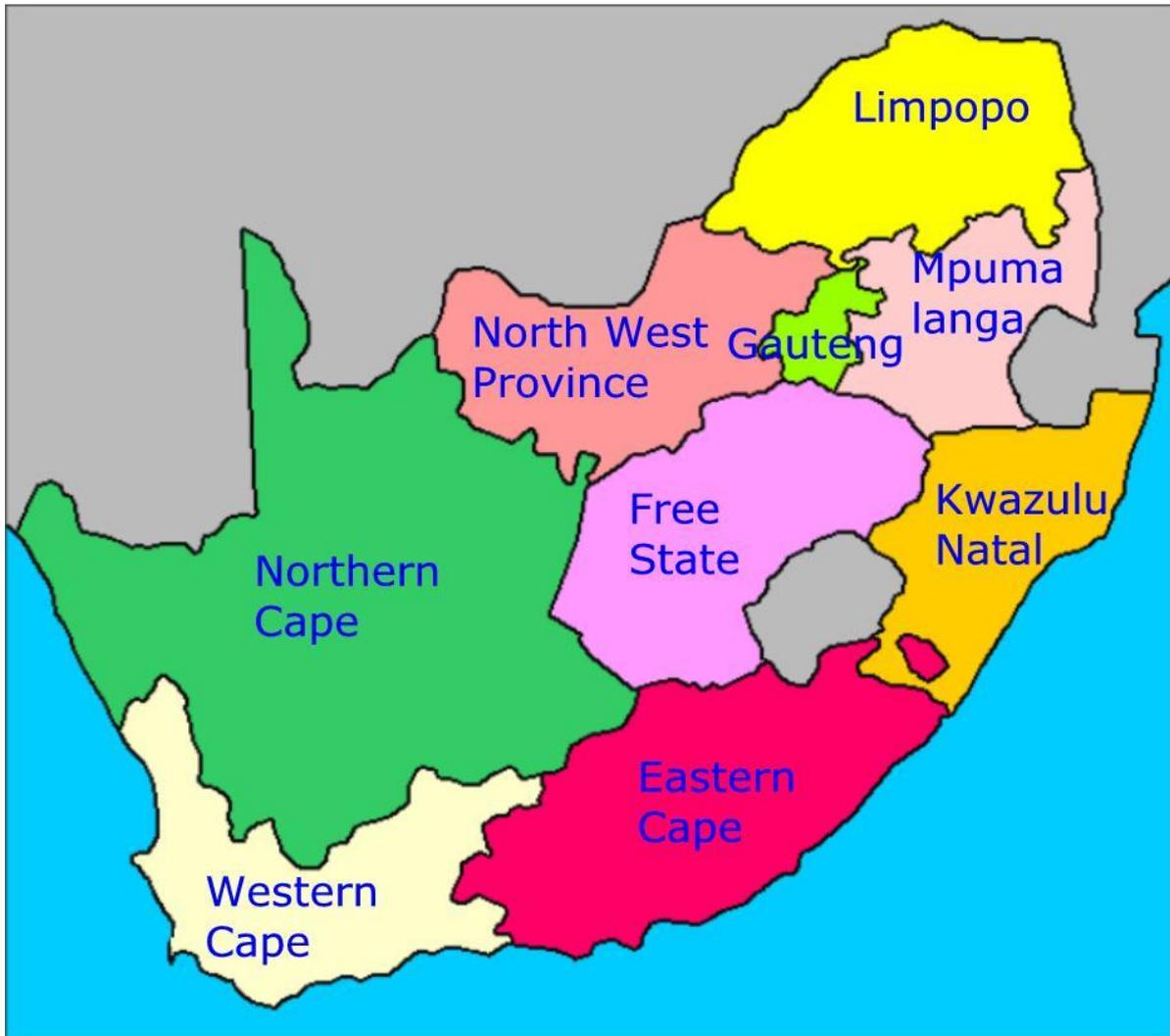


**Government of South Africa/UNFPA 4<sup>th</sup> Country Programme  
2013-2019 Evaluation**

**Final Evaluation Report  
Submitted to UNFPA South Africa Country Office  
11<sup>th</sup> October 2019**

## Map of South Africa



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## Abbreviations and Acronyms

A&Y	Adolescents and Youth
AYFS	Adolescent and Youth Friendly Services
AYP	Adolescents and Young People
CARMMA	Campaign for Accelerated Reduction of Maternal Mortality in Africa
CO	Country Office
CP	Country Programme
CPE	Country Programme Evaluation
CPR	Contraceptive Prevalence Rate
CSE	Comprehensive Sexuality Education
CTOP	Choice of Termination of Pregnancy
DBE	Department of Basic Education
DOE	Department of Education
DOH	Department of Health
DOWCD	Department of Women, Children and Persons with Disabilities
DPME	Department of Performance and Monitoring and Evaluation
DSD	Department of Social Development
EC	Eastern Cape
FP	Family Planning
GBV	Gender-Based Violence
GDP	Gross Domestic Product
HEAIDS	Higher Education and Training Health, Wellness and Development Centre
HDI	Human Development Index
ICPD	International Conference on Population and Development
ICPD POA	International Conference on Population and Development Programme of Action
IDP	Integrated Development Plan
ISHP	Integrated School Health Policy
KZN	KwaZulu-Natal Province
LMIS	Logistics Management Information System
LARCs	Long Acting and Reversible Contraceptives
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, and Intersex
MDG	Millennium Development Goal
MMR	Maternal Mortality Ratio
MTSF	Medium Term Strategic Framework
NASRHRFS	National Adolescent Sexual and Reproductive Health and Rights Framework Strategy
NDP	National Development Plan
NFCPP	National Contraception and Fertility Planning Policy and Service Delivery Guidelines
NPFWEG	National Policy Framework for Women's Empowerment and Gender Equality
NPP	National Population Policy
NYP	National Youth Policy
ROSSC	Regional Operations Shared Services Centre
SBCC	Social and Behaviour Change Communication
SDGs	Sustainable Development Goals
SRH	Sexual and Reproductive Health
SRH&R	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infections

TFR	Total Fertility Rate
TOR	Terms of Reference
TTC	Thuthuzela Care Centres
UNCT	United Nations Country Team
UNFPA	United National Population Fund
UNSCF	United National Strategic Cooperation Framework
WPD	World Population Day
YAP	Youth Advisory Panel

## Key Fact Table for South Africa

<b>Land</b>	
Geographical location	Southern Africa
Land area	1,219,602 sq. kms
<b>Government</b>	
Type	Constitutional Democracy
Key political events	First fully democratic elections in 1994. The Constitution of the Republic of South Africa, 1996, was approved by the Constitutional Court (CC) on 4 December 1996 and took effect on 4 February 1997.
<b>People</b>	
Population	58,78 million <sup>1</sup>
Population growth rate	1,4% <sup>2</sup>
<b>Economy</b>	
GDP per capita	7432.90 US dollars <sup>3</sup>
GDP growth rate	-3.2% (Jan-March2019) <sup>4</sup>
<b>Social indicators</b>	
Human development index	0.699 <sup>5</sup>
Unemployment (Total 15-24 years)	55,2% <sup>6</sup>
Life expectancy at birth (male/female) years	61.5 for males <sup>7</sup> 67.7 for females <sup>8</sup>
Under five mortality (per 1000 live births)	22,1 infant deaths per 1 000 live births <sup>9</sup>
Mortality rate (deaths of women per 100,000 live births)	134 per 100 000 <sup>10</sup>
Births attended by skilled personnel (%)	94% <sup>11</sup>
Health expenditure (as a % of GDP)	7.6% <sup>12</sup>
Contraceptive prevalence rate (modern methods)	58,3% <sup>13</sup>
Unmet need for family planning (% of currently married women, 15 – 49 years)	18% <sup>14</sup>
Estimated number of People living with HIV	7,97 million <sup>15</sup>

<sup>1</sup> Statistics South Africa, July 2019, Mid-year Population Estimates 2019, <http://www.statssa.gov.za/publications/P0302/P03022019.pdf>

<sup>2</sup> Statistics South Africa, July 2019, Mid-year Population Estimates 2019, <http://www.statssa.gov.za/publications/P0302/P03022019.pdf>

<sup>3</sup> <https://tradingeconomics.com/south-africa/gdp-per-capita>

<sup>4</sup> <https://tradingeconomics.com/south-africa/gdp-growth>

<sup>5</sup> UNDP, 2018, Human Development Indices and Indicators: 2018 Statistical Update [http://hdr.undp.org/sites/all/themes/hdr\\_theme/country-notes/ZAF.pdf](http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/ZAF.pdf)

<sup>6</sup> Statistics South Africa. May 2019. [Youth graduate unemployment rate increases in Q1: 2019.](http://www.statssa.gov.za/?p=12121) <http://www.statssa.gov.za/?p=12121>

<sup>7</sup> Statistics South Africa, July 2019, Mid-year Population Estimates 2019, <http://www.statssa.gov.za/publications/P0302/P03022019.pdf>

<sup>8</sup> Statistics South Africa, July 2019, Mid-year Population Estimates 2019, <http://www.statssa.gov.za/publications/P0302/P03022019.pdf>

<sup>9</sup> Statistics South Africa, July 2019, Mid-year Population Estimates 2019, <http://www.statssa.gov.za/publications/P0302/P03022019.pdf>

<sup>10</sup> <https://bhekisisa.org/article/2018-03-28-00-maternal-mortality-ratio-south-africa-decreased-by-29/>

<sup>11</sup> Statistics SA, 2017, Media Release: South African and Demographic Health Survey. <http://www.statssa.gov.za/?p=9836>

<sup>12</sup> <https://www.southafricanmi.com/south-africas-gdp.html>

<sup>13</sup> Statistics SA, 2017, Media Release: South African and Demographic Health Survey. <http://www.statssa.gov.za/?p=9836>

<sup>14</sup> Statistics SA, 2017, Media Release: South African and Demographic Health Survey. <http://www.statssa.gov.za/?p=9836>

<sup>15</sup> Statistics South Africa, July 2019, Mid-year Population Estimates 2019

HIV prevalence, 15-49 years (%)	19,07% <sup>16</sup>
HIV prevalence, 15-24 years: male/female (%)	4,3% <sup>17</sup>

### Sustainable Development Goals

Sustainable Development Goals	Indicator and source	Status
Goal 2: End hunger, achieve food security and improved nutrition and promote sustainable agriculture	Proportion of children under 5 years who are underweight	16% <sup>18</sup>
	Proportion of under 5 years severely underweight	3.0% <sup>19</sup>
Goal 3: Ensure healthy lives and promote well-being for all at all ages	Maternal mortality ratio (per 100,000 live births)	133 <sup>20</sup>
	Births attended by skilled health personnel	97% <sup>21</sup>
	Antenatal care coverage	69.6% <sup>22</sup>
	Infant mortality rate (per 1,000 live births)	22,3 <sup>23</sup>
	Under 5 years mortality rate (per 1,000 live births)	30,2 <sup>24</sup>
	HIV prevalence among general population	22,1%
	HIV prevalence among 15-24 year olds	7.1% <sup>25</sup>
	Level of comprehensive knowledge about HIV among 15-24 year olds	24.3% <sup>26</sup>
	Proportion of adult population infected with HIV accessing ARVs	28.9% (15-49 year olds) <sup>27</sup>
	TB prevalence rate (per 100,000)	834 <sup>28</sup>
	Contraceptive prevalence rate	58,3% <sup>29</sup>
	Unmet need for family planning	18% <sup>30</sup>
	Proportion of pupils completing primary school	94.4% <sup>31</sup>
	Ratio of girls to boys in secondary school	
	Ratio of girls to boys in TVET institutions	8.6% G to 7.2% B <sup>32</sup>
	Literacy rates of 15-24 year olds	94.05%
Literacy level among men aged between 15-49 years	92.2% <sup>33</sup>	
Literacy level among women aged between 15-49 years	95.9% <sup>34</sup>	
Goal 5. Achieve gender equality and empower all women and girls	Proportion of seats held by women in the National Assembly	42% <sup>35</sup>

<sup>16</sup> Statistics South Africa, July 2019, Mid-year Population Estimates 2019

<sup>17</sup> Statistics South Africa, July 2019, Mid-year Population Estimates 2019

<sup>18</sup> [http://www.statssa.gov.za/MDG/SDG\\_Baseline\\_Report\\_2017.pdf](http://www.statssa.gov.za/MDG/SDG_Baseline_Report_2017.pdf)

<sup>19</sup> [http://www.statssa.gov.za/MDG/SDG\\_Baseline\\_Report\\_2017.pdf](http://www.statssa.gov.za/MDG/SDG_Baseline_Report_2017.pdf)

<sup>20</sup> [http://www.statssa.gov.za/MDG/SDG\\_Baseline\\_Report\\_2017.pdf](http://www.statssa.gov.za/MDG/SDG_Baseline_Report_2017.pdf)

<sup>21</sup> [http://www.statssa.gov.za/MDG/SDG\\_Baseline\\_Report\\_2017.pdf](http://www.statssa.gov.za/MDG/SDG_Baseline_Report_2017.pdf)

<sup>22</sup> [http://www.statssa.gov.za/MDG/SDG\\_Baseline\\_Report\\_2017.pdf](http://www.statssa.gov.za/MDG/SDG_Baseline_Report_2017.pdf)

<sup>23</sup> [http://www.statssa.gov.za/MDG/SDG\\_Baseline\\_Report\\_2017.pdf](http://www.statssa.gov.za/MDG/SDG_Baseline_Report_2017.pdf)

<sup>24</sup> [http://www.statssa.gov.za/MDG/SDG\\_Baseline\\_Report\\_2017.pdf](http://www.statssa.gov.za/MDG/SDG_Baseline_Report_2017.pdf)

<sup>25</sup> [http://www.statssa.gov.za/MDG/SDG\\_Baseline\\_Report\\_2017.pdf](http://www.statssa.gov.za/MDG/SDG_Baseline_Report_2017.pdf)

<sup>26</sup> [http://www.statssa.gov.za/MDG/SDG\\_Baseline\\_Report\\_2017.pdf](http://www.statssa.gov.za/MDG/SDG_Baseline_Report_2017.pdf)

<sup>27</sup> [http://www.statssa.gov.za/MDG/SDG\\_Baseline\\_Report\\_2017.pdf](http://www.statssa.gov.za/MDG/SDG_Baseline_Report_2017.pdf)

<sup>28</sup> [http://www.statssa.gov.za/MDG/SDG\\_Baseline\\_Report\\_2017.pdf](http://www.statssa.gov.za/MDG/SDG_Baseline_Report_2017.pdf)

<sup>29</sup> Statistics SA, 2017, Media Release: South African and Demographic Health Survey. <http://www.statssa.gov.za/?p=9836>

<sup>30</sup> Statistics SA, 2017, Media Release: South African and Demographic Health Survey. <http://www.statssa.gov.za/?p=9836>

<sup>31</sup> [http://www.statssa.gov.za/MDG/SDG\\_Baseline\\_Report\\_2017.pdf](http://www.statssa.gov.za/MDG/SDG_Baseline_Report_2017.pdf)

<sup>32</sup> [http://www.statssa.gov.za/MDG/SDG\\_Baseline\\_Report\\_2017.pdf](http://www.statssa.gov.za/MDG/SDG_Baseline_Report_2017.pdf)

<sup>33</sup> [http://www.statssa.gov.za/MDG/SDG\\_Baseline\\_Report\\_2017.pdf](http://www.statssa.gov.za/MDG/SDG_Baseline_Report_2017.pdf)

<sup>34</sup> [http://www.statssa.gov.za/MDG/SDG\\_Baseline\\_Report\\_2017.pdf](http://www.statssa.gov.za/MDG/SDG_Baseline_Report_2017.pdf)

<sup>35</sup> [http://www.statssa.gov.za/MDG/SDG\\_Baseline\\_Report\\_2017.pdf](http://www.statssa.gov.za/MDG/SDG_Baseline_Report_2017.pdf)

Goal 7. Ensure access to affordable, reliable, sustainable, and modern energy for all	Proportion of electricity generated from renewable sources	6 089,80 GWh <sup>36</sup>
Goal 8. Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all	Annual GDP Growth (2016)	-1.3% <sup>37</sup>

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<sup>36</sup> [http://www.statssa.gov.za/MDG/SDG\\_Baseline\\_Report\\_2017.pdf](http://www.statssa.gov.za/MDG/SDG_Baseline_Report_2017.pdf)

<sup>37</sup> [http://www.statssa.gov.za/MDG/SDG\\_Baseline\\_Report\\_2017.pdf](http://www.statssa.gov.za/MDG/SDG_Baseline_Report_2017.pdf)

## Executive Summary

### 1. Purpose of the UNFPA/ Government of South Africa 4th Country Programme Evaluation

The purpose of the country programme evaluation (CPE) was to enhance the accountability of UNFPA South Africa Country Office for the relevance and performance of the 4<sup>th</sup> country programme; and to broaden the evidence base for the design of the next programming cycle. The evaluation was commissioned by the UNFPA Country Office (CO) in South Africa in line with the standard procedure. The primary users of the CPE are the decision-makers within UNFPA and the Executive Board, government counterparts in South Africa, and other development partners including donors, the civil society, the private sector, as well as other UN agencies.

### 2. Evaluation objectives and scope

The specific objectives of this evaluation were to (i) provide an independent assessment of the progress of the programme towards the expected outputs and outcomes set forth in the results framework of the country programme; (ii) provide an assessment of the country office (CO) positioning within the development community and national partners, in view of its ability to respond to national needs while adding value to the country development results; and (iii) document lessons learned from the past cooperation that could inform the formulation of the 5th Country Programme of UNFPA support to the Government of South Africa.

The evaluation covered programme interventions implemented from 2013 to quarter 1 of 2019. This period included an extension period that commenced in 2018. Interventions evaluated were those implemented at the national level (by national partners) and in two provinces (KwaZulu-Natal and Eastern Cape) and across all four programme components – sexual and reproductive health, adolescents and youth, gender equality and women empowerment and population dynamics. In addition, the evaluation also assessed the integration of gender mainstreaming and human rights based approach to programming in all the programme components.

### 3. Methodology

The consultants utilised the standard evaluation criteria drawn from the United Nations Evaluation Group (UNEG), the Organisation of Economic Cooperation and Development (OECD) to undertake this evaluation. The standard criteria included relevance, effectiveness, efficiency, sustainability and coordination as well as the crosscutting themes of human rights and gender mainstreaming within the interventions supported by UNFPA. In terms of the evaluation process, first, a design report was developed detailing a brief country situation, evaluation objectives and questions, data collection and analysis methods, stakeholder selection and evaluation matrix and tools. Secondly, the consultants undertook data capture and analysis utilising extensive documents review, and semi-structured key informant interviews with selected persons at national and provincial level. Stakeholder validation meetings were held at province and national level at the end of each field data collection to validate the data and emerging issues. The third step in the evaluation process involved detailed analysis of the data to arrive at the evaluation findings, conclusions and recommendations.

### 4. Key findings of the evaluation

**Relevance:** The country programme is fully aligned to UNFPA Strategic Plan 2008-2012 and 2014-2017 through adjustments made in the CP business model, results framework, geographical coverage. The 4<sup>th</sup> CP outputs are also aligned to the outcomes of the UNFPA strategic plan 2018-2020 through the extension period. However, full alignment of the CP to the strategic plan for 2018-2022 was to be realised in 5<sup>th</sup> CP, but the development of the 5<sup>th</sup> SP was postponed to 2020. The 4<sup>th</sup> CP contributed to the UNSCF 2013 – 2017 results in the areas of human capabilities and governance and participation; the ICPD POA areas of gender, reproductive rights and reproductive health, HIV prevention, maternal and child health with a focus on safe motherhood, and population, development and environment. The CP is responsive to national policies and strategies relevant to all outcome areas and also took into account the needs of targeted populations through evidence-based programming. However, a detailed gender and human rights analysis to inform programming across all components was limited.

**Effectiveness:** The CP made good progress in the achievement of most programme output targets. A few targets were not achieved largely because of shifting government priorities or data was missing. In the SRH programmatic areas, the CP improved policy, developed tools and build capacity for national partners to deliver quality SRH services. For instance, the CP improved policy and capacity for emergency obstetric and neonatal care, Adolescents and Youth Friendly Services, and SRH/HIV service integration; and developed the strategy and improved capacity to delivery contraceptive/family planning services and for condom programming. With regard to adolescents and youth component, the CP contributed to increased access to SRH and HIV services through the development of the national youth policy, comprehensive sexuality education, intergenerational dialogue, establishing Youth Advisory Panel; youth-led empowerment interventions and low-cost sex worker programme. Through support to the National Department of Women, Children and Persons with Disabilities Office of the Premier, capacity development of CBOs and Traditional Leaders, men engagement, development of GBV policy for institutions of higher education, the CP contributed to prevention and response to GBV. In the population dynamics programmatic area, the CP contributed to integration of population data in integrated development plans, advancement of the ICPD agenda, generation and use of population data and south-south knowledge exchange and learning. Across all programme areas various gaps have been identified which affected the effectiveness of the interventions. Many of these are gender related pointing to the fact that gender mainstreaming across all the programme areas has not been substantive.

**Efficiency:** Strong partnership between UNFPA and government partners, use of implementing partners and service providers and the coordination, programming and communication role of UNFPA sub-offices were critical factors for efficient implementation of the country programme. However, the ability of UNFPA to operate efficiently was impacted by the reduction of UNFPA country office staff and budget cuts. The reduction of funding partly made it difficult for UNFPA to attract experienced service providers to support the programme implementation. On the other hand, the CP leveraged government resources for activity implementation. Funding for most of the activities was co-shared although government contribution cannot be quantified.

**Sustainability:** The planning and implementation modalities of the CP integrated sustainability measures. The CP annual workplans were derived from government department plans hence interventions supported were already integrated in government plans and budgets making it possible for government to implement follow up action after the CP support. The CP built also capacity of government partners to enable them replicate or scale up models supported by the programme. Another key aspect of sustainability is ownership of interventions supported by the national partners. Government departments, to a large extent, owned the interventions and led implementation which made it possible to sustain results achieved by allocating funds to the interventions.

**Coordination:** UNFPA role in coordination and functioning of UNCT is significant and visible. UNFPA contributes to the UNSCF results, is a member of UNCT and often act as resident coordinator where necessary, deputizes UNDP in chairing the Programme Management Committee and leads programming in youth development. It also collaborates with other agencies in joint programming for HIV and SRH. It is a member of the core team developing the UNSCF 2020-2025, the communication group and the UN Gender Theme Group among others.

## **5. Lessons and conclusions**

Lessons learnt from the 4th Country Programme evaluation are as follows:

- (i) High level ownership and leadership of the 4th Country Programme by government contributes greatly to successful implementation of programme interventions. In this respect, the 4th CP was signed-off by the Cabinet and relevant sector departments.
- (ii) Levering of government resources (financial and human resources) to a large extent mitigated the impact of the UNFPA Country Office staff and budget cuts and contributed to achievement of CP results
- (iii) High level technical expertise is a key requirement for UNFPA Country Office's effectiveness in supporting advocacy, policy dialogue and knowledge management

- (iv) UNFPA Country Office generated and utilised evidence to inform programming to ensure effective targeting of the most vulnerable adolescents, youth and women
- (v) Involvement of young people in programming and other decision-making processes is key in ensuring CP supported interventions are responsive to the needs of and utilise approaches appropriate for young people
- (vi) Gender mainstreaming across all CP outcome areas enhances programme effectiveness but it takes time to develop gender analysis and programming expertise

## **6. Strategic conclusions**

The strategic conclusions of the evaluation against each evaluation criterion are as follows:

**Relevance of the CP to UNFPA Strategic Plan, ICPA POA, SDGs and UNSCF:** The 4th CP is fully aligned to UNFPA strategic plans of 2008-2013 and 2014 – 2017, the UNSCF 2013-2017. Alignment to the UNFPA strategic plan 2014-2017 resulted significant change in the UNFPA mode of engagement, reduction of regular resources, staffing and geographical coverage. The CP is also aligned to MDGs, ICPD Programme of Action, and national policies and strategies.

**Relevance of the CP to national needs and priorities of stakeholders and target groups:** The 4<sup>th</sup> Country Programme was fully aligned to national policies strategies starting with the over-arching National Development Plan (vision 2030), the second Medium Term Strategic Framework and policies and strategies for health, gender, youth and population and development sectors. In addition, the CP fully took into consideration priorities of national partners and needs of targeted population in its programming. Adequate and appropriate processes were put in place to ensure stakeholder priorities and target population needs informed the annual work planning process.

**Effectiveness of the CP in achieving planned outputs:** Overall programme performance is on track with most output targets achieved. A few targets not achieved are related to areas which were changed by national partners due to emerging developments or where data is missing. On the other hand, gender mainstreaming not been effective due to weak gender analysis which affected programme design and implemented resulting in garmented results. The linkage between upstream advocacy, policy dialogue and knowledge management and downstream capacity building work was also not optimal.

**Efficiency of CP implementation:** Strong partnership between UNFPA and government, use of implementing partners and service providers, the role of UNFPA sub-offices in programming and leveraging of government resources contributed to achievement of output targets. These factors mitigated the impact of staffing and funding cuts on programme,

**Sustainability of the country programme:** Results realised from the interventions supported by the CP were largely sustained through capacity developed with CP support. Ownership of interventions by national partners was also key for sustainability of the results. Interventions that lacked these two factors faced challenges in sustainability. However, the fragmented approach to gender mainstreaming and not centralising gender equality as a driver of the programme will not lead to sustainable action in this regard.

**UNFPA contribution to functioning and consolidation of UNCT coordination mechanisms:** UNFPA contributed significantly to UNCT coordination mechanisms and the implementation of the UNSCF.

## **7. Strategic recommendations**

### **Recommendation 1: Align the 5th Country Programme to UNFPA Strategic Plan 2018-2022 and SDGs**

- Align the 5th Country Programme to the UNFPA 2018-2022 outcome and business mode. However, adapt UNFPA business model to South Africa's socio-economic situation. This alignment should recognise that while South Africa has a strong policy framework to support gender equality, the social, political, economic and cultural environments do not necessarily align with it. It therefore requires to prioritise targeting to reach those furthest behind by addressing inequalities

and disparities through analysis, design and implementation which is cognisant and responsive to the social, political and cultural reality of South Africa.

- The 5th CP should clearly align to SDGs most directly to Goal 3 (Ensure healthy lives and promote well-being for all at all ages); Goal 5 (Achieve gender equality and empower all women and girls); Goal 10 (Reduce inequality within and among countries); Goal 16 (Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels); and Goal 17 (Strengthen the means of implementation and revitalize the Global Partnership for Sustainable Development). Interventions relevant to these goals should be designed and prioritised, and mechanisms on how they will be supported and implemented put in place.

**Recommendation 2: Strengthen gender mainstreaming and human rights approach to programming in the 5<sup>th</sup> Country Programme**

- Assess the successes and gaps with regard to gender mainstreaming in all programme areas; and ensure that a holistic gender mainstreaming approach is adopted; starting with gender analysis and a deep understanding of the structural drivers of gender inequality. Leverage the Population Dynamic component to strengthen sex and age disaggregated data collection and analysis across all programmes.
- Develop a guide for human rights approach to programming and build the capacity of UNFPA staff and partners on this guide. This will strengthen the application of the rights based approach to programming in all CP outcome areas.

**Recommendation 3: Strengthen the linkage between upstream and downstream support**

- Strengthen the linkage between upstream advocacy, policy and knowledge management interventions and the downstream capacity building and successful models demonstrating effective policy implementation in order to facilitate policy implementation and replication of successful models countrywide.

**Recommendation 4: Strengthen the monitoring and evaluation for the country programme**

- Align the CP interventions to government priorities and review targets accordingly on an annual basis: Results were not achieved in instances where government priorities shifted. Going forward, there is a need to review such targets annually to ensure the CP is focusing on achieving targets that are aligned to government priorities.
- 4b. Strengthen the monitoring systems to ensure data for all indicators is collected and reported. There were instances of indicators with missing data (especially those introduced at the stage of CP extension. For the 5th CP, UNFPA and partners should identify output indicators with clear data sources and collect and report data for all the indicators.

