation, the institutional structure for the coordination of policy implementation has remained weak, and focus on implementation of the policy under a comprehensive programme not encouraging. This concern was also shared by NPCS during the field work for this report. The evaluation found that NPCS has been going through a process of institutional restructuring, and the Directorate of Development Planning (DDP), in which Population ‘Unit’ is housed, is conscious of the weak position of the population sector and plans to address this in the emerging new structure of NPCS.
In addition, the institutional framework for population policy and programming oversight (the Inter-Agency Technical Committee for Population and the National Advisory Committee on Population) will be re-visited in the light of the new NPCS structure in order to ensure effective coordination of population and related activities (poverty reduction, disaster preparedness, employment creation, environmental sustainability, gender, etc.) and the integration of population issues into the forthcoming NDP4.

**e) Impact**

Through UNFPA’s interventions in supporting the availability of data on population, Government has improved its evidence-based policy formulation and programme design capability both nationally and across the sectors. The NDP3 process in particular benefited from availability of such data for generating indicators in target setting and monitoring of progress. Updated data from the NIDS and NDHS provided a sound basis for monitoring and evaluating progress in the implementation of ICPD and MDGs; both reports of MDGs (2008) and ICPD@15 (2009) utilized fairly current data in their preparation. Now that the NDP4 process is on, Government is awaiting the preliminary results of the just concluded 2011 census of population and housing to employ the most recent development indicators for setting programme targets.

CO support to statistical services has focused on capacity building at CBS; during the programme cycle a lot of capacity has been built among CBS staff and through CBS itself among staff in some sectors (Health, Labour, Agriculture, etc), in UNAM, as well as in all the 13 the regions where Statistics officers have been appointed. Through the CO and in collaboration with UNDP and UNICEF, the NamInfo has been developed and institutionalized, relevant officials have been trained, and the national socio-economic and demographic database has been made accessible to all users nationwide. While capacity for data collection and analysis has been strengthened in CBS and selected sectors, the newly created Namibia Statistical Authority will require sustained backup for some time to come.

CO’s intervention has also generated limited but growing impact of research and training in population and development through support to Statistics Department, UNAM. Some funds were made available to students in their final year to conduct small-scale studies, which were put together in a Department Report (2009); also CO provided funds for the staff of the Department to conduct a study on Youth Migration. The preliminary report of the research has been published by the University with UNFPA fund. Such support should extend to in-depth analysis of the 1991, 2001 and 2011 population and housing census data to facilitate comprehensive overview and appraisal of Namibia’s population dynamics and the socio-economic correlates of population trends.

Overall, the impact of the CP on the relevant national indicators can be gleaned from trends in appropriate ICPD and MDG indicators. Both the MDG Report (2008) and ICPD@15 Report (2009) show that most of the population and development indicators have shown an improving trend over time. However, the problem of attribution should be underscored in interpreting these population indicators, given that they are outcome indicators to which all the sectors and development partners might have contributed, rather than project output indicators relating to UNFPA interventions. Nevertheless, it is
satisfying to note that the expected improvement has been achieved in most of those areas in which UNFPA’s interventions have focused in the past five years or so.

In 2006, the Central Bureau of Statistics (CBS) issued the results of population projections for Namibia (2001-2031); the Medium variant of the projections were based on the following demographic assumptions: TFR 4.1 (2001), 3.5 (2016), 3.0 (2026), and 2.4 (2031). Regarding mortality, approximated by Life Expectancy at birth for both sexes, it was assumed that Life Expectancy would increase during the projection cycle as follows: Females from 50 years (2001) to 60 years (2021), and 65 years (2031); while for Males from 48 years (2001) to 58 years (2021) and 63 years (2031).

Regarding RH, the ICPD @ 15 Report (2009) indicates that the rates of immunization have increased and infant mortality rates have been falling, from 67 per 1000 births in 1992 to 52 per 1000 births in 2000. However, the maternal mortality ratio has been showing an upward trend from 225 per 100,000 live births in 1992 to 271 in 2000, and 449 in 2007 (MHSS, 2008). This trend occurred despite the fact that in urban as well as rural areas, births are increasingly attended by qualified health professionals. According to DHS 2006/7 adult (15-49 years) mortality (females & males) between 2000 and 2007 had also doubled. On the side of reproduction, the 2006 DHS results show that Namibia has been experiencing consistent decline in fertility, from a Total Fertility Rate (TFR) of 5.4 (1990-1992) to 3.6 in 2005-2007. Education is one social factor that is highly correlated with reproductive performance in Namibia, as elsewhere. The declining trend in TFR in the country is an encouraging sign of development.

The results from the biennial Sentinel Surveys (2002-2008) show that the incidence of HIV/AIDS rose from 19.3 percent in 2000 to 22.0 percent in 2002 and gradually reduced thereafter to 19.7 percent in 2004, 19.6 percent in 2006 and 17.8 % in 2008. Although this decrease is encouraging, the HIV/AIDS prevalence rate is still to high and may have contribute to the increase in maternal and adult morbidity and mortality in Namibia during the 4th CP period. Despite the deteriorating maternal mortality indicators, the trends in other reproductive health indicators are improving such as: teenage pregnancies in Namibia has been declining from 22% in 1992; to 15 % in 2006, while unmet need for family planning has been decreasing from 24 % in 1992 to 7% in 2006 and contraceptive prevalence rate has also increase from 23 % in 1992 to 47 % in 2006.

Regarding gender, the Government has gone a long way in ensuring gender balance in education in Namibia. In 2006, the net attendance rate for primary school was 91% for boys as well as girls, but 47% and 43% respectively for secondary school. Improvement has also been made with regard to Early Childhood Development (ECD) whereby more girls (59.5 percent) than boys (40.4 percent) were enrolled in ECD centres throughout the country. By 2003, literacy rates stood at 82 percent for women and 83 percent for men, but there wide regional disparities. Government set the goal to reach 30 percent of women representation in politics and decision making positions; by 2006 this goal was partially met and exceeded in some cases: women represented 45 percent of the members in local authorities; 27 percent in the Parliament; 33 percent of the employed in the public and private sectors; and the percentage of women in wage employment is about 44 percent. Also the number of women employed in the public sector is slightly more than
men, but they lag behind their male counterparts when it comes to employment in the private sector.

There are, however, other challenges that the gender sector must address in Namibia. HIV/AIDS still poses as a major developmental challenge for the country and its impact is disproportionately felt by women. Women who die from HIV/AIDS are on average 5-10 years younger than men, and the proportion of young women living with HIV/AIDS is 29 percent compared to only 8 percent for young men. In addition, women tend to be concentrated in low or unpaid position in formal sector employment while men are more in high paying/high profile positions.

National efforts in addressing these overall indicators should continue to be supported by all development partners, particularly UNFPA in areas of maternal mortality and gender disparities. In order to make Government and agency-delivered interventions more effective, UNFPA should continue to support the promotion of the coordination of population activities by the NPCS.

\textit{f) Sustainability}  

The 4\textsuperscript{th} CP gives priority to capacity development as a way of achieving sustainability of development programme activities, particularly regarding population issues, in the country. The P&D component was anchored on building sustainable and relevant capacity at national and regional levels for population data generation, analysis, and integration of population issues into development policies and plans. In the light of the achievements and shortcomings of past capacity-building activities, emphasis has been placed during the past five years on enhancement of capacities of institutions implementing P&D, including DDP and CBS in NPCS, HIS in MoHSS, the 13 Regional Offices and UNAM, with targeted support for training for growth in staff participation. The staff of CBS and MoHSS have been exposed to techniques in data collection, analysis and report preparation through related exercises – NIDS, NDHS and the 2011 Census. It may, however, sound rather too optimistic to suggest that no further technical and financial assistance would be required in future to conduct similar surveys. The high rate of staff turnover, particularly those with statistics background, has continued to undermine past capacity building efforts. Government does not seem to have control over this; thus efforts must continue to be geared towards building more capacity in the belief that the attritions experienced in one institution is but capacity strengthening in another. Indeed, further support will be needed to establish and sustain the smooth functioning of the newly created Namibia Statistical Authority.

UNFPA interventions in statistics and RBM training during the 4\textsuperscript{th} CP were specifically aimed at strengthening the capacity at NPCS to collected and analyse data in a timely manner through support to NDHS for the NIDS projects, and the Poverty Unit of NPCS for its analytic work. Capacity was also developed for about 220 MoHSS staff from their national and regional offices to utilise the new District Health Information System (DHIS). The training sessions and study tour to Tanzania for the DevInfo exposure were designed to strengthen CBS staff capacity to use the database technology as a monitoring tool. To the extent that NamInfo has been institutionalized and quite a large crop of users
trained in its use and management, it may be safe to conclude that accessing the national database is sustainable.

In addition, CO supported MISA capacity building for coverage of population, RH and gender issues in the print media. Although still limited, media reporting on population and development issues in Namibia is sustainable. However, CO should continue to link up with the media to update them on emerging issues in population and any new strategy meant for the general public.

Regarding this end of programme evaluation, an inclusive approach, involving a broad range of partners and stakeholders was been adopted by CO. The evaluation included a process of stakeholder mapping in order to identify both UNFPA’s direct partners as well as stakeholders who do not work directly with UNFPA, yet play a key role in a relevant outcome or thematic area in the national context. These stakeholders include representatives from the Government, civil-society organizations, the private-sector, UN organizations, other multilateral organizations, bilateral donors, and most importantly, the beneficiaries of the programme.

4.3 Gender

a) Adequacy of design
The expected outcomes of the gender component are: (a) Strengthened commitment and leadership of the Government and other stakeholders to create an enabling environment for scaled-up multi-sectoral responses; (b) Improved income-earning and access to food for vulnerable households; and (c) Increased awareness of and capacity for protecting the rights of children, women and other vulnerable groups.

The Gender Component has four specific outputs:

i) Strengthened community capacity in the Caprivi Region to address livelihood issues, food security and nutrition to respond to the impact of HIV/AIDS;

ii) Communities mobilized against gender based violence, and women and girls aware of their rights and how to access available services;

iii) Strengthened capacity to integrate gender issues into National Plans and Programmes and;

iv) Increased level of knowledge and commitment to an expanded HIV/AIDS response, gender issues and women’s empowerment among national and local leaders.

The Gender Component was expected to contribute to all the three UNDAF outcomes, which are: the HIV/AIDS response is strengthened through increased access to prevention, treatment, care and impact mitigation services, especially vulnerable groups by 2010; livelihoods and food security among most vulnerable groups are improved in highly affected regions by 2010 and; The capacity of Government and civil society institutions is strengthened to deliver essential/critical services by 2010.
Programme interventions which were implemented for achieving the Country Programme outputs and UNDAF outcomes consisted of sensitization of national, traditional and community leaders and parliamentarians on gender issues. Furthermore, laws and legislation that protect the rights of women and girls should be enforced. The interventions also entailed improving livelihood and income options for women and girls. In addition, the institutional strengthening of the Ministry of Gender Equality and Child Welfare for Gender Mainstreaming has been a major undertaking of the 4th Country programme.

b) Effectiveness of Program Delivery
The Gender component directly contributed to all three UNDAF outcomes so that by 2010, and through extension of the program by 2011: a) HIV/AIDS response is strengthened through increased access to prevention, treatment, care and impact mitigation services, especially vulnerable groups; b) Livelihood and food security among most vulnerable groups improved in highly affected location; c) The capacity of the Government of the Republic of Namibia and civil society institutions is strengthened to deliver essential/critical services

In order to contribute to the delivery of the above UNDAF outcomes, the gender component focused on achieving the country program outcomes of strengthened commitment and leadership of GRN and other stakeholders to create an enabling environment for scaled up multi-sectoral response; improved income earning and access to food for vulnerable households as well as increased awareness and capacity for protecting the rights of children, women and other vulnerable segments of society.

Regarding the output on increased level of knowledge and commitment to an expanded HIV/AIDS response, gender issues and women’s empowerment among national and local leaders, CO interventions included advocacy and awareness raising activities such as training sessions, workshops and stakeholder consultations. The training and workshop activities mainly targeted parliamentarians, religious and traditional leaders on how gender inequities fuels HIV/AIDS epidemic. It also entailed lobbying authorities to make more resources and opportunities for women to combat HIV/AIDS. This strategy was considered beneficial and effective by implementers and beneficiaries. The capacity of parliamentarians and gender focal persons was built. However, it was noted that the program activities would yield greater results if they would target also technical officials who work with Standing Committees of Parliament. It was further noted that since Members of Parliament (MPs) involved in these activities now considers regional visits as part and parcel of their duties, it would be more effective for the CO to consider a direct relationship between UNFPA and the National Assembly.

Human Resources
Under this component, the CO appointed a National Program Officer (NPO) for Gender with the responsibility to serve as the link between CO on the one hand and Government and other implementers on the other. The NPO has been effective in developing relevant annual work plans for the component in collaboration with appropriate implementing agencies. Effective delivery of CP activities under this component has been encouraged
through attendance at consultative meetings and workshops and periodic evaluation of the inputs into the component program as well as revision of budgets. Although the Annual Tracking Study by UNFPA are unavailable, quarterly reports and field mission reports availed to the evaluator confirm this.

Regarding the strategy of providing technical support (through consultants) to implementing partners, key informant interviews show that this strategy yielded expected returns to a degree, particularly concerning gender policy issues, accounting and the generation of gender statistical profiles. The provision of a Gender Advisor and a Project Accountant proved to be effective and productive. Such interventions have led to the successful revision of the National Gender Policy and efficient disbursement of funds to the regions, respectively. It was however suggested that investments in terms of capacity building and actual production of defined outputs should be made to build institutional capacity at the Ministry.

Support for the possible development of a Master Degree program in Gender at the University of Namibia was mentioned as a feasible and effective means of creating capacity at the MGECW as it would increase access and widen professional development of implementers. This would also increase capacity in the country, especially if it targets focal persons in the different ministries of GRN. UNFPA could assist in enabling Namibia to create an adequate pool of national gender experts. It was noted that while consultants play a pivotal role in service delivery, in a long term, the MGECW has not been able to establish high-level expertise in gender equality, mainstreaming and related areas. Overall, the programs targeted the right beneficiaries. Implementers indicated that although some programs i.e. garden projects, targeted women from vulnerable groups, implementers included men taking due cognizance of positive roles and responsibilities, and ensuring that men have the same information as their female counterparts. Furthermore, the knowledge base for program beneficiaries was increased.

**Financial Resources**

In terms of financial resources allocated to Gender, allocations began with US$183,596.92 in 2006, reaching a pick in 2009 of US$1,345,808.54 before dropping to US$643,147.44 in 2011.

The table 7 shows the trends in allocation, expenditure and implementation rate for the 2006 – 2011 period of support. As can been seen from the table 4, and Figure 3, the rate of implementation is relatively high with an overall implementation rate of 79.31%

**Table 4: Gender Financial implementation**

**Fig. 3: Gender Financial implementation**
**c) Efficiency**

Developing capacity for gender mainstreaming was a key activity of 4th CP. Major national and sectorial policies were reviewed through funding from UNFPA CP, by way of recruiting consultants. Among others, a high number of law enforcers and MGECW officials were trained on male involvement, gender responsive programming and on community dialogue approaches. The strategy of outsourcing was considered efficient as it enhanced delivery mechanisms. Additionally, to the extent possible local consultants were recruited and worked closely with implementers and beneficiaries.

Besides challenges related to Joint Gender programs major desired achievements were recorded due to timely availability of funds. The CO supported GRN and the civil society to develop IEC materials and their translation into several major languages. CO in its quest to strengthen evidence-based planning supported the Ministry to do knowledge, attitudes and practices study on factors and traditional practices that may perpetuate GBV in Kavango, Erongo, Caprivi, Karas, Kunene, Ohangwena, Omaheke and Otjozondjupa regions in 2008. In addition, through support from the Co, the Ministry produced a report on Namibia’s implementation of Beijing Platform and on CEDAW. Furthermore, a Statistical Profile on Women and Men in Namibia was produced in 2010. Another relevant area relates to support to national leaders capacity to understand issues of SRH, GBV and HIV/AIDS. Furthermore, in 2009, CO supported the MGECW to draft the 4th CEDAW Progress Report, which was finalized in 2010. That said, while there is commitment to provide services to survivors of GBV, concern remains in regard to the limited number of programs and of social workers, medical doctors and psychologists who are qualified in screening, care and referral for GBV survivors. In this regard more than 470 pre-and in-service health professionals were trained. Service delivery was rated highly during the evaluation.