**Recommendation 5: Improve UNFPA capacity to deliver 5<sup>th</sup> CP**

- Strengthen the UNFPA Country Office and the Regional Expert Hub as well as Regional Operational Shared Service Centre (ROSC) to improve UNFPA capacity and programme efficiency. This will ensure that UNFPA South Africa has predictable support from the Regional Expert Hub and ROSSC.
- Maintain UNFPA sub-offices in KZN and EC to continue supporting implementation and communication between partners and UNFPA. These offices contributed to achievement of 4th CP results. They currently have a lean staff which should be maintained for continued support to the 4th CP.
- Review the workload of UNFPA staff in the country office to match job requirements to existing capacity and also determine the number of staff establishment needed to deliver the 5th CP.

- Conduct an assessment of staff's capacity to implement gender mainstreaming, and consider the need for specific gender expertise to provide technical support to programmes and partners. Also explore other tools and processes that could strengthen effective gender mainstreaming from programme design to implementation and results to ensure sustainable outcomes.
- Review the process for selection of service providers, and be selective on the type of interventions to be executed by service providers to avoid seeking service providers for interventions with small budgets which don't attract experienced organisations. Secondly, involve national partners in the selection of service providers beyond the review of terms of reference to enhance their ownership of the technical support provided by service providers.

**Recommendation 6: Enhance the inclusion of men and LGBTQI communities in gender mainstreaming interventions in all CP outcome areas**

- Develop approaches for involving men and boys in all outcome areas of the CP in a more impactful way to promote gender equality, enhance access to SRH for both men and women and also strengthen men/boys involvement in addressing harmful socio-cultural gender practices. In addition, use an intersectional approach include disabled groups and LGBTQI communities in programming.

**Recommendation 7: Rationalise UNFPA participation in UNCT coordination mechanisms**

- Given the lean staffing levels, UNFPA country office should review staff participation in the UN coordination mechanisms and prioritise those that UNFPA must participate in based on its mandate. On the other hand, should the UNFPA staff workload rationalisation recommended under 5 above be done, time and effort spent in participation in coordination structures should also be included in the review.

## Chapter 1: Introduction

### 1.1 Purpose and objectives of the country programme evaluation

The purpose of the country programme evaluation (CPE) was to:

- i. Enhance the accountability of UNFPA South Africa Country Office for the relevance and performance of the 4<sup>th</sup> country programme; and
- ii. Broaden the evidence base for the design of the next programming cycle; and generate a set of clear forward-looking and actionable recommendations logically linked to the findings and conclusions. These recommendations were expected to include specific guidance on the development of the 5<sup>th</sup> country programme.

The specific objectives of the evaluation were to:

- i. To provide an independent assessment of the progress of the programme towards the expected outputs and outcomes set forth in the results framework of the country programme
- ii. To provide an assessment of the country office (CO) positioning within the development community and national partners, in view of its ability to respond to national needs while adding value to the country development results
- iii. To document lessons learned from the past cooperation that could inform the formulation of the 5<sup>th</sup> Country Programme of UNFPA support to the Government of South Africa.

### 1.2 Scope of the evaluation

The timeframe, geographical and programmatic scope of the evaluation was as follows:

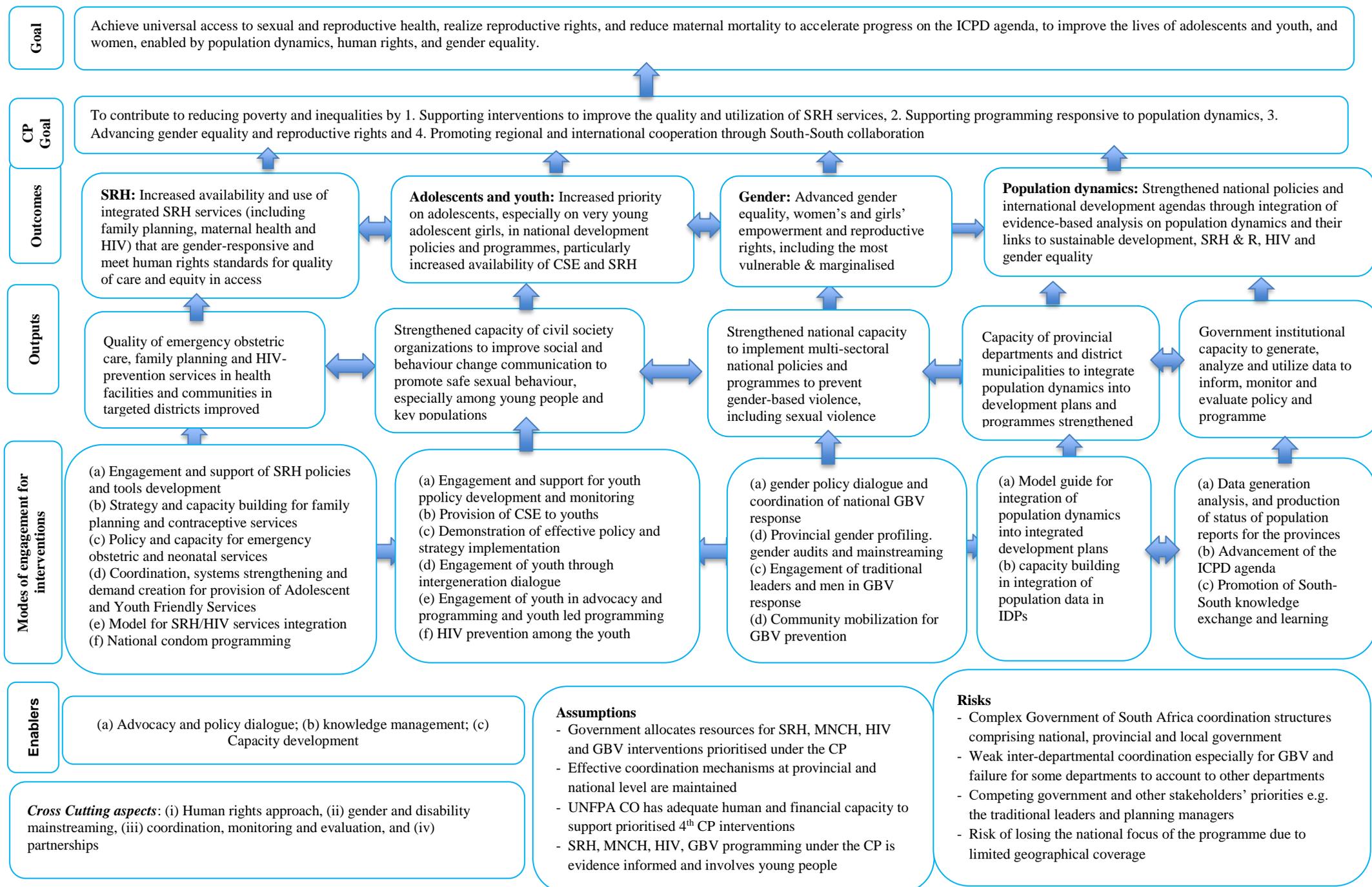
- i. Programme period: The evaluation covered interventions planned and/or implemented within the 4<sup>th</sup> country programme period from 2013 to quarter 1 of 2019 (to the extent possible). This timeframe includes the CP extension period 2018 to 2019.
- ii. Geographical scope: The evaluation covered the two provinces where UNFPA implement interventions: KwaZulu-Natal (uThukela district) and Eastern Cape Province (Alfred Nzo and OR Tambo districts) as well as interventions implemented in other districts in the two provinces and those implemented at national level.
- iii. Implementing partners: Programmes implemented by respective UNFPA implementing partners from national, provincial to district levels were evaluated.
- iv. Programmatic coverage: The evaluation covered the technical areas of the 4<sup>th</sup> CP namely; Sexual and Reproductive Health, Adolescents and Youths, Gender Equality and Women Empowerment, and Population Dynamics. In addition, the evaluation covered crosscutting aspects such as human rights-based approach and gender, coordination, monitoring and evaluation, and partnerships.

### 1.3 Reconstruction of the Theory of Change

The evaluation examined the UNFPA 4<sup>th</sup> CP outputs and how the outputs contributed to overall outcomes or achievement of the results of the country programme, as well as those in higher level plans such as the UN Strategic Cooperation Framework (UNSCF), UNFPA Strategic Plan and national plans. To illustrate the links from inputs, outputs and to outcomes of the 4<sup>th</sup> CP, the Theory of Change (TOC) for the 4<sup>th</sup> CP was reconstructed. The figure below shows the reconstructed TOC.

The analysis of the TOC shows that the logical design of the CPE was clear and the if the modes of engagement and interventions were delivered within the context of the identified enablers and assumptions, the CPE would logically achieve its outputs and contribute to the outcomes. The evaluation assessed this logic.

Figure 1: Summary of Theory of Change of UNFPA/Government of South Africa 4th Country Programme



## 1.4 Methodology and process

### 1.4.1 Methodology

This evaluation enhances the accountability of UNFPA South Africa Office for the relevance and performance of the 4th Country programme as well as supports evidence-informed decision making to guide the 5th Country Programme. The primary users of the CPE are the decision-makers within UNFPA and the Executive Board, government counterparts in South Africa, and other development partners including donors, the civil society, the private sector, as well as other UN agencies.

The CPE was guided by the standard evaluation criteria drawn from the United Nations Evaluation Group (UNEG), the Organisation of Economic Cooperation and Development (OECD) and as stipulated in the terms of reference. The 4<sup>th</sup> CP was assessed in relation to relevance, effectiveness, efficiency, sustainability and coordination as well as the crosscutting themes of human rights and gender mainstreaming within the interventions supported by UNFPA.

The evaluation team reviewed and refined the evaluation questions developed by the Evaluation Reference Group (ERG) as presented below. These questions guided the development of the evaluation matrix which details the assumptions, indicators and relevant data sources for each evaluation question as highlighted in Annex 4.

#### a) Relevance

EQ 1a: To what extent is the country programme adapted to: national needs and policies; priorities of the programme stakeholders and target groups; the goals of the ICPD Programme of Action, SDGs, and the strategies of UNFPA?

EQ 1b: To what extent has the country office been able to respond to changes in national needs and priorities caused or to shifts caused by major political change? What was the quality of the response?

#### b) Effectiveness

EQ 2a: To what extent did the interventions supported by UNFPA in all programmatic areas contribute to the achievement of planned results (outputs and outcomes)? Were the planned geographic areas and target groups successfully reached?

#### c) Efficiency

EQ 3: To what extent has UNFPA made good use of its human, financial and technical resources to pursue the achievement of the outcomes defined in the county programme?

#### d) Sustainability

EQ 4a: To what extent have UNFPA supported interventions contributed to the development of capacities of its partners?

EQ 4b: To what extent have the partnerships established by UNFPA promoted the national ownership of supported interventions, programmes and policies?

#### e) Coordination

EQ 5: To what extent has the UNFPA Country Office contributed to the functioning and consolidation of UNCT coordination mechanisms?

The Evaluation Reference Group (ERG) reviewed the evaluation criteria (in the original draft TOR) and reduced them from 9 to the 5 criteria (as outlined in the final TOR) and as presented above. This process established a more focused scope for the evaluation. The ERG also reviewed the evaluation matrix to ensure its relevance, comprehensiveness and appropriateness in guiding the evaluation.

### 1.4.2 Data collection and analysis

The CPE was undertaken through a participatory process involving UNFPA staff and key stakeholders at national, provincial and district levels. The evaluation methodology was fully in line with the

guidance provided by UNFPA and the UNEG. To answer all the evaluation questions, the evaluation adopted three data collection methods and systematically triangulated data from these sources.

- (i) Documents review: an extensive documents review was undertaken to understand the design of the programme, its underpinning theory of change and to collect data relevant to the evaluation criteria. Documents reviewed included:
  - Strategic framework documents including the overarching UNFPA strategic plans, UN strategic cooperation framework, national and sectoral strategic plans and relevant policy documents.
  - Programme documents such as UNFPA country programme documents, theory of change, results framework, annual work plans, implementing partners project plans, programme and project reports and monitoring data among others.
  - Programme products which included policy documents, service delivery guidelines and tools, and training manuals
  - Reports of surveys and assessments conducted under the programmes and those carried out nationally that provide data relevant to the four outcome areas
- (ii) Key informant interviews: key informants were interviewed at national, provincial and district levels to collect primary data to supplement data from documents reviewed. Key informants were purposively selected based on their role in the programme to ensure data on all programmatic components; targeted provinces and districts and data from all different categories of stakeholders were collected to allow triangulation. A semi-structured interview guide was used during these interviews. Key questions were tailored to each category of key informants according to their role in the programme. In this respect, the interview guide has key questions tailored to UNFPA staff, national partners; implementing partners and service providers; and frontline service providers. Key informants interviewed were as follows:
  - National level key informants: UNFPA staff, other UN Agencies, government departments and civil society organisations, implementing partners and service providers; and
  - Provincial level key informants: Office of the Premier, Population Units, Department of Health (DOH), Department of Co-operative Governance and Traditional Affairs (COGTA), Department of Basic Education (DBE), Statistics South Africa, implementing partners and service providers.
  - District level key informants: DBE and DOH officials, implementing partners and other persons involved in CP activity implementation.
- (iii) E-questionnaire: An e-questionnaire was used to collect additional data on gender mainstreaming and human rights approach to programming. A purposive sampling approach was used to identify the key informants to provide the information required. The selection of key informants was made in consultation with the Evaluation Reference Group at UNFPA.
- (iv) Validation: Validation meetings for the findings and recommendations of the evaluation were conducted in at provincial and national level. The consultant held a validation meeting with stakeholders in KwaZulu-Natal and Eastern Cape Provinces. At national level, the evaluation findings and recommendations were presented to the National Coordination Forum.

The methods for data analysis applied in this evaluation were as follows:

- (i) Overall data analysis was guided by the evaluation questions, assumptions and indicators outlined in the evaluation matrix. The analysis of gender and human rights was guided by the following questions (drawn from the UNEG gender framework).
  - Relevance: To what extent are interventions aligned with international gender instruments, national policies on gender and the different needs of men and women? To what extent are

the interventions informed by substantive gender analyses that identify underlying causes and barriers gender equality?

- Effectiveness: To what extent does the Theory of Change and results framework of the intervention integrate gender equality? To what extent was a gender mainstreaming strategy incorporated in the design and implementation of the interventions?
  - Efficiency: Does the short-term process achievements (participation and inclusiveness, etc.) and medium-term results (developing an enabling environment, building capacity, etc.) integrate and reflect gender equality? Was provision made for adequate resources for integrating gender equality in the CP interventions?
  - Sustainability: Has institutional change conducive to systematically addressing gender equality concerns been created?
  - Coordination: To what extent has UNFPA proactively driven and supported the meaningful integration of gender equality across interventions?
- (ii) Data collected from all sources was matched with the relevant evaluation question. This allowed the consultants to (i) assess whether the data was relevant to the evaluation; and (ii) assess whether data was adequate to address the indicators and assumptions for each evaluation question; and (iii) identify data that required further clarification. At this stage, data was also cleaned by cross checking factual accuracy.
- (iii) Source specific data analysis: Data from each source (documents and each category of key informants) was analysed against the indicators and assumptions of each evaluation question to identify the responses to each evaluation question from each data source.
- (iv) Triangulation of data: The consultants proceeded to triangulate the responses from the different data sources to identify key findings for each evaluation question. The consultants identified where there was convergence of the responses for each evaluation questions. A few areas of divergence were identified and the consultants arrived at key findings based on further careful in-depth analysis and consultations with UNFPA staff.
- (v) Both data source specific data analysis and data triangulation were undertaken through testing the indicators and assumptions to ensure the analysis was focused on answering the evaluation questions. This process also enabled the consultants to identify the relevant evidence supporting the findings for each evaluation question.

### 1.4.3 Limitations encountered during the CPE

<b>Limitations and risks</b>	<b>Mitigation response</b>
Due to the long period of implementation of the 4 <sup>th</sup> CP (from 2013 to 2019), there was change of staff and lack of some data especially for the earlier years 2013/2014.	The consultants relied on detailed annual work plans and detailed activity reports as well as triangulated data collected from several key informants to establish a comprehensive picture of the interventions supported by the programme.
A few key informants were not available for interviews particularly at the national level.	This data gap was filled through interviewing and seeking clarification from UNFPA staff and stakeholder validation of the findings of the evaluation
Unavailability of some of the documents (and data) to support results achieved by the Country Programme	The consultants triangulated data from key informants and documents to assess the extent to which results were achieved. However, consultants were unable to quantify results of all interventions and this gap is highlighted appropriately in the findings section of the report.
Lack of data for most of the output indicators for the programme extension period	Qualitative data was used to assess interventions relevant to the indicators with no data and to identify the achievements of these interventions.

#### 1.4.4 Evaluation process

The evaluation process followed the UNFPA CPE Handbook which describes five phases of evaluation as outlined below:

**Phase 1: Preparation:** This phase was led by the UNFPA Country Office and commenced prior to the evaluation consultants being recruited. It involved the designation of the Evaluation Manager, establishment of the Evaluation Reference Group (ERG) and development of the terms of reference (TOR) for the 4<sup>th</sup> CP evaluation. The consultants reviewed and interpreted the TOR to understand the objectives, criteria and scope as well as the gender and human rights focus of the evaluation.

**Phase 2: Design phase (development of the design report):** This phase was led by the consultants and involved a preliminary review of key documents such as (i) UNFPA evaluation guidance documents including the evaluation handbook and UNEG standards and norms; (ii) key documents related to the 4<sup>th</sup> CP for South Africa including the 4<sup>th</sup> CP document and its extensions, UNFPA strategic plans, UNFPA theory of change and UNSCF; (iii) documents related to the South Africa socio-economic and governance context and (iii) documents applying a gender lens to understand the challenges, commitments, strategies and progress in gender mainstreaming and gender indicators in South Africa. The review of these documents informed the design of the evaluation which resulted in the development of the “evaluation design report”, which detailed the evaluation questions, methodology for data collection and analysis and a work plan for field work, reporting and dissemination of the evaluation. Given that the gender specialist was recruited midway through the evaluation exercise, the design report was revised to incorporate the evaluation of the 4<sup>th</sup> CP from a gender perspective.

**Phase 3: Field work:** The lead consultant carried out in-depth review of key documents and data collection from key informants during this phase. Key informants were identified in consultation with the evaluation manager and the UNFPA coordinators in KwaZulu-Natal and Eastern Cape provinces. The provincial UNFPA programme officers identified the persons to be interviewed and made appointments, managed transport logistics and introduced the consultant to the key informants. Key informant interviews were carried out in KwaZulu-Natal from 4<sup>th</sup> to 7<sup>th</sup> June 2019, and in the Eastern Cape from 11<sup>th</sup> to 14<sup>th</sup> June 2019. The consultant held a debriefing session on the last day of the field work with stakeholders in each province to provide feedback on data collected and emerging issues from the interviews for validation. Interviews at national level were carried out in July 2019. Documents review continued through the field work phase. Given the late start of the gender analysis, the gender expert reviewed documents and the data collected by the lead consultant, and filled data gaps through interviewing selected key informants.

**Phase 4: Reporting:** The lead consultant undertook data cleaning, collation and initial analysis to identify preliminary findings and recommendations; and presented these to findings and recommendations to the Country Programme National Coordinating Forum (NCF) convened from 15-17 July 2019. Stakeholders discussed and provided comments on the findings and recommendations which contributed to the in-depth data analysis and informed the draft of the evaluation report that followed. The gender specialist participated in the NCF meeting to gain an in-depth understanding of the programme as well as consult with the UNFPA staff and partners. The draft report was completed and submitted to the Country Office and ERG for review and comments.

**Phase 5: Dissemination and follow up:** The UNFPA Country Office reviewed the draft report and also circulated the report to stakeholders for their final comments and these comments were incorporated into the final evaluation report.

### Timeframes for key tasks

Activity/Milestone	May				June		July			Aug.	Sept.
	06-09 May	13-17 May	20-24 May	27-31 May	3-14 June	17 Jun - 5 July	8-12 July	15-19 July	22 – 26 July		
Submission of draft evaluation inception report											
Receipt of UNFPA comments on inception report											
Final inception report											
Documents review											
Development of key informant interviews guide											
Making key informant appointments											
Field data collection											
Data analysis											
Development of draft evaluation report											
Receipt of comments from UNFPA ERG on the draft report											
Final report submission											

## Chapter 2: Country Context

### 2.1 Development challenges and national strategies

#### 2.1.1 Country context overview

South Africa is located on the southern tip of the African continent and occupies an area of 1,219,602 square kilometres. The country borders Botswana, Lesotho, Namibia, Mozambique, Swaziland and Zimbabwe.

South Africa became a democracy in 1994 with the end of the apartheid governance system. The country adopted a new constitution in 1996 founded on the values of human dignity, human rights, freedom, non-racialism, non-sexism and rule of law<sup>38</sup>. “South Africa has a three-tier system of government and an independent judiciary. The national, provincial and local governments have legislative and executive authority in their own spheres and are constitutionally recognised as distinct, interdependent and interrelated<sup>39</sup>. The National Government comprises the cabinet led by the presidency, deputy president and ministers

Women occupy 46% (13 out of 28) ministerial positions while 42% (16 out of 38) of deputy ministers are women. Even though South Africa is now one of the top eight countries in the world with a cabinet made up of close to 50% women, this may not necessarily translate to positive action for women and girls. “Representation can and does assist in doing this to some regard, but it is fundamental that government represents progressive stance on issues impacting women in all the work they do and also keep in mind that women represented are not a homogenous group and that simply having women represented does not mean that they will necessarily have the same view on many issues, nor is it automatic that they will take a particular position simply because they are women.”<sup>40</sup>

South Africa has 9 provinces. Each provincial government is led by an executive council consisting of a premier and members of the executive council (MECs); and legislature consisting of between 30 and 80 members. Constitutionally, provinces have legislative powers, concurrent with the national government in several sectors including health, education and other socio-economic development sectors<sup>41</sup>. At provincial levels (that is the 8 provinces where the African National Congress (ANC) is in power), women’s representation is also prioritised and 50-60% of women are MECs – 60% in the case where the Premier of the province is a male. Women premiers have dropped from 44% in 2004 to 22% in 2019.<sup>42</sup>

At the local level, the constitution provides for establishment of three categories of municipalities: category A which are metropolitan municipalities, category B constituting local municipalities and category C which are district municipalities. In total, there are 278 municipalities comprising 8 metropolitan, 44 district and 226 local municipalities. The municipalities are focused on growing local economies and providing infrastructure and service that meets local needs. In 2015, there were 9,676 councillors nation-wide, 3,792 (39%) of whom were female. Elected every five years during municipal elections, councillors sit on the municipal council, which is the decision-making and political body directing the mandate of the municipality.<sup>43</sup> These councils are a key stakeholder in interventions aimed at addressing local needs and improving service delivery including those supported by UNFPA.

South Africa is a multiracial democratic society, which officially embraces its diversity. The right to equality and the elimination of discrimination is entrenched in the country’s Constitution. According to the 2019 mid-year population estimates, 80,7% of South Africans are ‘Black Africans’, 8.8% are

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<sup>38</sup> Twenty-year review of South Africa, 1994-2014

<sup>39</sup> Republic of South Africa, Government Communication and Information System, South Africa Yearbook, 2015/16

<sup>40</sup> Daadi Patel, A. 2019. Gender parity in cabinet does not guarantee progress for women – activists. <https://mg.co.za/article/2019-05-30-gender-parity-in-cabinet-does-not-guarantee-progress-for-women-activists>

<sup>41</sup> Republic of South Africa, Government Communication and Information System, South Africa Yearbook, 2015/16

<sup>42</sup> Gender Links, <https://genderlinks.org.za/what-we-do/governance/advocacy/south-africa-gender-and-elections/>

<sup>43</sup> Statistics South Africa, <http://www.statssa.gov.za/?p=8137>

Coloured, 7,9% are white, 2,6% are ‘Indian or Asian’. The distribution of population by race is shown in the table below:

*Table 1: South Africa population distribution by race and sex, 2019*

<b>Population Group</b>	<b>Male</b>	<b>% distribution of males</b>	<b>Female</b>	<b>% distribution of females</b>	<b>Total</b>	<b>% distribution of total</b>
Black African	23 124 782	80,7	24318477	80,8	47 443 259	80,7
Coloured	2 513 221	8,8	2 663 530	8,8	5 176 751	8,8
Indian/Asian	768 594	2,7	734 413	2,4	1 503 007	2,6
White	2 266 151	7,9	2 385 855	7,9	4 652 006	7,9
<b>Total</b>	<b>28 672 748</b>	<b>100</b>	<b>30 102 275</b>	<b>100</b>	<b>58 775 022</b>	<b>100</b>

South Africa has an estimated GDP per capita of USD 5,691<sup>44</sup> and is classified, by the World Bank, as an upper-middle-income country. The country has experienced slow economic growth since the 2008/9 global recession, averaging 2.3% in the years between 2010 and 2015<sup>45</sup>. In 2016, the economy grew 0.4% from the 1.5 per cent registered in the previous year<sup>46</sup>. South Africa’s Human Development Index value for 2017 is 0.699 placing it in the medium human development category, and is ranked 113 of 189 countries.

Between 1990 and 2017, South Africa’s HDI value increased by 13.1%; life expectancy at birth increased by 1.3 years, mean years of schooling increased by 3.6 years and expected years of schooling increased by 1.9 years. Table A reviews South Africa’s progress in each of the HDI indicators<sup>47</sup>.

*Table 2: Trend in South Africa Human Development Index 1990 to 2017*

<b>Year</b>	<b>Life expectancy at birth</b>	<b>Expected years of schooling</b>	<b>Mean years of schooling</b>	<b>GNI per capita (2011 PPP\$)</b>	<b>HDI value</b>
1990	62.1	11.4	6.5	9,391	0.618
1995	61.2	13.0	8.2	8,885	0.649
2000	56.3	13.0	8.8	9,340	0.630
2005	52.6	12.9	8.9	10,590	0.614
2010	55.9	12.8	10.0	11,639	0.649
2015	62.0	13.3	10.1	12,073	0.692
2016	62.8	13.3	10.1	11,948	0.696
2017	63.4	13.3	10.1	11,923	0.699

The National Development Plan 2030 (NDP), developed in 2012, provides a roadmap for planning across sectors and all levels of government for 20 years. The NDP is implemented in 5-year medium-term strategic frameworks (MTSF) and sectoral plans developed by each national government department. The first MTSF (2014-2019) had two overarching strategic themes – radical economic transformation and improving service delivery. The second MTSF is currently under development.

In a gendered analysis of the National Development Plan (NDP), the Commission for Gender Equality found that the gender-blind nature of the NDP contributes to a lack of understanding of the impact the policies suggested by the NDP may or may not have on women. “By having asked the question about how the issues are framed, based on which assumptions and what is left unattended, we could show that

<sup>44</sup> World Bank Group, <http://data.worldbank.org/country/south-africa>.

<sup>45</sup> World Bank Group, 2017, South Africa Economic Update: Private Investment for jobs.

<sup>46</sup> World Bank Group, 2017, South Africa Economic Update: Private Investment for jobs

<sup>47</sup> Human Development Report, 2018

a gendered analysis will start from different assumptions and policies based on gender disaggregated data would make a difference to women's lives".<sup>48</sup>

Provincial governments develop spatial development frameworks articulating the provinces' growth and development strategies across all sectors while local/municipal governments develop and implement Integrated Development Plans (IDPs). An inter-governmental relations framework Act (2005) brings together national, provincial and local governments to promote and facilitate linkages and coherence in development planning.

Development Partners, including UNFPA, have to take into account this government structure to effectively align their support to various levels of government according to their mandates. UNFPA, through the 4<sup>th</sup> CP, supported partners at all levels of government.