**d) Relevance**

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6 The implementation rate for 2011 is at the time of reporting and not for the full year. It is likely to be higher than this rate.
NDP3 recognizes that Gender inequality is still persistent in Namibia with low representation of women in the political, social and economic spheres particularly where food security and livelihood and vulnerability concerns are high. Some of the cultural practices including gender stereotyping are major challenges to achieve gender equality. In recognition of this among other factors, GRN established a High Level Strategic Inter-Ministerial Committee on GBV that reports directly to cabinet through the MGECW. CO is a member of the committee. In 2009, CO and other UN Agencies supported the MGECW which embarked on a Zero Tolerance GBV Mass Media Campaign. The campaign was a major drive relevant to priorities of the state and it was launched by Rt.Hon. Nahas Angula, the Prime Minister of the Republic of Namibia. The campaign focused on three major gender issues namely Human Trafficking, Baby Dumping and Passion Killing. Furthermore, a familiarization trip on protection services for GBV survivors was undertaken by GRN, UN Agencies and NGOs to South Africa and Kenya, which attested to the importance the MGECW attached to the need of a well-coordinated one-stop-center that integrates all protection services for GBV (One Stop Centre) in Namibia.

e) Impact
With support from the CO, Namibia now has a revised National Gender Policy (2010 – 2015). It is evident that the revised gender policy, which provides a strategic basis for further programming and the development of the current Gender Plan of Action and its Monitoring and Evaluation Plan, provides scope for efficient planning and implementation. The National Gender Policy will further enhance the Ministry’s role in ensuring that gender equality and issues of empowerment are integrated in the GRN’s next 5year national development plan (NDP4), which is planned to commence in 2012. Gender mainstreaming is a major focus of the Ministry of Gender and a priority of the GRN. In support of this, CO supported trainings of a pool of resource persons (Gender Focal Points) from various Government and CSOs institutions who actively participate and provide inputs in the development of various national documents. Furthermore, due to CO support for leadership and awareness, Parliament created a Standing Committee and members of this Committee were able to visit more than 8 region and reports of their discussions with service providers and community members have been published with support from UNFPA. Another evident impact is the cases of GBV being reported at the Rundu One Stop Centre which was established by Government end of 2010 as a result of UNFPA’s advocacy effort. Although there are some administrative challenges, women are accessing services that are integrated and comprehensive.
Furthermore and in recognition of the negative role GBV play, UNAM with support from CO developed a module to address GBV prevention and management which is now integrated into a compulsory Core-Curriculum for all 1st year UNAM students in all its 11 campuses countrywide.

f) Sustainability
Both implementers and beneficiaries acknowledge the enormous support provided by UNFPA to strengthen community capacity as well as mobilizing communities against GBV and building the capacity of the MGECW for mainstreaming gender equality and women empowerment. Thus, the 4th CP placed emphasis on capacity building through
targeted training and skills transfer. With CO support, Government of the Republic of Namibia integrated gender equality and women empowerment issues into NDPIII and several policies particularly for ensuring that RH is part of the national gender policy, Combating of Rape and Domestic Violence Acts. Civil society organizations and national institutions have integrated the CP activities into their own plans. Thus, the strategic support of UNFPA will enable these institutions to institutionalize these interventions. For instance, although limited by financing, the MGECW have considered statistical profiles on men and women as a key mechanism of measuring progress on gender mainstreaming.

Issues of GBV, SRH and child mortality are now major items on the agenda of the Parliamentary Committee on Gender and Family Affairs, formally a Human Resources and Community Development Committee. The committee has taken ownership of the program. However, the weakness is that the committee members are not Cabinet members and may have little influence in making decisions. A direct link between Parliament and UNFPA would however allow for better institutionalization of the leadership and advocacy programs, which would permit sustainability of this intervention. Moreover, since members of the standing committees of parliament change frequently, it is important that training support to MGECW and Parliament targets all members of parliament and parliamentary support staff, which would mean decreasing knowledge gaps in the event trained members are moved to other committees.

In collaboration with UNDP, CO supported the MGECW to conduct Sector based gender assessment and Gender Responsive Budgeting and a result the Ministry of gender is closely working with the Ministry of Finance to ensure that each Line Ministry articulate gender related activities and budgets. The Ministry of Gender is now a member of the Budget Hearing Committee. This approach will ensure that all sectors will mainstream gender with budgets funded from national resources. This process only commenced in 2010 for 2011. Other strategies which address capacity development in a sustainable manner include:

- Integration of the GBV module into existing curriculum at tertiary institution.
- Handing over certain interventions to other agencies such as FAO for agricultural related activities
- Advocating for partnership between Government and CSOs especially in the area of Gender equality
- UNFPA has participated in the development of an exit strategy based on the intervention supported by joint MDG-F gender programme indicating how good practices will be mainstreamed into existing programmes by various partners
- The CO will also foster a relations with the UN Women to take over some of the gender mainstreaming activities

From the perspective of financial sustainability, gender component program began functioning with US$183,596.92 in 2006, which accumulated to a sum of US$ 511,143.03 over five years. When compared to N$554,703.100 allocated in 2011/2012 budget to the MGECW out of the N$36,713,197.341 total budget, the share granted to MGECW is only 1.5%. This presents a short coming from the perspective of financial sustainability. Although beneficiaries and implementers have a strong commitment to achieving the UNDAF and NDPIII outcomes, and have demonstrated ownership and
responsibility over the activities of the 4th CP, every stakeholder stressed the importance of UNFPA continuing its support to implementers.

4.4 Programme Coordination and collaboration

4.4.1 Coordination
Cooperation of various agency activities and joint programmes has been a major challenge. The National Planning Commission Secretariat (NPCS) is the government agency responsible for the coordination of external assistance to Namibia, including support by UNFPA to population activities. Both Government and UNFPA jointly prepared the 4th CP (2006-2010), which was approved by the Executive Board of UNDP and UNFPA in October 2005.

The major constraint to effective coordination has been the erosion of institutional structures for population policy coordination that took many years of Government investments and UNFPA support to build. In this regard, Government should consider reviving the Advisory Committee on Population as well as its technical arm, the Inter-Agency Technical Committee on Population and Development under its new structure in order to ensure a comprehensive and coherent process of policy implementation at national and regional levels. The revision of the 1977 Population Policy still in progress should go hand in hand with review of the Action Plan for Population Policy Implementation (2004-2014). Unless the population programme is well coordinated in the country, population activities with numerous actors and overlapping activities will be difficult to sustain. The evaluation team was informed that NPCS is currently being restructured, and that the concern about coordination of population activities will be considered in the process. This is where CO has an important role to play, to enhance the effectiveness of UNFPA interventions and improved efficiency of resource utilization.

The Population Planning and HIV/AIDS Monitoring (PPM) sub-Division of the Poverty Reduction and Human Resource Planning Division (PRHRPD) in the NPCS is responsible for population activities, including facilitating the coordination of population activities, integration of population issues into development policies and plans, and monitoring the implementation of the Action Plan for Population Policy Implementation. PPM is poorly staffed; only one of the two officers has a background in Population Studies/Demography; yet they are supposed to be responsible for monitoring the implementation of the national Population Policy. To say the least, NPCS, with the support of UNFPA, should consider a deliberate plan to improve the capacity of PPM; including training of the staff in post, recruitment of two or more Demographers, and supply of basic equipment/software for population data processing and analysis.

In terms of coordination of RH programme, integration of RH and HIV/AIDS still poses serious challenges. MoHSS has two directorates, the Directorate of Special Programmes which is responsible for managing HIV/AIDS related interventions, while the Directorate of PHC is responsible for managing RH/FP interventions. This has resulted in parallel/vertical programmes that do not seem to speak to each other. Attempt has been
made to address this issue in the current draft RH policy, but how it will implement programme remains a major challenge at both national and regional levels.

The Ministry of Gender Equality and Child Welfare has been coordinating activities relating to improving the level of knowledge and commitment among national and local leaders to address HIV/AIDS response, gender issues and women’s empowerment. There is a technical committee that is chaired by MGECW, where programme activities for national and regional leaders are planned and coordinated. Various UN agencies such as UNDP, UNFPA and UNICEF jointly played an important role in providing technical skills and resources through the Joint Gender Programme.

Coordination was achieved in part through the CP monitoring and evaluation processes. Under the current 4th CP, programme operations have been monitored and evaluated both by CO and programme implementers through field visits and commissioned reviews and evaluations. CO has also used the GRN/UNFPA Annual Review and Planning meetings to achieve some measure of coordination among the 4th CP implementers. Such meetings were held regularly since 2006, the latest one has just been concluded on 18 November 2011 at which the evaluators were present.

UNFPA commissioned Mid-Term Evaluation of the 4th CP in 2008, where all three components were evaluated at length. The purpose of the mid-term evaluation was to measure the extent of implementation, to identify lessons learnt, what worked and what did not work, and to feed derived recommendations that could assist programme management (including Government and other implementers and UNFPA) in achieving improved implementation results during the second half of the programme cycle. This evaluation was also required to confirm the relevance of, or suggest modifications to, the CP strategies to ensure delivery of the programme outputs before the end of the current programme period. Despite of 2008 evaluation of the whole CP, COMBI evaluated its project by means of a survey. All these periodic reviews and evaluations are aimed at efficiency of the 4th CP.

4.4.2 Collaboration
Efficiency in RH implementation was achieved through collaboration with international and local agencies in the field. UNFPA, in collaboration with UNICEF and WHO, supported the costing of the roadmap to accelerate the reduction of maternal and newborn mortality and morbidity. The implementation of SRH was supported through the UNFPA collaboration with NGOs such as NAPPA, NAMPANN, White Ribbon Campaign, Men for Change and Ombetja Yehinga Organisations. UNFPA CO collaborated with FBOs and civil organizations, to strengthen SRH and gender programmes, especially in conducting community outreach programmes. Community outreach programmes were critical in creating awareness and in bringing about behavior change. Key comparative advantage of these organizations, especially FBOs is their natural capacity to have a ready audience. The Finnish Embassy has supported government in strengthening the EOC through training of doctors in anaesthesia and procurement of equipment. UNFPA engaged the embassy as part of its leveraging process for improved RH service provision. The Ministry of Youth has the mandate of addressing issues facing out of school youth,
and has the comparative advantage be it the structure or programming in addressing youth issues. While having comparative advantage they have very few programmes for out of school youth, and majority of the programmes are during the week with no programmes in the evenings or during the weekend when the youth are vulnerable. UNFPA participated in other coordinated initiatives such as: Costing of roadmap, integration of AFHs&S in the institutions of High Learning i.e. UNAM and NHTC.

Pharmaceutical and related supplies committee is responsible for the coordination of the RHCS activities. The committee coordinates the procurement and distribution of all medicines and related products. This committee also handles provision of support for capacity building for service providers and strengthening of medicines regulation system that assures quality, safety and effectiveness of medicines including RH commodities. It coordinates aspects of registration, inspection and quality surveillance. The review of National Medicine Policy has been initiated and guidance and support has been provided to ensure a functional pharmacy system including information system.

CO collaborated with UNDP and UNICEF in the introduction of, and establishment and use of NamInfo (demographic & socio-economic database). Through that collaborative effort, the capacity of planners, implementers and even parliamentarians was built; the national database was established and is being used by all. The project in partnership with UNDP and UNICEF continued to roll out NamInfo, used for sensitizing key stakeholders from the MOHSS (DSP/HIV), Office of the Prime minister (Emergency Management Unit) and for conducting regional training activities for Omusati, Oshana and Ohangwena Regions.

On gender issues UNFPA collaborated with selected NGOs, namely, Namibia Planned Parenthood Association (NAPPA), Namibia Men Planned Parenthood Network (NAMPPAN) and Ombetja Yehinga Organization (OYO) in creating awareness and demand for SRH services, HIV prevention and GBV prevention among young people. Also, CO in collaboration with UNHCR implemented the integration of Gender; Sexual Reproductive Health and HIV/AIDS program in Osire Refugee Camps’ program (a camp hosting 7000 refugees outside Otjiwarongo in Otjozondjupa region). Over 2000 young people were sensitized. Twenty nine SRHR Task Force members and health workers were trained as trainers, who further trained 22 mentors and group leaders of the Osire Girls and boys Club.

Collaborative efforts have proved quite effective and have been used to demonstrate efficiency in resource utilization due to synergy. CO should explore further areas of collaboration with partner agencies, especially in addressing the challenge of minority population groups.

### 4.4.3 Monitoring and Evaluation

The NPCS through its Population Planning and HIV/AIDS Monitoring (PPM) sub-Division of the Poverty Reduction and Human Resource Planning Division (PRHRPD) is responsible for population and development, including facilitating the coordination of population activities, integration of population issues into development policies and
plans, and monitoring the implementation of the Action Plan for Population Policy Implementation (2006-2014). However, activities in the Action Plan were neither effectively coordinated nor monitored. In the absence of a centralized monitoring mechanism, CO and GRN have resorted to Annual Review and Planning meetings as a way of coordinating and monitoring the 4th CP programme. Beginning with the CP Annual Review and formulation of Annual Work Plans, CO worked with NPCs to bring together all programme implementers to identify work to be done, areas of UNFPA intervention, and the responsibilities of implementing agencies. Such meetings were held regularly since 2006, the latest one has just been concluded on 18 November 2011 at which the evaluators were present. Much as these annual review and planning meetings produced monitoring results, the scope has been limited (mainly UNFPA CP) and participation hardly inclusive of UN collaborating agencies.

CO monitoring visits to RH projects are done at both national as well as regional levels to lower levels, through the NPO. Occasionally, the heads of regions also do carry out visits. Reports are written to these effects and are shared among the implementing partners. The country support team based in Harare initially provided the required technical back-stopping specifically to the UNFPA and national managers at Headquarters. Process evaluation has been ongoing in all regions; progress reports are also written at all levels of implementation monthly, quarterly as well as annually. These reports are submitted to immediate supervisors who ultimately submit them to the UNFPA country office through the responsible programme officers. Reports are also submitted to the Ministry of Health and Social Services through the responsible managers. The data collected ideally form basis for further interventions. The review found in some facilities that the collection of this information seems to be a routine exercise only, as they are not often fed into the central HIS in the Ministry of Health and Social Services; this could jeopardize the usefulness of such data. Quarterly review meetings are held with life-style ambassadors and their supervisors. At these meetings they present their reports to managers from head office as well as regional offices. At every review meeting a new topic is introduced so that their knowledge is enriched and managers are equipped better to appropriately guide the people they serve.

In terms of P&D project monitoring and report preparation, the NPO has been diligent; the Annual Reports are comprehensive and analytical. The Annual Work Plans have been used both as a planning tool as well as a monitoring mechanism. Future P&D efforts should focus on monitoring the implementation of the Action Plan for population policy implementation, including the revival of the activities of the Advisory Committee on Population and Development, the Inter-Agency Technical Committee on Population and Development, revision of Action Plan itself, given that the Population Policy is being revised.

Regarding Gender, the NPO has been monitoring programme activities through periodic field visits and continuous communication with project implementers. However, there were no monitoring sessions in place to assess the impact of the information sessions to MP’s, traditional leaders, regional and local leaders; nor was there a mechanism in place through which the gender related and HIV/AIDS related issues could be addressed and
tabled in parliament after field visits. Again, a coordinated monitoring mechanism through the Action Plan for Population Policy implementation would be more effective in assuring more effective programme performance.

4.5 Implementation of crosscutting issues in 4th CP

4.5.1 Population communication
There is no separate provision for population communication through the use of Information, Education and Communication (IEC) for the promotion of population issues in the 4th CP. Rather, population communication or Advocacy is treated as crosscutting and, as such, each component is required to integrate advocacy activities into its component activities.

CO provided support in 2007 to NPCS Poverty Monitoring Unit to edit the Poverty DVD into small chapters that could be easily used in educational settings and information sessions. The DVD was edited and reproduced, ready to be disseminated. The DVD covered issues about what constitutes poverty, definition of poverty status and what people who live in poverty think should be done to eradicate poverty, and identification of those mostly affected by poverty having regard to gender, reproductive health and related population issues. The Poverty Unit within NPCS used the DVD as a sensitizing tool in their advocacy campaigns against poverty and later disseminated it to key stakeholders, including members of parliament, policy makers, educators and the public at large.

Also in order to promote population communication issues, under P&D, CO entered into a working agreement (for direct execution by CO) to build NGO capacity in the promotion public education on population issues through the print media. The Media Institute of Southern Africa (MISA) was the NGO contracted by UNFPA to implement the work agreement. The objective was to “Strengthen Media capacity in reporting on Reproductive Health, Gender and Population and Development issues”. The basic strategy involved training on and exposing of media practitioners and media houses to population and development issues so as to ensure regular coverage of relevant events and publication of well researched articles on such issues as population dynamics and sustainable development, gender and reproductive health and rights within the context of HIV/AIDS and development as articulated both in the ICPD and the MDG frameworks.

Support provided by CO to MISA consisted of: i) recruitment of a local consultant for training of media practitioners on Reproductive Health issues; ii) organization of ‘Press Club’ activities to provide a platform for media practitioners, experts and other interested parties in the areas of RH, Gender and P&D to meet and share experiences on specific issues and; annual Media Awards to outstanding journalists who are judged as excelling in reporting population and related development issues during the year. These interventions proved quite useful to MISA by expanding its horizon to special issues on development outside the conventional news coverage; exposing journalists to topics about population, gender and RH usually consigned to ‘specialists’ and; providing the public valuable insights into human issues which are often taken for granted for lack of information. So far, MISA has been working with UNFPA on an ad hoc basis; the next
level should be through AWP in which UNFPA support to IEC is more coherent and comprehensive in coverage, not only for the print media but also Radio and TV as well.

Under P&D, CO continued in 2008 to support MISA in the drive to create awareness and enlightenment among media practitioners on issues around Reproductive Health, HIV and AIDS, Population Development, Gender, Human Rights and the Millennium Development Goals; and to have a more diverse and regular coverage of those population, poverty and development issues in the print media. The specific activities supported were the following: Monthly press club gathering for media practitioners to sensitize them on the linkages between RH, Gender, P&D and HIV/AIDS; Annual Media awards (health category); and Editors’ Forum (dialogue) with Government, NGOs and MPs on GBV, RH and HIV/AIDS.

UNFPA support to population communication proved very vital to the success of the 2011 census exercise and support by CO was timely and effective. CBS appointed a Publicity Officer and developed a programme of activities geared towards maximizing awareness of census objectives and operation, the expected role and responsibilities of every individual, and sources of information. Various information tools were produced with UNFPA funds: IEC materials; Posters, Brochures, Media advertisements, Display Banners, Census Activity Calendar, T-Shirts, FQA pamphlets and printing of Census Project Document. All these materials were distributed and disseminated as appropriate and contributed immensely to the overwhelming positive response by the populace to the census administration.

4.5.2 Integrating Population, Gender and RH issues

The PDS sub-programme was designed to contribute both directly and indirectly to the implementation of RH component and to the promotion of gender equality and the empowerment of women. A primary consideration in the design of the P&D component was building sustainable and relevant capacity at national and regional levels. To this end, P&D capacity building activities emphasized RH and gender issues at data collection, analysis and utilization stages and through the training activities. On integration and related matters, CO provided technical and financial support through training of Regional Managers and Planners in the utilization of sex-age-disaggregated data (Census, NIDS, DHS, and PPA) for planning. Examples of integrated plans are NDP2, NDP3, and the 13 Regional Development Plans.

The inputs made by CO into the design of 2006/2007 NDHS, the 2006 NIDS and the 2011 census questionnaires ensured that gender and RH issues were well incorporated. The results of the two surveys have already been published and the contents reflect gender and age disaggregation and analysis of data. Similar support has been provided by CO through appointment of a CTA to ensure gender and age disaggregation of the census data analysis and in the preparation of thematic reports.

UNFPA’s support to the Participatory Poverty Analysis in the 13 regions was also designed to sensitize communities on the relevance of gender and RH issues to poverty and its reduction. In addition, the MISA project was aimed at enhancing the capacity of
the NGO for a more effective coverage of population, RH, gender and HIV/AIDS issues in the media in Namibia.

4.5.3 Human Rights Approach

The purpose of the United Nations is about upholding the principles of peace, justice and human rights in the delivery of support to all nations and globally. The on-going UN-reform is based on a revival of the UN Charter; and in the launch of the UN reform, the Secretary-General explicitly stated that all major UN activities should be guided by human rights principles. Human rights of children and women are further specified in the Convention on the Rights of the Child (CFC) and the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW), the International Conference on Population and Development, 1994 (ICPD), and in the 2000 Millennium Development Goals (MDGs).

The intricate linkages of the ICPD-PoA to the MDGs framework are globally and regionally acknowledged. Mid-way through implementing the 20-year ICPD PoA (1994-2014), the UNFPA re-emphasized the significance of population issues in the current efforts to end poverty and meet the MDGs. The report notes that efforts to end poverty and meet the MDGs by 2015 depends on success in implementing all actions identified in the ICPD PoA, particularly promoting women’s rights, providing universal access to comprehensive reproductive health services, and ensuring that development plans and policies take population trends into account are key.

The Human Rights Approach (HRA) is premised on the principle that delivery of UN support for the achievement of national/regional development goals (including achievement of MDGs) should be done within the context of adherence to human rights principles - Equality and non-discrimination; Inclusive participation; Transparency; Accountability; The rule of law; Sustainability; Freedom of the media; Harmony and tolerance. In short good governance should be the basis for development policies and programmes, particularly in the developing countries of the world.

In terms of programming, UNFPA in Namibia has been an active and constructive partner in United Nations reform efforts, guided by the ICPD agenda firmly in all planning frameworks, especially at the country level in line with General Assembly resolution 59/250 on the TCPR. UNFPA in Namibia has continued, within the context of the Strategic Plan (2008-2011) to dedicate increased effort to the challenge of linking ICPD goals with the MDGs in national planning and development processes within the context of the new development cooperation environment. UNFPA in Namibia has also supported the Government to implement national priorities related to ICPD goals based on the principle of national ownership and leadership, and has operated in an inclusive manner on national capacity development, with focus on human capacity and supporting systems and institutional development, as exemplified by the support provided to all

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Government implementing agencies (NPCS, MoHSS and MGCW) and NGOs during the current CP.

5. Future direction

The report of the Midterm review (MTR) of the UNFPA Strategic Plan, 2008-2013 was officially released (UNFPA, November 2011). The report articulates UNFPA’s new Strategic Plan, 2012-2013, which focuses on accelerating progress and national ownership of the ICPD PoA. The plan sets the strategic direction and provides the overall framework for guiding UNFPA support to programme countries, including Namibia, to achieve their nationally-owned development objectives during the reference period in the three interrelated focus areas of population and development, reproductive health and rights and gender equality. It is an integrated agenda of population and development, SRH and reproductive rights, and gender equality has been developed. Therefore, the outcomes under the new development results framework (DRF) are no longer compartmentalized into three areas but instead form a coherent package of core areas where the organization will focus its efforts in the remaining two years of the strategic plan.

There are 7 outcomes of the CP goal:

- **Outcome 1:** Population dynamics and its inter-linkages with the needs of young people (including adolescents), SRH (including family planning), gender equality and poverty reduction addressed in national and sectoral development plans and strategies.
- **Outcome 2:** Increased access to and utilization of quality maternal and newborn health services.
- **Outcome 3:** Increased access to and utilization of quality family planning services for individuals and couples according to reproductive intentions.
- **Outcome 4:** Increased access to and utilization of quality HIV- and STI-prevention services especially for young people (including adolescents) and other key populations at risk.
- **Outcome 5:** Gender equality and reproductive rights advanced, particularly through advocacy and implementation of laws and policy.
- **Outcome 6:** Improved access to SRH services and sexuality education for young people (including adolescents).
- **Outcome 7:** Improved data availability and analysis resulting in evidence-based decision-making and policy formulation around population dynamics, SRH (including family planning), and gender equality.

UNFPA urges country offices to take responsibility for translating the changes described in the revised strategic plan into local contexts, in conjunction with national partners. Again, emphasis should be placed on national ownership, needs and capacities, and the programme should result in more focused country programmes that prioritize rigorously among the possible areas in which UNFPA can work.
5.2 Implications for Namibia CO

5.2.1 Ongoing and activities and emerging issues

While awaiting the formulation of the next UNDAF by UNCT and NDP4 by the Government in which national priorities will be re-defined, recent developments within the government seem to indicate how and in which areas UNFPA could focus future P&D investments. Significant among these is the 2011 census; the enumeration was carried out in August 2011 and should be regarded as an ongoing activity. Only recently, UNFPA hired a Census Consultant to assist CBS in the task of census data collection, analysis and report production. The evaluation has noted that the census management has produced a work plan involving the following critical activities for which UNFPA’s support would be critical:

Namibia 2011 Census: Schedule of PostEnumeration Activities

- Data capture: Ongoing
- Data cleaning and tabulation: February-March 2012
- Preparation of Provisional Report: Nov 2011 – March 2012
- Dissemination/Archiving: Jan. 2014 – Feb 2014

Closely related to census activities is the need to continue to support capacity building for data utilization for policies and plans, with focus on both NPCS and the newly approved institution, the Namibia Statistical Authority under the Statistical Act 2011. Research and training in population in support of development policies and plans at both national and regional levels should be encouraged; this should provide an opportunity for strengthening the capacity of the Statistics Department at UNAM to train more statisticians and demographers in support of statistical services and population programme implementation in the country.

Regarding RH, although programme delivery at intervention areas proved to be effective, at national level, despite several years of interventions in safe motherhood in the country, maternal mortality has increased from 271 to 449/100,000 live births between 2000 and 2007. There is a great need to continue the UNFPA support to RH, and for monitoring RH trends, maternal audits and other aspects of data collection, analysis and dissemination. In addition, the Health Information System (HIS) is not as strong as it should be, and the database has not been effectively linked with programme and regional level data being routinely collected. As part of its support to statistical services in the country, UNFPA should support capacity strengthening at HIS and promote linkages with NamInfo and regional and other sources of RH data to assure continuous updating of health-related data in the country.

One neglected, but crucial, area of demographic and socio-economic in formation has been vital registration and production of vital statistics. Government has recognized the importance of registration of vital events and the production of vital statistics for planning and decision making. However, statistics on vital events in Namibia are not well
developed; they are extracted from the registration records which themselves suffer from a lot of limitations (UNECA, 1994). Civil registration in Namibia is carried out by the Civic Registration Office in the Ministry of Home Affairs and Immigration while the vital statistics are compiled by the Central Bureau of Statistics under the National Planning Commission. The 2001 census results show that 75% of live births and 70% of deaths in 2001 were registered. Government has recently started to implement plans for improving the vital registration system in the country, and has been supported by UNICEF through a Pilot project launched on 31 October 2008. Given that UNFPA has been the lead agency in supporting statistical services in Namibia since independence and because of the Fund’s comparative advantage in population and related statistical data collection and analysis, this should be yet another opportunity to support the Government and possibly collaborate with UNICEF again as has been successfully demonstrated with the NamInfo project.

In regard to geographical focus of UNFPA support to gender, and with the experience and approach of Intra-Health International in Omaheke, UNFPA should consider concentrating on two-to-three regions and dedicate its resources comprehensively in those regions. This would enable effective design of interventions, efficient M&E regime and the capacity to speedily do an impact assessment and adopt best practices and discard others can be enhanced. Current program has ensured integration of GBV, SRH and HIV/AIDS and P&D issues in the national development plans. Future program should also target beneficiaries at decision-making level by enabling the MGECW to extend training on GBV and SRH to cabinet members and their support staff.

5.2.2 Coordination of population policy implementation

In addition, UNFPA plans to introduce a quality assurance system to ensure that managers exercise their leadership roles rigorously, including by monitoring potential risk areas and enforcing adherence to risk mitigation measures.

- Output 2: Strengthened stewardship of resources through improved efficiency and risk management.

This MRF output addresses one important gap in the delivery of support to the country, i.e. coordination and management of the national population programme.

In this regard, UNFPA should consider renewing and strengthening its support to population policy implementation now that the National Population Policy 1997 is being reviewed. During the years since its formulation, the institutional structure for the coordination of policy implementation has remained weak, and focus on implementation of the policy under a comprehensive programme not encouraging. This concern was also shared by NPCS during the field work for this report. The evaluation found that NPCS has been going through a process of institutional restructuring, and the Directorate of Development Planning (DDP), in which Population ‘Unit’ is housed, is conscious of the weak position of the population sector and plans to address this in the emerging new structure of NPCS. In addition, the institutional framework for population policy and programming oversight (the Inter-Agency Technical Committee for Population and the

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8 GRN, Civil Registration and Vital Statistics in Namibia, presented at the Workshop on Improvement of Civil Registration and Vitals Statistics in SADC Region, Malawi, 1-5 December 2008
National Advisory Committee on Population) will be re-visited in the light of the new NPCS structure in order to ensure effective coordination of population and related activities (poverty reduction, disaster preparedness, employment creation, environmental sustainability, gender, etc.) and the integration of population issues into the forthcoming NDP4.

5.2.3 Cross-cutting issues

For Namibia, one additional cross-cutting population issue which has also been taken on by some UN agencies (ILO, FAO, UNICEF) and to which UNFPA CO could subscribe has to do with ‘Minority Populations’ in Namibia, particularly the San who are the poorest of the poor. A recent ILO report (2011), based on Government and related sources, indicate that the San men and women in Namibia and across the age spectrum, are at the lowest level of the country’s development strata; they are poorly educated, lack adequate housing, suffer from poor health and reproductive health status due to food insecurity and poor access to health services and facilities; they also suffer from widespread unemployment and underemployment and are poorly rewarded for work done. Also in terms of governance, they seem to have been sidelined until recently; but they still remain poorly represented at local, regional and national levels of decision making. Various other measures of poverty and deprivation also indicate the unequal situation among the ethnic groups in Namibia and the precarious position of the San. The ILO report in reference recommends, among others that: i) sensitization and awareness campaigns on reproductive health issues which the Ministry of Health and Social Services has been promoting over the years should be extended to San communities as well; this would provide information on unwanted teenage pregnancies, prevention of communicable diseases including HIV and STIs, male involvement in reproductive health and responsible parenthood; ii) in order to present a complete demographic profile of the San population, there need for in-depth analysis of relevant data from Government databases, complimented by primary data from a survey of the San population; and iii) programmes of public education on gender issues (education, reproductive health, etc.) should be supported in San communities.

Based on the above, and in support of the UN ‘Delivering as One’ initiative, CO could collaborate with the other UN agencies already involved in a joint programme on San peoples in Namibia to better address P&D, RH and gender related issues among this minority group.

6. Main Conclusions

Considering the population and development challenges faced by GRN as efforts are being made to prepare NDP$, the support of UNFPA in the areas of RH, P&D and Gender under the 4th CP still remains relevant.

The entire programme was anchored on building sustainable and relevant capacity at national and regional levels for addressing SRH issues, including Family Planning and reduction in the spread of HIV/AIDS and teenage pregnancies; generation and utilization
of population data and analysis for integration of population issues into development policies and plans; and addressing gender disparities. Support was provided by CO for community mobilization activities targeting community leaders and males in order to improve decision making on health care seeking behavior and eventually increase utilization of EmOC services; this has stimulated community preparedness and support system for improving referral of cases from community to first level of health care system.

Reproductive Health
Although the national data show a downward trend in teenage pregnancy rate, there is still a concern at the regional level. Of all three intervention areas, only one is below the national figure (Oshikoto: 14%). Antenatal care is reasonably high nationally and regionally. This trend could be nurtured to remain. Family planning is showing an upward trend in the intervention areas, but it is still below the national targets in all intervention areas. With regard to maternal and neonatal care, capacity was developed to provide safe deliveries and respond to emergencies. Relevant protocols were developed and availed to those institutions for use. Equipment and supplies were provided and back-up systems built to support the initiative of increased skills to attend to mothers and newborn babies. However, current strategies using advocacy and mobilization could be strengthened and conducive environment created among the community volunteers to enhance the mobilization process. Male involve should be encouraged by the line ministries and male engagement groups should be established in all 13 regions of the country to support the reproductive health component.