### **2.1.2 Challenges and national responses for sexual and reproductive health (SRH)**

South Africa has made progress in the reduction of maternal deaths especially since 2010 but failed to achieve the Millennium Development Goal (MDG) target. Between 1998 and 2009, South Africa experienced a significant increase in the maternal mortality ratio (MMR) from 134 deaths per 100,000 live births to 311 deaths per 100,000 live births respectively. Since 2010 the country has consistently made progress in reducing maternal deaths with the MMR declining from 270/100,000 live births in 2010 to an estimated 141/100,000 live births by 2015. However, the country did not meet its MDG target of 38/100,000 live births<sup>49</sup>.

Antenatal Care services have improved over time with 94% of women aged 15-49 years receiving antenatal care from a skilled provider during pregnancy. Three in four women (76%) have at least four ANC visits while 47% have their antenatal visit in their first trimester. The percentage of pregnant women receiving care from a skilled provider range from 89.9% in Gauteng province to 98.5% in Eastern Cape province. Deliveries in a health facility increased from 83% in 1998 to 96% in 2016. Nearly all deliveries (97%) are assisted by a skilled provider. 87% of the mothers received a postnatal check with 84% having this check within the first 2 days after delivery<sup>50</sup>.

A comprehensive enquiry into maternal deaths carried out in 2018 found a significant drop in maternal deaths by 52% from 2011 to 2016. The highest number of provincial maternal deaths were recorded in KZN (222) followed by Gauteng (175) and Eastern Cape (142) provinces. Maternal deaths were 34.2% in regional hospitals, 24.6% in tertiary hospitals, 30.2% at district hospitals and only 6.8 per cent in national central hospitals. Overall, 68.3% of maternal deaths were due to respiratory failure followed by immune system failure at 62.8% and septic shock at 14.6%. Factors contributing to maternal deaths include delayed access to medical help, no antenatal care, lack of trained staff, lack of Intensive Care Unit (ICU) facilities and delay in initiating critical care due to overburdened services including weaknesses in the referral of emergency cases<sup>51</sup>.

The total fertility rate (TFR) declined from 2.62 children per woman in 2009 to 2.32 children per woman in 2019<sup>52</sup>. The TFR among women in non-urban areas dropped from 3.9 in 1998 to 3.1 in 2016 while in urban areas, there was a marginal increase from 2.3 to 2.4 over the same period. TFR varies by province, ranging from 2.1 in Western Cape to 3.1 in Northern West and Limpopo. It also varies by education level where by TRF falls with increasing education, from 3.6 among women who did not complete primary education to 2.2 among women with more than a secondary education. Wealth is also a factor in determining TFR in South Africa. In this case, women living in the poorest households have a TFR of 3.1 compared to 2.2 among women in wealthiest households. With regard to population groups, Black Africa women have the highest TRF at 2.7 children per women, followed by Coloured (2.5 children), Asian (1.7 children and White (1.5 children) women. The contraceptive prevalence rate

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<sup>48</sup> Commission for Gender Equality. 2013. Gender Analysis of the National Development Plan Vision 2030

<sup>49</sup> Republic of South Africa, Statistics South Africa (2015) Millennium Development Goals 5: Improving Maternal Health 2015

<sup>50</sup> South Africa Demographic and Health Survey, 2016

<sup>51</sup> Saving Mothers 2014-2016: Seventh triennial report on confidential enquiries into maternal deaths in South Africa: Short Report, 2018

<sup>52</sup> Statistics South Africa, Mid-Year Population Estimates 2019

(CPR) is 60% among sexually active women and 55% among in-union women and nearly all those who use a contraceptive use a modern method. The proportion of women in-union with unmet need for contraceptives declined slightly from 17% in 1998 to 15% in 2016. The unmet need is higher among sexually active women 15-19 years (31%) and 20-24 years (28%) than other age groups (14-18%)<sup>53</sup>.

Efforts to reduce maternal deaths and improve access to family planning services include the implementation of the three streams of primary healthcare re-engineered through municipal ward-based community health worker teams, integrated school health programmes and district clinical teams within facilities and districts to implement interventions that reduce maternal, neonatal and child mortality. Other interventions include the promotion of contraceptive use, especially the long acting contraceptives and implants through training and mentorship of healthcare workers; and strengthening of emergency medical services.

South Africa is among the countries most impacted by the HIV epidemic. In 2017, the country had an estimated 7.2 million people living with HIV, and 270,000 new HIV infections and 110,000 AIDS related deaths. HIV prevalence is estimated at 18.9% among the general population with variations across provinces. For instance, KwaZulu-Natal has a prevalence of 12.2% compared to 6.8% and 5.6% in Northern Cape and Western Cape respectively. Prevalence among women is nearly four times greater than that of men in the same age. Young women aged 15-24 years account for 37% of new HIV infections<sup>54</sup>. Among key populations, HIV prevalence among sex workers is estimated at 57.7% although it varies between areas with prevalence in Johannesburg estimated at 71.8%, 53.5% in Durban and 39.7% in Cape Town. Men who have sex with men (MSM) have a prevalence of 26.8% while transgender women are twice likely to have HIV as MSM<sup>55</sup>.

The impact of HIV is reflected in the AIDS related deaths and the effect this has on households. Approximately 71,000 deaths occurred due to AIDS in 2018. Of these, 33,000 deaths occurred among women 15 years and over and the same number of deaths occurred among men 15 years and older. This has contributed to a large number of single-parent headed households as well as a large number of orphans estimated at 1,200,000 in 2018<sup>56</sup>.

Tremendous effort has been made to reduce the HIV epidemic in South Africa. As at 2017, 90% of the people living with HIV were aware of their HIV status, 68% of these were on HIV treatment while, of those on treatment, 78% were virally suppressed. Women are more likely to test for HIV than men due to poor health seeking behaviour among men. The mother to child transmission of HIV rates fell from 3.6% in 2011 to 1.5% in 2016<sup>57</sup>. To scale up behaviour change, effort has been made to increase condom distribution and uptake through rebranding of condoms; and increased HIV awareness through intensifying communication programmes and youth-led sexual and reproductive health and HIV prevention advocacy.

South Africa launched the National Strategic Plan for HIV, TB and STI 2017-2022 which focuses on providing comprehensive HIV prevention and care countrywide while concentrating efforts in 12 districts that account for 82% of all people living with HIV and for the majority of new HIV infections, and 19 districts with the highest TB burden. The plan prioritises key and vulnerable populations to be provided with high impact prevention and treatment services and strengthened efforts to address social and structural HIV and TB vulnerability factors. In addition, the country also developed the South Africa National Sex Worker HIV Plan 2016-2019 focusing particularly on delivery of integrated HIV, TB and sexual and reproductive health services to sex workers and their clients that integrate human rights and stigma reduction.

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<sup>53</sup> South Africa Demographic and Health Survey, 2016

<sup>54</sup> UNAIDS (2017) "Ending AIDS: Progress towards 90-90-90 targets"

<sup>55</sup> UNAIDS Data 2018

<sup>56</sup> Ibid

<sup>57</sup> Ibid

### **2.1.3 Challenges and national responses for adolescents and young people**

South Africa has a young population with adolescents and young people aged 10-24 years constituting 26% of the total population while those under 30 years constitute 56% of the population. Adolescents and young people in South Africa are vulnerable to significant health and general wellbeing challenges which include early and unintended pregnancies, sexual and gender-based violence, HIV infection, low education completion rates and unemployment.

According to the South Africa Demographic and Health Survey of 2016, about 16% of adolescent girls aged 15-19 years had begun childbearing, 12% had given birth, and another 3% were pregnant with their first child at the time of the survey. The proportion of adolescent girls who had begun child bearing varied by province with the Western Cape having the lowest proportion at 8% and Northern Cape having the highest proportion at 20%. KwaZulu-Natal has a proportion of 19.4 while Eastern Cape has 17.9%. Early child bearing is also more prevalent in non-urban areas (18.6%) compared to urban areas (13.6%). Teenage mothers are more likely to experience adverse pregnancy outcomes and are more constrained in their ability to pursue educational opportunities than young women who delay childbearing. Children born to very young mothers are at increased risk of sickness and death<sup>58,59</sup>. Barriers to family planning and other SRH services among adolescent girls and young women (AGYW) include low knowledge and misconceptions of the side effects of modern contraceptives; low level of awareness of the benefits of contraceptives and lack of transport and long distances to health facilities, and stigma around teenage pregnancy among others.

The Integrated School Health Policy and the National Youth Health Policy as well as the National Contraceptive and Fertility Planning Policy and Guidelines provide guidance in the delivery of adolescents and youth friendly services and expanding access to family planning and SRH services. Some of the efforts targeting adolescent girls include strengthening of collaboration between the departments of health, education and social development to bring SRH services closer to schools, generate demand and provide adolescent and youth friendly services.

Youth in South Africa face a significant unemployment challenge. Unemployment among 15-24 year olds was 50.3% in 2015 and almost six times that for 55-65 year olds (8.4%)<sup>60</sup>. By 2016, youth unemployment among 15-24 years rose to 54.5% while 31.2% of the youth aged 25-34 years were unemployed<sup>61</sup>. Women (28.7%) are more likely to be unemployed than men (24.4%), with an almost 20% difference in labour force participation between males and females. Young Black African women are particularly disadvantaged within the labour market<sup>62</sup>.

The country has developed the National Youth Policy which adopts a multi-sectoral approach to addressing challenges facing the youth including youth unemployment. The National Youth Development Agency in collaboration with the Department of Performance and Monitoring and Evaluation (DPME) is coordinating implementation of this policy across all relevant sectors.

### **2.1.4 Challenges and national responses to gender equality and women's empowerment**

The South African society is marked with patriarchal norms and male dominance across sectors, despite strong legislative frameworks that promote equality and the recognition of women's rights. South Africa ranks at 19th out of 149 countries in the World Economic Forum (WEF) Gender Gap Report, 2018. But it ranks 117 out of 149 in relation to the gender pay gap.<sup>63</sup> In fact, research has shown that the gender pay gap has actually increased since 2017, This is despite the fact that the country has had the Employment Equity Act since 1998. In its most recent report, the Commission for Employment Equity continues to bemoan the lack of progress in addressing gender disparities in the workplace. Women

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<sup>58</sup> Statistics South Africa. 2017

<sup>59</sup> South Africa Demographic and Health Survey 2016 Key Indicators Report. <http://www.statssa.gov.za/?p=9836>

<sup>60</sup> Department of Women, Status of Women in the South African Economy, 2015

<sup>61</sup> 2017/2018 Budget

<sup>62</sup> Statistics South Africa, Millennium Development Goals Country Report 2015

<sup>63</sup> World Economic Forum, <https://www.weforum.org/reports/the-global-gender-gap-report-2018>

make up about 23% at top management and only 3.3% of the Johannesburg Stock Exchange (JSE) listed company CEOs are women.<sup>64</sup>

Violence against women and children is also alarmingly high. 26% of ever-partnered women age 18 years and older have experienced physical, sexual and emotional violence committed by a partner in their lifetime. The most common violence experienced by women is physical violence (21%), emotional violence (17%) followed by sexual violence (6%). The proportion of women who have experienced any form of violence by a partner varies by province from 19% in KwaZulu-Natal to 38% in Eastern Cape. Patriarchal societal and cultural norms, negative gender attitudes and unequal power relations between men and women are some of the causes of the violence against women.

In response to the high prevalence of violence against women, the Government has put in place laws and policies including the Domestic Violence Act of 1998 which provides a path to seeking justice for survivors of such violence, and the National Policy Framework for Women Empowerment and Gender Equality providing a policy environment to develop and implement appropriate programmes. The South Africa State has also ratified key international and regional instruments promoting and protecting the rights of women including the United Nations Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the African Heads of State Solemn Declaration on Gender Equality in Africa and the Southern Africa Development Community Protocol on Gender and Development.

At community level, the government has set up Thuthuzela Care Centres (TTCs) linked to public health facilities and police service in areas with a high prevalence of violence to shelter and provide medical and psychosocial support to GBV survivors. However, these TCCs have not been without challenges, including poor internal co-ordination and continuing follow up care. “Indeed, emotional support services in the TCCs are treated as after-thoughts in many facilities. This is reflected in the inadequate funding for the service; the amount of space given to the service, as well as its physical location; and where in the TCC process counsellor is located.”<sup>65</sup> The country is currently developing a GBV Strategic Plan to scale up a coordinated response towards violence against women and femicide. Previous attempts to develop the plan were hampered by numerous changes in leadership in the Ministry of Women (which has also had various name changes).

Unemployment is a significant challenge in South Africa and the labour market is remains more favourable to men than women. Men are more likely to be in paid employment than women, regardless of race. Between 2008 and 2018, both the official and expanded unemployment rates were higher amongst women than men. The rate of unemployment amongst women was 29,5% in the second quarter of 2018 compared with 25,3% amongst men, according to the official definition of unemployment. According to the expanded definition, the rate of unemployment amongst women was 7.5 percentage points higher than that of males<sup>66</sup>.

Per capita income (female USD 9,060 and male USD 14,894) contributed the largest to the country’s Gender Development Index in 2018 highlighting the stark difference in command over resources between the sexes, with men earning twice as much as females<sup>67</sup>. Inequality is also a factor of access to education, health and other social services. These inequalities are further deepened by race with black African women being the most affected. According to Statistics South Africa, households led by black

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<sup>64</sup> Commission for Employment Equity, [http://www.labour.gov.za/DOL/documents/annual-reports/Commission%20for%20Employment%20Equity%20Report/2017-2018/downloads/documents/annual-reports/employment-equity/2017-2018/18ceereport\\_amended.pdf](http://www.labour.gov.za/DOL/documents/annual-reports/Commission%20for%20Employment%20Equity%20Report/2017-2018/downloads/documents/annual-reports/employment-equity/2017-2018/18ceereport_amended.pdf)

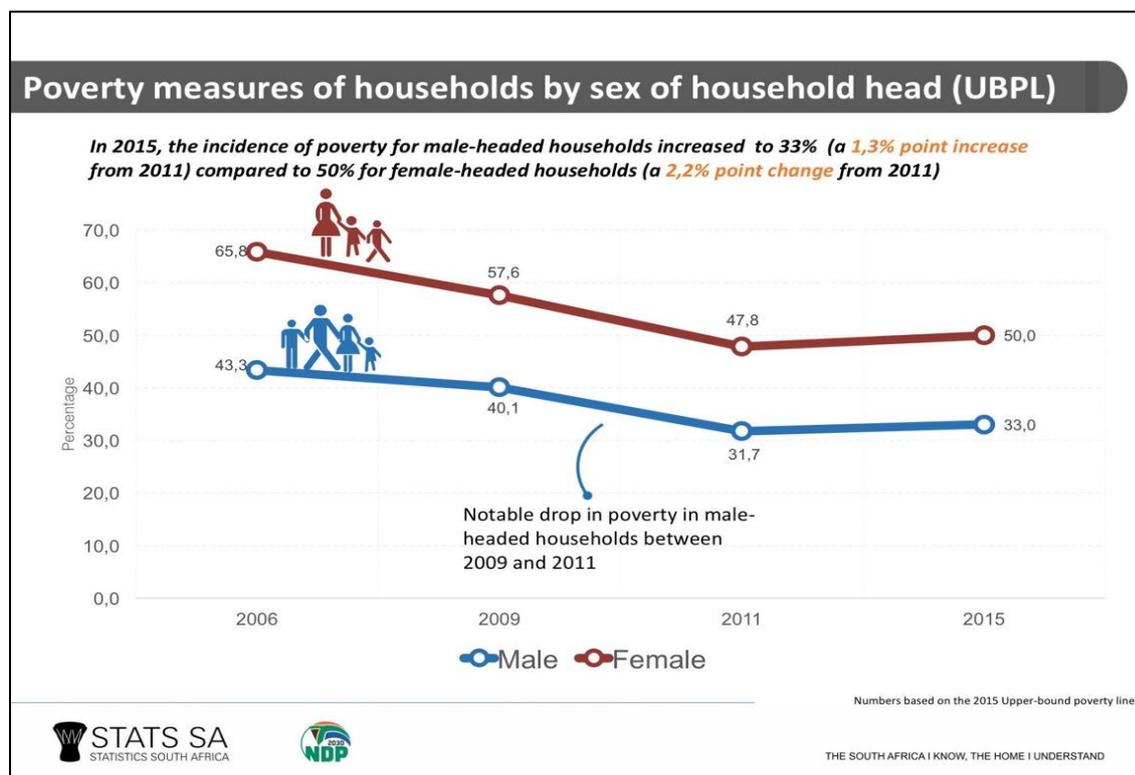
<sup>65</sup> Vetten L. (2015). *“It sucks/It’s a wonderful service”*: Post-rape care and the micro-politics of institutions. Johannesburg: Shukumisa Campaign and ActionAid South Africa.

<sup>66</sup> Statistics South Africa. 2018. How do women fare in the South African labour market? <http://www.statssa.gov.za/?p=11375>

<sup>67</sup> UNDP, Human Development Report 2016, Briefing note for countries on the 2016 Human Development Report, South Africa [http://hdr.undp.org/sites/all/themes/hdr\\_theme/country-notes/es/ZAF.pdf](http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/es/ZAF.pdf)

African women, as well as people living in the rural parts of the Eastern Cape and Limpopo were the most vulnerable to poverty and likely to have little to no education<sup>68</sup>.

Figure 2: Poverty measures of households by sex of household head



### 2.1.5 Challenges and national responses for population dynamics

The population of South Africa is estimated at 58.8 million. Approximately 51% of the population is female. Gauteng accounts for the largest share of the population (26%) followed by KwaZulu-Natal (19%) while Northern Cape province has the least proportion of the population at 2%<sup>69</sup>. The table below shows South Africa's population by province.

Table 3: Mid-year population estimate for South Africa by province, 2019

Province	Total Population
Eastern Cape	6712276
Free State	2887465
Gauteng	15176115
KwaZulu-Natal	11289086
Limpopo	5982584
Mpumalanga	4592187
Northern Cape	4027160
Northern Western	1263875
Western Cape	6844272
Total	58775020

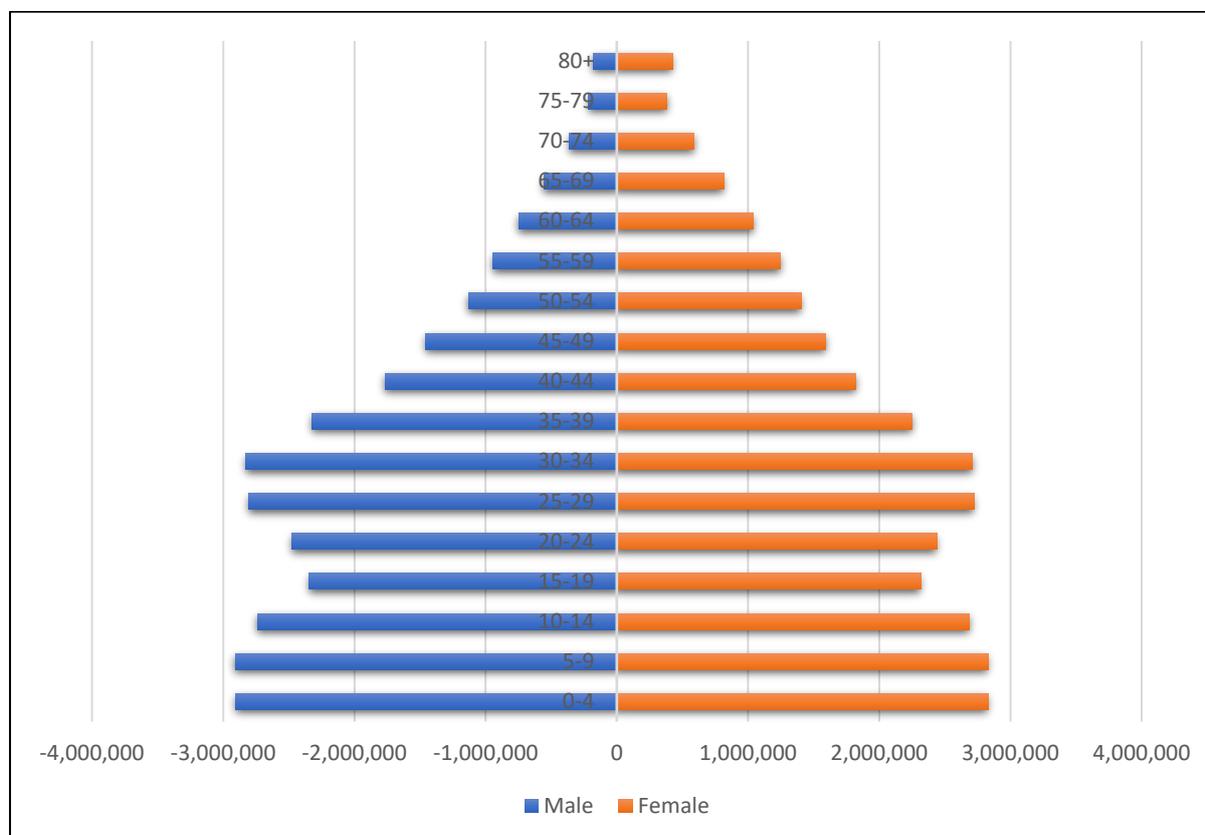
About 28.8% of the population is aged younger than 15 years and approximately 9,0% (5,3 million) is 60 years or older. Of those younger than 15 years of age, the majority reside in Gauteng (21,5%) and

<sup>68</sup> Ntsabo, M. 2017. Stats SA: Women and children hit hardest by poverty. The Daily Vox. <https://www.thedailyvox.co.za/stats-sa-women-and-children-hit-hardest-by-poverty-mihlali-ntsabo/>

<sup>69</sup> Statistics South Africa 2019 Report

KwaZulu-Natal (21,1%). Of the elderly (those aged 60 years and older), the highest percentage 23,9% (1,27 million) reside in Gauteng. The proportion of elderly persons aged 60 and older is increasing over time.

Figure 3: South Africa's Population Pyramid (Source: Stats South Africa)



Life expectancy at birth declined between 2002 and 2006 largely due to the impact of the HIV epidemic. Due to various HIV interventions and the marginal decrease in infant and under 5 mortality rates, there has been an increase in life expectancy since 2007. By 2019, life expectancy at birth was estimated at 61.5 years for males and 67.7 years for females<sup>70</sup>.

About 60% of the population lives in urban areas and this proportion is projected to increase to 70% by 2030. Urbanisation in South Africa is a complex issue grounded in the apartheid policies that shaped the relationship between urban and rural areas<sup>71</sup>. It is also affected by migration, international and national. People migrate due to economic, social-political, cultural or environmental reasons. Gauteng province receives the highest number of in-migrants for the period 2016 to 2021.<sup>72</sup>

The population age structure for South Africa, with the dynamics in declining infant and child mortality rate, has a proportionately large number of youth and working age population and a proportionately low number of young and old. Consequently, the dependency ratio is at a level where there are adequate number of working people to support the non-working population. According to the World Bank estimates, the dependency ratio for South Africa has been falling consistently from a high of 85.4% in 1966 to 52.11% in 2018.

To address the populations dynamics including the youth dividend and population, environment and development nexus, the government has put in place the national population policy advancing the ICDP agenda. Government periodically collects population data through several surveys notably the population census, demographic and health survey and vital statistics tools which informs development

<sup>70</sup> Mid-year population estimates, Stats South Africa  
<sup>71</sup> South Africa National Development Plan 2030  
<sup>72</sup> Statistics South Africa, <http://www.statssa.gov.za/?p=11331>

planning. At national level, the government has over time developed strong capacity to collect and analyse population data while efforts are on-going to build capacity at provincial and municipal (local government levels) to analyse and apply population data in the development of integrated development plans.

## **2.2 The role of external assistance**

### **2.2.1 Official Development Assistance**

South Africa is an upper middle-income country with strong macroeconomic performance, fiscal policy robustness, good infrastructure, a diversified economy and a vibrant private sector. Due to its considerable large fiscal space, South Africa is one of the least aid dependent countries in Africa. According to OECD statistics for 2010 Official Development Assistance (ODA) totalled US\$1,114 billion. Development assistance has remained at the same level with the data for 2017 indicating ODA of US\$ 1.173 billion<sup>73</sup>. ODA is used by the South Africa government as a strategic extra-budgetary resource to improve systems, share best practices, experiment with new models, unlock bottlenecks, add value and play a catalytic role in service delivery. Large investments in ODA have also been channelled to address the HIV/TB epidemic and improve sexual and reproductive health with the main funders being the Global Fund to Fight AIDS, TB and Malaria and the US Government. A large volume of external assistance also enters the country through non-governmental organisations. South Africa is also involved in South-South and BRICS<sup>74</sup> as well as bilateral cooperation with other countries where it benefits from knowledge and technology exchange<sup>75</sup>. Technical assistance, though small, plays a catalytic role in leveraging domestic resources.

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<sup>73</sup> <https://www.oecd.org/dac/financing-sustainable-development/development-finance-data/Africa-Development-Aid-at-a-Glance-2018.pdf>

<sup>74</sup> BRICS: Brazil, Russia, India, China and South Africa cooperation

<sup>75</sup> <https://www.oecd.org/dac/effectiveness/South%20Africa%202.pdf>

## Chapter 3: United Nations/ UNFPA response and programme strategies

### 3.1 UN and UNFPA Response

The United National Strategic Cooperation Framework (UNSCF) 2013-2017<sup>76</sup> guided the UNFPA and other UN agencies support to the Government of South Africa during this period. The framework is a broad-based plan, developed through a participatory and consultative process coordinated by government (Department of International Relations and Cooperation) and the UN Country Team; and aligned to the Government's plan of action in pursuit of its development objectives as reflected in the New Growth Path (NGP), the National Development Plan (NDP) vision 2030 and the Medium-Term Strategic Framework (MTSF). The UNSCF identifies areas of comparative advantage and value addition of UN to a country.

The focus of the UNSCF 2013-2017 was on the following thematic areas: inclusive growth and decent work, sustainable development, human capabilities, and governance and participation; and cross cutting areas of HIV and TB, gender equality and rights; as well as a focus on youth. Within these thematic areas, the UN defined 11 key results areas to guide its programming. UNFPA 4<sup>th</sup> CP was aligned to five key results (6, 8, 9, 10 and 11) under the human capabilities and governance and participation thematic areas.

The UNFPA Country Office was reported to be an active partner within the UN in planning and development of the UNSCF and overseeing its implementation. The UNFPA Country Office (CO) participates actively in the UNCT, is the deputy chair of the Programme Management Team that oversees implementation of the UNSCF, leads the technical team for youth development and is a member of the Gender Thematic Group for the UN agencies. UNFPA participation in the coordination of UNSCF is elaborated in Chapter 4.

### 3.2 UNFPA response through the country programme

#### 3.2.1 The Previous UNFPA Country Programme

The 3<sup>rd</sup> Country Programme was undertaken from 2007 to 2010, with further extension until 2012 to align with the United Nations Development Assistance Framework (UNDAF) and the national planning cycle. The CP was implemented in four provinces prioritised based on population and development indicators – KwaZulu-Natal, Eastern Cape, Limpopo and the Free State. This is in addition to supporting national departments relevant to the UNFPA mandate and collaborating with tertiary institutions and civil society organisations.

The goal of the CP was to (a) improve the quality of life of South Africans, by helping to reverse the spread of HIV; (b) reduce gender inequities; and (c) enhance the centrality of population issues in development policies and programmes.

The CP focused on three programme areas – Population and Development, Gender, Sexual and Reproductive Health including HIV prevention. The outputs and outcomes for the programme were as follows:

<b>3<sup>rd</sup> CP outcomes and outputs</b>
<b>Population and Development</b>
<b>Outcomes:</b> a) strengthened national macro-economic capacity for policy formulation, implementation and coordination b) strengthened government ability to develop and implement coordinated interventions to address economic and employment inequities within the economy.
<b>Outputs</b>
<ul style="list-style-type: none"><li>• Strengthened government capacity to integrate population, gender, environment and HIV/AIDS issues into development.</li><li>• Strengthened government capacity to develop and implement policies and programmes on employment and training.</li></ul>

<sup>76</sup> United Nations Strategic Cooperation Framework 2013-2017

- Strengthened government capacity to generate, analyse and disseminate policy relevant data, including Millennium Development Goal-related indicators.