The TOT trainings of health workers and training of LAs in their respective regions and districts, as well as the youth clubs have contributed significantly to sustainability. However, these structures are also funded by UNFPA and might collapse if the support is withdrawn. Hence the ministry has introduced a new cadre of health extension workers. A number of countries have now made significant progress to improve equity of access to primary health care services and in bridging the gap between health facilities and communities by introducing health extension workers with a reasonable degree of success. In addition, GRN itself adopted a Roadmap which could be used for funding of some essential activities such as those aimed at reduction of maternal and neonatal mortality and morbidity. After doctors received necessary training in anaesthesia through the intervention of CO, regional hospitals were able to conduct caesarean sections, without transferring uncomplicated cases. CO also supported community shelter to pregnant women whose distance could not allow them to access health facilities, and this support has increased the enrollment to the shelter, thus contributing to a higher trend in deliveries attended by skilled attendants in Eenhana district health facility.

The provision of high quality RH services specifically, improved maternal health and essential obstetric care services, is an important undertaking under the 4th CP. RH interventions also strengthened capacity for the management and monitoring of adolescent friendly reproductive health services at the regional and district levels, and is directly linked to the achievement of UNDAF outcomes 1 and 3: the HIV/AIDS response is strengthened. The initial increase in recorded number of maternal deaths in
intervention areas was due to better coverage of records; post-intervention records have started to show a decline in the number of maternal deaths. At national level, despite several years of intervention in safe motherhood, maternal mortality has increased from 271 to 449/100,000 live births between 2000 and 2007. There is a great need for monitoring RH trends, maternal audits and other aspects of data collection, analysis and dissemination.

**Population and Development**

Support to statistical services has been effectively delivered by CO through investments in capacity building of implementers and beneficiaries, technical and financial inputs for the production and publication of output reports and their dissemination, and through acquisition of equipment, programme monitoring and evaluation. The strategy of providing technical support to implementing partners has also yielded expected returns to investment in terms of capacity building and actual production of defined outputs, especially in the generation and analysis of gender disaggregated data for policy and planning. CO interventions through deployment of technical personnel, both local where possible and international where local capacity was lacking, have proved to be productive and efficient. With the support by CO, Government successfully implemented the Participatory Poverty Assessments (PPAs) project; undertook and published the 2006/2007 National Demographic and Health Survey and the 2006 National Inter-Censal Demographic Survey. Equally important, the 2011 Population and Housing Census project has recently completed the head count and plans are in place for in-depth analysis of data and preparation of thematic reports. Notably, CO in partnership with UNDP and UNICEF, supported the introduction and establishment of the use of NamInfo (demographic & socio-economic database). Capacity building also extended to the Statistics Department UNAM to train graduates in Demography and specifically to conduct research on Youth Migration. Support was also provided to NPCS for the revision of the National Population Policy (1997), and preparation of the ICPD @ 15 Report.

In the light of the achievements and shortcomings of past capacity-building activities, emphasis has been placed during the past five years on enhancement of capacities of institutions implementing the 4th CP, including MoHSS, DDP and CBS in NPCS, MGECW, the 13 Regional Offices, and UNAM. Such capacity building interventions will henceforth be better focused on the new Namibia Statistical Authority which replaces CBS.

**Gender**

Again, UNFPA support to the achievements of gender outputs consisted of capacity building, research/assessment, advocacy and community mobilization interventions. Among others, significant achievements include the empowerment of women through trainings and sensitizations to ensure protection of their reproductive rights in Caprivi region, particularly in Singalamwe, Makaravani and Mubiza communities. Through NAPPA, the CO supported the production and translation of materials into local vernacular for young people on sexuality and GBV.
Ministry of Gender Equality and Child Welfare and key line Ministries and NGOs were capacitated in gender mainstreaming using the SADC gender mainstreaming tool; paralegals were empowered with knowledge and skills on various gender laws to further sensitize their respective communities. A total of 41 TOT male representatives were equipped with knowledge and skills to further mobilize men and boys to address GBV, HIV and promote SRH during 2012. In terms of institutional capacity building, the CO provided technical and financial support for the revision of the 1997 National Gender Policy; provided technical support during the drafting of the National Gender Plan of Action and the drafting of the GBV Plan of Action. A module for addressing GBV for nursing students and all 1st year students at the University of Namibia was also developed; so also the development of the a Framework on Gender Equality and SRH for Council of Churches in Namibia, Member Churches and Organizations. Several gender studies were conducted for the provision sex and gender data for programming and reporting internationally.

These interventions among others, have led to a better understanding of the linkages between population dynamics, poverty, and the demographic and socio-economic causes and consequences of the HIV/AIDS epidemic in the project areas. The results reveal that major strides were made in the implementation of the program and that overall, the program was effectively implemented. Gender equality issues were adequately considered in the formulation of the 3rd National Development Plan (NDP3) of the Government of Namibia. Financial resource disbursement and implementation rates met expectations of the stakeholders. The program targeted the right audiences and it was pointed out that the interventions should be intensified. Although all implementers demonstrated that they have now taken ownership of the intervention, lack of financial resources constitutes a major challenge for sustainability.

Programme performance
In terms of efficiency in financial management, implementation rates for specific activities were quite high.; average for the period reached 88.6% for RH; 93.6 for P&D; and 80% for Gender. CO has established a viable accounting system and its application during the 4th CP posed no problem to management. The Accounts section in CO has been efficiently managed by an Operations Manager supported by a Finance/Administrative Assistant, under the able supervision of the accounting office, the UNFPA Representative and professional oversight through annual audits. There are only a few records of complaints about delay in the transfer of funds by implementers, implying that financial management did not create any problem for programme delivery during the programme period. Programme finances have been subjected to annual auditing as requested and, overall, the reports have been generally satisfactory.

There is one particular area where CO/GRN intervention, though critical, was almost lacking. This has to do with policy implementation and coordination of population activities in the country. Apart from fragments of what used to be Population Unit in NPCS, none of the established institutional structures for policy implementation, and hence, coordination of population activities, has been active. This leaves a huge gap in GRN/UNFPA collaboration under the 4th CP in Namibia, which NPCS plans to consider
in the ongoing re-structuring of the institution. With RH, integration of RH and HIV/AIDS still poses serious challenges at management level. MoHSS has two directorates, the Directorate of Special Programmes which is responsible for managing HIV/AIDS related interventions, while the Directorate of PHC is responsible for managing RH/FP interventions. This has resulted in parallel/vertical programmes that do not seem to speak to each other. Attempt has been made to address this issue in the current draft RH policy, but it will implement programme remains a major challenge at both national and regional levels.

Strategic direction
The review has noted the new Strategic Direction of UNFPA (2012-2013). While underscoring the new outcomes of the development results framework (DRF) and the outputs of the management results framework (MRF), as well as the cross-cutting issues identified, this evaluation found that recent developments within the government seem to indicate how and in which areas UNFPA could focus future interventions. Significant among these is the 2011 census project, which has only recently completed the head count and should be regarded as an ongoing activity well into the 5th CP. CO could provide the agency’s comparative advantage in joint programming to address the challenge of marginalized minority population groups in the country, including the San. In addition, UNFPA may wish to collaborate with UNICEF in supporting GRN to address the challenge of vital registration and production of vital statistics in Namibia.

7. Important Lessons Learned

General
i) Delay in signing an agreed Annual Work Plan or a cooperative agreement by Government led to unnecessary delay in the release of funds during the 1st quarter of the year and thus hampered the pace of implementation.

ii) The GRN/UNFPA Annual Review and Planning meeting has been useful in achieving some measure of programme coordination; CO and the implementers have ample opportunity at such meetings to agree on realistic output indicators, together with their baselines and targets; this input should facilitate programme monitoring and evaluation.

iii) Collaboration with local higher education institutions in the long term is an effective way of building capacity and creating awareness.

Reproductive Health
i) The lack of feedback on some important issues of support due to poor communication, as in the case of two line ministries (MoHSS and MYNSSC) and their community mobilization structures (Life style Ambassadors and Youth clubs), negatively affected the effectiveness of programme interventions.

ii) If the work of different stakeholders in the communities and how they deal with the communities are not well-monitored by the coordinating Ministry
(MoHSS), there will not a standard in terms of community expectations by the beneficiaries and this often leads to confusion in the communities.

**Population and Development**

i) Through the PPA project, it was clear that solutions to most of the critical population and poverty-related problems being faced by the people are best addressed with them and not for them.

ii) High rate of professional staff turnover undermines capacity building investments, but such movements are not detrimental to capacity development at national level; therefore capacity building should be an ongoing intervention;

iii) The success of the NamInfo institutionalization project demonstrates that inter-agency collaboration (UNFPA, UNICEF) among the UN family could be cost-effective.

**Gender**

i) The absence of a comprehensive and effective gender management structures at all levels, which would have enabled implementers to have a strong advocacy, lobbying skills and an efficient coordination system, has affected program implementation negatively.

ii) Male involvement is a key strategy for addressing GBV.

iii) Using Food security as an entry point for addressing GBV, SRH and HIV, is only successful if the agricultural related projects/initiatives are also effective and successful.

8. Recommendations

The following recommendations are made based on the major conclusions and challenges faced by the programme implementation processes. Although debatable, the recommendations are arranged by programme component in order of priority.

**8.1 General**

i) GRN and UNFPA should involve all relevant programme managers, coordinators and implementers when output indicators, baselines and targets are being set in CPAP, so that the whole team has a common understanding of the implications and in order to assure ownership.

**8.2 Reproductive Health**

j) Although programme delivery at intervention areas proved to be effective, at national level, despite several years of interventions in safe motherhood in the country, maternal mortality has increased from 271 to 449/100,000 live births between 2000 and 2007. There is a great need to continue the UNFPA support to
RH in terms of capacity building, monitoring of RH trends, maternal audits and other aspects of data collection, analysis and dissemination.

k) National data is showing a downward trend in teenage pregnancy rate, there is still a concern at the regional level. Of all three intervention areas, only one is below the national figure only with 1% (Oshikoto: 14%), UNFPA could probably venture in the general educational curriculum and strengthen the life skills education from earlier stages (10 years). This could probably help them if they understand their body. This could be coupled with strong community advocacy groups to strengthen the parent-child communication on sexual issues.

l) Family Planning is another source of concern, while Namibia is a youthful society, FP services are widely available and accessible but the rates remain low. Although there is an upward trend in the intervention regions, all three are still below their national targets. Ministry should seriously look into their current strategies, (strengths, weaknesses and opportunities) and strengthen this very important RH service.

m) There is a need for IEC materials to be developed in local languages and real life issues in the communities be illustrated; the use of cartoons should be minimized to enable the communities to identify with the real issues in their midst.

n) Issue of stock-outs of condoms is a serious concern in the era of HIV/AIDS and need should be addressed promptly; the discrepancy in condom distribution from the national level to the regions and within the regions is a peculiar one that needs an urgent investigation, given that the regions are experiencing stock-outs for as long as 3-4 months.

o) GRN and UNFPA should continue to support SRH interventions nationally, and should encourage the regions should not lose the focus on the ongoing HIV/AIDS prevention strategies.

p) Male involvement in sexual and reproductive health should be encouraged by the line ministries, not only for intervention areas, but such groups need to be established in all 13 regions of the country to support RH in general and maternal health in particular.

8.3 Population and Development

h) The NDP4 formulation process by Government should endeavour to integrate population issues (population dynamics, SRH, gender, youth, environment, etc.) into the Plan.

i) GRN and UNFPA should continue to support the ongoing census project and capacity building for data utilization for policies and plans, with focus on both NPCS and the newly approved institution, the Namibia Statistical Authority.

j) NPCS, with the support of UNFPA, should strengthen the population staff capacity of DDP; including training of the staff in post, recruitment of two or more Demographers in order to enhance the Directorate’s capacity for coordinating population activities in the country.

k) The ongoing revision of the National Population Policy should be concluded by Government as soon as possible, and strategy for its implementation put in place.

l) Given that UNFPA ha s been the lead agency in supporting statistical services in Namibia since independence and because of the Fund’s comparative advantage in
population and related statistical data collection and analysis, support to Government in strengthening the civil registration and vital statistics, the next CP should provide intervention in this area and possibly collaborate with UNICEF again as has been successfully demonstrated with the NamInfo project.

m) Research and training in population in support of development policies and plans at both national and regional levels should be encouraged; this should provide an opportunity for strengthening the capacity of the Statistics Department at UNAM to train more statisticians and demographers in support of statistical services and population programme implementation in the country.

n) Government should revive the activities of the Advisory Committee on Population as well as its technical arm, the Inter-Agency Technical Committee on Population and Development, in order to be able to design and implement a comprehensive and coherent programme of population/RH/Gender policy implementation at national and regional levels.

8.4 Gender

f) Gender mainstreaming through sector-based analysis should be supported and greater coordination between the MGECW and key line Ministries such as Health, Education, Finance and Agriculture which will enable sectors justify for gender responsive budgeting based on gaps identified in the assessment.

g) Technical and system support for strengthening coordination and gender management system In regard to geographical focus of UNFPA Namibia, UNFPA should consider concentrating gender interventions on two-to-three regions and dedicate its resources comprehensively in those regions based on criteria.

h) An integrated approach and increased research to understand root causes of GBV should be undertaken by the MGECW with support from UNFPA.

i) In recognition of the fact that the majority of the population of Namibia is young, increased support for youth-focused projects on GBV, SRH and HIV/AIDS should be intensified and coordinated by MGECW and implemented with relevant stakeholders.

j) More support to be provided for the One Stop Centre approach for addressing violence against women and also support MGECW for the establishment of networks with various key partners for effective service delivery.
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- The 4th Country Programme Document
- The CPAP document
- The mid-term evaluation report
- The UNFPA Strategic Plan
- The UNFPA Finance Management Manual;
- Project Annual Reports;
- Annual Work Plans
- Policies and Procedures Manual, applicable editions at the time of programme development and at the time of evaluation;
- Reports of Annual Review Meetings;
- Project mission reports;
- Audit reports;
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**Reproductive Health**

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Annex 4: Summary of implementation achievements
Annex 4.1: RH - Summary of implementation achievements

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<th>Output indicator</th>
<th>Baseline/Target</th>
<th>Performance*</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Output 1:</strong> Young people participate in and have access to HIV/AIDS information, life skills and opportunities in 24 health districts</td>
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<tr>
<td><strong>Indicator 1A:</strong> Increase in condom use in intervention areas among 15-39 age group</td>
<td><strong>Baseline:</strong> National: 66% Oshikoto: 59%; Caprivi: 77%; Otjizondjupa: 62% <strong>Target:</strong> National: 80% Oshikoto: 80% Caprivi: 80% Otjizondjupa: 80% (NDHS, 2000)</td>
<td>This target could not be measured, due to lack of age-specific data in all intervention sites. However, UNFPA support facilitated implementation of HIV/AIDS Communication for Behavioural Impact project in the selected regions to participate and communities have more access to HIV/AIDS information. It is difficult to determine if this target has been achieved due to the lack of specific data indicating the required age breakdown in all intervention sites. However, CO interventions include the following: 1.1 TOT on Communication for Behavioural Impact (COMBI) was conducted for 34 participants from Caprivi, Otjizondjupa and Oshikoto regions which equipped them with necessary knowledge and skills to train Life Style Ambassadors (LAs). LAs revealed adequate awareness on the components of COMBI project during the Focus Group Discussions (FGD). 1.2 1000 LAs were capacitated in three UNFPA/GRN focused regions, to do house to house visits during the campaign. It was evident from the FGDs how best some new members of the youth clubs benefited from door-to-door approaches before joining the youth clubs. 1.3 IEC materials were produced and distributed for COMBI programme for mobilization purposes 1.4 Young people were encouraged to participate in the National HIV testing days and know their HIV status. As a result, a total of 2943 people were tested during National Testing Days (NTDs) in Oshikoto 1.5 Contraceptives, including condoms and condom dispensers were procured for distribution and utilization. 1.6 Supervisory visits and review meetings were conducted and LAs were updated on PMTCT, VCT, DSI, STIs, FP and TB information were conducted for monitoring and evaluation.</td>
<td>According to 2006/7 DHS the Condom use has increased from 66% to 79 nationally. But DHS does not have a breakdown for regional condom usage, therefore difficult to comment on the 80% achievement for the regions.</td>
</tr>
<tr>
<td><strong>Indicator 1B:</strong> Increase in condom distribution</td>
<td><strong>Baseline</strong> Caprivi: 2030400 Oshikoto: 164160 Otjizondjupa: 187200 <strong>Target</strong> Caprivi: 4,210,237.00 Oshikoto: 3,443,270.00 Otjizondjupa: 6,518,960.00</td>
<td>Achievements: Condoms distributed were as follows: Caprivi: 5,060,160 Oshikoto: 4,443,270.00 Otjizondjupa: 6,518,960.00 The targets were achieved, as condom distribution exceeded the targets.</td>
<td>Condom distribution exceeded targets in the intervention areas which could be seen as an indication of increase in demand for condom; hence this can be used as a proxy for condom usage to complement Indicator 1A.</td>
</tr>
</tbody>
</table>
However, condom distribution is not a reliable indicator for condom usage. This could be supported by magnitude of condoms distributed, against ever increasing pregnancy rates, STIs and HIV prevalence rates in general.

<table>
<thead>
<tr>
<th>Indicator 2: Decrease in the number of teenage pregnancies (10%) in intervention areas</th>
<th>Baseline: National: 18% Oshikoto: 17% Caprivi: 27% Otjondjupa: 28%</th>
<th>Achievements: National: 15% Oshikoto: 14% Caprivi: 30% Otjondjupa: 27%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Targets National 16% Caprivi 17% Oshikoto 7% Otjozondjupa 18%</td>
<td>CO interventions below contributed towards achievement of targets as follows: National: 15%; Oshikoto: 14%; Caprivi: 30%; Otjozondjupa: 27%. CO interventions included the following: Capacity of both the implementers and youth were developed through different ways and using various means to prevent/reduce teenage pregnancies and its consequences: 1.1 Three hundred learners mobilized on prevention of teenage pregnancies. Implications of pregnancies too early in life. 1.2 13 nurses were equipped with knowledge and skills on AFHS and post abortion care 1.3 Capacity of implementers, including UNAM and NHTC were built regarding AFHS 1.4 Four (4) training workshops conducted on suicide for teenagers 1.5 Hundred (100) young people reached with community mobilization messages 1.6 5000 young people reached with SRH mobilization 1.7 15 community based RH agents trained in SRH and rights, GBV, HIV/AIDS 1.8 15 NAPPA health workers trained on VCT and Rapid Testing (RT) 1.9 One professional nurse recruited and permanently employed by NAPPA 1.10 Training manuals for student were developed on AFHS and printed on annual basis for UNAM and NHTC. 1.11 350 copies of different SRH DVDs procured for Desert Soul and OmbetjaYehinga for mobilization 1.12 Youth friendly clinics, mostly serving the young people were established and supported in Katima Mulilo, (Caprivi region), Khomas clinic in Windhoek and recently inaugurated youth clinic (11 Nov 2011) in Outapi. 1.13 Youth clubs established (Eenhana, Katima, Oshakati and Outapi)</td>
<td>Establishment of Youth friendly services increased uptake of reproductive health services. Although downward trend is observed in national data, Oshikoto &amp; Otjozondjupa regions show decrease while Caprivi is on the increase in teenage pregnancies. The set targets were not achieved, According to COAR, (2007) some of the reasons for potential increase in teenage pregnancies were: impact of the global economic crisis, resulted in retrenchment of many workers leading to increase in unemployment which may contribute to potential increase in teenage pregnancies, baby dumping, HIV/AIDS, STIs etc.</td>
</tr>
</tbody>
</table>
### Output 2: Increased availability of comprehensive, high-quality HIV prevention and youth-friendly health services and care, including VCT and sexual and reproductive health services

#### Indicator 1:
Increase in % of people aged 15-34 in intervention areas utilizing reproductive health services

<table>
<thead>
<tr>
<th>Service</th>
<th>National</th>
<th>Caprivi</th>
<th>Oshikoto</th>
<th>Otjozondjupa</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANC</td>
<td>80</td>
<td>84</td>
<td>76</td>
<td>74</td>
</tr>
<tr>
<td>FP</td>
<td>38</td>
<td>46.3</td>
<td>49.2</td>
<td>68.2</td>
</tr>
</tbody>
</table>

#### Targets
- **ANC**
  - National: 85
  - Caprivi: 90
  - Oshikoto: 82
  - Otjozondjupa: 80

- **FP**
  - National: 48
  - Caprivi: 56
  - Oshikoto: 60
  - Otjozondjupa: 78

#### Indicators performance
- **ANC**
  - National: 82
  - Caprivi: 91
  - Oshikoto: 91
  - Otjozondjupa: 68 (DHS 2006/7)

- **FP**
  - National: 48%
  - Caprivi: 41
  - Oshikoto: 43
  - Otjozondjupa: 57 (NDHS 2006/7)

All three intervention areas were below their targets. Caprivi with 15%, Oshikoto, 17%, and Otjozondjupa with 11% below their target.

ANC attendance is high in all intervention areas. All regions are exceeding their targets with a margin of 6% respectively.

Capacity of health workers were developed to render quality RH services in following aspects:

1. **UNFPA provided support to strengthen capacity of health providers, especially in AFHS (400 nurses), FP (32 providers), and EOC (344 providers) were equipped**
2. **TOT courses were provided on AFHS as well as on Pap smear screening skills**
3. **UNFPA supported 3 week in-country training on FP. A group of national TOTs established through this activity.**

CO provided technical and financial support to facilitate the access and demand of RH services as well as for better coordination of RH programme the following were done:

1. **CO in collaboration with MoHSS and NGOs has supported programmes in creating awareness on the utilization of FP.**
2. **Technical support was provided to UNAM and NHTC to train pre-service health workers in Integrated sexual and reproductive health.**
3. **The increase in utilization of RH services is more evident in the youth friendly clinics (Khomas and Katima).**
4. **FP policy was revised to accommodate adolescent friendly approach**
5. **To increase the availability and accessibility, the CO supported Ministry in procurement of contraceptives including**

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**National data used for baselines do not have age breakdown for regions. Only mostly attended RH (FP & ANC) services are presented.**

98% of service delivery points provided at least 3 modern methods according to 2009 Health Facility Census. Despite of the availability of FP methods and accessible FP facilities which are mostly open for five days, the utilization remains low.
Condoms and condom dispensers. Contraceptives such as: Nur-esterate 85000 ampoules for MoHSS and 5230 assorted contraceptive unit) for NAPPA were procured.

1.8 CO provided both technical and financial support to MYNSC for capacity building of health officers for the implementation of SRH programmes at youth centres.

1.9 Three regional programme coordinators were recruited and deployed to the three main intervention areas i.e. Caprivi, Oshikoto and Otjonzondjupa.

1.10 CO provided financial support to SRH guidelines on syndromic management of STIs.

Community mobilization was strengthened to enhance the utilisation of RH services among young people:

1.11 Community mobilization activities targeting young people and men and women on condom promotion and utilization reached 3218 members i.e. youth, women and men were reached during these activities.

1.2 UNFPA work in partnership with other UN agencies, MoHSS, Ministry of Broadcasting to support the national HIV/AIDS campaigns through radio, TV and community activities.

1.13 UNFPA led the BCC components using Communication for Behavioural Impact approaches.

1.14 Utilisation of LAs in conducting house to house visits have contributed to the increase, demand and utilization of both condoms and RH services, in increasing accessibility of condoms, especially after hours.

Indicator 2: By 2008, increase in trained VCT community counsellors from 72 to 502

- **Baseline:** 72
- **Target:** 502

This target was not evaluated as the CO support was unilateral and was also provided for only for 1 year (2007) to Otjozondjupa region.

According to Mid-term review (2008) UNFPA only supported Otjozondjupa during 2007 and support was discontinued since then. Therefore this indicator was not evaluated.

Output 3: Strengthened capacity to address reproductive health needs in emergency settings

**Indicator 1:** Government officials and providers sensitized

- **Baseline:** 0
- **Target:** Increased awareness of 3500 of the target group (GRN officials and service providers) on RH and protection issues in emergency settings

This target was achieved.

1.1 Two government officials and 2 parliamentarians were supported to attend RHCS Advocacy capacity Building workshop in Gaborone (2007). After attending the workshop, the two Parliamentarians have taken initiatives to advocate for RHCS through meeting RHCS coordination mechanism and sensitized other Parliamentarians.

CO provides leadership and support in the protection issues during emergencies and facilitated inclusion of RH in the national emergency plans.
1.2 Through CO advocacy efforts with the Office of the Prime Minister, Gender & SRH issues were incorporated in the national emergency plan.

1.3 The health workers were oriented on correct usage of RH kits during emergencies.

1.4 TOT volunteers were equipped with knowledge and skills on SRH & GBV.

1.5 CO supported implementation of an ISRH programme in Osire Refugee Camp which has a population of over 6,000 inhabitants 40% of whom are children and young people.

1.6 CO with UNHCR implemented integration of Gender; SRH and HIV/AIDS programme in Osire Refugee camps (Over 2000 young people were sensitized, 29 SRHR task Force members and workers were trained as trainers, who further trained 22 mentors and group leaders of Osire.)

1.2 Camp fire concept was introduced to build the capacity of camp managers. Camp managers from 71 camps were equipped with knowledge and skills on GBV, SRH and HIV.

1.3 29 volunteers were given refresher training on GBV, SRH and Hygiene promotion.

1.4 Thousand one hundred seventy four (1174) floods affected communities (654 women, 120 men and 400 school learners) were sensitised on SRH, HIV/AIDS and GBV in Caprivi and Kavango regions.
**Indicator 2:**
Protocols and training manuals developed and utilized

**Baseline:** 0
**Target:** Protocols/training manuals developed

This target is achieved. There is evidence that training was provided, using some protocols developed.

**The following protocols were developed to cater for RH in emergency settings:**

1.1 1000 copies of IEC materials on SRH & Rights developed for youth in emergency areas
1.2  UNFPA in collaboration with UN agencies (UNICEF, UNDP, WHO, UNHCR) supported government to develop a national disaster policy that clearly highlights the importance of RH and gender issues.
1.3  CO participated in drafting of a national emergency plan which never existed.
1.4  CO strengthened RHCS through capacity building of health service providers on FP and procurement and provision of RH commodities, including RH kids

Certain important items were procured and necessary emotional support given during emergency settings as follows:

1.1  Emergency delivery and hygiene kids were procured and distributed for the utilization
1.2  Camera procured for Emergency programme
1.3  Dignity kids for 3500 women procured in Okavango and Caprivi
1.4  Recreation items such as 4 volley balls, 20 netballs with their pumps; 2 netball nets; 544 cotton wool and 69 hooks were procured for communities affected by floods to keep up their spirits and thus not always think of the emergency.
1.5  UNFPA supported procurement of delivery and dignity kids for the flood victims as well as procurement of RH commodities (85,000 ampoules of norethynodrel contraceptives were purchased)
1.6  In ensuring accessibility of condoms, CO procured 100 condom dispensers as well as 200,000 female condoms and 85,000 ampoules of Norethynodrel contraceptives
1.7  UNFPA procured and distributed dignity kids (1950) and family tents to ensure that affected women have access to critical service
1.8  Provide psychological support for 300 affected youth and 100 women in Kavango and Caprivi

Involvement of the UN agencies is clear. The capacity was built and equipment and supplies provided. Awareness was created and protocols developed. Therefore, envisaged set target was achieved.

Output 4: Increased availability of high quality maternal care services, including essential obstetric care, in two thirds of intervention area.
<table>
<thead>
<tr>
<th>Indicator 1: Increased proportion of births attended by skilled birth attendants in intervention areas</th>
<th>Oshikoto</th>
<th>Achievements</th>
<th>Caprivi: Achieved 80%</th>
<th>Oshikoto: 79%</th>
<th>Otjozondjupa: 80% (NDHS, 2006/7);</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline: 66%</td>
<td>Target: 78%</td>
<td></td>
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</tr>
<tr>
<td>Caprivi</td>
<td>Baseline: 67%</td>
<td>Target: 80%</td>
<td></td>
<td></td>
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<tr>
<td>Otjozondjupa</td>
<td>Baseline: 61</td>
<td>Target: 75</td>
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</tbody>
</table>

The set targets were met in all three intervention areas.

CO made the following inputs, which contributed to the regional outcomes indicated above.

**Capacity development**

1.1 CO supported MoHSS to recruit regional RH Coordinators to implement and coordinate RH programmes in their respective regions

1.2 Health workers were equipped with TOT skills on Emergency Obstetric Care/Life Saving skills to render quality midwifery care.

1.3 Directors, CMOs, PMOs and Health workers were capacitated to conduct Maternal Perinatal Neonatal Death Reviews (MPNDR). This training made health workers more alert to keep correct records of maternal deaths occurring in departments other than maternity.

1.4 Provide ongoing support for training of health workers on maternal death audits and EmOC

1.5 (2010) Six medical officers were trained in administering anaesthesia with the objective of increasing caesarean section coverage and to improve maternal and neonatal health in the region. As a result of this intervention, meeting the need for EmONC has improved as 100% of women estimated to have major direct obstetric complications were treated in BEmONC and the CEmONC.

1.6 All 4 district hospitals in Otjozondjupa Region with population of less than 500,000 were providing ECmOC compared to previous years an increase from 50% to 100%.

**Policy/guidelines/protocol/**

1.1 Emergency Obstetric Care guidelines were developed

1.2 UNFPA supported recruitment of a consultant to assist government to develop guidelines/protocols for maternal death audits

1.3 Guidelines on Completing the MPNDR developed as well as tools were developed and utilized

1.4 The Namibia Roadmap for acceleration the reduction of maternal and newborn morbidity and mortality in Namibia revised and implemented

**New emergency skills were developed and also extra equipment and supplies provided to accelerate the reduction of maternal mortality rate.**

American College of Nursing and Midwives are assisting MoHSS in EmONC training. Currently they are waiting to finalise
| Indicator 2: Increase in the number of skilled attendants in intervention sites/areas |
|---|---|---|
| **Baseline:** | Oshikoto 33% | Baseline: EmOC facility need assessment report |
| Caprivi 66% | Baseline: EmOC facility need assessment report |
| **Target:** | Oshikoto 60% | Baseline: EmOC facility need assessment report |
| Caprivi 86% | Baseline: EmOC facility need assessment report |

It is difficult to measure this indicator due to lack of information to use as a benchmark. However, many inputs were made during the 4th CP which could indicate whether there has been an increase in the skilled attendants or not.

Capacity of health workers were developed to render quality EOC:
1.1 Capacity of service providers developed to deliver quality EOC. A total of 183 health workers are able to perform maternal and neonatal death audits and 104 HCW are able to carry out intervention related to 9 signal functions of EmONC
1.2 CO strengthened capacity of health services providers for them to have the skills and capacity to perform EmOC signal functions (344 health providers, including midwives and medical doctors have been trained)
1.3 Four capacity building and skills update on EmONC were conducted and 9 participants from various selected regions were reached
1.4 Establishment/strengthening capacity of referral system for EOC in the regions
1.5 Strengthen capacity of Regional Management Teams and District Coordinating Committees (DCC) teams to supervise and monitor maternal and newborn health services, especially EOC
1.6 UNFPA advocated for the recruitment of OB/GY and 1 medical officers to be stationed in Tsumeb hosp in order cut down on the cost of referrals to Oshakati and Windhoek hosp.
1.7 Capacity of 6 medical officers were developed in administering of anaesthesia to facilitate EmONC service and avoid unnecessary referrals
1.8 Male participation and Collective action for improved referral of high-risk pregnancies to health facilities provided
1.9 In addition, 26 TBAs were trained in identification of danger signs and symptoms of pregnancy and refer
1.9 Community leaders and men sensitized on male involvement in maternal health
1.10 Hundred and fifty (150) women mobilized in Tsumeb district on how to improve health facility delivery
1.11 As a result of community mobilization activities by LAs in Caprivi, the region reported significant increase in partner referral from 737 in 2008 to 1149 in 2010.

Also the enrollment of clients for ARV has increased to an average of 40 clients per week compared to 20-30 in the past

From all indications, the set target has been met. As a result of community mobilization activities by LAs in Caprivi, the region reported significant increase in partner referral from 737 in 2008 to 1149 in 2010. Also the enrollment of clients for ARV has increased to an average of 40 clients per week compared to 20-30 in the past.

CO support provided for EOC greatly contributed to the achievement of this indicator as well.

Equipment and supplies provided

1.12 Improved availability of relevant, supplies and drugs for the delivery of maternal and newborn health, including ANC, FP, PNC and EOC and PMTCT
Annex 4.2: P&D - Summary of implementation achievements.