#### **Sexual and Reproductive Health and Rights**

**Outcomes:** a) strengthened capacity of government to implement the comprehensive National HIV and AIDS Plan; b) improved and expanded of the National Health System to deliver high quality services

#### **Outputs**

- Strengthened capacity of the Government, non-governmental organizations (NGOs) and civil society to prevent HIV infection, especially among youth.
- The Government is supported in achieving universal access to HIV/AIDS prevention, treatment, care and support services.
- Strengthened capacity of healthcare workers to deliver reproductive health services, including high-quality family planning and services to prevent and manage gender-based violence and avoid unwanted and teenage pregnancies.
- Accelerated and increased use of female condoms.
- A strengthened national monitoring and evaluation framework, especially with regard to the compilation and analysis of HIV/AIDS data and reporting on reproductive health commodities

#### **Gender equality and women empowerment**

**Outcome:** a) enhanced structures and capacities to prevent and respond to violence against women.

#### **Outputs**

- Increased community capacity to prevent and respond to gender-based violence
- Strengthened capacity of different sectors of government and other relevant institutions in gender auditing, gender budgeting and gender mainstreaming.
- Strengthened provision of comprehensive services for female victims of gender-based violence and abuse.
- Strengthened capacity of national, provincial and local authorities and law enforcement agencies to implement human rights-based policies and programmes to prevent gender-based violence.

According to the end of CP evaluation, key achievements of the 3<sup>rd</sup> CP included:

- (i) The development of capacity of planning practitioners at national, provincial and municipal levels on integration of population data into development planning. These practitioners were trained on Applied Population Sciences Training and Research (UPSTAR), Population, Environment and Development Nexus and HIV integrated management.
- (ii) Improved capacity to deliver HIV prevention and SRH services through health worker training, expanded NGO partnership and increased coverage of HIV counselling and testing as well as increased public awareness of SRH and family planning.
- (iii) Enhanced capacity to prevent and respond to gender-based violence through strengthening the capacity of the Department of Women, Children and People with Disabilities, development of Gender Equity Policy, operationalisation of gender mainstreaming at national and provincial level and traditional leaders' engagement.

### **3.2.2 Current UNFPA Country Programme**

The results framework for the 4<sup>th</sup> CP articulated the UNFPA South Africa programmatic response. The 4<sup>th</sup> CP prioritised 2 provinces, a reduction from the 4 provinces covered in the 3<sup>rd</sup> CP, namely KwaZulu-Natal and Eastern Cape provinces. The CP focused on programmatic areas covered in the 3<sup>rd</sup> CP – sexual and reproductive health, gender and population dynamics and added a specific focus on the adolescents and youth programme area.

Table 4: 4th Country Programme Outcomes and Outputs

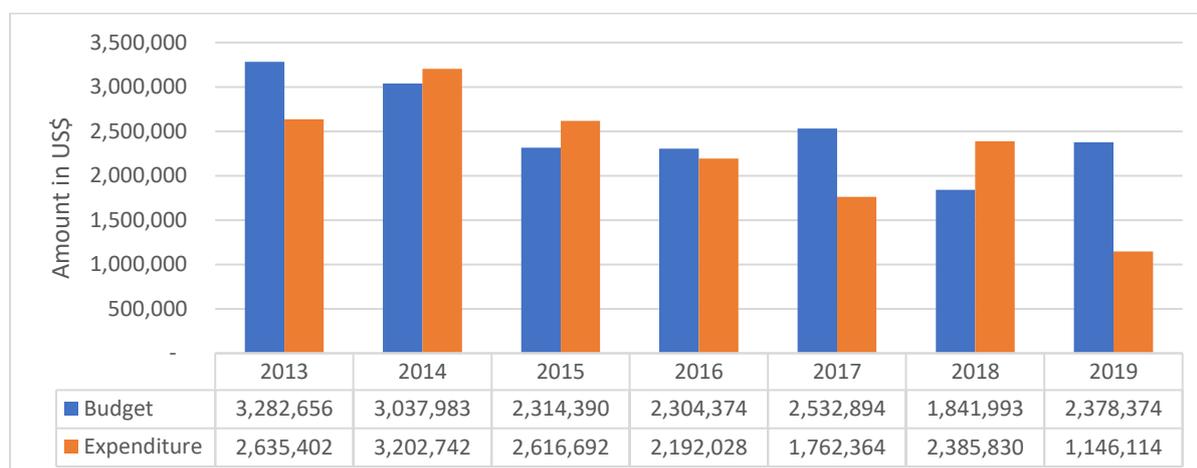
<p><b>National development priority or goal:</b> A long and healthy life for all South Africans</p> <p><b>UNSCF Focus area 3 Human Capabilities, Key Result Area 2:</b> Accelerated progress towards the sustainable achievement of the health related MDGs.</p> <p><b>UNSCF Focus area 4 Governance and Participation, Key Result Area 2:</b> Strengthened capacity of state institutions to provide access to services and support systems that enhance social protection, safety and security in communities, and justice for all.</p> <p><b>UNSCF Focus area 4 Governance and Participation, Key Result Area 1:</b> Improved capacity of national, provincial and local governments to plan, implement, monitor, and evaluate government policies for improved service delivery and strengthened participatory democracy.</p>	
<p><b>UNFPA Strategic Plan Outcome</b></p>	<p>Country Programme Outputs (original and for extension period)</p>
<p>Outcome 1: Increased availability and use of integrated sexual and reproductive health services (including family planning, maternal health and HIV) that are gender-responsive and meet human rights standards for quality of care and equity in access</p>	<p>Output 1: Improved quality of emergency obstetric care, family planning and HIV-prevention services in health facilities and communities in targeted districts</p>
<p>Outcome 2: Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health</p>	<p>Output 2: Strengthened capacity of civil society organizations to improve social and behaviour change communication to promote safe sexual behaviour among key populations</p> <p><u>Outputs for Extension period</u></p> <p>Output 2. Increased adolescent and young people’s knowledge and skills towards adoption of protective sexual behaviours</p> <p>Output 3. Policies, strategies and programmes in key sectors address the determinants of adolescent and youth sexual and reproductive health, gender equality and GBV</p>
<p>Outcome 3: Advanced gender equality, women’s and girls’ empowerment, and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth</p>	<p>Output 3: Strengthened capacity of national and provincial departments and district municipalities to implement policies and programmes to prevent gender-based violence, including sexual violence</p> <p><u>Output for extension period</u></p> <p>Output 4: Strengthened civic society and community mobilization to abandon discrimination gender and discriminatory gender and socio-cultural norms (New)</p>
<p>Outcome 4: Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality</p>	<p>Output 4a: Strengthened capacity of provincial departments and district municipalities to integrate population dynamics, especially youth development, HIV/AIDS, and environmental sustainability into development plans and programmes</p> <p>Output 4b: Strengthened government institutional capacity to generate, analyse and utilize data to inform, monitor and evaluate policy and programme implementation</p>

The 4<sup>th</sup> CP was implemented jointly by UNFPA and the Government of South Africa. UNFPA worked in partnership with departments with relevant mandates to the CP programmatic areas (departments of health, social development, women, education, performance & M&E and other government institutions) at national levels and provincial government departments in the two prioritised provinces. Other partners included civil society organisations. The CP maintained the coordinating sub-offices in the two provinces to sustain gains made in coordination, improved partnerships and implementation efficiencies at the province and community levels as recommended in the 3<sup>rd</sup> CP evaluation.

### 3.2.3 Financial Structure of the Programme

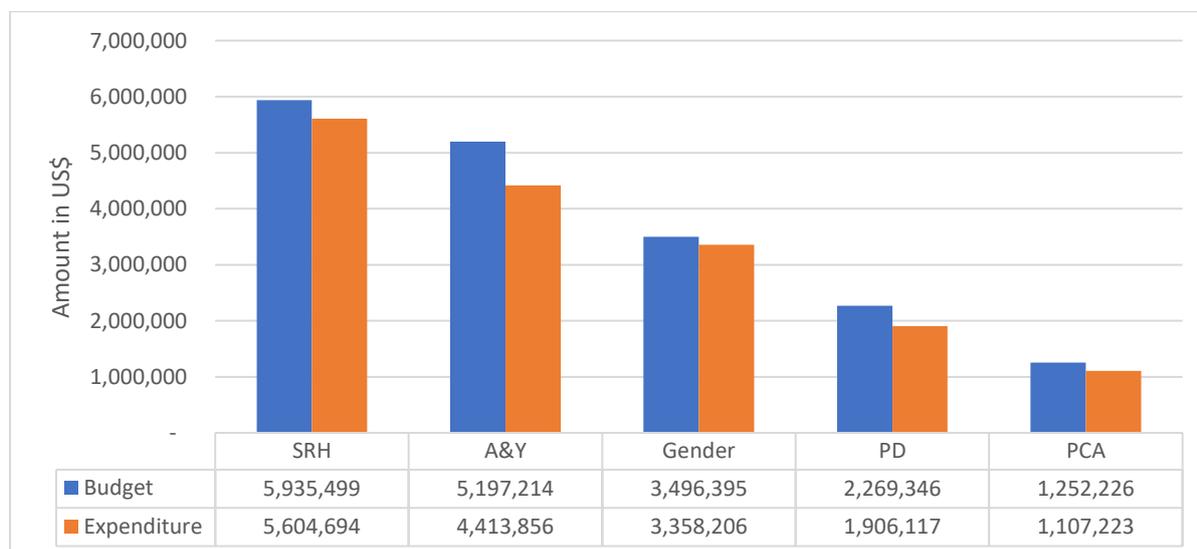
The 4<sup>th</sup> CP was approved with a budget of \$12 million. The CP budget was reviewed in 2014 during the alignment to the UNFPA Strategic Plan 2014-2017. The aligned indicative budget for the programme was also \$12 million with regular resources and other resources constituting 50% of the budget each. Figure 1 below summarises the budget against expenditure over the programme period including the extension up to mid-2019.

Figure 4: Total budget vs expenditure



Budget overspend occurred in 2014, 2015 and 2018 with the most significant overspend in 2018. 2013, 2016, 2017 and 2019 were characterised by underspend against the budget.

Figure 5: Total budget vs expenditure by programme area

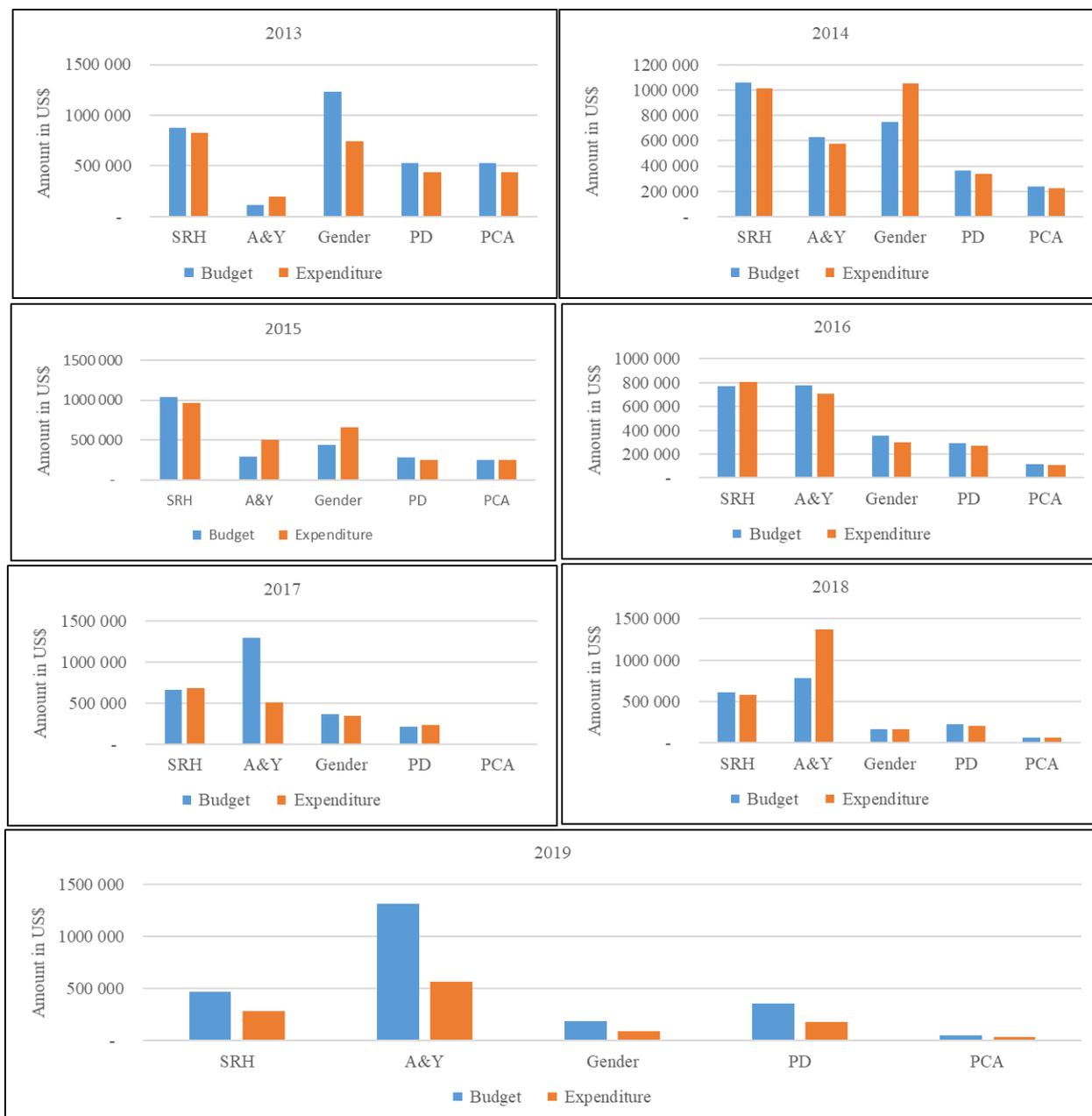


Total budget expenditure by programme areas 2013 – 2019: over 34% of the budget was spent on SRH interventions followed by adolescents and youth (27%) with expenditure on population dynamics at 12%. Spending on gender equality and women empowerment specific interventions was third highest although gender issues were also addressed across all the programmatic areas. 7% of the expenditure was on programme management and assistance.

The following figures provide budget and expenditure by year and by programme area. It shows the trend in expenditure year by year. Outcome 2 and 3 were allocated 27% and 20% of the resources respectively. However, in some of the years, resources allocation to these outcomes increased due to successful resource mobilisation from other sources such as the Safeguard Young People and Safer South Africa programmes. Outcome 4 (population dynamics) largely relied on the regular resources.

The Gender budget has steadily decreased from US\$1.2 million in 2013 to under US\$ 200, 000 in 2019. Whilst the SRH programme is also recognised as a programme with a strong gender focus, this programme’s budget has also decreased significantly between 2014 and 2019. The A&Y budget also increased over the period, with the largest spend on this area from 2017.

Figure 6: Budget vs expenditure by programmatic areas by year



A total of US\$3,813,022 was mobilised between 2013 and 2019 from other resources except the UNFPA regional office, UNBRAAF, RHCS and integrated innovation funds. This constitutes 21% of the total budget for the CP.

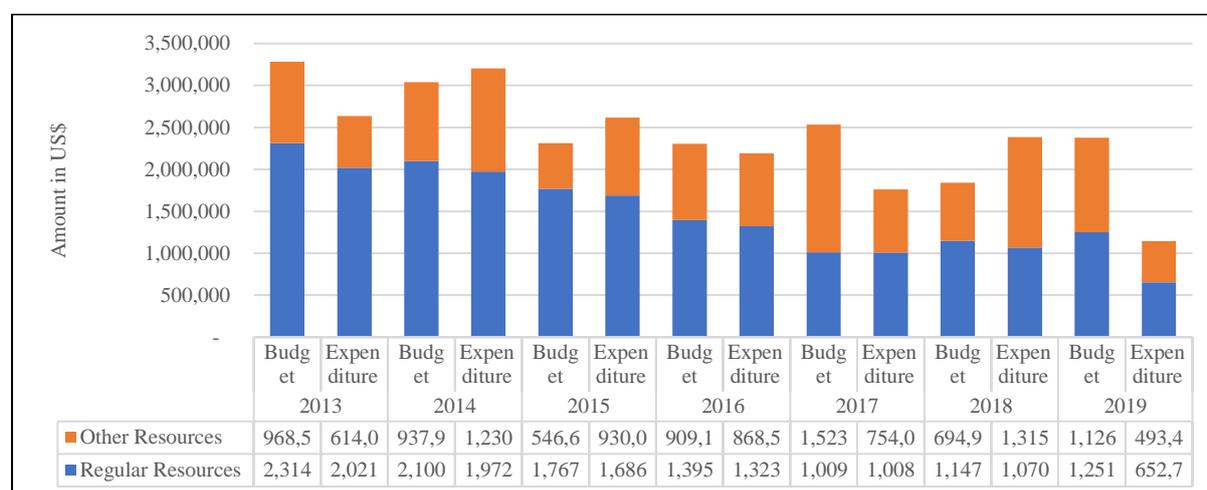
Table 5: Mobilized Resources excluding funds from Regional Office (UBRAF, RHCS, SYP, Integration and Innovation) 2013-2019

Funding Source	2013	2014	2015	2016	2017	2018	2019	Total
DFID								
GBV	856 764	477 982	150 000	30 123				1 514 869

DFID Maternal Health	458 015							458 015
Johnson & Johnson				121 262	836 857		458 810	1 416 929
3FPBF (Avenir)			83 605		75 876			159 481
CAA48 (Canada)				30 123				30 123
Total	1 548 384	477 982	233 605	181 508	912 733		458 810	3 813 022

The figure below shows budget and expenditure by origin of funds. It demonstrates the successful resource mobilisation efforts from other resources. Most non-regular resources were for adolescents and youth (safeguard young people) programme funded by UNFPA regional office and the Safer South Africa (gender-based violence) programmes funded by DFID as well as the UBRAF funds from UNAIDS. The figures also show the substantial reduction of regular resources from 2015 in line with the resource allocation criteria adopted for upper-middle income countries.

Figure 7: Budget and expenditure by origin of funds 2013-2019



## Chapter 4: Findings

This chapter addresses the questions set out in the evaluation matrix, exploring the indicators and assumptions and outlining the key findings for each evaluation question under each evaluation criteria. The chapter follows the structure of the evaluation matrix.

### 4.1 Evaluation Question 1: Relevance

- a) **To what extent is the country programme adapted to: national needs and policies; priorities of the programme stakeholders and target groups; the goals of the ICPD Programme of Action, SDGs, and the strategies of UNFPA?**
- b) **To what extent has the country office been able to respond to changes in national needs and priorities caused or to shifts caused by major political change? What was the quality of the response?**

#### Summary of Findings

- a) The country programme is fully aligned to UNFPA Strategic Plan 2008-2012 and 2014-2017 and UNSCF 2013-2017. Adjustments were made in the CP business model, results framework, geographical coverage to respond to changes introduced through the UNFAP Strategic Plan 2014-2017. The CP also contributed to the UNSCF 2013 – 2017 results in the areas of human capabilities and governance and participation. The programme was also aligned to the MDGs but comprehensive alignment to SDGs will be done in the 5<sup>th</sup> country programme.
- b) The 4<sup>th</sup> CP is fully aligned to ICPD POA especially in areas of gender equality and women empowerment, reproductive rights and reproductive health including promotion of family planning, HIV prevention, maternal and child health with a focus on safe motherhood, integration of population dynamics in development and supporting South Africa to advance ICDP agenda.
- c) The country programme is fully aligned to the national policies and strategies which ensured the CP contribution to both the development and implementation of the policies and strategies to demonstrate their effectiveness in all outcome areas. However, research conducted by the Commission on Gender Equality has noted that the NDP is gender blind and whilst the CP aligns with NDP, this weakness should be noted.
- d) The country programme took into account the needs of targeted populations through evidence-based programming. Assessments and surveys conducted identified the needs of target populations that informed the support provided by the CP. Further, targeted populations (youth led organisations or adolescents and young people themselves) are engaged in the development and implementation of some of the interventions. However, a detailed gender and human rights analysis to inform gender and human rights based programming across all interventions limited.
- e) UNFPA response to changes and requests outside of annual work plans is guided by criteria – relevance to UNFPA mandate and mode of engagement, contribution to planned results and availability of funds. Requests meeting these criteria are often supported.

#### 4.1.1 Strategic alignment

##### 4.1.1.1 Alignment of the 4th Country Programme to UNFPA Strategy

The 4<sup>th</sup> CP contributes to the overall UNFPA strategic goal – the achievement of universal access to sexual and reproductive health, realisation of reproductive rights, reduction of maternal mortality to accelerate progress on ICPD agenda. During the period of the CP implementation (2013-2019), three UNFPA strategic plans were developed and the CP had to be adjusted to be consistent to these strategic plans.

**Alignment to UNFPA Strategic Plan 2008-2013:** The original CP developed in 2012 was aligned to the UNFPA strategic plan of 2008-2013. The CP identified five outputs through which it contributed to the four UNFPA strategic outcome areas of maternal and new-born health, prevention services for HIV and sexually transmitted infections, gender equality and reproductive rights and population dynamics.

**Alignment to UNFPA Strategic Plan 2014-2017:** One year into the 4<sup>th</sup> CP implementation, UNFPA developed its corporate strategic plan for 2014-2017 introducing modes of engagement relevant to different country settings, an integrated results framework and a new resource allocation system. The 4<sup>th</sup> CP was distinguished by the classification of South Africa in the “yellow” quadrant as an upper middle-income country with high need as well as high capacity to finance its interventions. In this context, the CP was required to focus on upstream work of advocacy, policy dialogue and knowledge management and less on capacity building and service delivery. To align to the 2014-2017 strategic plan, the 4<sup>th</sup> CP: (i) Maintained support for upstream advocacy, policy and knowledge management with the capacity building component to be phased out over the remainder of the programme cycle; (ii) Developed a partnership plan for implementation of the CP and advancing the ICPD agenda at country level; (iii) Revised the results framework to align the outputs in the original CP to the four outcome areas of strategic plan 2014-2017 resulting in the development of an integrated results framework; (iv) Reviewed funding arrangements and resource allocation in line with the Resource Allocation System (RAS) which saw a gradual decrease of regular resources from 10-12% in 2014/15 to 6-8% in 2016/17.

At the time of making these changes, national partners expressed reservations with the feasibility of this business model given the high levels of income inequalities and the poor health indicators in the country, particularly the maternal and child health, high HIV prevalence and high prevalence of Gender-Based Violence. In addition, stakeholders observed that South Africa has strong legal and policy frameworks, and strategic plans for most sectors including health and gender; and the major need for UNFPA assistance is in policy and strategy implementation and monitoring at all levels. Further, the 8 districts targeted by the CP were the poorest performing in health and socio-economic indicators; the situation in these districts was far from an “upper-middle income”.

The number of districts covered by the CP was reduced from 8 to 3 due to the reduction of funding and the realisation that a huge amount of resources (human, financial and time) were required to achieve the CP results in the 8 prioritised districts. The positive outcome of this change is that the concentration of resources in the two districts improved the CP performance and contributed to achievement of planned targets.

The 4<sup>th</sup> CP adopted human rights based approach and gender mainstreaming as key enabling factors for attainment of the UNFPA goal as articulated in the UNFPA strategic plan. Human rights based approach can be seen on how the 4<sup>th</sup> CP ensured the provision of adolescents and youth friendly services, involvement of young people in design and implementation of interventions, establishment of the Youth Advisory Panel which brought the voice of young people into programming and decision-making processes among others. Tools were introduced to collect sex and age disaggregated data to support programming. The 4<sup>th</sup> CP also promoted gender equality across all outcome areas of the CP through identifying SRH, HIV prevention and family planning needs of adolescents and young women and through outcome 3 which focused specifically on gender equality and women empowerment with particular attention to Gender-Based Violence. However, the human rights and gender analysis was not always consistently applied across all outcome areas<sup>77</sup>.

**Alignment to the UNFPA Strategic Plan 2018-2022:** This strategic plan aligns UNFPA programmes to the Sustainable Development Goals and also makes adjustments to the UNFPA business model. However, the 4<sup>th</sup> CP outputs for the extension period aligns with the outcomes of the 2018-2022 strategic plan. However, full alignment of the CP with this strategic plan was to be realised in the 5<sup>th</sup> CP in 2017, but the development of the 5<sup>th</sup> CP was postponed to 2020.

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<sup>77</sup> Finding from documents review, UNFPA staff responses and key informants

#### **4.1.1.2 Alignment of the 4th Country Programme to ICPD POA, MDGs and SDGs**

The 4<sup>th</sup> CP is fully aligned to ICPD POA especially in the thematic areas of (i) Gender equality and women empowerment where the CP supported the reduction of harmful traditional practices such as early and forced marriage and violence against girls and women; (ii) Reproductive rights and reproductive health focusing on capacity building to ensure reproductive health services are available and removing barriers to make the services accessible to all individuals, providing choice to enable girls and women exercise their reproductive health rights, and addressing unmet family planning need through expanding contraceptive services; (iii) Sexually Transmitted Infections and HIV where the CP supported HIV prevention among vulnerable and key populations; (iv) Maternal and child health with particular attention to emergency obstetric and neonatal care; and (v) Population and development focusing on integration of population dynamics into integrated development plans.

The 4th CP was developed during the era of Millennium Development Goals (MDGs). The country programme was responsive to the MDG 5a and 5b on maternal and reproductive health, MDG 3 on gender, MDG 4 on reducing child mortality, MDG 6 on combating HIV and AIDS, and MDG 7 on integration of sustainable development into country policies and programmes and reversing loss of environmental resources. The CP supported the government in implementation of the “county down to MDGs” interventions which aimed at accelerating South Africa’s achievement of MDG targets by 2015.

On the other hand, the CP did not take deliberate steps to align to the Sustainable Development Goals (SDGs) which came into action after 2015. This alignment could have taken place in 2017 during the development of the 5<sup>th</sup> CP. However, the development of the 5<sup>th</sup> CP was postponed to 2020, at the request of Government, in order to harmonise the Government and UN Strategic Cooperation Framework planning cycles. Currently, the government is finalising its Medium-Term Strategic Framework (MTSF) which will inform the UNSCF 2020-2025 and UNFPA 5th Country Programme.

#### **4.1.2 Relevance and responsiveness to national policies and priorities of stakeholders and target populations**

##### **4.1.2.1 Overview**

The 4th CP is aligned to priorities of the National Development Plan (vision 2030) in the thematic areas of health, safety and security, and population and development. In the health sector, the NDP prioritises the increase of the average life expectancy at birth and reduction of maternal, infant and child mortality. Within the security and safety thematic area, the NDP recognises the alarming levels of violence against women and children and prioritises evidence-based interventions for addressing the root causes of violence and providing services to survivors of such violence. The NDP also underscores the need to harness demographic dividend through interventions that empower the youth in all social and economic spheres. The 4<sup>th</sup> CP is responsive to these overarching priorities set out in the NDP. In addition, the CP is also fully aligned to the second Medium Term Strategic Framework 2014-2019 (which operationalises the NDP) priority actions aimed at provision of quality healthcare and social security for all citizens and contributing to a better Africa and a better world.

##### **4.1.2.2 Sexual and reproductive health and rights**

The SRH component of the 4th CP is aligned to and supports the implementation of following policies:

National Adolescent and Youth Health Policy which promotes health and wellbeing of young people aged 10-24 years and provides guidance to government departments and organisations (including UNFPA) working with the National Department of Health (NDOH) on how to respond to health needs of young people. The objectives of this policy are to (i) Promote health and wellbeing of adolescents and youth; (ii) Provide comprehensive, integrated sexual and reproductive health and rights services; and (iii) Empower adolescents and youth to engage in the development of policy and programmes for the youth.