Output 1: Strengthened national statistical system to ensure effective development and application of tools for evidence-based policy making, planning, implementation, monitoring and evaluation

<table>
<thead>
<tr>
<th>Output indicator</th>
<th>Baseline/Target</th>
<th>Performance</th>
<th>Remarks</th>
</tr>
</thead>
</table>
| **Indicator 1.1:** Regional poverty profiles (RPP) produced. | **Baseline:** 0  
**Target:** RPP available for 10 regions by the end of 2008 | 1.1 Technical Assistance(TA) for Participatory Poverty Assessments (PPAs) focusing on Gender and Reproductive Health issues in all 13 regions.  
1.2 Wide dissemination of the findings of the Participatory Poverty Assessments (PPAs) focusing on Gender and Reproductive Health issues.  
1.3 Support provided to NPCS Poverty Monitoring Unit to produce a Poverty Video. | CO made inputs into the PPA process to ensure that population, RH, Gender and HIV/AIDS issues were reflected in the reports & video outputs. |
| **Indicator 1.2:** Reproductive health and gender issues in the context of HIV/AIDS integrated into poverty monitoring and analysis. | **Baseline:** Limited integration of health & gender  
**Target:** Full integration of health & gender issues | 1.1 2nd MDG Report for Namibia (2008)  
1.2 Final Progress Report on the Third Medium-Term Plan on HIV&AIDS (2009-2010)  
1.3 Supported NPC – Poverty Bulletin  
1.5 NPC – National Development Plan 3  
UNFPA contributed to health system review and supported the development of the health strategic plan for 2009/2013  
1.6 In 2008 launched the roadmap to accelerate reduction of maternal and newborn mortality and morbidity.  
1.8 Prepared the Namibia ICPD @ 15 Report and submitted to ECA (2009).  
1.9 NPCS- Participatory Poverty Assessment Reports (2008)  
1.10 Co supported MOHSS to conduct an Essential Indicator Capacity workshop for staff from all 13 regions that were trained to analyze raw data from the District Health Information System, producing regional and national Statistical Abstracts for use by regional planners and managers. | UNFPA contributed to the formulation of the National Development Plan 3 (NDP3, 2007-2012) launched in Nov 2008; key population issues addressed in the plan are: a) making quality health care accessible, affordable and equitable; b) developing human capacity c) targeting more resources towards the poor in rural and urban areas; and d) addressing gender equality and GBV. \(\vdots\) |
| **Indicator 1.3:** Introduction and use of DevInfo database. | **Baseline:** No DevInfo  
**Target:** DevInfo database introduced by the | 1.1 All 13 Regional Councils and their key staff were sensitized;  
1.2 Promotional materials and NamInfo database CD have been produced and disseminated during the training sessions;  
1.3 TOT training on the Administration and Use | UNDP and UNICEF, CO provided support to the process of operationalizing NamInfo |
The NamInfo web version was successfully launched in November 2007. NamInfo regional focal persons from eight regions conducted training in their respective regions for 85 regional staff on the application of NamInfo software (2007). An education database was developed with the help of 13 education planners from all thirteen regions nationwide. 80% of Parliamentarians, and all senior policy makers and planners use DevInfo and age-sex disaggregated statistical data.

**Indicator 1.4:** Increased number of users and organizations accessing data from the Central Bureau of Statistics

| Baseline: | Limited access to & use of CBS data |
| Target: | % increase number of users accessing data from CBS |
| a) CO Capacity building for users | |
| 1.1 Trained national & regional planners in integration with UNAM support | |
| 1.2 Trained national & regional planners in the RBM approach | |
| 1.3 Trained 20 Government staff from different line ministries responsible for statistics trained in the basic SADC Model & (which cover issues on Official statistics); those with adequate background were trained on advanced course in sampling; | |
| 1.4 Trained 26 planners and managers from NPCs and Regional Councils trained in Results Based Management; | |
| 1.5 Trained in scanning technology provided for CBS staff; | |
| 1.6 CBS supported to acquire a new Data Server that will enable them to process the NIDS data and used for the 2011 Census. | |
| 1.7 Nine (9) staff members from NPCs & MoF trained as TOT in RBM in Canada; 5 other staff trained in RSA on skills for integrating population, environment & development into plans. | |

b) Utilization of CBS data

| 1.1 UN in preparing CCA & UNDAF used CBS data | |
| 1.2 NAMInfo is operational and used by all key ministries and all Regional Councils by 2010 | |
| 1.3 CBS established Regional Offices in each of the 13 regions to provide statistical services. | |
| 1.4 Extensive use of CBS data for NDP3 and Regional Plans for each of the 13 regions | |
| 1.5 NGOs, CBOs increasing use of CBS data | |
| 1.6 Private agencies for marketing research | |
| 1.7 Supported UNAM final year population and development (P&D) B.Sc. students on their final year projects using raw data from government sources (including CBS); report published by UNAM in a collection of case studies. | |

**Indicator 1.5:** Increased availability and use of disaggregated population data for policy & planning

| Baseline: | 2001 census data, 2000 NDHS |
| Target: | Conduct 2006 NDHS; 2008 NIDS 2011 census |
| 1.1 Supported (technical & financial) the 2006/7 Demographic & Health Survey (DHS). | |
| 1.2 Supported COMBI Survey 2007, which collected baseline information in order to measure key SRH, including HIV/AIDS, knowledge, behaviour, access to services and condom use, in Oshikoto, Otjozondjupa and Caprivi Regions (UNFPA focused regions) | |
| The 2007 Study report has been finalized and The DHS focuses on the demographic characteristics and the health status of the population. It collects sex disaggregated data on the following aspects: fertility | |

Now that the National Statistical Act is in place it should be easier and more effective to strengthen the entire government capacity of statisticians by continuing to concentrate on the Central Bureau of Statistics. Statisticians will henceforth be recruited, employed and deployed to the different sectors and regional offices by the Central Statistical Services. There has been increase in the availability of current data. The 2006 Demographic Survey and the 2006/7 DHS have been launched. The NamInfo data base has been updated and more national and Regional staff have been trained to use and update the database. This, coupled with capacity building, has increased data utilization for evidence-based planning and decision making.
report printing and disseminated for the following regions Caprivi, Kunene, Ohanagwena and Otjozondjupa regions. The study was extended in 2008 to Omahke, Karas, Kavango and Erongo regions. There is a plan to replicate the study in the remaining 5 regions of the country.

1.3 Supported the 2011 census, recently completed: Recruitment of 3 international consultants (Demographer, Cartographer and Data processor) with the assistance of Sub- regional Office to assist the Central Bureau of statistics (CBS) to assess its capacity to implement the 2011 Census and to produce the 2011 census project document with implementation plan as well as the budget. Census CTA recruited for conduct of census, busy with data capture. A schedule of Post-Enumeration Activities (2011-2014) prepared

1.4 Supported 2006 National Demographic Sample Survey; data analysis and publication.

1.5 Provided Technical Assistance to CBS for the timely utilization of sex-age-disaggregated data;

1.6 Training workshops conducted for Regional Planners in the utilization of sex-age-disaggregated statistical data of (Census, NIDS,DHS, PPA) for evidence-based planning and project proposal writing and the use of tools like DevInfo;

1.7 Strengthened HIS capacity in collection, analysis and interpretation of sex-age-disaggregated data especially on RH;

1.8 Organized training workshops to sensitize Parliamentarians, media practitioners and senior policy makers, on the use and interpretation and on reporting population dynamics, poverty and HIV/AIDS, and related socio-economic statistics for evidence-based policies and programmes, in the context of the formulation of NDP3;

1.9 Supported the MoHSS to build capacity in the utilization of the new District Health Information System (DHIS) through the provision of funds to conduct training for National, Regional and District staff.

1.10 Strengthened the capacity of Media Practitioners for Population, RH and Gender Reporting.

1.11 The DHS (2006/7) launched in 2008 which assist in assessing progress on indicators.

1.12 Research conducted on population & development by UNAM; generated sex-disaggregated data on Youth migration.

rate, family planning, infant and child mortality, adult and maternal mortality, maternal and child health, HIV/AIDS, nutrition and morbidity.

Although data is regularly collected at health facilities for example, little or no attempt made to analyze data collected and provide feedback to these health facilities.

Capacity of MoHSS strengthened in the HIS sector in collection, analysis and interpretations sex-age-disaggregated data especially for RH data.

The CO strategy is to strengthen the entire government capacity of statisticians instead of concentrating on the Central Bureau of statistics. Staff from other line ministries can easily joint CBS, this will reduce delay outputs during staff turnover. This strategy will work well in the context of the National Statistical Act, which centralizes the entire statistical system.

Capacity of NPCS in coordinating population activities is weak.

Annex 4.3: Gender – Summary of achievements

<table>
<thead>
<tr>
<th>Output indicator</th>
<th>Baseline</th>
<th>Target</th>
<th>Performance</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator 1:</td>
<td>None</td>
<td>Not</td>
<td>1.1 Training provided to parliamentarians and Ministerial</td>
<td>This particular</td>
</tr>
</tbody>
</table>
increased number of constituencies recognizing the pivotal role of gender in combating HIV and expressing support for allocating greater resources to women’s empowerment.

determined focal persons on gender-budgeting in the first year of the 4th CP implementation

| Output 2:: (Gender Mainstreaming) Strengthened capacity to integrate gender issues into National Plans and Programs |
| --- | --- | --- | --- |
| Indicator 1: By 2007, review of policies and laws and identification of key areas of interface between HIV/AIDS and gender completed. | 2006: existing policies Policies reviewed by 2007 | 1. CO supported the National Gender policy review in 2009 and finalized in 2010. Supported was also provided through the recruitment of a Gender Advisor and through input during the revision phase 2. CO also provided support for the gender national plan of action which was also developed and finalized in 2010. 3. Thirty five (21 females and 14 males) Ministry of Gender Equality and Child Welfare and NGOs staff equipped with skills on community dialogue, the inter-linkages between GBV, HIV and AIDS, women’s rights using the Gerald Egan model of the skilled helper. 4. The trained staff reached 1140 community members in 9 regions. The CO also supported training for 35 Namibian Planned Parenthood Association (NAPPA), MGECW staff and volunteers on Youth, GBV and SRH who in turn reached 940 community members, youth members (49%) with messages in GBV and SRH | Although the work was planned to be completed by 2007, the targeted policies for review were done |

| Increase in % allocation to gender/women’s empowerment | 2006: 8.2% 12.2% by 2010 | 1. According to budgetary figures from the Ministry of Finance, the MGECW received N$554,703100, which accounts for 1.5% of the total budget of year 2011/2012 | It is unclear whether this indicator refers to the Ministry’s own allocation to Gender and Women Empowerment or to the National budget. If the baseline of 8.2% related to the national budget allocation, 1.5% allocation would suggest a decrease |

| 80% implementation of revised gender action plan | 0% 80% | According to the 4th CP, the Gender Action Plan should have been revised by 2007 and implementation should have begun by 2008. The Action Plan has been revised finalized in 2010. | Implantation is planned to begin by 2012 |

| 100% of all gender focal persons in GRN Ministries and | 0% by 2006 100% by 2010 | The CO supported the Ministry of Gender Equality and Child Welfare to train 30 Gender Focal persons and 50 Paralegals on national gender related legislations and the CEDAW. | This initiative has helped the MGECW to make in-roads |
national institutions are from senior management level

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>1. National Gender Plan of Action finalized CO supported the project and gave input in the implementation</td>
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</tbody>
</table>

**Output 3: (Caprivi Livelihood) Strengthened community capacity in the Caprivi region to address livelihood issues, food security and nutrition and to respond to the impact of HIV/AIDS**

<table>
<thead>
<tr>
<th>Indicator 1: Increased number of women in the Caprivi Region accessing reproductive health information and services</th>
<th>Baseline: 46%</th>
<th>Target: 95% by 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Activities aimed at increasing in target communities of Singalamwe and Schumansburg the number of people accessing FP services from health facilities. According to the reports from the Ministry of Health, the number of people accessing family planning services in the target community increased, but data at this level do not exist.</td>
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<tr>
<td>2. CO provided technical and financial support through the partnership with Red Cross to equip 1174 (654 women and 120 men and 400 school learners) flood affected communities in camps with knowledge on GBV, HIV and AIDS, SRH issues in the in Kavango &amp; Caprivi Regions of Namibia, as a result these communities were more aware of their rights.</td>
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<tr>
<td>3. Women were happy to receive dignity kits and were able to do their daily activities and restore their dignity as a woman during flood times</td>
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<tr>
<td>Consultations and the regional level indicated that this type of support should be continued</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicator 2: Increased number of women accessing markets and microcredit schemes</th>
<th>Baseline: 20%</th>
<th>Target: 100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. It was also intended that the number of project beneficiaries taking 3 meals per day be increased. UNFPA, together with FAO initially supported the establishment of garden projects in Singalamwe and Schumansburg.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. A garden was established at Singalamwe with 30 members (women). The intended projects of fish ponds and at a garden at Schumansburg did not materialize due to the area’s accessibility problems as it is in a low-lying area prone to floods. Mubiza and Makaravani were later added and supported under the UN joint program, with each having more than 30 members.</td>
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<tr>
<td>3. Many of the members are from vulnerable households.</td>
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<tr>
<td>4. The output was a JP of UNFPA with other UN Agencies in which UNFPA focused on community mobilization for RH, HIV Prevention and gender equality. Training on income generation, book-keeping and on how to start a small business were activities undertaken</td>
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<tr>
<td>5. A Peace Corp Volunteer was recruited and a construction of a village house was done</td>
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<tr>
<td>It appears that the accessing markets were not necessarily the target of the interventions. As such, interventions were focused mainly on establishing the gardens and through training, provide capacity for production and income generation. Micro-credit schemes existed in Caprivi, through Project Hope, but it was not supported by UNFPA</td>
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</tr>
</tbody>
</table>

**Output 4: Communities mobilized against gender based violence, and women and girls aware of their rights and how to access available services**
| Indicator 1: Change in men’s and women’s attitude towards gender-based violence in intervention areas | Baseline: 26%-90% of men who believe wife beating is justified | Target: 15% of men who believe wife beating is justified | 1.1 Advocacy for strengthened leadership, activities undertaken by Gender and Family Affairs Committee  
1.2 NAPPA focused on youth and leadership/empowerment, material generated and translated into local languages  
1.3 Study on Knowledge and attitudes conducted, the latest (2006/2007) DHS indicates that 41% of men believe that wife beating is justifiable, while 35% of women agree that wife beating is justifiable  
1.4 CO supported MISA Namibia on gender reporting and GBV in particular. Increased knowledge and awareness, through local media reports led to change of attitudes and increased reports of GBV incidence  
1.5 Thirty five (21 females and 14 males) Ministry of Gender Equality and Child Welfare and NGOs staff equipped with skills on community dialogue, the interlinkages between GBV, HIV and AIDS, women’s rights using the Gerald Egan model of the skilled helper:  
1.6 The trained staff reached 1140 community members in 9 regions. The CO also supported a training for 35 Namibian Planned Parenthood Association (NAPPA), MGECW staff and volunteers on Youth, GBV and SRH who in turn reached 940 Community members, youth members (49%) with messages in GBV and SRH.  
1.7 Twenty six support staff (of whom 13 were females) of the National Assembly sensitized on Gender, GBV, SRH, HIV and AIDS to provide quality technical support in public statement, dialogues, advocacy, debates of members of parliament. |
| Indicator 2: Prevention of gender-based violence integrated into community policing activities in intervention areas | Baseline: weak integration of GBV into community policing interventions | Target: GBV well integrated community policing intervention | 1.1 With support from CO, implementers increased training and sensitization on SRH and GBV held in communities and at schools. NAPPA intensified its youth leadership program and development IEC materials, which were translated into local languages  
1.2 The CO supported the MOHSS with RH and Dignity Kits to ensure that women and girls special needs are met in emergency situations. There is a need to strengthen the civil society’s participation in the enforcement of RR policies.  
1.3 In creating an enabling socio cultural environment the CO supported the NGOs (White Ribbon Campaign and NAMPANN) to create awareness on the importance of male involvement in prevention of GBV, HIV and aids as well as supporting Reproductive Health for girls and women.  
1.4 The CO also supported capacity development of Members of Parliament to understand issues of RH, GBV and HIV and AIDS and their roles as MPs. Even though there is no evidence that genital mutilation is being practiced in Namibia, sensitization on this practice is conducted among target communities. |
| Indicator 3: Increase in number of law enforcers trained in preventing gender-based violence | Baseline: Limited number of officers trained in GBV prevention | Target: Full integration of GBV prevention module in police training | 1.1 Training sessions held for the members of the Women and Child Protection Unit. Efforts are being made for the GBV module to be integrated at the police and military training schools  
1.2 UNAM module also covers training of pre-and-in-service law enforcers  
1.3 CO supported the Women and Child protection through the Ministry for Health and Social Services with emergency contraceptives to ensure the availability for all girls and women survivors of GBV. |
Annex 5: Terms of reference
For
End of Program Evaluation of the
UNFPA Namibia

5 Background and Context for the evaluation

Namibia is completing the implementation of the 2nd UNDAF (2006-2013). UNCT together with the Government agreed that Namibia would be a self starter for Delivering as One Country.

The United Nations Population Fund (UNFPA) is currently supporting the fourth Country Programme (4th CP) for the period 2006 to 2010, which was further extended to 2012 to be aligned with the National Development Plan, to assist the Government of Namibia in contributing to the improvement of the quality of life of its population.

The goal of the 4th CP is to contribute to the Government’s aim of improving the quality of life of the people of Namibia through: (i) improving reproductive health; (ii) reducing the spread of HIV; (iii) ensuring gender equality; and improving the utilisation of data for development and the integration of demographic, reproductive health, gender equality and HIV variables into national programming.

In order to achieve the above objectives, UNFPA supports the implementation of programmes with other United Nations Agencies and partners in the areas of maternal and neonatal health, adolescent sexual and reproductive health, HIV prevention, gender based violence and data for development.

The 4th CP addresses national priorities in line with the Millennium Development Goals (MDGs) and the Programme of Action of the International Conference on Population and Development (ICPD). It reflects the 2004 CCA and the 2006-2012 United Nations Development Assistance Framework (UNDAF) and addresses key national priorities and development challenges outlined in the second and third National Development Plans and Vision 2030. The CP was approved in October 2005 by the Executive Board and its implementation started in late 2006. The programme consists of three components: Reproductive Health, Population and Development, and Gender, which strive to achieve the following outcomes:

Reproductive Health Component

The expected outcomes of the reproductive health component are: (a) reduced high-risk behaviour among vulnerable groups through interventions that address underlying causes; (b) increased access, utilisation and provision of comprehensive, high-quality reproductive health services, including HIV prevention, treatment and care, and voluntary counselling and testing (VCT); (c) strengthened national and regional capacity for humanitarian and emergency response management; and (d) strengthened institutional and community capacity for effective delivery and utilisation of critical services in health and education. Reproductive Health programme expected outputs are: (i) Young people participate in and have access to HIV/AIDS information, life skills and opportunities in 24 health districts (ii) Increased availability of comprehensive, high-quality HIV prevention and youth-friendly health services and care, including VCT and sexual and reproductive health services (iii) Strengthened capacity to address reproductive health needs in emergency settings (iv) Increased availability of high-quality maternal health care services, including essential obstetric care in two thirds of intervention areas.

Population and Development Component

The outcome of this component is as follows: a strengthened national statistical system to ensure effective development and application of tools for evidence-based policymaking. This component will seek to forge a better understanding of the linkages between population dynamics, poverty and the demographic and socio-economic causes and consequences of the HIV/AIDS epidemic. It will help to formulate and implement national policies and programmes aimed at mitigating the consequences of the AIDS epidemic, alleviating poverty and bringing about gender equality and equity. The programme will support the implementation of the national poverty reduction strategy and will also support national and regional networks of parliamentarians, the media and faith-based organisations on population and development. Population and Development programme expected output is: (i) Improved availability and utilisation of age- and sex-disaggregated data for planning, implementing, monitoring and evaluating poverty reduction strategy and development plans.

Gender Component

The expected outcomes of the gender component are: (a) strengthened commitment and leadership of the Government and other stakeholders to create an enabling environment for scaled-up multi-sectoral responses; (b)
improved income-earning and access to food for vulnerable households; and (c) increased awareness of and capacity for protecting the rights of children, women and other vulnerable groups. Gender programme expected outputs are: (i) Increased level of knowledge and commitment to an expanded HIV/AIDS response, gender issues and women’s empowerment among national and local leaders (ii) Strengthened capacity to integrate gender issues into HIV/AIDS policies and programmes (iii) Strengthened community capacity in the Caprivi Region to address livelihood issues, food security and nutrition and to respond to the impact of HIV/AIDS (iv) Communities mobilised against gender-based violence, and women and girls aware of their rights and how to access available services.

It is against this background that UNFPA is commissioning this end of programme evaluation to assess the effectiveness, efficiency, relevance and impact of UNFPA 4th Country programme in contributing to the improvement in the lives of the people of Namibia. The evaluation will cover the 4th CP implementation period from January 2006 to September 2011, and putting into account the mid-term evaluation conducted in 2008. The evaluation findings and recommendations will constitute key inputs for the formulation of the next GRN/UNFPA Country Programme (5th Country Programme). A team of Consultants will work together to evaluate the programme as a whole, with the Lead Consultant responsible for overall coordination of the entire evaluation process as well as be responsible for one of the components that he/ she is competent in and the local consultants will be responsible for the other two components.

6 Purpose of the evaluation

UNFPA policy requires that a summative evaluation is conducted at the end of each programme cycle in order to determine the impact of the interventions. The end-of-programme evaluation is an imperative exercise to determine the value added by UNFPA in supporting government to improve the lives of Namibians. This evaluation will follow a mid-term evaluation (MTR) which was completed in 2008.

The purpose of this evaluation is to conduct an independent end-of-programme cycle evaluation to assess the achievement of the results, the factors that facilitated/hindered achievement, and to compile lessons learned so as to inform development of the next country programme cycle that begins in 2013.

The audience for this evaluation will be implementers and the beneficiaries of the CP. These will include UNFPA, government departments, civil society, tertiary institutions and other relevant stakeholders who will use the results for decision-making to inform the planning, programme, budgeting, implementation and reporting cycle and will also be use to inform the UNDAF process.

7 Objectives of the evaluation

The objectives of the UNFPA Country Programme Evaluation are:

1. To provide an independent evaluation of the achievement or lack thereof, towards the expected outcomes and outputs envisaged in the 4th GRN/UNFPA CP. Where appropriate, the evaluation will also highlight unexpected results (positive or negative) and missed opportunities;
2. To provide an analysis of how relevant the 4th CP was in response to national needs/priorities and changes in the national development context;
3. To assess UNFPA CO resources (e.g. coordination, organisational, leadership and management, human resources, financial resources) and capacity to deliver on the country programme outcomes and outputs;
4. To look at cross cutting aspects such as the human rights based approach, gender mainstreaming, emergencies and humanitarian assistance, special attention to marginalised populations, coordination and partnership in a Delivering as One Country.
5. To present key findings, draw key lessons, and provide a set of clear and forward looking options leading to strategic and actionable recommendations for the next Programming cycle.

8 Scope of evaluation

The end of programme evaluation will cover the following:

- **Geographical regions** – National level and the 4 regions (Caprivi, Ohangwena, Otjozondjupa, Oshikoto)
- **Programme aspects** – The three technical areas of the country programme (Population and Development, Reproductive Health and Gender).
- In addition for each thematic area, the evaluation should look at cross cutting aspects such as the human rights based approach, gender mainstreaming, emergencies and humanitarian assistance, special attention to marginalised populations, coordination and partnership and working of joint programmes.
- **Evaluation criteria** – Relevance, effectiveness, efficiency, impact and management systems (human resources, financial resources, systems).
9 Evaluation Questions and Criteria

The analysis of results will identify challenges and strategies for future interventions. A core set of criteria shown below will be applied in assessing the results (indicative evaluation questions identified below will be finalised during the development of the inception report and desk review with the consultants):

a) Strategic direction
i. Is UNFPA Namibia currently supporting programmes and interventions for which it has a comparative advantage?
ii. What national priorities can UNFPA Namibia focus on in the next country programme?

b) Effectiveness of programme
i. Did UNFPA Namibia implement and support programmes using the most effective means?
ii. Were the programmes and activities supported by UNFPA Namibia targeted at the right beneficiaries?
iii. To what extent were expected results achieved?
iv. What could UNFPA Namibia and its partners have done better to improve programme delivery?

c) Efficiency
i. Did UNFPA Namibia use the most cost efficient ways of programme delivery?
ii. Were programme inputs and service delivery timely, and did they achieve desired results?
iii. Did service delivery meet minimum standards of quality for the beneficiary?
iv. What could UNFPA Namibia have done better to improve the efficiency of programme delivery?

d) Relevance
i. Are the programmes that UNFPA Namibia supporting still relevant to the needs of the population of Namibia?
ii. Are the strategic actions, outputs and indicators of the 4th CP contributing to the strategic priorities of the Namibia national development plan as well as the UNDAF?

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

f) Sustainability
i. Can the Government of Namibia and other stakeholders continue implementing current interventions without UNFPA support?
ii. Were partners, including the Government of Namibia involved in design, planning, implementation, monitoring and evaluation of the 4th CP?
iii. Are UNFPA programme indicators included in partners’ strategic plans for the implementation of P&D, RH, Gender and HIV related programmes?

10 Evaluation Methodology

The end of programme evaluation will employ a combination of qualitative and quantitative methods to answer the questions that will be developed to assess progress, performance and relevance of the 4th GRN/UNFPA CP. More specifically, the consultant(s) shall include the following methods in their assessment:

Data Collection
In terms of data collection, the evaluation will use a multiple method approach that will include desk/document reviews, group and individual interviews and field visits as appropriate. The sampling frame will include all government implementing partners at National level and the 4 regions (Caprivi, Ohangwena, Otjozondjupa, Oshikoto), tertiary institutions (UNAM, National Health Training Center), and four non-governmental organisations / civil society organizations.

Validation
The consultants will use a variety of methods to ensure that the data is valid, including triangulation.

Stakeholders’ Involvement
An inclusive approach, involving a broad range of partners and stakeholders, will be taken. The evaluation will include a process of stakeholder mapping in order to identify both UNFPA’s direct partners as well as stakeholders who do not work directly with UNFPA, yet play a key role in a relevant outcome or thematic area in
the national context. These stakeholders may include representatives from the Government, civil-society organisations, the private-sector, UN organisations, other multilateral organisations, bilateral donors, and most importantly, the beneficiaries of the programme.

The limitation of the proposed methodology is that the sample will be too small for quantitative inferences and the issue of attribution which make it difficult to prove beyond doubt that the observed outcomes are as a result of a 4th GRN/UNFPA CP intervention than any other external factors.

11 Gender and Human rights
The study will ensure fair representation and participation of women, as well as other minority groups, marginalised populations which are often subject to discrimination.

Gender and human rights principles of empowerment, participation, non-discrimination, and accountability will be applied. Gender analysis and human rights based frameworks will be taken into account in line with the UN policies and instruments, and data will be disaggregated by sex, age and special groups. The gender component of the CP will be assessed using the criteria of relevance, efficiency, effectiveness, impact and sustainability. Both rights-holders and duty-bearers will be engaged as key informants, in validating the findings and as part of the study results dissemination audience.

12 Work plan and Activity Schedule
The consultancy will be for a maximum of 25 working days. The assignment starts on the 17 October 2011, and ends the 18 November 2011. Below is the breakdown of days

<table>
<thead>
<tr>
<th>Activity/Milestone</th>
<th>No Days</th>
<th>Responsibl e Person</th>
<th>Timeframe (beginning of the week )</th>
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<tbody>
<tr>
<td>Selection of consultants</td>
<td>UNFPA</td>
<td>10/10 24/10 31/10 07/11 14/11 21/11</td>
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<tr>
<td>Signing of contracts</td>
<td>UNFPA</td>
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<tr>
<td>Inception report</td>
<td>2 Consultants</td>
<td></td>
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<tr>
<td>Desk. Review of relevant documents and consultative meetings and Debrief (Desk Report)</td>
<td>3 Consultants</td>
<td></td>
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<tr>
<td>Data collection (including field visits to project sites) (field report)</td>
<td>8 Consultants</td>
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<tr>
<td>Data analysis and Report writing and presentation of First draft report to UNFPA/Committee (1st draft report)</td>
<td>4 Consultants</td>
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<tr>
<td>Prepare and presentations of report to a stakeholders meeting (Workshop Report)</td>
<td>2 UNFPA/Consultants</td>
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<tr>
<td>Final report writing incorporating comments (final CPE Report)</td>
<td>6 Consultants</td>
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<td>Management Response</td>
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<td>Dissemination of the results</td>
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<tr>
<td>Total consulting person days</td>
<td>25</td>
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13 Deliverables
The following are some of the expected key deliverables:
(a) An inception report (showing the Objective, proposed design, methodology, data collection tools, work plan, deliverables, and deadlines);
(b) Desk review report and data collection tools;
(c) 1st draft evaluation report
(d) Workshop report
(e) A final evaluation report. The final Evaluation CP Report should contains the sections as outline in Annex 1

14 Responsibilities of the Consultants

91
The assignment shall be carried out by an Evaluation team of three competent consultants, one international and two local. The evaluation team will include a Lead Consultant (international consultant) with expertise in P&D and two local consultants with expertise in RH and Gender.

The lead consultant will be (a) responsible for the overall coordination and management of the evaluation team (c) responsible to compile the P&D Evaluation Report (b) responsible for consolidating the three Components reports (P&D, RH, Gender) and be accountable for the completion of a Final End of 4th CP Evaluation report that UNFPA deems to be satisfactory and responsive to the agency’s needs. The local consultants (RH & Gender) will be responsible for RH and Gender evaluation reports. All consultants will be responsible for the overall planning, data collection, validation and implementation of the evaluation until the production of the final report.

15 Qualifications and Competencies

Lead Consultant’s
- Postgraduate degree in social sciences, public health or field related to UNFPA’s mandates (RH, population and development, and gender) with expertise in Population and Development;
- At least 10-15 years of relevant experience;
- Recent, successful experience as an evaluation team leader;
- Sound knowledge of development issues and challenges in Namibia in the areas of UNFPA’s mandates;
- Proven leadership and management skills; and,
- Excellent writing and presentation skills in English

Local Consultant(s)
- Postgraduate degree in social sciences, public health or development
- At least 10 years of experience;
- Experience in programme evaluation in RH and/or Gender
- Good writing skills in English

16 Management and support arrangements

An CP Evaluation management Committee (CPEMC) made up of evaluation and programme experts from UNFPA, National Planning Commission (NPC) and other government agencies and Civil Society partners will be set-up for quality assurance purposes. The team will be responsible for approval of inception report, monitoring progress and quality of evaluation activities, review and comment on drafts report.

The Consultant(s) will conduct the task in line with the terms of reference under the overall supervision of the CP Evaluation management Committee (CPEMC). The evaluation will be managed by the UNFPA M & E Officer who will be responsible for convening, coordinating and supporting the (CPEMC) meetings and consultants.

17 Contractual agreements

A Special Service Agreement (SSA) will be signed with the Consultant(s). The evaluation team shall commence the performance of the SSA during the period of October to November, 2011. Evaluator(s) will have at most 25 working days maximum to complete the assignment. Payment modalities will be as follows:
(a) Upon a satisfactory Inception Report – 20%
(b) Upon successful completion of 1st Draft Evaluation Report – 30%
(c) Upon a satisfactory final report – the remaining 50%

ANNEX I Evaluation Report Outline

UNFPA evaluation reports should include all the following elements:

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

Table of Contents
Acknowledgements
Identify those who contributed to the evaluation.

List of acronyms

Executive summary
A self-contained paper of 1-3 pages, summarising essential information on the subject being evaluated, the purpose and objectives of the evaluation, methods applied and major limitations, the most important findings, conclusions and recommendations in priority order.
Introduction
Describe the project/programme/theme being evaluated, including the problems being addressed by the interventions. Summarise the evaluation purpose, objectives, and key questions. Explain the rationale for selection/non selection of evaluation criteria. Describe the methodology employed to conduct the evaluation. Detail who was involved in conducting the evaluation and what were their roles. Describe the structure of the evaluation report.

Methodology
Explanation of methodological choice, including constraints and limitations.

Findings/Analysis
State findings based on the evidence derived from the information collected. To the extent possible measure achievement of results in quantitative and qualitative terms, and analyse the linkages between inputs, activities, outputs, outcomes and, if possible, impact. Discuss the relative contributions of stakeholders to achievement of results.

Conclusions
Conclusions should be substantiated by the findings and be consistent with the data collected, and must relate to the evaluation objectives and provide answers to the evaluation questions.