National Contraception and Fertility Planning Policy and Service Delivery Guidelines (NCFPP), and Choice of Termination of Pregnancy (CTOP) Act of 1996: The NCFPP takes into account the needs of

vulnerable groups such as sex workers, the LGBTQI community, migrants, men and women living with disabilities; adopts an approach of intersectionality of rights; education and health; and defines duty bearers and rights holders. The 4<sup>th</sup> CP provided support in line with the NCFPP and CTOP such as development of plans and tools for family planning and contraceptive counselling, training of healthcare workers on contraceptive methods and termination of pregnancy, monitoring of contraceptive uptake, integration of family planning, HIV and TB among others.

**Integrated School Health Policy:** The CP contributed to implementation of this policy through strengthening linkages between schools and health facilities, increasing awareness of the youth on their SRH rights, increasing demand for SRH services and improving integrated service delivery through better coordination among DOH, DOE and DSD and other stakeholders in schools and communities.

The CP is also aligned to the National Adolescent Sexual and Reproductive Health and Rights Framework Strategy (NASRHRFS) 2014-2019 which prioritises the needs of adolescents 10-19 years and adopts a multi-sectoral and multi-partner (government, civil society, international partners and private sector) implementation approach. The 4<sup>th</sup> CP supported interventions relevant to five priority areas of this framework: increased coordination, collaboration, information and knowledge on ASRH&R; development of innovative approaches for provision of comprehensive ASRH&R information, education and counselling; strengthening ASRH&R service delivery; creating effective community support networks for adolescents; and formulating evidence-based legislation, policies, strategies and guidelines for ASRH&R. NASRFS integrates gender and human rights considerations into these priority areas and this facilitates the mainstreaming of human rights and gender approach into the CP supported interventions.

#### **4.1.2.3 Adolescents and Youth**

The three outputs of the CP under the adolescents and youth programmatic area are fully aligned to national policies and strategies. The key policy guiding the CP support to adolescents and youth is the National Youth Policy (NYP). The priorities of this policy which the CP supports include promotion of youth access to healthcare (including SRH&R and prevention of HIV infection), combating substance abuse and optimising the machinery for effective service delivery by government and non-state actors across all sectors. However, the NYP does not define or include vulnerable groups such as youth engaged in sex work; LGBTQI youth, youth living in the street, youth who are migrants (illegal and legal) in the situational analysis<sup>78</sup>. The NYP also does not include specific chapter on gender equality, equity and health; which is one of the recommendations made by the UN Guide and a key principle of the UNFPA in gender mainstreaming.

Interventions supported by the CP are also aligned to the National HIV, TB and STI Strategic Plan (NSP) 2017-2022, the Integrated Strategy on HIV, STI and TB in school 2012-2016 and National Sex Worker HIV Strategic Plan 2016-2019. With regard to the NSP 2017-2022, the CP is aligned to (i) Goal 1 on reduction of new HIV and TB infections and STIs through provision of sensitive and age-appropriate sexual and reproductive health services and comprehensive sexuality education; (ii) Goal 3 on reaching key population with customised and targeted interventions; and (iii) Goal 4 addressing social and structural drivers of HIV, TB and STI.

The Country Programme supported implementation of the Integrated Strategy on HIV, STI and TB 2012-2016 for schools in conjunction with the Integrated School Health Policy. The priorities of this strategy include increased HIV, STI and TB knowledge and skills among learners and educators; reduction in risky sexual behaviour among learners and educators; and removal of barriers to retention of vulnerable learners in schools.

The CP's support to sex worker HIV and SRH interventions responded to the priorities set out in the National Sex Worker HIV Strategic Plan 2016-2019. The objectives of this plan are to reduce the risk of HIV infection among sex workers and their clients; to provide healthcare services to sex workers

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<sup>78</sup> This is also supported by the 'Guide to the implementation of the World Programme of Action for Youth; UN Department of Economic and Social Affairs (UN Guide).

including psychosocial support; and to develop effective mechanisms to deal with human rights abuse and violence. The CP was instrumental in the development of this strategic plan and supported a low-cost model sex worker programme to demonstrate the implementation of this strategic plan.

#### **4.1.2.4 Gender equality and gender-based violence**

This third outcome areas of the 4<sup>th</sup> CP is aligned to the key policy and legal framework for gender equality and women empowerment in the country: (i) the South Africa's National Policy Framework for Women's Empowerment and Gender Equality (NPFWEG), (ii) the Domestic Violence Act, (iii) the National Plan of Action for Children (NPAC) South Africa 2012-2017, and Integrated Programme of Action on Violence Against Women and Children 2013-2018.

The NPFWEG includes a number of principles that guide its implementation: (i) equality of all persons and non-sexism and non-racism as enshrined in the Constitution of South Africa; (ii) an understanding that women are not a homogenous group and can be further distinguished in terms of race, class, sexuality, disability, age and other variables. This principle informs all policies and programmes promoting gender equality. (iv) women's rights be seen as human rights; and (v) customary, cultural and religious practices be subject to the right to equality. These principles articulate a clear understanding and application of a human rights approach. The NPFWEG locates issues of gender equality within the framework of human rights and it articulates the importance of inclusivity, interdependence and inter-relatedness of human rights and the rights holder/ duty bearer dichotomy.

To promote the principles and priorities of NPFWEG, the CP supported the strengthening of coordination structures for gender equality and violence against women and children (VAWC) interventions especially at national, provincial and local government levels; establishing integrated coordination framework and process for gender mainstreaming; and improving monitoring and evaluation. Other interventions involved engagement of traditional leaders, men and communities in GBV prevention. Whereas these interventions were responsive to needs of girls and women, the follow up of issues to ensure effective utilisation of outputs achieved such as the gender profile/indicator assessments, gender audit results, Local Action Plans as well Community Safety Plans was inconsistent.

#### **4.1.2.5 Population dynamics**

The CP is consistent with two objectives of National Population Policy of 1998, namely: (i) To systematically integrate population factors into all policies, plans, programmes and strategies at all levels and within all sectors; and (ii) To make available reliable and up-to-date information on the population and human development situation in the country in order to inform policy making and programme design, implementation, monitoring and evaluation at all levels and in all sectors. Further the NPP underscores the interdependence of human rights; and the interrelationships between population, sustained economic growth and sustained development which is part of the requirement of a human rights approach. The guiding principles of the NPP recognise the need to respect human rights, including the universal right to development. The NPP aims to advance gender equality and equity and the empowerment of women. In aligning to the NPP, the 4CP supported capacity building for integration of population dynamics into IDPs and technical support for the design and implementation of Demographic and Health Survey (DHS) as well as advocacy for the ICPD agenda in the country.

### **4.1.3 Consideration of priorities of stakeholders and needs of target populations during programming**

The evaluation found that the 4<sup>th</sup> CP took deliberate measures to ensure stakeholder priorities and needs of targets populations were incorporated into programming. First, the CP was jointly developed by UNFPA and national partners ensuring that the programme document reflected priorities of national partners. The final CP document was signed off by Cabinet which demonstrates high level government ownership of the programme.

The process for development of annual work plans ensures stakeholders priorities are at the centre of programming. At provincial level, priority activities included in annual work plans are identified by district officials and signed off by each department head. The Provincial Coordinating Forum (PCF)

reviews and consolidates the workplans into an integrated provincial work plan. At national level, national departments use a similar approach to develop their annual work plans. All work plans are reviewed and endorsed by the programme National Coordinating Forum. During the planning process, the UNFPA Country Office is fully engaged and ensures work plans are relevant to its mandate and fit within available resources.

There are also processes in place for identifying and incorporating needs of target populations into interventions of the CP. Target population needs are identified through assessments and surveys. Examples of assessments carried out include the assessment of health facility capacity to deliver adolescents and youth friendly services, assessment of the underlying causes of teenage pregnancy among girls in schools, a survey on reasons for removal of implants, an assessment of the Obstetric Maternity Units and the Emergency maternal services (EMS). Other surveys included the comprehensive needs assessment for the Safer South Africa programme and Safeguard Young People Programme and an assessment of the needs of traditional leaders in prevention of GBV. The CP also identified needs of target population through involvement of these groups in the design and implementation of interventions. For instance, young people are involved in the planning and implementation of the DREAMS Thina Abantu Abasha project, youth advisory panel participation in periodic programme reviews, use of a youth-led organisation in implementing Nzululwazi model among others. Lastly, UNFPA staff participate in national and provincial technical working groups and other forums where needs of target populations are analysed and identified and the outcome of such discussions feed into programming.

#### **4.1.4 Response to changes in national priorities and needs/ requests for support outside of the work plans**

Partners from time to time requested for support for activities not included in the work plan. New activities are triggered by needs emerging during implementation or new priorities expressed by policy makers. Examples of support for new activities requested include the rebranding condoms following an assessment on the bottlenecks for low uptake, sensitisation of traditional leaders on GBV, and support for DOH to attend midwifery conference. UNFPA response to such requests is guided by criteria – whether the request is within the overall mandate and mode of engagement adopted by UNFPA, contributes to achievement of CP results and whether funds are available to support the new activity. UNFPA responded positively to request meeting these criteria.

At the political front, there were no major changes affecting the programme during the implementation period. South Africa held local government elections and general elections during the period of the programme but the outcomes of these elections did not impact in the programme plans. However, a few notable changes that occurred include the deactivation of the National Council on GBV which affected implementation of the activities for capacity building of gender coordination structures. The Department of Women (DOW) was also affected by a number of leadership changes as well as the amendment of its mandate. The Inter-Ministerial Committee on GBV which was initially coordinated by the DOW was later coordinated by DSD during the period of these changes. This affected the DOW's focus on the National Strategic Plan to End GBV. The plan did not progress and has only recently been revitalised and once again placed on the government agenda. These change notwithstanding, the programme was largely implemented as planned and achieved most of its output targets as elaborated in section 4.2 below.

## 4.2 Evaluation Question 2: Effectiveness

- a) **To what extent did the interventions supported by UNFPA in all programmatic areas contribute to the achievement of planned results (outputs and outcomes)? Were the planned geographical areas and target groups successfully reached?**

- a) The CP made good progress in the achievement of outputs in all programmatic areas. Targets set for the planned outputs were largely achieved and some over-achieved. A few targets were not achieved largely because of shifting government priorities or data was missing.
- b) In the SRH programmatic areas, the CP improved policy and capacity for emergency obstetric care through harmonisation emergency services and set up of Obstetric and Neonatal Care Ambulances; improved capacity and strengthened health systems for the provision of Adolescents and Youth Friendly Services, and SRH/HIV service integration; and developed the strategy and improved capacity to delivery contraceptive/family planning services and for condom programming.
- c) The CP prioritised adolescents and youth; and supported critical programmes which contributed to improving their access to SRH and HIV services. These include development of the national youth policy, comprehensive sexuality education, Intergenerational dialogue, the Nzululwazi model demonstrating implementation of ISHP, Youth Advisory Panel enhancing involvement of young people in decision making, programming and advocacy; youth-led empowerment interventions, training on Adolescent Sexual and Reproductive Health (ASRH) and subsequent mentorship of youth-led Community Based Organisations (CBOs), and low-cost sex worker programme.
- d) Through strategic support to the National Department of Women, Children and Persons with Disabilities, Office of the Premier in the two targeted provinces, capacity development of CBOs and Traditional Leaders, men engagement, policy development for GBV in institutions of higher education and strengthening of coordination mechanisms for GBV, the CP contributed to prevention and response to GBV. Interventions for gender equality and women empowerment were mainly focused on GBV prevention and most were short-term.
- e) In the population dynamics programmatic area, the CP contributed to integration of population data in Integrated Development Plans (IDPs), advancement of the ICPD agenda, generation and use of population data and south-south knowledge exchange and learning. These interventions advanced the ICPD Programme of Action.
- f) Across all programme areas various gaps have been identified which have affected the effectiveness of the interventions. Many of these are gender related pointing to the fact that gender mainstreaming across all the programme areas has not been substantive. This was also confirmed by key informants consulted.

### 4.2.1 Sexual and Reproductive Health and Rights

*Table 6: Summary achievements for Sexual and Reproductive Health*

**UNFPA Strategic Plan Outcome 1:** Outcome 1: Increased availability and use of integrated sexual and reproductive health services (including family planning, maternal health and HIV) that are gender-responsive and meet human rights standards for quality of care and equity in access

**Outcome indicators of South Africa CP:**

Contraceptive prevalence rate (total): Baseline 65%, Target Not available

% of births attended by skilled birth attendant: Baseline 91%, Target Not available

Percentage of women and men aged 15-49 who had more than one sexual partner in the past 12 months who reported use of a condom during their last intercourse (female/male: Baseline 57%, Target 100%

<b>Country Programme Output 1: Improved quality of emergency obstetric care, family planning and HIV-prevention services in health facilities and communities in targeted districts</b>					
<b>Indicators</b>		<b>Baseline</b>	<b>Target</b>	<b>Achievement</b>	<b>% achievement</b>
1	Number of tools with evidence produced to inform maternal health, family planning and HIV policy and programming at national and sub-national levels.	New indicator, not measured in 3 <sup>rd</sup> CP	49	50	102%
2	Number of health care workers trained on the new FP guidelines in the UNFPA supported districts	New indicator, not measured in 3 <sup>rd</sup> CP	8825	8978	102%
3	Number of UNFPA supported districts with functional Logistics Management Information Systems (LMIS) for forecasting and monitoring reproductive health commodities.	0	6	1	17%
4	Number of health facilities that provide integrated SRH and HIV services in UNFPA supported districts ( <i>Extension period</i> )	10 (2017)	25	10	40%
5	Number of women 10 – 49 (disaggregated by age groups) who are provided with integrated sexual health services (more than one service component) in UNFPA supported facilities ( <i>Extension period</i> )	47,520 (2017)	72,520		
6	Number of institutions/organizations supported to promote integrated SRH and HIV prevention services to youth and key populations ( <i>Extension period</i> )	56 (2017)	60		

#### 4.2.1.1 The achievement of planned results

The country programme performance has largely been on track and most of the SRH output indicators have been achieved. Targets for indicator 1 and 2 were achieved reflecting the high investment of the programme in these areas. The target for indicator 3 (number of districts with functional LMIS) was not achieved because national partners did not identify LMIS as a priority area for the CP while 40% achievement of the target for indicator 4 does not indicate the actual performance of the programme because data for 2018 is missing. However, qualitative data (through interviews and documents review) shows that SRH/HIV/FP integration was implemented in selected facilities in both Eastern Cape and KwaZulu-Natal (KZN) provinces. Data for indicator 5 and 6 is not available and therefore performance against targets for these indicators cannot be quantified. These indicators were included in the results framework for the extension period and lack of data could be attributed to lack of adjustment of the monitoring tools. Feedback provided during the NCF by the SRH team shows that access to SRH services was impaired by young women accessing SRH services late and access to termination of pregnancy is still a major challenge.<sup>79</sup>

SRH interventions were implemented through a partnership between UNFPA and national and provincial governments, implementing organisations and service providers. This section detailed the CP contribution to improving the quality of family planning (FP) and contraceptive use, obstetric emergency care, SRH/FP and HIV integration and adolescents and youth friendly SRH services.

#### Development of SRH tools

The CP support for the development of tools<sup>80</sup> (indicator 1) contributed to improved implementation of SRH and HIV policies and programmes. Tools developed included policies, guidelines, monitoring tools, service delivery aids, training manuals and programme assessment reports. The tools were utilised to improve capacity development and delivery of quality SRH/FP/HIV services. The “tools” developed are the national adolescent and youth health policy, national manual of family planning training, contraceptive and family planning and counselling tool, the translated family planning communication tools for CHWs for KZN, emergency medical services assessment, emergency medical services policy and emergency medical services standard operating procedures and action plans for KZN, Antenatal Care and Postnatal Care job aids, family planning communication materials, family planning monitoring and evaluation tool, national facilitators guide for family planning trainers, an assessment of Midwife Obstetric Units (MOUs) and Maternity Waiting Homes, family planning assessment,

<sup>79</sup> Outcome 1: Access, coverage, quality and safety of SRH services improved, presentation at NCF, July 2019

<sup>80</sup> The term tools used in the indicator encompasses policies, plans, guidelines, training manuals and assessments

adolescents and youth friendly services (AYFS) assessment in health facilities and institutes of higher learning, baseline data for Safeguarding Young People programme, mapping of SRH and HIV service points in 8 districts, assessment of the comprehensive sexuality education, midwifery workforce audit, logistics management information system assessment, development of the maternal health for neonatal, child and adolescents investment Case, early implant removal study, contraceptive and fertility planning strategy for KZN, HIV/TB/SRH integration manual. National strategic plan for HIV, TB and STI 2017-2022, guidelines for hepatitis, job aids for hepatitis and sex worker HIV plan.

Although this is not an exhaustive list of the “tools” developed with the support of the programme, it demonstrates the CP’s extensive investment of resources to improve the quality of sexual and reproductive health services. These tools were developed with the leadership of partners, through a participatory and consultative process and based on evidence. UNFPA worked jointly with national partners to train relevant personnel on the use and implementation of these “tools”, in most cases, through a cascaded approach involving training of master trainers from government and using the master trainers to train and mentor end users of these tools.

### **Family planning and contraceptive services**

Support for family planning contributed to availability, demand for and use of long acting and reversible contraceptives (LARCs) including implants and the provision of termination of pregnancy services. Key interventions supported include:

Contraceptive strategy development: The CP supported the development of the contraceptive strategic plan for KZN province (which was an update of the existing contraceptive strategy developed in 2011). This strategic plan prioritised the re-introduction of LARCs, provision of termination of pregnancy (TOP) services and integration of contraceptives with other SRH and HIV services. The strategy integrated contraception and fertility planning to include pregnancy prevention and planning for pregnancies and, therefore, offer more choices for women. The process for development of this strategy was government led and highly participatory which promoted support for family planning among leaders in the province. In EC province, the CP supported the development of the provincial family planning (FP) plan which aimed at increasing the coverage of FP services. However, the EC province continues to show a low uptake of the LARCs.

Capacity building for healthcare workers (HCWs) to provide quality contraceptive counselling: A contraceptive and fertility counselling tool was developed and rolled out in both KZN and EC provinces to improve counselling of clients on all contraceptive methods. Professional nurses were trained on the use of this tool. Further, an assessment conducted on the use of LARCs found that women were removing implants due to misconceptions and side effects; and poor counselling skills on LARCs among healthcare workers resulting in insertion of the implant with no proper counselling. Master trainers were trained to provide refresher training and mentorship for healthcare workers targeting health facilities with low uptake of contraceptives and high rate of implant removal. Further, the CP supported the roll out of the revised national family planning guidelines through printing of the guidelines and training professional nurses. Nurses working in clinics in institutions of higher learning were also targeted for training to reach tertiary education students.

Family planning education and awareness: The CP contributed to increased awareness of contraceptive use through support for the development of an Integrated SRHR User Tool for use by enrolled nurses to provide health education. Enrolled nurses were trained in all KZN districts on the use of this tool in health facilities and this contributed to increased uptake of SRH services including contraceptives. A dual protection campaign was also launched in KZN (involving political and community leaders) to promote the use of condoms and one other family planning method to address HIV, STI and family planning. In addition, IEC materials (posters, brochures and fliers) were developed to raise awareness among communities on SRH/FP. Implementation to date has identified the need to extend education and awareness to non-traditional settings like schools and using age appropriate social behavioural communication targeted at the youth.

Performance monitoring and improvement in provision of contraceptives: This intervention involved the development of the Couple Year Protection Rate (CYPR) dashboard for use by health facilities to

assess performance in the provision of contraceptive services. The dashboard was also a tool for service quality monitoring and improvement. It was piloted in 5 facilities in uThukela district. The evaluation of CYPR dashboard found that some of the staff who had been trained moved to new facilities, two facilities recalled being trained but were not using the dashboard, and the facilities lacked colour printers to print out the dashboard. There were also data gaps in the dashboard because staff were not consistently entering data. The dashboard also needed to be modified to provide a correct baseline taking into account the use of long acting contraceptives. 3 out of the 5 facilities were using the dashboard but not optimally. Key informants observed that such an initiative requires institutionalisation within the health system to succeed.

Capacity development in the provision Termination of Pregnancy (TOP) services: The CP supported training of doctors and professional nurses on the Choice of Termination of Pregnancy to increase service availability. Since South Africa legalised termination of pregnancy, all maternity facilities should offer this service to minimise illegal abortion. However, maternity facilities providing TOP services are still limited partly due to inadequate skills and values of service providers. The programme supported an intensive 9 days training of doctors and nurses, in KZN and Eastern Cape provinces in value clarification, followed with a clinical training on CTOP and a practical training phase.

### Emergency obstetric care

Improvement of obstetric emergency care through policy improvement, systems strengthening and capacity building: This initiative was supported as part of the Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA). One of the factors accounting for maternal deaths in South Africa is the delay in inter-facility referral of emergency obstetric cases. The CP supported the harmonisation of emergency medical services to address this delay in KZN. This support involved the development of the policy on obstetric and neonatal ambulance utilisation; establishment of Obstetric and Neonatal Ambulance (ONA) service; development of standard operating procedures, establishing a team to provide the emergency obstetric and neonatal referral services comprising HCWs, ambulance drivers and personnel; training of the emergency service team

Obstetric and Neonatal Ambulance Service in KZN Province



and establishing communication between maternity services and the ONA. The District Clinical Specialist Team and Advanced Midwife supervised, monitored and continuously mentored the ONA service team and also reviewed implementation and addressed bottlenecks. This process led to better relationship and attitudes among HCWs and ambulance service personnel resulting in improved team work, response time and reduction of delays in inter-facility referrals of emergency obstetric and neonatal cases. An evaluation carried out in the initial stages of the ONA service found that ONA carrying obstetric patients had an improved response time from 105.8 minutes to 69.0 minutes (an improvement of 35%). Whereas key informants observed that the ONA services have been strengthened over time and made a contribution to reduction of maternal deaths, there was no quantitative data to back up this claim<sup>81</sup>. Challenges facing the ONA service are mainly administrative and systemic such as occasional lack of adequate ambulances and staff transfers. In Eastern Cape province, guidelines on emergency obstetric and neonatal care were developed and Emergency Medical Services personnel and HCWs trained. Interventions to improve the obstetric emergency services were not implemented extensively in Eastern Cape as is the case in KZN. In Eastern Cape, UNFPA support for CARMMA focused on the assessment of health facilities readiness to provide maternal and child health services

<sup>81</sup> Report on improving harmonization of emergency medical response services in transferring patients with obstetric and neonatal emergencies between health facilities in KwaZulu-Natal, African Federation for Emergency Medicine, November 2015.

and implementation for the assessment findings and recommendations such as ensuring contraceptives were available at all service points in health facilities.

### **Adolescents and youth friendly services**

Extensive support was provided in both KZN and Eastern Cape provinces to increase availability and access to adolescents and youth friendly (AYFS) sexual and reproductive health and rights services through a multisectoral and multi-partner approach with linkages to communities and education institutions. Implementation of this initiative involved an assessment of health facility readiness to offer adolescent and youth friendly SRH services based on the national standards for AYFS; development of a plan to address identified gaps, including gaps in LGBTI access to SRH services; training of HCWs to delivery AYFS, weekly compliance monitoring and mentorship visits to the health facilities by district teams; collecting age and sex disaggregated data and using the data to understand the profile of SRH cases in the catchment areas; establishing youth zones with a dedicated peer worker to facilitate provision of AYFS. For health facilities to effectively manage the AYF SRH services, a champion was identified in each facility to lead this initiative and AFYS committees set up involving community stakeholders to use facility data to follow up and address underlying causes of SRH facing the A&Y such as teenage pregnancies GBV and HIV infections.

The DOH assigned a school health team to cover 11 schools to provide SRH education and refer those who need services to health facilities. The DOH also brought SRH services nearer to school using mobile clinics to enable in-school youth access services. Ground breakers based in health facilities also visited schools to create demand among the 10-24 year olds. These teams worked with Life Orientation Teachers and Learner Support Agents to provide information and education on SRH to in-school youth.

Lovelife, an implementing partner, developed the mobsite application to generate demand and connect AYP to SRH services. AYP registered on the mobsite and were connected to health facilities near them and also received appropriate SRH and HIV information. Those accessing SRH services would rate the youth friendliness of the service. This system generated data on the number of youth utilising services in the adolescents and youth friendly facilities. UNFPA provided tablets to health facilities to assist AYP to register on the mobsite application.

Ward Based Outreach Teams comprising a professional nurse, community health worker (CHW) environmental health and health promotion officers) conducted outreach events targeting out-of-school youth. DOH also extended SRH services to the community using CHWs who visit households to (among other services) conduct pregnancy tests among AGYW to identify pregnancies early and refer them to health facilities. This ensures that AGYW seek maternal services before week 20. However, this remains challenge with many young pregnant women still presenting too late for the required services.

This initiative resulted in increased networking in schools as peer educators (peer buddies) in school received information from mobsite and disseminated to their peers. The age and sex disaggregated data enabled the champions in health facilities to tailor services to AYP needs and the committee with community members (young mothers, traditional leaders, community members, DOE, DOH, AYP, DSD) to review the data and develop a plan of action e.g. finding out where cases are coming from and moving services there or intervening with prevention services. Key informants observed that this initiative contributed to increased access to SRH services although quantitative data to this effect was not available. On the other hand, the AYFS champions are overburdened because they are using paper-based tools to capture data which takes time; the turnover of the trained staff in both provinces is also a challenge for service delivery and requires that new staff are continuously trained while the AYP lack data/resources for internet connectivity and health facilities also lacked resources to set up internet connectivity at the youth zones.

### **SRH/FP/HIV service integration**

This intervention demonstrated a model for integration of SRH/HIV services in health facilities to increase service coverage. A delegation from KZN and EC was supported to undertaken a benchmarking tour to Botswana in 2017 where they learnt lessons how Botswana has integrated HIV/SRH/GBV service delivery using the kiosk, supermarket and mall models. Upon return, DOH

piloted SRH/HIV integration in selected facilities within the framework of IDEAL Clinics. IDEAL clinics have three streams – acute, chronic and MNCH. SRH/HIV was integrated in all the streams. The CP supported the training of HCWs integrated service delivery followed by implementation. An implementing partner was contracted to monitor implementation of SRH/HIV/FP services. Client exit interviews were conducted on a continuous and identified gaps were addressed. A tool was developed for use by HCWs to record the package of services offered to individual clients. The table below shows the results from implementation of the integrated service delivery.

Table 7: uThukela SRH/HIV Integration Project: Analysis of integrated service uptake<sup>82</sup>

Tracer Indicator	Health Facilities											
	AE Haviland		Injisuthi		Wembezi		Ncibidwane		Ntabahlophe		Average	
	Base-line	End-line	Base-line	End-line	Base-line	End-line	Baseline	End-line	Base-line	End-line	Base-line	End-line
Eligible Female offered cervical cancer service (%) and #	44% (7/16)	44% (14/32)	0 (20)	45% (13/25)	12.5% (2/16)	60% (35/58)	0% (13)	41% (7/17)	31% (5/16)	69% (29/42)	18% (14/81)	53% (98/174)
HIV Clients that received other services other than the service they came for (%) and #	39% (7/18)	75% (21/28)	0% (20)	72% (26/36)	26% (5/19)	79% (49/62)	0% (8)	69% (9/13)	33% (6/18)	73% (30/41)	20% (17/83)	74% (134/180)
Types of services mentioned to clients during consultations (#)	2	5	1	5	4	5	0	4	4	7	2	5

Service integration contributed to reduction of HIV stigma, patient waiting time (as a package of services are offered in one-stop-shop) and patient travel costs given that repeat visits were reduced. This pilot intervention has also been benchmarked by other facilities within the provinces. The challenge in implementation of service integration is mainly the staff turnover and ensuring commodity supplies for all components of the integrated services.

### Condom programming

UNFPA is a strategic partner for the NDOH condom programme and provided technical support to the department in all aspects of condom programming. Aspects of condom programming supported include development of technical specifications for male and female condoms and lubricants; development of the condom distribution plan; condom rebranding and positioning to increase uptake; field tested condom branding in KZN and Gauteng provinces; integration of condoms in SRH to promote dual protection; development of the condom communication strategy to create demand and development of the condom strategic plan. UNFPA is also a member of the national technical working group through which it provides technical advice. The CP support to condom programming contributed to increased uptake of condoms in the country.

Challenges in this area included lack of education and information on lubricants; socio-cultural barriers to access to and use of condoms; poor parent and child communication on SRH which affects the use of condoms by young people; limited education and information on female condoms; limited relevant and responsive marketing and education on condom use specially targeting young people ; lack of accurate data on condom distribution; limited comprehensive sexuality education; challenges in transport for distribution of condoms; and uptake of emergency contraception.

<sup>82</sup> uThukela SRH/HIV Integration project report by Optidel – Global Public Health and Environment, March 2019

#### 4.2.1.2 Integration of gender and human rights-based approach

The implementation of this programme area reflects the importance of SRH services in protecting women’s right to health and the fact that SRH is an important factor in helping women to have a better and safer future. All the SRH and HIV interventions supported by the CP addressed the SRH needs of adolescents and young women. However, there was a gap in the involvement of men in maternal and child health and family planning services. There were no specific interventions targeting men. As noted by key informants “Our programmes tend to be biased towards adolescent girls and young women, very few elements on engaging men and boys as partners.”<sup>83</sup>

UNFPA’s human rights approach is also highlighted by the UN vision of leaving no one behind. The CP applied the human rights approach in some of the SRH interventions. For instance, support for the provision of Adolescents and Youth Friendly Services addressed the key human rights principle of removing barriers to improve access to services for vulnerable groups. This intervention removed barriers AYP face within the health systems and at community level to access SRH services. Another intervention that has a human rights dimension is the capacity development on provision of termination of pregnancy services in order to expand SRH choices for women. Condom branding and scale up of female condoms was also designed to expand choice for women in negotiating and/or practicing safe sex.

Whereas SRH interventions by the CP have gender and human rights dimensions, there was limited analysis of the intersectionality of gender mainstreaming and human rights which recognises that these factors are further affected by other social determinants like race, disability status, sexual orientation, education, age and geography amongst others. To date the approach, whilst focusing on women, has been weak in addressing the needs of specific groups like youth, men and people with disabilities.

#### 4.2.2 Adolescents and Youth

Table 8: Summary achievements for adolescents and youth

<b>UNFPA Strategic Plan Outcome 2:</b> Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health						
<b>Outcome indicators of South Africa CP:</b> Percentage of young women and men aged 15-24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (female/male): Baseline: 28.6%, Target: Not available						
Output 2: Strengthened capacity of civil society organizations to improve social and behaviour change communication to promote safe sexual behaviour among young people and key populations						
Output indicators		Baseline	Target	Achievement	% achievement	Comments
1	No. of institutions / organisations supported to promote integrated SRH and HIV prevention services to youth and key populations	0	240	719	300%	Over achieved due to high demand for scaled up roll out of CSE training support particularly in the Eastern Cape province
2	Number of UNFPA supported districts with SBCC implementation plans	0	8	4	50%	Not achieved due to reduction of number of districts covered by the CP
3	No. of young people reached through media platforms created and managed by trained youth	Not available	1,364,542	19,615,519	1438%	Overachieved due to strategies used (see explanation below)
4	Number of participatory advocacy platforms that advocate for increased investments in	Not available	14	19	136%	Over achieved due to increased number of advocacy events and platforms where YAP members participated

<sup>83</sup> Observation from key informant.

	marginalized adolescents and youth					
Output 2 (for extension period): Increased adolescent and young people’s knowledge and skills towards adoption of protective sexual behaviours						
<b>Output indicators</b>		<b>Baseline</b>	<b>Target</b>	<b>Achievement</b>	<b>% achievement</b>	<b>Comments</b>
5	Number of young people reached with SBCC messages in the UNFPA supported districts	263 577 (2017)	338,577	See indicator 3		Indicator overlaps with and is reported under indicator 3 above
6	Number of young people that successfully complete the CSE out of school program in UNFPA supported districts	0 (2018)	5,000			No data available
7	Number of schools or teaching institutions that integrate CSE into their curriculum	3 (2017)	10	See indicator 1		Indicator overlaps with and is reported under indicator 1 above
Output 3 (for extension period): Policies, strategies and programmes in key sectors address the determinants of adolescent and youth sexual and reproductive health, gender equality and GBV						
<b>Output indicators</b>		<b>Baseline</b>	<b>Target</b>	<b>Achievement</b>	<b>% achievement</b>	<b>Comments</b>
8	Number of platforms with youth leadership that advocate for increased investments in marginalized adolescents and youth	3 (2017)	6	See indicator 4		Indicator overlaps with and is reported under indicator 4 above

#### 4.2.2.1 The achievement of planned results

The planned output result for the Adolescents and Youth component (as indicated above) was the strengthening of CSOs capacity to improve social and behavioural change communication (SBCC) to promote safe sexual behaviour among young people. During the programme extension, two outputs were added: increased knowledge and skills of AYP towards protective behaviours and having policies, strategies and programmes that address determinants of AYP SRH, gender equality and GBV. All these outputs have a common focus on increasing knowledge and skills among AYP through SBCC interventions. This is affirmed by the fact that indicators for the added outputs also overlap with indicators for the original output as noted in the table above. Although the output focuses on strengthening the capacity of CSOs, the CP supported both CSOs and government departments to delivery SBCC interventions in order to reach AYP both in-school and tertiary institutions and out-of-school.

All targets for indicators for these outputs were overachieved except one. Indicator 1 was overachieved due to the scale up of the roll-out of CSE especially in schools in Eastern Cape province. Indicator 3 was overachieved by a huge margin due to implementation strategies such as Lovelife mobi-clinic locator in EC and KZN which proved very successful, YAP members engaging the media and students in attendance, media interviews conducted community radio stations, engaging the youth on Twitter and Facebook platforms, social media engagement and reach to young people during World Population Day (WPD), the launch of State of the World Population (SWOP) report and the commemoration of International Day of the Child, SBCC activities on family planning; intergenerational dialogues. Indicator 4 was also overachieved due to the increased number of events and platforms in which YAP members participated. The target for indicator 2 on number of districts with SBCC implementation plans was not achieved due to the reduction of districts covered by the CP from 8 to 2 and partly due to the implementing partner<sup>84</sup> appointed to develop SBCC plans that did not

<sup>84</sup> Malengo Consulting appointed to develop the SBCC plans with key messages on FP and HIV prevention for two districts in KZN and EC could not develop quality plans and messages due to limited capacity in the area of SBCC. See 2016 CP annual report.

deliver quality plans and messages. These results were achieved through interventions supported by the CP to strength capacity of institutions at national and provincial levels as well community-based interventions that reached AYP with integrated SRH/HIV information and services.

The CP strengthened the enabling policy environment for delivery of youth programmes including SRH/HIV through development of the national youth policy and M&E framework. In this regard, the CP supported the Department of Planning and Monitoring and Evaluation to undertake a comprehensive survey on the Status of the Youth in the country which provided a profile of challenges facing young people in all aspects. The study informed the development of the National Youth Policy, as a strategic guide for all sectors and stakeholders on how to support youth development in the country. The policy was developed through a comprehensive participatory process involving all key stakeholders and was approved by cabinet. The CP also supported the developed and roll-out of the Monitoring and Evaluation Framework for National Youth Policy and training of M&E focal persons from government departments at national and provincial levels on the implementation of this framework. Government departments are currently reporting to DPME on indicators on the M&E framework relevant to their sectors.

The CP developed the capacity of education institutions to deliver CSE to in-school youth in both KZN and EC. Life Orientation Teachers (LOT) in both KZN and EC attended an online training CSE training modelled around the UNESCO CSE technical guidelines. The teachers were expected to pass on the information to learners after the training. However, the post training plan to ensure teachers provide CSE in schools was not well coordinated. Teachers could not access the training materials on-line due to lack of access to computers and lack of computer literacy among some teachers. The initiative also lacked a monitoring, reporting and follow-up mechanism. In the Eastern Cape Province, follow up interventions supported by UNFPA, GIZ and UNESCO sought to address these weaknesses. A CSE manual was developed to ensure LOT had access to CSE content, and master trainers were trained who in turn trained teachers. A total of 798 LOT and 124 education officials have been trained on CSE. A monitoring mechanism is being developed to monitor whether the trained teachers are delivery CSE to learners. Therefore, data on learners reached is not available and the evaluation could not ascertain whether the trained teachers are delivering CSE to learners. Another related initiative is in Eastern Cape, is the signing of a Memorandum of Understanding between DOE, DOH and DSD to cooperate in implementation of the Integrated School Health Policy including CSE as a key step towards sustaining CSE.

Support for implementation of the Nzululwazi model contributed to achievement of three aspects of the CP output: strengthening capacity of government departments (DOE, DOH and DSD) to deliver SRH/HIV services; strengthening coordination among these departments and reaching directly to target populations – in school and out-of- school youth and community members. The support demonstrated an effective model for implementing the Integrated School Health Policy launched in 2012/2013 but was not sufficiently implemented. The model, named after Nzululwazi Senior Secondary School in Alfred Nzo district in Eastern Cape, was initiated in 2014 in response to high teenage pregnancy in this school (45 pregnancies reported in 2013 and at least 21 in 2014) and implemented through a partnership of DOE, DOH and DSD with UNFPA support and Restless Development as an implementing partner. Implementation started with a baseline assessment which identified underlying factors accounting for the teenage pregnancy in the school, key

Implementation of Nzululwazi model activities



among them being high incidence of sex between the girls and teachers and older men in the community as well as boys; low knowledge of HIV, barriers of access to SRH services such as unaffordable transport to the clinics and lack of confidentiality at the clinic, substance and drug abuse and general delinquency among students, limited support from parents and the community. A technical team was formed to coordinate the initiative; the School Governance Body was trained to support implementation; 20 students peer educators were identified and trained and conducted CSE education sessions in the school; youth led intergenerational dialogues were conducted to develop actions plans to prevent teenage pregnancy and increase access to SRH/HIV services and “One Man Can” campaign was undertaken targeting men and boys focusing on social and sexual behaviour change. DOH brought SRH/HIV services on site to address the issue of distance to health facilities, and DSD deployed a social worker to provide SRH/HIV counselling and link eligible AYP to social grants<sup>85</sup>. An operational research carried out in 2016 showed increased knowledge of HIV and SRH and increased protective behaviour among learners; increased access to and uptake of adolescent friendly SRH services with 195 girls taking up contraceptives, 35,600 condoms distributed, and 213 tested for HIV. Teenage pregnancies in the school reduced from 45 in 2013 to 2 in 2016<sup>86</sup>. UNFPA provided financial and technical assistance support and facilitate national level advocacy for the adoption of the model as a good practice for implementing the ISHP.

The CP support for Intergenerational dialogue and Communication on ASRH training initiatives in KZN and EC provinces built the capacity of local actors to address causes of teenage pregnancy, HIV and gender-based violence and at the same time directly increased knowledge of AYP SRH and HIV prevention. The initiative broke barriers in communication barriers between AYP and adults (parents, community leaders and service providers). The UNFPA support was provided under the regional Safeguard Young People Programme. At the national level, the initiative was part of the broader national programme implemented in several other provinces coordinated by DSD. Assessments were conducted to identify SRH/HIV challenges facing AYP and the establish a baseline data; followed by mentorship of youth-led Community Based Organisations (CBOs) and subsequent facilitation of intergenerational dialogue sessions on SRHR, HIV, and GBV; and development of an action plan based on agreed solutions. An evaluation of the Intergenerational Communication on ARHR training shows that almost all (99%) persons interviewed (AYP and adults) found the training relevant to their needs and concerns; over 75% of the respondents indicated improved knowledge on STIs, SRHR and obligations, teenage pregnancy and gender; and those comfortable to talk about SRHR issues ranged from social workers (100%) to parents (64.3%)<sup>87</sup>.

Other related interventions addressing SRHR/HIV issues among in-school and out-of-school youth included (i) Connecting in-school youth to AYFS in health facilities using the mobsite app implemented by Lovelife; (ii) promotion of contraceptive use to prevent teenage pregnancy, GBV reporting and raising awareness among adolescent girls on how to access ANC services implemented by CHIVA; and (iii) Youth Advisory Panel (YAP) members engaging AYP in SRH/HIV matters using intergenerational dialogues and other platforms. Key informants observed that behaviour among AYP in the targeted school has changed, for instance there has been a reduction of student strikes; learner pregnancies have reduced and LSAs reports show learners accessing health facilities have increased<sup>88</sup>.

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<sup>85</sup> Case Study: A Coordinated Multi-Sectoral Approach to ASRHR Service Delivery and Demand Creation, Restless Development.

<sup>86</sup> Research report for: Adolescents and Youth Sexual and Reproductive Health and HIV prevention operational research of the Safe Guard Young People Programme intervention in Nzululwazi and surrounding community in Alfred Nzo District, Eastern Cape.

<sup>87</sup> Evaluation of the Implementation of the Training Course: Intergenerational Communication on Adolescent Sexual and Reproductive Health and Rights, Quest Research Services, 2018

<sup>88</sup> This is the key informant observations on the achievements of this initiative but LSA reports were not obtained to ascertain this observation

YAP members participating in launch of State of the World Population report in 2018



Involvement of young people in decision making and programming is critical for development of policies and strategies and implementation approaches responsive to their needs. Under the Safeguard Young People programme, the UNFPA supported the establishment of the Youth Advisory Panel to enhance the voice of the young in the country programme. The YAP members played a key role in advocating for SRH rights and HIV issues among AYP (including LGBTI youth) from community to international platforms. Two cohorts of YAP members were recruited through an open process during the period of

country programme. The qualifications for YAP members partly contributed to the achievements of this initiative given that a YAP member needed to have experience in youth activism, be involved in advocacy or community development and have links to youth networks or organisations. YAP members interviewed indicated that they participated in activities convened by UNFPA at community level to sensitise their peers on SRH and HIV issues including early marriages, teenage pregnancy, HIV prevention, substance and drug abuse, depression and mental health, employment and youth participation in local development processes. They also participated in the Provincial Coordinating Forum and the National Coordination Forum for the country programme where they presented reports on their activities and participated in progress review of the country programme. During these forums, they were listened to and provided input into the reports and plans presented by government departments and other implementing partners. The YAP also participated in international forums such as the Pan Africa Forum in Ethiopia, where they interacted with other young people and advanced the youth agenda. The YAP also participated in a satellite SRH and HIV advocacy event during the South Africa AIDS Conference which was broadcast. This initiative built the capacity of the YAP members themselves through training, information sharing and participation in the CP coordination meetings and international forum. Key informants, including the YAP members, noted that individual YAP members gained experience which has helped some of them to advance in their careers and to continue advocating for youth issues in different settings after completing their YAP term. However, they were few in number (12 in total) which limited the impact they would have; their operations at community level was limited to the district they were assigned; the implementation modalities were not thought through effectively and they largely depended on activities organised by UNFPA or UNFPA implementing partners and their work plans were not always followed. While the recruitment process for YAP members was open and any young person would apply, this process disconnected YAP members from other networks or platforms that represent young people in the country.

UNFPA, in partnership with Johnson and Johnson, increased knowledge of SRH and built skills in leadership and employability among AYP through the DREAM Thina Abantu Abasha project. This project started in 2018 and implementation is on-going. It is being implemented in two districts (Umgungundlovu and eThekweni) in KZN province and two districts (City of Johannesburg and Ekurhuleni) in Gauteng province. It demonstrates how to successfully implement a youth-led project and offers lessons on UNFPA partnership with private sector. The results achieved so far are shown below<sup>89</sup>:

Item /Indicator (Data to be updated)	Target	Result
Youth Leaders Field Team	165	154
Youth Leadership Team Members	6	8

<sup>89</sup> Data from project M&E records

Programme Trainers	11	12
Targeted young people for training	240,000	267,000
Community activation		65,000
Road shows		34,000
Community radio		128,000
Social Media		40,000

Johnson and Johnson is providing funding, strategic guidance and undertaking media activities while UNFPA is responsible for technical, administrative, human resources and financial management, implementation, monitoring and reporting and management of stakeholders of the project. At project start-up, UNFPA played a key role in introducing the project in the targeted districts by engaging with district and community leaders including ward councillors for buy-in and support and undertook community dialogue meetings to confirm the local needs of AYP in these districts and the relevance of the project objectives. The project is managed and implemented by young people themselves. UNFPA recruited Youth Leader Leadership Team members who manage the planning, implementation and monitoring of the project and Youth Leaders Field team who mobilise and train AYP in the targeted communities. A standardised training manual is being used to delivery training to AYP. AYP are reached were trained through community activation meetings, roadshows, community radio and social media platforms. Some of the challenges of the project originated from the local political environment where ward councillors wanted to influence the selection of the youth to be employment in the project. This led to one district in KZN being dropped from the project. Principals of schools would also like to deal directly with the DBE or young people should have an official letter from DBE to access in-school youth. Managing young people poses different challenges given their potential to focus on issues outside of project objectives. It is also difficult to reach AYP during school holidays and exam period which also affects implementation.

The CPs further supported capacity building and increase in knowledge and access to SRH services among sex workers through two interventions: (i) Development of the South Africa National Sex Worker HIV Plan 2016 – 2019 which aims to reach 70,000 sex workers over three years period using a peer educator led approach to address the multiple drivers of HIV and opportunistic infections. This was the first national plan for HIV dedicated to addressing the biomedical, behavioural and structural challenges sex workers face in accessing HIV services. The plan increased the visibility and commitment of government to prioritise HIV and SRH service delivery to this key population. (ii) Implementation of a Low-Cost Integrated Model for Sex Work Programming in Chris Hani district, Eastern Cape province in 2017. Through this programme, the CP demonstrated a cost-effective approach for reaching sex workers in a low density and rural setting using the peer-led approach recommended in the national sex worker HIV plan. Sex worker peer education were identified and trained to reach out to peer and refer them to health facilities for SRH/HIV services; a coordination mechanism endorsed by province and district DOH were established and reviewed the project quarterly; health workers in health facilities in the catchment areas were trained on sex worker friendly services and integrated sex worker SRH/HIV services in the facilities; creative workshops were held where sex workers were sensitised on SRH and HIV issues by both peer educators and healthcare workers; and a monitoring system that tracked individual sex workers health status was operationalised. The project is also being replicated in KZN. The table below shows the coverage of the project in the second half of the year showing the uptake of services by sex workers. A total of 428 unique individuals<sup>90</sup> were reached in the first quarter (July-September 2017) and 550 in the second (October – December 2017).

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<sup>90</sup> A unique identifier system was developed based on sex worker's name and, through this, the project was able to track how many times an individual worker is reached per quarter.

Table 9: Coverage of project activities July-Dec. 2017<sup>91</sup>

Indicator	July		Aug.		Sept.		Oct.		Nov.		Dec.	
	Unique	Non Unique										
Number of sex workers reached during outreach	208	179	311	141	256	108	371	215	488	252	221	83
Number of sex workers referred for HTS	11		10		22		9		11		2	
Number of sex workers referred for STI screening	8		7		6		1		10		2	
Number of sex workers referred for TB screening	10		15		20		1		18		4	
Number of sex workers referred for ART	3		8		7		5		30		10	
Number of sex workers referred for family planning	0		4		20		3		35		13	
Number of sex workers attending risk reduction workshops	49		147		145		116		131		63	
Number of health talks held at health facilities	0		4		5		6		5		3	
Male condoms distributed	4835		7200		4280		7380		8400		4460	
Female condoms distributed	416		622		561		738		4200		226	
Lubricants distributed	1850		3110		2580		3690		1102		2230	

In Eastern Cape, the CP contributed to the strengthening of coordination of the HIV response to improve policy implementation, access to HIV services among AGYW and men as key vulnerable populations. With regard to coordination, the CP supported the EC Province AIDS Council to undertake coordination activities to improve implementation of programmes, prioritising programmes for AGYW as part of implementation of the HIV/TB/STI policy in the province. This support was for holding a conference on HIV/TB/STI policy in Eastern Cape; bringing together about 300 stakeholders including departments, implementing partners and AGYW organizations among others to deliberate modalities for implementation of the HIV/TB/STI policy within schools (in the context of the ISHP) focusing on the protocol for coordination the multiple partners involved in implementation; standardization of operating procedures for the policy; and linking implementation of the policy to the ISHP. The CP also supported the AIDS Council to establish a coordination mechanism for implementation of this policy.

Support was also provided for advocacy for HIV prevention among AGYW as part of the activities leading up to the World AIDS Day in 2018 for a period of 6 weeks. Activities supported included HIV prevention outreaches to schools to raise awareness on HIV prevention among the youth and HIV testing; referral of AGYW sero-positive to be initiated on treatment; and raising awareness on treatment adherence among adolescents and young people

Further, CP supported the EC Province AIDS Council to hold a men's parliament event attended by about 130 participants and officiated by the Deputy Speaker. This was a high visibility event where resolutions were taken on how men can take up HIV space and encouraged to test for HIV, initiate and adhere to treatment. A post conference plan was developed and UNFPA is currently supporting costing and finalization this plan. Key issues relevant to HIV prevention among men identified during this event include need for user friendly healthcare, easy access to services for those who cannot go to facilities and giving them a chance to participate and report GBV.

#### 4.2.2.2 Integration of gender and human rights based approach

Reporting on the activities of this programmatic areas does include gender disaggregated data. For example, peer education sessions in the Alfred Nzo district reached 280 females and 140 males.<sup>92</sup> However, it is not clear, for example, what the gender representation of peer educators was, or the out of school youth that were reached. Reference is also made to the youth interventions in the Nzulwazi

<sup>91</sup> Report of the Low-Cost Integrated Model for Sex Work Programming: Report and recommendations, SWEAT, 2018

<sup>92</sup> 2016 Annual Report

project that included discussions on GBV and human rights. The reporting also focuses on quantitative outcomes rather than whether the interventions implemented showed a change in mindset and behaviour. The challenge is that interventions implemented focus on collecting quantitative and not also qualitative feedback.

The different and responsive approaches adopted by the programme is commendable. Starting with the National Youth Policy (NYP)M&E framework which is critical in supporting the country to understand the youth in all its facets, but more importantly to track any measure progress. The NYP includes extensive gender analysis. The focus on addressing gender-based violence including violence perpetrated in education institutions is critical in addressing the vulnerability of adolescent girls and young women especially to HIV infection.

The YAP and “She Conquers” programmes do reflect a responsiveness to youth centred approaches and recognising young women and girls as vulnerable groups requiring specific attention. These interventions incorporate a gender and human rights approach to programming.

### 4.2.3 Gender Equality and Gender Based Violence

Table 10: Summary achievements for gender equality and gender-based violence

<b>UNFPA Strategic Plan Outcome 3: Advanced gender equality, women’s and girls’ empowerment, and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth</b>						
<b>Outcome indicators of South Africa CP:</b>						
Proportion of men and women who think that abuse or violence against women is acceptable or tolerable: Baseline and target data not available						
<b>Country Programme output 3: Strengthened national capacity to implement multi-sectoral national policies and programmes to prevent gender-based violence, including sexual violence</b>						
<b>Output indicators</b>		<b>Baseline</b>	<b>Target</b>	<b>Achievement</b>	<b>% achievement</b>	<b>Comments</b>
1	Number of advocacy sessions supported to strengthen national coordination mechanisms for implementation of multi-sectoral policies and programmes on GBV prevention and response and improve SRH/GBV linkages		27	26	96%	Achieved: Advocacy sessions in provinces (EC/Free State) under Safer South Africa Programme and also at national level
2	Number of UNFPA supported districts that integrate GBV into their planning processes		5	6	120%	Achieved: Districts supported in KZN, EC and Free State
3	Number of institutions supported to implement and institutionalise initiatives to engage men and boys and communities on GBV prevention and SRHR		39	44	113%	Achieved: Institutions supported include Traditional Councils, CBOs, Ground breakers
4	(For CP extension period) Number of national strategies and plans integrating gender-based violence prevention, protection and response interventions	0 (2017)	2			New indicator introduced for extension period; no data available
5	(For CP extension period) Number of institutions and CSOs that integrate gender-based violence and sexual and reproductive health and rights, in their advocacy and community mobilization initiatives including men and boys engagement with UNFPA support.	0 (2017)	10			New indicator introduced for extension period; no data available

#### 4.2.3.1 The achievement of planned results

The CP output for the gender component was to strengthen national capacity to implement multi-sectoral national policies and programmes to prevent gender-based violence, including sexual violence.

Three indicators originally defined for this component were all indicators as indicated above. Data is not available for the two indicators introduced during the extension period. A major programme that contributed to the achievement of the output for this component was the Safer South Africa Programme funded by DFID and implemented jointly with UNICEF. Other interventions for addressing gender-based violence were funded from regular resources.

At national level, the CP supported capacity building, research and policy dialogue. Technical and financial support was provided to the Department of Women, Children and Persons with Disabilities (DOWCD) to carry out a National Study on Violence Against Women focusing on how violence manifests itself in different provinces in South Africa and violence against LGBTI women. This study provided evidence to inform policies, strategies and programmes. The DOWCD was also supported to commission an independent assessment of the action plan for 365 days of gender activism focusing on extent of implementation of the plan across sectors; the coordination of the plan given that implementation was led by two clusters (social cluster and justice, crime prevention and security cluster) and the interface with civil society.

There was also extensive contribution of the CP towards capacity building for the National Council for Gender Based Violence as one way of strengthening national coordination mechanisms for GBV policy and programme. UNFPA supported the process for hiring of the Chief Executive Officer for the Council, provided technical support for the development of policy and technical papers on topical gender based violence issues for use by stakeholders, holding of a national conference on GBV which reviewed the mandates of various government departments and identified the role of each department in prevention and response to GBV. As a product of this conference, each department was to be accountable for specific gender mainstreaming targets but this approach did not work well because of the accountability mechanism was not aligned to government structure. For instance, other departments found it difficult to account to another department at the same. Further the deactivation of the National Council for GBV and reconfiguring of the Department of Women weakened the institutional coordination framework for interventions addressing violence against women and children.

Sexual and gender-based violence is prevalent in tertiary institutions in South Africa. The Higher Education and Training Health, Wellness and Development Centre (HEAIDS) is an institution supporting all tertiary institutions in the country to address health challenges facing students. To address GBV among youth in tertiary institutions, the UNFPA, in collaboration with UN Women, supported HEAIDS to develop the Sexual and GBV Policy for Higher Education. UNFPA provided technical assistance for this extensive exercise that took a period of two years to complete and have the policy approved. HEAIDS is currently negotiating with UNFPA for a fulltime technical assistant to work with student leadership in addressing gender-based violence in tertiary institutions.

At provincial level (in KZN and EC and), capacity development and development of strategic and technical tools and knowledge products enabled the Office of the Premier to improve oversight for gender mainstreaming and response to GBV. Relevant support provided included the conducting of gender indicator baseline surveys to establish provincial gender profiles; conducting gender audits to assess departmental capacity to mainstream gender; development of gender mainstreaming guide focusing on the priority sectors in both provinces and support for the development of gender plan in KZN. UNFPA continued to participate in the gender machinery in both provinces where departments and municipalities discuss gender issues and UNFPA provides information on good practices and the global picture on gender. In addition, the CP supported the training of provinces and selected municipalities on gender responsive budgeting to influence resource allocation.

The programme also built the capacity of traditional leaders to prevent and response to GBV. A delegation of traditional leaders (including representatives from national level) visited the Amhara Region in Ethiopia to learn best practice in addressing gender-based violence especially abduction of girls. The delegation implemented a pilot project adopting the Ethiopian model. In Eastern Cape, the support was provided to conduct a study on harmful traditional practices. The findings and the lessons from the Ethiopia Model informed a pilot project implemented in Ngquzi Hill, Lusikisiki where early and forced marriage is most prevalent in the province. A training manual was developed, community resource persons were trained (elders, policy, young people, social workers) and in turn sensitised the

community on prevention of forced and early marriage. This pilot project prompted government to look at early and forced marriage as a key issue in the country. In KZN, the CP supported sensitisation of traditional leaders to increase their awareness in the prevention of GBV in their communities.