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

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

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

Bibliography
List of interviewees and other references material used

ANNEX 6: 4th CP Evaluation Detailed Work Plan

<table>
<thead>
<tr>
<th>Sunday</th>
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<tr>
<td>Inception</td>
<td>Present Desk</td>
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<td>Report</td>
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<td>Desk review</td>
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<tr>
<td>Travel Katima</td>
<td>Travel to</td>
<td>8h00- Field</td>
<td>6h00 - 14h00</td>
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<td>Mulilo (KM)</td>
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<tr>
<th>Date</th>
<th>Location</th>
<th>Activity Description</th>
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<tr>
<td>06 Nov</td>
<td>Otjozondjupa</td>
<td>Rest Overnight in Otjiwarongo</td>
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<td>Otjozondjupa</td>
<td>9h00 – Meet MOHSS Regional Director and staff</td>
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<td>Otjozondjupa</td>
<td>14h00-Meet MGECW &amp; other IP</td>
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<td>Otjozondjupa</td>
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<td>Otjozondjupa</td>
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<td>Windhoek</td>
<td>Travel to WHK</td>
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<td>Windhoek</td>
<td>Meet National level that was not met</td>
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<td>10 Nov</td>
<td>Windhoek</td>
<td>Present Field mission report</td>
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<td>Windhoek</td>
<td>Data analysis and Report writing First draft Evaluation Report</td>
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<td>11 Nov</td>
<td>Windhoek</td>
<td>Data analysis and Report writing</td>
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<td>Windhoek</td>
<td>Field Mission Report</td>
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<td>12 Nov</td>
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<td>13 Nov</td>
<td>Windhoek</td>
<td>Data analysis and Report writing First draft Evaluation Report</td>
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<td>Windhoek</td>
<td>Data analysis and report writing</td>
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<td>15 Nov</td>
<td>Windhoek</td>
<td>Prepare workshop Presentation s for stakeholders meeting (Workshop Presentation s)</td>
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<td>Windhoek</td>
<td>Prepare workshop Presentation s for stakeholder s meeting</td>
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<td>Windhoek</td>
<td>Brief Evaluation Committee</td>
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<td>Windhoek</td>
<td>Travel to Ondangwa for stakeholder s workshop</td>
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<tr>
<td>17 Nov</td>
<td>Windhoek</td>
<td>8h00-17h00 Stakeholder s Workshop – Present 1st Draft Evaluation Report. Final report writing incorporating comments (final CPE Report)</td>
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<td>18 Nov</td>
<td>Windhoek</td>
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<td>19 Nov</td>
<td>Windhoek</td>
<td>Submit component programme report to Team Leader</td>
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<td>21 Nov</td>
<td>Windhoek</td>
<td>Lead Consultant preparing Final Report</td>
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<td>22 Nov</td>
<td>Windhoek</td>
<td>Lead consultant Final report writing incorporating comments (final CPE Report)</td>
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<td>Windhoek</td>
<td>Continue consultation with UNFPA</td>
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<td>23 Nov</td>
<td>Windhoek</td>
<td>Lead consultant consolidates Report</td>
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<td>Continue consultation with UNFPA</td>
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<td>24 Nov</td>
<td>Windhoek</td>
<td>Lead consultant consolidates Report</td>
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<td>Windhoek</td>
<td>Present Final report to UNFPA by 10h00</td>
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Annex 7: Evaluation research instruments

Annex 7.1: RH Evaluation instrument

End of Program Evaluation of the
UNFPA Namibia

Reproductive Health Component

Questionnaire for Programme Managers, Implementers and Beneficiaries
[October 2011]
This is an independent evaluation of the 4th GRN/UNFPA Country Programme (4th CP) of support to population activities in Namibia during the period 2006 – 2012. This independent evaluation at the end of the programme cycle is designed to assess the achievement of the results, the factors that facilitated/hindered achievement, and to compile lessons learned so as to inform development of the next country programme cycle that begins in 2013. You are kindly requested to answer the questions in this schedule and, if possible, provide any additional information that will facilitate this important exercise. Thank you for your support.

A. Background information
1. Name of Government Ministry, Parastatal or Agency...........................................
........................................................................................................................................

2. Name of Official completing questionnaire..............................................................
Directorate/Division/Unit ..................................................................................................
Rank or Position..............................................................................................................

3. Involvement in Reproductive Health Programme implementation since
when? ..................................................................................................................................

4. Please describe the nature of your intervention.........................................................
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5. How many officials under your supervision are involved in the implementation of
RH activities under the current 4th CP?

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<th>Name of official</th>
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<th>Description of work carried out</th>
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B. Programming
1. How inclusive or participatory was the process of formulating the 4th CP?  

2. Considering the RH/HIV/AIDS/ISRH/EOC/RH in Humanitarian settings challenges faced in this country, is the strategy of this component adequate?  

3. Is UNFPA currently supporting health programmes and interventions in which it has comparative advantage?  

4. What would be your suggestion for future strategic interventions by UNFPA to address RH issues in Namibia?  
   a) (Policies, guidelines, training manuals and IEC materials development and printing)  
   b) (Advocacy and community mobilization interventions)  
   c) (Quality health through provision of equipment and supplies)  
   d) (Research, review, monitoring and evaluation)  
   e) (Staff and resources for intervention)  
   f) (Capacity development of health service providers and programme managers for improved health)
C. Programme management

1. How are the RH/AFHS/HIV/AIDS/PMTCT activities under your Department/Directorate/Unit being coordinated?

2. What steps were taken to revise the RH/HIV/AIDS Policy/ ISRH guidelines?


4. What are your suggestions for future UNFPA intervention in health related/Gender and P&D policies in this country?

5. Assess the capacity in your Directorate for implementing the RH/HIV/AIDS/Gender Policy

6. What is the status of the Inter-Agency Technical Committee for RH, Gender & Development?
a) Managers and Implementers

1. What were the specific RH/HIV/AIDS/AFHS/Emergency RH/Sex works activities carried out by your Directorate/Region under the 4th CP since 2006?

2. Comment on the role of your Directorate/Department/Unit in integrating RH issues into national and regional development policies and plans.

B) Beneficiaries

1. List the specific benefits you gained from RH programme interventions.

2. How comfortable are you in conveying gained knowledge and skills to your peers/communities.

3. How effective were the mobilisation strategies on the prevention of HIV/AIDS and teenage pregnancy?

4. Comment on the relevance of the mobilisation strategies used for RH/AFHS?

5. Comment on UNFPA technical contribution to programme delivery.
6. What could they (UNFPA) done better to support/improve programme implementation?
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7. Comment on the relevance of UNFPA supported programmes to the needs of the target populations?
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8. What suggestions do you have for improvement of RH/HIV/AIDS mobilisation strategies?
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E. Resources – availability and utilization
1. Comment on the adequacy of UNFPA inputs (technical, material, financial) into your RH/ISRH/HIV/AIDS activities under the 4th CP since 2006
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2. List the protocols and training manuals developed and utilised from RH/ISRH/HIV/AIDS activities in your Directorate since 2006
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3. List the equipment and supplies procured/renovated for quality maternal health from RH/HIV/AIDS/ISRH activities in your Directorate since 2006
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4. What additional resources would your Directorate/Department/Unit need to more effectively address RH/HIV/AIDS/ISRH activities in the country?
5. Comment on efficiency of resource utilisation under the 4th CP in general

6. Comment on the modalities of funds disbursement to your institution (Probe timeliness, methods, reporting and feedback)

7. Comment on whether current interventions with various institutions will be able to continue without UNFPA support?

8. Which strategies are in place to ensure sustainability?

9. Comment on the effectiveness of UNFPA programme?

F. Capacity building – institutional & human

1. List the health service providers and programme managers for improved maternal health from RH activities in your Directorate since 2006
   a) Health service providers
   b) Programme managers
   c) VCT community counselors
   d) Volunteers (Youth groups)
2. What structures are in place for the coordination of the implementation of the national Action Plan for RH policy implementation? ..............................................................

3. How effective are the current arrangements for the coordination of RH, Gender, Youth and related activities in the country? ..............................................................

4. What would be your suggestion for an effective national coordination structure for RH and related activities in Namibia? ................................................................

5. Assess the adequacy of the existing capacity in your Directorate for supporting the coordinating structure for RH/AFHS/HIV/AIDS/ activities in the country………………

6. How can the UNFPA support human capacity strengthening to effectively address RH policy, Action Programme for Policy Implementation, and coordination of RH activities in the country? ................................................................

E. Future orientation of RH
1. The next GRN/UNFPA CP for 5 years will start in 2013; what would be your suggestions for RH activities during the 5th CP? ..............................................................

2. What do you think that UNFPA could have done better since the start of the 4th CP in 2006? ................................................................

3. Comment freely on the 4th CP, GRN and UNFPA. ................................................................

Annex 7.2: Population and Development Component Questionnaire

End of Program Evaluation of the
UNFPA Namibia
Population and Development Component

Questionnaire for Programme Managers and Implementers  
[October 2011]

This is an independent evaluation of the 4th GRN/UNFPA Country Programme (4th CP) of support to population activities in Namibia during the period 2006 – 2012. This independent evaluation at the end of the programme cycle is designed to assess the achievement of the results, the factors that facilitated/hindered achievement, and to compile lessons learned so as to inform development of the next country programme cycle that begins in 2013. You are kindly requested to answer all applicable questions in this schedule and, if possible, provide any additional information that will facilitate this important exercise. Thank you for your support.

A. Background information
1. Name of Government Ministry, Parastatal or Agency.................................................................
2. Name of Official completing questionnaire.............................................................
   Directorate/Division/Unit ...................................................................................................
   Rank or Position...........................................................................................................
3. Involvement in Population and Development (P&D) programme implementation since when? ...................................................................................................................
4. Please describe the nature of your intervention........................................................................
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5. How many officials under your supervision are involved in the implementation of P&D activities under the current 4th CP?

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<th>Description of work carried out</th>
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Pls add more names if needed

B. Programming
1. How inclusive or participatory was the process of formulating the Annual Work Plan for the implementation of the 4th CP? ..................................................................................................................
2. Considering the P&D challenges faced in this country, is the strategy of this component adequate?..................................................................................................................
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3. What would be your suggestion for future strategic interventions by UNFPA to address P&D issues in Namibia? (Use the list in Table below for your answer)

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<tr>
<th>P&amp;D issues</th>
<th>Future UNFPA intervention</th>
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<tr>
<td>Population and housing census</td>
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<td>Vital registration</td>
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<td>special surveys</td>
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<td>Data storage and retrieval</td>
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<td>Data analysis, reporting and dissemination</td>
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<td>Integration of population issues into policies and plans</td>
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<td>Population and related policies and programme implementation</td>
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<td>Capacity building</td>
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<tr>
<td>Programme coordination</td>
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C. Programme management
1a. How effectively are the P&D activities under the 4th CP being coordinated?.................................................................
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1b. What is your opinion about UNFPA’s role in management and coordination of population activities in this country?................................................................................................
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2. Population Policy
2.1 What steps were taken to revise the National Population Policy?................................................................................................
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2.2 What is the current status of the national Population Policy?..............................................................................................
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3. What are your suggestions for future UNFPA intervention in population policy and programme in this country?................................................................................................
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4. Assess the capacity in your Directorate for implementing the National Population Policy………………………………………………………………………………………
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5. What is the status of the Inter-Agency Technical Committee for Population & Development?………………………………………………………………………………
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6. National Statistical Plan
6.1 What steps were taken to revise the National Statistical Plan?........................................
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6.2 What is the current status of the National Statistical Plan in terms of implementation?
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D. Programme implementation

1. What were the specific P&D activities carried out by your Directorate under the 4th CP since 2006? (Census, surveys, research, capacity building, etc.)………………………………
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2. Comment on UNFPA’s inputs into your P&D activities during the 4th CP ………
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3. In your own opinion how successful were each of the P&D activities carried out during the reference period? (Explain)…………………………………………………………
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What are your plans for completing any ongoing UNFPA-supported P&D projects or activities in your Directorate/Department/Unit?……………………………………………………
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2. Comment on the role of your Directorate/Department/Unit in integrating population issues into national/ regional development policies and plans.

3. Describe the efforts by your Directorate, with support by UNFPA, to encourage the utilization of population data for development planning (viz. NDP, Regional Planning, etc.).

4. How effective was the intervention on Participatory Poverty Assessment in addressing the challenge of poverty in the country?

5. What specific challenges were faced in developing and implementing the National Action Plan for Population Policy Implementation?

6. List any publications from P&D activities in your Directorate/Department/Unit since 2006.

E. Resources – availability and utilization
1. Comment on the adequacy of UNFPA inputs (technical, material, financial) into your P&D activities under the 4th CP since 2006.

2. What additional resources would your Directorate/Department/Unit need to more effectively address P&D activities in the country?

3. Comment on efficiency of resource utilization under the 4th CP in general.

5. Capacity building – institutional & human
1. What structures are in place for the coordination of the implementation of the national Action Plan for population policy implementation? ..............................................................
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2. How effective are the current arrangements for the coordination of population, RH, Gender, Youth and related activities in the country? ............................................................
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3. What would be your suggestion for an effective national coordination structure for population and related activities in Namibia? ........................................................................
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4. Assess the adequacy of the existing capacity in your Directorate for supporting the coordinating structure for population activities in the country. ..............................................................
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5. How can the UNFPA support human capacity strengthening to effectively address population policy, Action Programme for Policy Implementation, and coordination of population activities in the country? ............................................................................................................................
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E. Future orientation of P&D
1. The next GRN/UNFPA CP for 5 years will start in 2013; what would be your suggestions for P&D activities during the 5th CP? ..............................................................
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2. What do you think that UNFPA could have done better since the start of the 4th CP in 2006? ............................................................................................................................
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Comment freely on the 4th CP, GRN and UNFPA ............................................................................................................................
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Please attach any publications, reports or documents produced by your Directorate which you consider relevant to this evaluation (List):

Annex 7.3 Gender Evaluation Research instrument
Annex 7.3: Gender Component Questionnaire

End of Program Evaluation of the
4th GRN/UNFPA Country Program (2006 – 2012)
UNFPA Namibia

Gender Component

Questionnaire for Program Beneficiaries
[October 2011]

This is an independent evaluation of the 4th GRN/UNFPA Country Programme (4th CP) of support to Gender Equality and Women Empowerment activities in Namibia during the period 2006 – 2012. This independent evaluation at the end of the programme cycle is designed to assess the achievement of the results, the factors that facilitated/hindered achievement, and to compile lessons learned so as to inform development of the next country programme cycle that begins in 2013. You are kindly requested to answer the questions in this schedule and, if possible, provide any additional information that will facilitate this important exercise. Thank you for your support.

A. Background information
1. Name of Agency/Project…………………………………………
   ...............................................................................................................
2. Name of Official completing questionnaire…………………………………………
   Rank or Position……………………………………………………………………….
3. Involvement in Gender and Women Empowerment implementation since when? ………………………………………………………………………………….
4. Please describe the nature of your project…………………………………………
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5. How many officials under your supervision are involved in the implementation of Gender and Women Empowerment activities in this project under the current 4th CP?

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B. Programming
1. How inclusive or participatory was the process of formulating the 4th CP? Were you involved in the process that led to the formulation of the Country Program?
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2. Considering the Gender and women empowerment challenges in your community, is the strategy of this component adequate to address these challenges?
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3. What would be your suggestion for future strategic interventions by UNFPA to address Gender Equality and Women empowerment issues in your community?
   a) Relevance of approach (training manuals and campaign materials)
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   b) Target and appropriateness (Advocacy and community mobilization interventions)...........................
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   c) Effectiveness (Quality provision of and access to services)...........................
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   d) Sustainability (project ends in February 2012, how do you plan to continue, (strategy, staff and resource plan for intervention)..........................
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4. What are your suggestions for future UNFPA intervention in population policy and programme in this country?...........................
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C) Benefits

9. List the specific benefits you gained from the UNFPA program interventions...

10. How comfortable are you in conveying gained knowledge and skills to your peers/communities?

11. How effective were the training strategies on the prevention of GBV and access to SRH?

12. Comment on the relevance of the training on GBV and SRH you received?

D: Future Orientation

13. What suggestions do you have for improvement of GBV, SRH mobilisation strategies?

14. How effective are the current arrangements for the coordination of RH, Gender, Youth and related activities in the country?

15. What would be your suggestion for an effective national coordination structure for Gender-based Violence and related activities in Namibia?

16. Comment freely on the training support you have received from UNFPA.