Under the Safer South Africa Programme, the CP supported capacity building for community-based organisations to mobilise communities and traditional leaders for GBV prevention and response. UNFPA implemented outcome 3 of this programme: “Social change mobilised in Eastern Cape and Free State Provinces to address violence against women and children”. Implementing partners identified and trained local CBOs in the targeted communities to support implementation; community dialogue meetings were held with about 60 people per meeting; during these meetings, community members selected champions to form Community Action Teams (CATs) and also developed Local Action Plans to address identified GBV issues. The CATs were extensively trained to lead implementation of the LAPs in collaboration with traditional leaders and other community stakeholders. The programme also supported the development of the Provincial Plan of Action on Violence Against Women and Children (VAWC) which demonstrated the commitment of the Office of the Premier to put VAWC at the highest level of the government agenda. Advocacy was also undertaken to integrate LAPs into the local government Integrated Development Plans (IDPs). This process, however, required extensive engagement over time and only one LAP was integrated into IDP in Eastern Cape Province. The CATs were also registered as CBOs to enable them receive funds from government to implement the LAPs. A key challenge of this initiative was the weak coordination of GBV interventions or programmes in the provinces. As a result, the programme supported the establishment of the GBV Coordination Forum in the Office of the Premier with facilitation of an independent consultant championing the process. This coordination mechanism has filtered to district level.

One of the results areas of the CP is the engagement of men and boys on GBV prevention and SRH. To this end, the CP supported the provincial men parliament forum in KZN hosted by uThukela district. This forum encouraged men to test for HIV, screen for TB and GBV. The forum also engaged men on their role in preventing GBV. The province plans to hold district level men’s parliament forums. In EC Province, a Gender Summit was held bringing together all the 8 districts to deliberate the challenges in prevention and response to GBV and identify solutions. Resolutions of the gender summit were consolidated to form the provincial approach to GBV and integrated into the 2019-2020 provincial plan. The Premier appointed the MEC for Sports, Recreation and Culture as a GBV champion tasked to lead districts in holding GBV summits. Deliberations and resolutions of these summits will inform the development of the province GBV strategic plan. This Gender Summit was instrumental in establishing the status of GBV in the province, triggering allocation of resources and increasing awareness on GBV prevention in the province.

To achieve the same result (engagement of men, boys and communities in GBV) the CP also supported extensive capacity building for traditional leaders, especially in EC Province. This initiative involved a comprehensive assessment of traditional leaders’ knowledge of gender, GBV and human rights; training of traditional leaders (171 trained from 5 traditional councils in EC and Free State provinces; development of community safety plans (during the trainings) and implementation of these plans post training. As a follow up, focus group discussions and key informant interviews were conducted to assess progress made in implementation of the community safety plans and identify further knowledge gaps. To address deficiencies in knowledge and implementation of community safety plans, refresher trainings were held (a total of 5 trainings). A review of this initiative found that traditional leaders made progress in integrating GBV and human rights issues in their meetings. However, they lacked financial resources to follow up on GBV cases and no mentors to provide on-going support in advising on GBV and human rights and in implementation of the community safety plans.

#### **4.2.3.2 Integration of gender and human rights-based approach**

The whole gender equality and women empowerment programmatic area is gender focused. Within this component, the CP concentrated on one key area – gender-based violence which also demonstrate a rights based analysis and approach to programming. All the interventions supported in this area integrate a human rights based approach and address underlying vulnerabilities of girls and women to gender-based violence. The approach adopted by the CP also involved men in the prevention of GBV.

## 4.2.4 Population Dynamics

Table 11: Summary achievements for population dynamics

<p><b>UNFPA Strategic Plan Outcome 4:</b> Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality</p> <p><b>Outcome indicators of South Africa CP:</b> Proportion of new national development plans that address population dynamics by accounting for population trends and projections in setting development targets: Baseline 100% (NDP Vision 2030), Target: 100% (all new plans)</p> <p><b>Country Programme Output 4a:</b> Strengthened capacity of provincial departments and district municipalities to integrate population dynamics, especially youth development, HIV/AIDS, and environmental sustainability into development</p>						
Output indicators	Baseline	Target	Achievement	% achievement	Comments	
1	Number of districts with strengthened capacity to integrate SRHR, youth, gender mainstreaming and population dynamics into plans and programmes	0	8	11	138%	Overachieved due to increase in number of districts trained. Also, number of districts covered year to year differs. See results framework annex
2	Number of reports with evidence produced at provincial or district level to promote integration of SHR, gender, youth and population dynamics into plans and programmes	New indicator, not measured in 3 <sup>rd</sup> CP	11	11	100%	Consolidated guide on integration of population data in IDPs disseminated to 11 districts covering KZN and EC
<p><b>Country Programme Output 4b:</b> Strengthened government institutional capacity to generate, analyse and utilize data to inform, monitor and evaluate policy and programme implementation</p>						
Output indicators	Baseline	Target	Achievement	% achievement	Comments	
3	Number of tools, survey reports and instruments reflecting analysis of population variables at national level	New indicator, not measured in 3 <sup>rd</sup> CP	9	5	56%	Partially achieved: Main survey and being Demographic and Health Survey and Youth Policy M&E framework
4	No. of south-south interactions supported in the areas of SRHR, youth, gender and population dynamics	15	22	20	91%	Achieved: South Africa delegates visiting other countries and also other countries visiting South Africa to learn and exchange knowledge
5	No. of country delegations supported to promote the ICPD agenda and inclusion of SRHR in discussions of SDGs beyond 2015 at regional and global forums	New indicator, not measured in 3 <sup>rd</sup> CP	20	17	85%	Indicator not reported on in 2018

### 4.2.4.1 The achievement of planned results

The population dynamics component of the CP had two outputs. The first output was to strengthen capacity of provincial departments and district municipalities to integrate population dynamics into development. Targets for indicators for this output were all achieved, with an overachievement on the number of districts strengthened to integrate gender mainstreaming, youth and SRH into Integrated Development Plans (IDPs) due to the request from the provincial government in KZN to include all districts in training.

Under this output, UNFPA supported the Department of Social Development as the lead partner and worked with the University of KwaZulu-Natal, Statistics South Africa, COGTA and other service

providers. Statistics South Africa was instrumental in providing population data and supporting data analysis.

Several interventions were implemented to achieve this output. The CP provided technical assistance to EC and KZN provinces to develop a good practice models for integration of population data into IDPs. The technical assistance analysed IDPs in selected districts in KZN and EC, identified gaps, identified sources of data to address the gaps and develop a model for how IDPs can be developed in the future. In EC Province, this exercise was undertaken in Ingquza Hill and Mhlontlo Local Municipalities in the OR Tambo District and iLembe district in KZN.

In KZN, UNFPA technical assistance reviewed and revised the four population and development thematic areas of education, social justice, health and employment in the iLembe Integrated Development Plan and documented the process into a guidance note to inform integration of population data into IDPs. This was followed with the finalisation and dissemination of a consolidated guide (model) for integration of population factors into development plans. During this process, inadequate capacity of the local municipality officials was evident and the guide highlighted capacity building initiatives needed to respond to the capacity gaps. UNFPA responded to address the capacity gaps by supporting KZN Provincial Population Unit to strengthen capacity of IDP planners/ managers from 11 districts as well as officials DSD, Stats South Africa and DOH. The training focused on the revised IDP guidelines incorporating population and development related issues into development plans.

In EC Province, district government officials in Alfred Nzo and OR Tambo were supported to coordinate youth SRHR interventions through quarterly coordination forum. As a result, a multi-sectoral AFYS forum was set up under DOH leadership.

Overall, the development of the good practice model was a complex process involving multiple stakeholders (government, private sector and civil society) and the process has the potential to be highly politicised. The role of COGTA in assessing IDPs is critical in finding out the extent to which the capacity developed and model guide for integrating population data into IDPs has influenced the planning process. Based on data from key informant interviews, it was observed that although IDP planners and managers understood and are aware of the importance of population dynamics indicators in IDPs, the situational analysis of IDPs covers most of the indicators related to population dynamics and some sector plans such as municipality safety plans include GBV as a spinoff. In a few IDPs analysed by COGTA, there was no graduation from the data analysis (situational analysis) to strategy and programmes.

Further capacity building support was also provided in terms of sponsoring individuals for training. For instance, 4 officials from KZN and 2 from EC provinces completed Applied Population Sciences Training and Research course, and one official from EC province was supported to attend Population, Environment and Development Nexus course while one official from Office of the Premier in KZN was supported to attend advanced M&E training in Canada<sup>93</sup>. However, key informants interviewed observed that most of the individuals trained move to better jobs upon completion of the course which negates the objectives of providing such support.

Output 2 of the population dynamics component focused on three aspects: strengthening capacity to generate, analyse and use data to inform policy and programming; advancement of the ICPD PoA and south-south knowledge exchange.

The CP partially achieved (56%) the target for the indicator measuring support to the development of tools, surveys and instruments reflecting population variables, to a large extent, due to South Africa having strong expertise in data generation and, therefore, did not prioritise CP support in this programmatic area. This notwithstanding, the CP provided technical assistance to NDOH and EC and KZN provincial governments to generate and update population data.

At the national level, support to the NDOH involved provision of technical assistance for planning and implementation of the Demographic and Health Survey of 2016. The technical advisor worked closely with NDOH over 2 years period in all aspects of the DHS. UNFPA was also a member of the survey

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<sup>93</sup> Data from CP annual reports

steering committee and technical working group and actively provided technical inputs. The programme further support for data collection and analysis of 2016 South Africa District Health Survey (SADHS), including age-disaggregated key indicators.

At provincial level, EC provincial government was supported to update the State of Population Report using Census 2011 data to provide government officials with up-to-date population data to use for planning. Similar project in KZN was expanded to update the State of the Province Report with broadened scope including economic development and poverty. Another intervention supported the improvement of data analysis capacity through training of IDP planners and managers from 11 districts in KZN on demographic dividend to strength their knowledge on the implications of demographic dividend for planning and implementation of IDPs. However, this workshop was limited to middle level managers and did not reach higher level provincial and district managers whose buy in is key to ensure implementation.

UNFPA (through this CP) also supported the Government of South Africa to advance the ICPD agenda and implement the ICPD PoA. The indicator measuring the CP performance in this area was 85% achieved. Most of the support provided enhanced advocacy for ICPD agenda within government, strengthened South Africa leadership in ICPD in the SADC region and also strengthened collaboration between government and civil society. Interventions supported were mainly production of country ICDP reports, country level advocacy events and regional and international missions.

For instance, the South Africa Government and UNFPA co-hosted a side even at the UNGASS in 2014 entitled “harnessing the demographic dividend and ensuring universal access to SRH: The future we want for Africa”. The event advanced the Addis Ababa declaration on population and development in Africa beyond 2014 and enhanced political commitment for investment in programmes promoting gender equality, women empowerment and young people. UNFPA supported a Youth Leadership Working Group member to attend the ICDP. The CP also strengthened government institutional capacity to implement ICPD Programme of action through building collaboration between government and civil society on ICPD issues. Two CSO delegates were supported to accompany the government delegation to the Commission on Status of Women conference.

National level ICPD advocacy events supported included the commemoration the World Population Day and launch the Status of the World Population report which generated publicity on themes of vulnerable communities and linkage with SRH&R; Government participation in the ministerial strategic dialogue on South-South Cooperation in Population and Development in Beijing in 2016; and the South Africa delegations attendance of the BRICS meeting, China Conference on Ageing and CSE for Out-of-School High Level consultation in Norway.

The third programmatic area for UNFPA support was the south-south knowledge exchange and learning. The CP had 91% performance against the set target. Lessons and knowledge gained through study visits was instrumental in improving programming for SRH/HIV and GBV. Follow up actions were taken after the visits to apply lessons learnt in most cases with good results. The visits were two way- South Africa visiting other countries and other countries visiting South Africa.

Knowledge exchange and learning visits supported are as follows:

- South Africa delegation visit to Brazil to learn and share knowledge on advocacy for ASRH&R. the delegation consisted of government and civil society representatives and worked with various NGOs and youth implementing ASRH&R programmes.
- UNFPA delegation from Somalia was supported to visit Lovelife to learn about their youth programmes focusing on sexual and reproductive health, HIV prevention and gender-based violence and promote youth-led programming. UNFPA also facilitated a visit by a young person from Nigeria to Lovelife NGO to learn and interact with Lovelife team about youth programmes implemented in South Africa.
- A mentorship programme for 8 young researchers to strengthen their research papers for presentation at the Union of African Population Studies conference. 11 students were supported to

attend the conference. This support improved research skills of young people on population dynamics.

- South Africa delegation to Botswana on south-south exchange learnt lessons on SRH/HIV integration. A key lesson was that planning for integration, supportive supervision and buy-in from programme managers were critical enablers for provision of integrated services. The delegation included NDOH, EC and KZN provincial programme managers and district managers. The DOH in EC and KZN provinces applied lessons learnt to implemented a pilot SRH/HIV service integration in selected health facilities as mentioned under outcome 1.
- South Africa delegation of 8 officials from Department of Basic Education and Department of Social Development visited Sweden in 2017 to learn best practices in provision of CSE. Findings and recommendations from this study tour were shared with other countries in East and Southern Africa during the Safeguard Young People Committee meeting. EC and KZN started an on-line CSE training for Life Orientation Teachers following this visit.
- National Population Unit undertook a visit to India to increase government and civil society capacity in SRHR programming in the context of middle-income countries. Lessons learnt were applied in strengthening implementation of ICPD PoA, the National SRH&R campaign, and informed the national Adolescent ASRH&R Framework Strategy.
- The South Africa delegation comprising government officials (DOH, DOE, DSD, Traditional Leaders and Civil Society) visited Ethiopia Amhara region to learn good practices in addressing GBV, particularly early and forced marriages (abduction or girls). On return, a pilot project applying lessons learnt (as highlighted under outcome 3) was implemented in Eastern Cape which proved successful.
- UNFPA facilitated a Botswana delegation consisting government, civil society and young people to visit South Africa to learn about “She conquers campaign” that targets AGYW. A key lesson learnt was the use of consolidated Primary Healthcare data collection tools doing away with numerous data collection tools previous implemented.
- UNFPA hosted a delegation from Eswatini UNFPA and Ministry of Health Team on a knowledge exchange visit focusing on HIV prevention among sex workers, GBV and adolescent and youth programmes. The delegation learnt lessons in implementation of low-cost sex work programme in low to medium sex worker density areas and the comprehensive management of SGBV programme (the Thuthuzela centres).
- To enhance national leadership on implementation of South-South interventions, the CP supported government to develop and finalise the Addis Ababa Declaration on Population and Development (AADPD) report. The development of the national report was co-convened by Department of Social Development and Department of International Relations. In addition, supported was provided to South Africa as chair of SADC to develop a regional AADPD report (please see attached) covering all SADC member states. It was initiated on the position of South Africa being chair for SADC and the report will hand over to next SADC which is Namibia to support SADC member states implementation

#### **4.2.4.2 Integration of gender and human rights-based approach**

The intervention for integrating population data in IDPs included a focus SRH and HIV indicators among other health issues, gender and the broader socio-economic situation for men and women. However, the evaluation found that integration of these population dynamics in the IDPs does not necessarily translate to programmes. The municipalities have capacity limitations in developing programmes that effectively address the issues identified through analysis of population data. They lack capacity analysis of gender disaggregated data is a significant challenge.

The South-South partnerships have offered meaningful learning opportunities which have helped UNFPA partners to learn new and better ways of collecting and using population data. The India study tour was instructive in the following areas: (1) using simple terms and tools, providing technical support

and monitoring has led to improved SRHR outcomes; (2) Recognising of key target groups like adolescents to ensure responsive government programming; and (3) understanding how existing community structures like women’s co-operatives can bring positive social change to communities. Further South-South engagements with Botswana and Eswatini whilst providing support to these countries, also brought valuable lessons about identifying key target populations to ensure responsive programming. The focus on areas like HIV, GBV and sex work is also positive as it relates to areas where the gendered impact of these issues is clear.

### 4.3 Evaluation Question 3: Efficiency

#### a) To what extent has UNFPA made good use of its human, financial and technical resources to pursue the achievement of the outcomes defined in the county programme?

- a) Strong partnership between UNFPA and government partners, use of implementing partners and service providers and the coordination, programming and communication role of UNFPA sub-offices were critical factors for efficient implementation of the country programme. UNFPA provided technical support while government led implementation of activities with support of implementing partners and service providers.
- b) Reduction of UNFPA country office staff and budget cuts affected the capacity of UNFPA to deliver the CP. UNFPA does not have sufficient number of skilled staff to implement the CP.
- c) Continued reduction of funding for the gender programme area has affected the scope, depth and impact of the programme.
- d) UNFPA staff are not fully equipped to implement the priority focus of gender mainstreaming.
- e) Reduction of funding also made it difficult for UNFPA to attract experienced service providers to support the programme implementation
- f) The CP leveraged government resources for activity implementation. Funding for most of the activities was co-shared although government contribution cannot be quantified.

Overall human resources capacity of the UNFPA South Africa Country Office was not sufficient for the delivery of the CP. The Country Office human resources capacity reduced significantly in alignment to the business model for upper middle-income countries. Staffing changes affected management, professional and operational staffing. The changes involved an upgrade of the Representative to the Representative for South Africa Country Office and Country Director for Botswana and Swaziland; conversion of Deputy Representative into Assistant Representative to assist the Representative and oversee overall programming, shifting expertise in technical specialist, operational and financial management to the regional office and abolishing vacant positions three vacant positions. The programme staff currently include: (1) Adolescents, youth and gender programme officer, (ii) SRH, HIV prevention and Key Populations and SRH Linkages Programme Officer, (iii) M&E and Population Dynamics, (iv) Advocacy, Communication and Partnerships Officer, and (v) two programme officers based on EC and KZN sub offices. Due to the changes in staffing of the Country Office, staff have heavy workloads which has impacted negatively on the efficiency of internal management processes, functioning of operations and support services as well as overall staff welfare. Secondly, even though gender is recognised as a core driver of the UNFPA strategy, it has been lumped with the A&Y programme, and staff across programmes lack the technical expertise to mainstream gender. There is no key technical gender resource who has the skills and competencies to support programme staff and partners.

The Country Office also has limited high level expertise to operationalise the business model for upper middle-income countries. Within the East and Southern Africa regional MIC countries there is competing demand for technical support from the Multi-Country Expertise Hub created leading to inadequate response to meet South Africa Country Office demand. Consequently, the Representative and Assistant Representative are often called upon to represent UNFPA in high level expert meetings with government.

The UNFPA Country Office had three Representatives and turnover of professional staff in the course of implementation of the CP. Interviews with key informants noted that these changes affected the institutional memory and staff morale.

The partnership between UNFPA and Government and implementing partners played a key role in achieving the CP output results. This partnership to a large extent made up for the limitation of the inadequate staffing at UNFPA. UNFPA staff work closely with government partners in designing interventions supported by the CP. Both UNFPA and Government counterparts are also involved in implementation of the interventions such as capacity building (training and mentorship) conducting assessments, monitoring, advocacy among others. For instance, UNFPA staff were involved in conceptual design, co-training of master trainers with government staff. Implementing partners, on the other hand, were funded to implement agreed interventions while UNFPA and government partners played a monitoring role. UNFPA also contracted services of service providers to provide technical assistance to government partners on its behalf. These modes of delivery enabled the staff to manage programmes, although each mode of engagement requires different expertise from staff.

The UNFPA sub-offices in KZN and EC provinces were instrumental in improving programme efficiency. Proximity of the sub-offices enabled UNFPA to work closely with government partners, implementing partners and service providers in identifying priorities for the CP, designing and implementing activities. The sub-offices regularly consultations with partners to address any emerging bottlenecks. They also facilitated communication between partners in the provinces and UNFPA Country Office to ensure timely implementation of activities. The coordinators are the face of UNFPA and enhanced partners trust and confidence in UNFPA<sup>94</sup>. However, these offices also lack the required technical capacity to implement gender mainstreaming, they also lack clear guidance and understanding of what gender mainstreaming means for UNFPA and how this should be translated into relationships with partners and in programme implementation.

Annual funding from regular resources for the CP was reduced over time, from \$2.3 million in 2013 to \$1.1 million in 2018 while other resources fluctuated according to resource mobilisation effort. The Gender programme has been hardest hit by reducing resources. This has led to a focus only on GBV and gender mainstreaming does not appear to be prioritised. This goes against the UNFPA's strategic commitment to gender equality and SDG 5. Reduction in regular resources was in line with Resource Allocation System (RAS) criteria for upper middle-income countries and this saw a reduction of resources available for funding activities.

A key impact of limited resources was the challenge in identifying experienced service providers in the market to support the programme as most experienced services providers could not submit applications. UNFPA also had to negotiate the price with service providers to fit within available budget but this process, in some instances, led to compromise in quality as service providers could not dedicate their experienced staff full time to the project. According to annual reports and key informant observations, some would not deliver their activities and had to terminate their engagement; some delivered unsatisfactory products while others completed their activities and delivered excellent products. Some of the partners also do not appear to have the necessary skills and experience to implement gender mainstreaming or implement effective GBV interventions.

Questions in efficiency in funds disbursement to implementing partners and service providers elicited mixed responses. There are instances where funds are made available to implementing partners and service providers on time and this facilitated activity implementation. Key informants who indicated delay in funds disbursement observed that funds disbursement for quarter 1 of the year is often delayed thus affecting activity implementation and putting pressure for accelerated implementation to complete activities within the year. The evaluation found out that delays in disbursement could be attributed to a delay in UNFPA receiving funds from development partners for programme funded from "other resources" as well as bottlenecks in internal processing of disbursement which requires all the paper work to be scanned and submitted to the Regional Operations Service Centre (ROSC).

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<sup>94</sup> Observations made by almost all stakeholders interviewed in KZN and EC provinces

Activities that did not require funds disbursement, particularly those that required UNFPA staff expertise, proceeded with in a timely manner. Key informants observed that activity implementation processes are just about rights with UNFPA sharing information on time, support being provided as expected and where there are likely to be delays, partners are informed in advance. Some partners noted that in some cases delays are due to bureaucratic by government processes rather than UNFPA.

Government leadership in overall coordination of the CP at provincial and national levels, through PCF and NCF, contributed to efficient planning and implementation. Through these forums, the CP and government department work plans were synchronized and government partners took a lead in implementation. Challenges facing implementation, especially with implementing partners and service providers, were discussed and resolved in these forums. However, these partnerships may still be negatively affected due to political shifts in government leadership which affect the implementation of government priorities. It also appears that UNFPA has limited power to influence structural change with government as a partner and this influences results. For example, the lack of influence and power of the gender machinery will not be substantially improved unless government addresses this.

To a large extent, resources provided by UNFPA have a leveraging effect on the part of government. UNFPA technical staff worked collaboratively with the government counterparts to implement activities and therefore leveraged expertise of government officials. Secondly, the Government of South Africa contributes to the core resources of the programme. Government contribution doubled from \$210,000 in 2012 to \$444,000 in 2013 and was expected to increase by 6% annually. National and provincial government also cost share for programme activities<sup>95</sup>. As observed by key informants, government co-funded interventions supported by the CP such as policy development, development of tools and guidelines, capacity building, and meetings, events, and missions. For instance, in policy development UNFPA provided technical support while the cost of meetings and consultation workshops was met by government. In conducting training, UNFPA provided expertise in the design and facilitation of training while government paid for venues and cost of participants and the cost of cascading training downstream. UNFPA paid for non-government partners to attend ICDP events while the cost of government officials was met by government. Government also funded the commodities and equipment needed to delivery contraceptives/family planning services, adolescent and youth friendly services, emergency obstetric and neonatal care among other interventions while UNFPA supported policy development, capacity building and monitoring.

#### **4.4 Evaluation Question 4: Sustainability**

- a) To what extent have UNFPA supported interventions contribute to the development of capacities of its partners?**
- b) To what extent have the partnerships established by UNFPA promoted the national ownership of supported interventions, programmes and policies?**

The planning and implementation modalities of the CP integrated sustainability measures

- a) The CP work plans were derived from government department plans hence interventions supported were already integrated in government plans and budgets making it possible for government to implement follow up action after the CP support.
- b) The CP built capacity of government partners to enable them replicate or scale up models supported by the programme
- c) Government departments, to a large extent, owned the interventions and led implementation which made it possible to sustain results achieved by allocating funds to the interventions.
- d) The current approach to gender mainstreaming will not lead to sustainable integration of gender equality in the future.

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<sup>95</sup> Data from the report on Alignment of the 4<sup>th</sup> CP of South Africa to the Strategic Plan 2014-2017

#### **4.4.1 Capacity building**

UNFPA contributed to development of capacities of its partners as one strategy for sustainability of the programme results. The assumption is that capacity building should enable partners to sustain improvements made through the programme or even scale up interventions. Capacity building of partners achieved through the CP is as follows:

##### **Sexual and Reproductive Health**

The capacity of DOH was built in contraceptive services/ family planning through establishing a team of master trainers mainly drawn from DOH, establishing a mentorship system and a system for monitoring of quality of contraceptive services. DOH has sustained the monitoring and counselling on contraceptive use using the master trainers put in place. Capacity of DOH was also built in Termination of Pregnancy service delivery through training doctors and professional nurses. DOH officials formed part of trainers conducting this training and this experience will enable them continue delivering similar trainings to increase coverage of TOP services. DOH capacity development in the provision of emergency obstetric and neonatal care was achieved through establishing the Obstetric and Neonatal Ambulances and training DOH District Clinical Specialist Team and Advance Midwife to supervise and monitor ONA services. There was extensive capacity building for DOH and health facilities to provide AYFS in both provinces. This capacity building focused on skills training to ensure compliance with AYF standards, coordination mechanisms between DOH, DOE, DSD and civil society and data collection tools to provide disaggregated data and committee to use the data to address identified issues. The overall aim of the training was strengthening the capacity of national and provincial DOH to deliver effective SRH services to adolescent girls and young women. The training focussed on improving access and expanded method choice for adolescent girls and young women, which was reinforced throughout the training. DOH capacity was also developed in SRH/HIV/FP service integration through south-south visit to Botswana and training of healthcare workers as well as instituting a tool to enable DOH monitor integrated services.

##### **Adolescents and youth**

Capacity of government departments at national and provincial levels was built to roll out the M&E framework for the national youth policy. As a result, the departments have started reporting. DOE capacity was strengthened in CSE involving training of master trainers to train teachers using the CSE manual and a monitoring system being developed to track implementation. Capacity development for implementation of the Integrated School Health Policy (ISHP) was also undertaken targeting DOE, DOH, DSD capacity through implementation of the Nzululwazi model and this has enabled the replication/ scale up of this model to more districts in the two provinces. The training manual<sup>96</sup> used includes specific sections on gender equality, human rights and the various factors that impact on SRHR, especially for vulnerable groups. The training shows a clear understanding of what is required to develop training content using a rights based framework.

##### **Gender equality and women empowerment**

Capacity development of the DOWCD at the national level was strengthened to develop policy, provide strategic direction in mainstreaming of gender in all sectors. As a result, DOWCD has steered coordination of Gender-Based Violence programmes albeit with some challenges as the National Council for GBV was disbanded and the Inter-Ministerial Committee on GBV has not been meeting regularly. At provincial level, capacity of Office of Premier in EC and KZN was developed to coordinate gender mainstreaming with a focus on GBV. OTP capacity was enhanced through gender audits which identified institutional capacity needs to mainstream gender. The OTP in the provinces are actively promoting gender mainstreaming in priority sectors and profiling GBV as a priority agenda. GBV Coordination Forum set up in EC and Free State is instrumental in harmonizing GBV interventions in the province. The follow-up support and training project for Traditional leaders in the Eastern Cape and Free State was to support previous training that had been conducted on gender-based

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<sup>96</sup> Adolescent Sexual Reproductive Health and Rights, Facilitator and Participants Manual, Sonke Gender Justice, 2013

violence. The report demonstrates progressive understanding of gender and gender-based violence by traditional leaders who formed part of the training. On assessment, the traditional leaders who formed part of the interviews were able to discuss the importance of inclusivity; for all people who may be living in the area under their traditional jurisdiction such as foreign nationals and people with different sexual orientations. The training showed the importance of continuous post training support and some of the spin offs of the training such as the continuation of training (attending other courses outside of the UNFPA programmes) and intervening more in domestic violence cases and inheritance in their communities. From assessments; the training showed that traditional leaders were able to understand the interconnectedness of human rights and causes of gender-based violence; they were able to share their learning with communities. A key recommendation from the report was that ‘Traditional councils need technical assistance in documenting their own local data on various issues including GBV and domestic violence’; and this suggests that there was an understanding from the traditional leaders that they have the ability to solve their own problems and to curb gender based violence in their communities.

### **Population dynamics**

Under this component, South-South interactions built the capacity of DSD, DOE and DOH to implement specific interventions. For instance, the visit to Ethiopia enabled the Office of the Premier, DOE and DOH, DSD and Traditional Leaders to increase knowledge and skills in addressing GBV, especially forced marriages. The lessons were applied in implementing a pilot project. The visit to Botswana enabled DOH to initiate integrated SRH/HIV service delivery while the visit to Sweden to learn good practices in CSE led to improved implementation of CSE in both provinces. With regard to integration of population data in IDPs, the CP training planners and managers from municipalities but there is limited evidence on whether capacity of DSD was developed or whether DSD needed such capacity building.

Interventions which did not contribute to capacity development of government partners or had no link to government face sustainability challenges. Interventions such as the community mobilization for social change implemented under Safer South Africa which involved Community Action Teams implementing Local Action Plan built capacity among local CBOs which face difficulties to operate after the programme. The DREAMS Thina Abantu Abasha is also not anchored in any government institution and capacity developed among young people is not institutionalized. Key informants also noted that some interventions where UNFPA used implementing partners and service providers to support government partners had limited impact in the development capacity of government partners as these partners focus more on achieving specific deliverables than capacity building.

#### **4.4.2 National ownership**

The CP was fully owned by the Government of South Africa from the development stage. The Government led by DSD was fully involved in the development of the CP and the final CP document was signed off by the implementing departments and cabinet. This process laid ground for ownership of the programme at implementation stage.

Implementation of the programme was also led by government partners. Annual work plans were developed by the departments drawing priorities from the department plans while ensuring relevance to UNFPA mandate. The DOW was a key partner in driving gender aspects of the programme but the number of changes in political leadership of this department have affected its ability to stay the course with some programmes. This department also suffers the same challenges as other gender machinery and its sphere of influence (with other government departments) and its resources are very limited. The work plans were signed off by the department head, reviewed and consolidated by Provincial Coordination Forum (PCF) and presented to and approved by the National Coordination Forum. This process promoted partners ownership and leadership in implementation of the CP.

Implementation of activities was done in collaboration between UNFPA and partners with the partners taking a lead. This process also ensured ownership of the CP. UNFPA played a role of a strategic partner supporting government to realise its objectives. The monitoring and reporting on programme implementation was also done by the partners. Each partner prepared a progress report which was

presented and reviewed at PCF each quarter while progress reporting was done at NCF every six months. To a lesser extent, a few interventions that did not involve government leadership were those where the CP supported civil society as mentioned under question (a) above and such interventions face sustainability challenges.

#### **4.5 Evaluation Question 5: Coordination**

##### **a) To what extent has the UNFPA Country Office contributed to the functioning and consolidation of UNCT coordination mechanisms?**

UNFPA role in coordination and functioning of UNFPA is significant and visible. UNFPA contributes to the UNSCF results, is a member of UNCT and acts as resident coordinator, deputizes UNICEF in chairing the Programme Management Committee and leads programming in youth development. It also collaborates with other agencies in joint programming for HIV and SRH. It is a member of the core team developing the UNSCF 2020-2025 and the UN Gender Theme Group among others.

UNFPA is extensively engaged in the UNCT coordination mechanisms and contributes significantly to the implementation of the UN Strategic Cooperation Framework (UNSCF) which is the overall strategic guide UN support to the Government of South Africa.

Country Representative is a member of UNCT and reports on UNFPA programme contribution to the UNSCF during these meetings. The representative also acts as resident coordinator (RC) in the absence of the coordinator and during such a period the representative has to be in-country and attends to the Botswana and Swaziland country offices virtually. The Assistant Representative is a member of the Programme Management Team (PMT) which leads the development, monitoring and advocacy for the UNSCF. UNFPA deputizes UNDP in chairing this committee.

The UNSCF has two Results Groups – Human Capabilities, and Governance and Participation. UNFPA participates and reports to these groups. Within the Governance and Participation Result Group, UNFPA leads the Technical Working Group for Youth Development with the Representative chairing the group and the Assistant Representative leading the technical team.

UNFPA staff are members of various thematic groups within the UN. Two staff are members of the Joint UN Team on AIDS (JUNTA) where UNFPA takes a lead on HIV prevention; one staff is a member of the GTG which leads the UN gender response; one staff represents UNFPA in the UN Monitoring and Evaluation Group which focuses on monitoring of the UNSCF. Other groups where UNFPA is represented are the UN Communication Group and the Operations and Management Team (OMT). UNFPA is also playing a lead role in the ENSCF core team which is currently leading the development of the UN Strategic Cooperation Framework for 2020 to 2025. This integrated approach by the UN will go a long way in supporting a unified approach to gender mainstreaming which will hopefully strengthen the commitment to SDG 5.

UNFPA is also involved in joint programming with other UN Agencies in advancement of the Delivering as One reforms. UNFPA implements the Joint UN Programme on AIDS in partnership with other agencies and UNAIDS as a lead and playing the role of lead agency for HIV prevention among adolescents and young people. It also implemented the Safer South Africa Programme in collaboration with UNICEF. UNFPA will play a key role in a new joint programme, funded by CIDA, “Together for ASRHR” as an accounting agency. This programme will be implemented in collaboration with WHO and UNICEF.

Although UNFPA is making significant contribution to the coordination of the UN programming through these coordination mechanisms, participating in the above committees and thematic groups adds to the already heavy responsibilities they have under the country programme.

## Chapter 5: Lessons and conclusions

This chapter presents the lessons learnt from the implementation of the 4<sup>th</sup> CP and conclusions arrived at through a synthesis of the evaluation findings outlined on chapter 4. It includes strategic conclusions for each evaluation criteria and programmatic conclusions for each Country Programme outcome area.

### 5.1 Lessons learnt

Lessons learnt from the 4<sup>th</sup> Country Programme evaluation are as follows:

1. High level ownership and leadership of the 4<sup>th</sup> Country Programme by government contributed greatly to successful implementation of programme interventions. In this respect, the 4<sup>th</sup> CP was signed-off by the Cabinet and relevant sector departments.
2. Levering of government resources (financial and human resources) to a large extent mitigated the impact of the UNFPA Country Office staff and budget cuts and contributed to achievement of CP results
3. High level technical expertise is a key requirement for UNFPA Country Office's effectiveness in supporting advocacy, policy dialogue and knowledge management
4. UNFPA Country Office generated and utilised evidence to inform programming to ensure effective targeting of the most vulnerable adolescents, youth and women
5. Involvement of young people in programming and other decision-making processes is key in ensuring CP supported interventions are responsive to the needs of and utilise approaches appropriate for young people
6. Gender mainstreaming across all CP outcome areas enhances programme effectiveness but it takes time to develop gender analysis and programming expertise

### 5.2 Conclusions

#### 5.2.1 Strategic conclusions

##### **Conclusion 1: Relevance of the CP to UNFPA Strategic Plan, ICPA POA, SDGs and UNCSF**

(Based on EQ1a)

- 1a. The 4<sup>th</sup> CP is aligned to the UNFPA strategic plan for 2008-2013 and 2014-2018, the UNSCF 2013-2017, MDGs and ICPD POA. However, it is yet to be aligned to the SDGs as well as UNFPA strategic plan for 2018-2022. As mentioned in section 4, the CP is not aligned to these frameworks due to postponement of the development of the 5<sup>th</sup> CP in order to harmonise Government, UN and UNFPA Country Office planning cycles.
- 1b. UNFPA Country Office for South Africa recognises the need to mainstream gender and apply human rights approach across all outcome areas. While the theory of change integrated gender across all elements, these have not been consistently and substantively integrated into targets, programme design, implementation and reporting

##### **Conclusion 2: Relevance of the CP to national needs and priorities of stakeholders and target groups**

(Based on EQ 1a)

- 2a. The 4<sup>th</sup> Country Programme was fully aligned to national policies strategies starting with the overarching National Development Plan (vision 2030), the second Medium Term Strategic Framework and policies and strategies for health, gender, youth and population and development sectors. In addition, the CP fully took into consideration priorities of national partners and needs of targeted population in its programming. Adequate and appropriate processes were put in place to ensure stakeholder priorities and target population needs informed the annual work planning process.

### **Conclusion 3: Effectiveness of the CP in achieving planned outputs**

(Based on EQ 2a)

- 3a. The performance of the CP is, to a large extent, on track with targets for most output indicators were achieved. A few targets not achieved are related to areas where government priorities shifted; and where data was missing (not collected) especially for indicators introduced during the CP extension. Data was collected because these indicators were not being tracked.
- 3b. The CP implementation related to gender mainstreaming have not been effective. Commitments on gender mainstreaming have not been supported by strong gender analysis for each programme, which affected programme design and implementation and led to fragmented results. There was good progress in some areas (like focus of training) but poor progress in others (weak gender disaggregated data collection and follow through on targets). This was further impacted by weak technical capacity on gender by UNFPA and partners; and a significant reduction of the financial resources which basically stopped gender mainstreaming and only focused on GBV programming. Furthermore, the lack of an intersectional approach to gender led to many groups who should not be left behind being excluded.
- 3c. The CP supported upstream interventions (advocacy, policy and knowledge management) downstream capacity building interventions aimed at demonstrating effective policy implementation and showcasing good service delivery models. In this context, the CP provided technical expertise, funding, capacity building, development of tools while government partners led implementation. Both approaches have merit and reinforce each other. However, the weakness is in connecting the two to ensure policy and strategy development is systematically followed with models demonstrating its effectiveness downstream; and likewise, advocating for national scale up of successful models field tested downstream.

### **Conclusion 4: Efficiency of CP implementation**

(Based on EQ 3a)

- 4a. Good performance of the CP, demonstrated through the achievement of most of the output targets, can be largely attributed to the strong partnership between UNFPA Country Office and national partners at all levels, use of implementing partners and (to some extent) service providers, the programming and coordination role played by UNFPA sub-offices and the overall ownership and leadership of government. Through partnership with government, the UNFPA CO leveraged government resources while building its capacity to deliver the CP.
- 4b. UNFPA country office has inadequate capacity to effectively deliver the CP. Whereas the UNFPA business model for middle income countries calls for lean staff establishment, the current staff have heavy responsibilities and may not effectively deliver expected results. This has a specific impact on the gender expertise required to successfully implement gender mainstreaming. Staff that are technical experts in specific areas, are not necessarily equipped to do gender mainstreaming.
- 4c. The challenge UNFPA faces in attracting experienced service providers to provide technical support to the programme partly hampered effective implementation. This is attributed to the small budgets allocated to interventions relative to other opportunities available to the experienced technical support providers in the market.

### **Conclusion 5: Sustainability of the country programme**

(Based on EQ 4a and 4b)

- 5a. The implementation approaches adopted by the CP integrated sustainability measures which have contributed to scale up or replication of some of the models beyond the CP targeted geographical areas and after completion of UNFPA support. Capacity building and ownership are two factors that have contributed to sustainability of results achieved by the CP. Where these two factors are absent, there tends to be challenges in sustaining results.

5b. The fragmented approach to gender mainstreaming and not centralising gender equality as a driver of the programme will not lead to sustainable action in this regard. South Africa is a country in which patriarchy leads to structural inequality and this requires sustained action to change the status quo.

### **Conclusion 6: UNFPA contribution to functioning and consolidation of UNCT coordination mechanisms**

#### **(Based on EQ 5a)**

6a. UNFPA contributed significantly to the UNCT coordination mechanisms and the implementation of the UNSCF. UNFPA is a member of most of the UN coordination structures and leads in convening structures relevant to its mandate. UNFPA CO Representative acts as Resident Coordinator when necessary; UNFPA co-chairs the Programme Management Team, leads the Youth Development Technical Working Group, is involved in joint programming with other UN agencies. However, participation in these structures adds to the heavy workload of staff in implementing the CP.

### **5.2.2 Programmatic conclusions**

(All conclusions are based on EQ2a)

#### **Conclusion 1: Sexual and reproductive health**

- 1a. The CP made huge investment in the development of policies, strategies, guidelines and tool and these were utilised to build capacity of healthcare workers to provide quality Family planning/contraceptive services, maternal and child health and integrated SRH/HIV services. These tools remain relevant and available for continued use.
- 1b. The CP support in expanding FP/contraceptive use was mainly in capacity development through training and mentorship and tools development while government provided infrastructure and commodities. The support expanded choices available for women and emphasised dual protection. The capacity established is in place to sustain, scale up and replicate services to more districts in the province.
- 1.c The CP supported the development of good practice models for provision of SRH: These include Obstetric and Neonatal Ambulance (ONA) service; an integrated multisectoral and multi-partner model for delivery Adolescent and Youth Friendly Services (AYFS); and SRH/HIV integration within the IDEAL clinics framework. These models are available for replication and scale up, a process which is already on-going.
- 1d. Some aspects of the programme were effective in ensuring that gender was mainstreamed. This included the training to health practitioners and traditional leaders; and recognising young women and girls as vulnerable groups for SRH services. However, the systemic mainstreaming of gender across the programme has not happened.

#### **Conclusion 2: Adolescents and youth**

- 2a. The National Youth policy developed with CP support was critical in mainstreaming youth development interventions in all sectors at national and province level. The M&E framework for the policy was rolled out and as a result sectors reporting against relevant indicators. This process has established a coordinated framework for tracking youth development in the country. The youth situational analysis carried in 2013/14 which provided baseline data for the M&E framework is due for updating.
- 2b. Capacity development for delivery of CSE was a critical intervention for increasing AYP knowledge of SRH and HIV. Teachers have been trained on CSE and are expected to pass the knowledge to learners. However, a key weakness is the follow-up mechanism to ensure teachers delivery CSE to learners in schools.
- 2c. The Nzululwazi model showcased an effective approach for implementation of the Integrated School Health Policy through a multi-sectoral and multi-partner approach that involves adolescents and young people. It included all features of UNFPA support – capacity building, technical and

financial support. This model has been well documented and accepted at province and national levels and has been replicated in several districts and schools. It provides an example on how the CP support demonstrates approaches for implementation of policy.

- 2d. Intergenerational dialogues provided a platform for in-school and out-of-school youth, parents, leaders and service providers to openly discuss the challenges facing AYP including GBV, teenage pregnancy, HIV, SRH as well as barriers to service delivery and find solutions. These dialogues broke communication barriers between AYP, and adults and service providers. The weakness with the dialogues is limited institutionalisation to ensure continuity without the support of implementing partners.
- 2e. The Youth Advisory Panel members advanced youth led advocacy for SRH, HIV and GBV issues and involvement of young people in decision making and programmes. These members participated in community level activities, CP coordination forums and national and international platforms. The YAP model has limitations of what it could achieve given the small number of YAP members, weak institutional linkage and weak ownership by government.
- 2f. The DREAM Thina Abantu Abasha project, a partnership between Johnson and Johnson and UNFPA, provides a model for youth-led project management, implementation, monitoring and reporting with technical and managerial support from UNFPA. Young people have been able to successfully run this project for one year. It also offers lessons for UNFPA-private sector partnership. The project shows that UNFPA needs to evolve its strategy for engaging private sector to align or take into account private sector management style and values.
- 2g. Low-cost sex worker programme is a good example on how the CP demonstrates implementation of national policies and plans. This programme contributed to implementation of the national sex worker strategic plan and developed an effective model for reaching delivering SRH/HIV services in an areas of low sex worker density. This programme had specific outcomes related to key populations like girls and young women but the targets made no mention of these groups and this may have affected the implementation and results. While results were generally positive, there is no clarity on whether the outcomes related to these groups have been achieved. This also speaks to an over-emphasis on numeric targets.

### **Conclusion 3: Gender equality and women empowerment**

- 3a. Capacity for coordination of GBV was strengthened at national level with support to DOWCD but this was not consistent and change of leadership in the department weakened coordination. Some of the planned capacity building interventions could not be implemented. Some departments also failed to account to other departments. However, the need for strong GBV coordination mechanism still remains. Reference has also been made to the fact that there was lack of closer collaboration within the GBV sector to build on existing programmes rather than starting new ones.
- 3b. GBV is prevalent in tertiary institutions. The CP supported HEAIDS to develop a GBV policy for higher education institutions and is currently negotiating to place a technical advisor in HEAIDS to support implementation of this policy. This partnership opens up an opportunity for the CP to reach over 2 million young people in tertiary institutions to prevent and respond to GBV and provide SRH services.
- 3c. Strategic support provided to KZN and EC Office of the Premier in conducting gender surveys, audits and mainstreaming plans was instrumental in raising visibility of gender issues and increasing resources allocated for gender programming. However, baseline data generated in 2013/14 has become outdated and there is a call for updated surveys and audits.
- 3d. Traditional leaders play a key role in prevention and response to Gender-Based Violence. The CP support to capacity building for traditional leaders increased their awareness and developed community safety plans to be implemented by the leaders. Most leaders have integrated an agenda on GBV in their meetings. The challenge has been the lack of resources and weak capacity of the leaders to implement these plans.

- 3e. Community Action Teams and Local Action Plans (LAPs) established under the Safer South Africa Programme are positive steps in involving the community in prevention and response to GBV. Attempt to have LAPs integrated into IDPs and/or linked to Community Safety Plans did not work well largely due to weak collaboration between government, traditional leaders and CBOs in implementation of this programme. Phase two of this programme established GBV Coordination Mechanism in the Office of the Premier to strengthen collaboration. However, the LAPs are yet to be integrated into integrated development plans.
- 3f. Men engagement through the Men Parliament forum and Gender Summit was an appropriate approach for reaching men and enhancing their involvement in prevention of GBV and HIV. However, the CP support was limited to one event with limited follow up action.
- 3g. Gender mainstreaming across the programmes has been fragmented and this is also reflected in the results. Reduction of the budget for this programme has been significant compared to other programmes, and ultimately gender mainstreaming suffered. A primary focus has remained on GBV instead of a dual focus as per the strategic vision.

#### **Conclusion 4: Population dynamics**

- 4a. Major focus of the CP was on integration of population dynamics in integrated development plans. A model guide for population data integration to IDPs was developed and planners/managers trained in both EC and KZN. However, evidence of improved strategies in IDPs and programmes drawn from the IDPs is limited. Planners/managers do integrate population data in IDPs within the situation analysis but have not graduated the process to development of related strategies and programmes. Other key stakeholders in the planning process – politicians, civil society and private sector – are yet to be involved. This also negatively affects gender mainstreaming in IDPs as gender disaggregated data is essential for responsive programmes and should not only be used in the analysis phase, but must also be used to inform programme design and implementation.
- 4b. South-South knowledge exchange and learning was a key intervention for the CP. Delegates from South Africa learnt lessons from several other countries and applied these lessons to develop models of good practice and improve service delivery. Other countries also visited South Africa to learn lessons on the delivery of SRH and HIV services. South-south knowledge exchange demonstrated South Africa's strength in SRH and HIV programming and potential to lead knowledge exchange initiatives in the region.
- 4c. The advancement of ICPD agenda was done mainly through national and international events designed around commemoration of international days and participation on international forums. Pre and post events activities were not clearly designed.

## Chapter 6: Recommendations

The recommendations of this evaluation are drawn from the conclusions outlined above. This chapter lists strategic and programmatic recommendations that would inform decision making in the development of the 5th Country Programme.

### 6.1 Strategic recommendations

#### **Recommendation 1: Alignment of 5th Country Programme to UNFPA Strategic Plan 2018-2022 and SDGs**

(Based on conclusion 1)

- 1a. Align the 5th Country Programme to the UNFPA 2018-2022 outcome and business mode. However, adapt the business model to the South Africa socio-economic situation. In order to address the poor SRH, HIV and GBV indicators, the 5th CP should maintain a balanced focus on both upstream policy, advocacy and knowledge management and downstream capacity development and technical support for service delivery. However, a systematic connection between downstream and upstream work should be established. Further, this alignment should recognise that while South Africa has a strong policy framework to support gender equality, the social, political, economic and cultural environments do not necessarily align with it. It therefore requires to prioritise targeting to reach those furthest behind by addressing inequalities and disparities through analysis, design and implementation which is cognisant and responsive to the social, political and cultural reality of South Africa.
- 1b. Align the 5<sup>th</sup> CP to Sustainable Development Goals: The 5<sup>th</sup> CP should take proactive measures to align to SDGs. Given that UNFPA strategic plan 2018-2022 and MTSF are aligned to SDGs; and the UNSCF 2020-2025 will also be aligned to SDGs, the 5<sup>th</sup> CP should logically be aligned to SDGs by ensuring consistency with these planning frameworks. In doing so, the 5<sup>th</sup> CP should clearly identify the SDGs it will directly contribute to. More meaningful alignment to SDG 5 should be reflected through how this will practically happen in the country programme and be supported by the required technical and financial resources.

#### **Recommendation 2: Strengthen gender mainstreaming and human rights approach to programming in the 5<sup>th</sup> Country Programme**

(Based on conclusion 2)

- 2a. Assess the successes and gaps with regard to gender mainstreaming in all programme areas; and ensure that a holistic gender mainstreaming approach is adopted; starting with gender analysis and a deep understanding of the structural drivers of gender inequality. Leverage the Population Dynamic component to strengthen sex and age disaggregated data collection and analysis across all programmes.
- 2b. Develop a guide for human rights approach to programming and build the capacity of UNFPA staff and partners on this guide. This will strengthen the application of the rights based approach to programming in all CP outcome areas.

#### **Recommendation 3: Strengthen the linkage between upstream and downstream support**

(Based on conclusion 4)

- 3a. Strengthen the linkage between upstream advocacy, policy and knowledge management interventions and the downstream capacity building and successful models demonstrating effective policy implementation in order to facilitate policy implementation and replication of successful models countrywide. The linkage of upstream and downstream interventions can be strengthened through involvement of partners from both national and provincial government at planning stage to identify their roles in these interventions and to enhance synergies.

#### **Recommendation 4: Strengthen the monitoring and evaluation for the country programme**

(Based on conclusion 4)

- 4a. Align the CP interventions to government priorities and review targets accordingly on an annual basis: Results were not achieved in instances where government priorities shifted. Going forward, there is a need to review such targets annually to ensure the CP is focusing on achieving targets that are aligned to government priorities.
- 4b. Strengthen the monitoring systems to ensure data for all indicators is collected and reported. There were instances of indicators with missing data (especially those introduced at the stage of CP extension. For the 5<sup>th</sup> CP, UNFPA and partners should identify output indicators with clear data sources and collect and report data for all the indicators.

#### **Recommendation 5: Improve UNFPA capacity to deliver 5<sup>th</sup> CP**

(Based on conclusion 5)

- 5a: Strengthen the UNFPA Country Office and the Regional Expert Hub as well as Regional Operations Shared Service Centre (ROSSC) to improve UNFPA capacity and programme efficiency. This will ensure that UNFPA has predictable support from the regional expert hub established support middle-income countries including South Africa. A work plan, based on Country Office needs for expert support should be developed and agreed on by both institutions. The same should be done with ROSSC to ensure support is predictable, the processes and requirements of ROSSC are understood and the roles of CO in processing financial and procurement transactions are clarified.
- 5b. Maintain UNFPA sub-offices in KZN and EC to continue supporting implementation and communication between partners and UNFPA. These offices contributed to achievement of 4<sup>th</sup> CP results. They currently have a lean staff which should be maintained for continued support to the 4<sup>th</sup> CP.
- 5c. Review the workload of UNFPA staff in the country office to match job requirements to existing capacity and also determine the number of staff establishment needed to deliver the 5<sup>th</sup> CP.
- 5d. Conduct an assessment of staff's capacity to implement gender mainstreaming, and consider the need for specific gender expertise to provide technical support to programmes and partners. Also explore other tools and processes that could strengthen effective gender mainstreaming from programme design to implementation and results to ensure sustainable outcomes.
- 5e. Review the process for selection of service providers and be selective on the type of interventions to be executed by service providers to avoid seeking service providers for interventions with small budgets which don't attract experienced organisations. Secondly, involve national partners in the selection of service providers beyond the review of terms of reference to enhance their ownership of the technical support provided by service providers.

#### **Recommendation 6: Enhance the inclusion of men and LGBTQI communities in gender mainstreaming interventions in all CP outcome areas**

(Based on conclusion 6)

- 6b: Develop approaches for involving men and boys in all outcome areas of the CP in a more impactful way to promote gender equality, enhance access to SRH for both men and women and also strengthen men/boys involvement in addressing harmful socio-cultural gender practices. In addition, use an intersectional approach include disabled groups and LGBTQI communities in programming. These approaches will strengthen sustainability of programme results.

#### **Recommendation 7: Rationalise UNFPA participation in UNCT coordination mechanisms**

(Based on conclusion 7)

- 7a. Given the lean staffing levels, UNFPA country office should review staff participation in the UN coordination mechanisms and prioritise those that UNFPA must participate in based on its mandate. On the other hand, should the UNFPA staff workload rationalisation recommended under 5 above

be done, time and effort spent in participation in coordination structures should also be included in the review.

## 6.2 Programmatic recommendations

### **Recommendation 1: Support the utilisation of policies, guidelines and tools developed under 4th CP**

(Based on conclusion 1a)

- 1a. The policies, guidelines and tools developed under 4th CP are available and still remain relevant. The 5th CP should support utilisation of these tools in EC and KZN provinces and advocating for NDOH and other provinces to use the tools (if similar tools do not exist in those provinces)
- 1b. Support the scale up of family planning and contraceptive services to other districts in KZN and EC using the capacity established in the 4<sup>th</sup> CP. UNFPA role in this case will be monitoring and mentorship to enable the trained staff roll out service delivery to more health facilities and replicate in other districts.
- 1c. Support documentation and advocate for replication of successful models developed under 4<sup>th</sup> CP to be taken up in other districts and nationally.
- 1d. Strengthen partners capacity to collect gender disaggregated data to build quality data to support strengthened analysis, programme design and implementation.

### **Recommendation 2: Improve implementation and sustainability of adolescents and youth interventions**

(Based on conclusion 2)

- 2a. Support a baseline survey for the status of youth in the country to provide data to update the youth policy M&E framework. Include comprehensive gender analysis into this survey. This will update the last comprehensive baseline conducted in 2013/2014.
- 2b. Review implementation approaches for CSE and develop clear implementation modalities that ensure follow up and reporting on learners reached with CSE in schools. This will build on the M&E framework for CSE being developed in Eastern Cape Province.
- 2c. Advocate for Nzululwazi model to be implemented at a large scale due to its proven success in Eastern Cape and KZN provinces. Knowledge exchange and learning visits can be sponsored from other provinces to EC/KZN to facilitate the scale up of this model.
- 2d. Establish a strategy for sustainability of intergenerational dialogue through establishing an institutional anchor, strengthening collaboration between DOE, DOH and DSD and establish linkages to community-based organisations to mobilise communities. An institutional anchor will be critical for sustainability.
- 2e. Re-configure the YAP model to enhance its effectiveness and coordination. Institutionalise the YAP model within the appropriate government department, decide on the sufficient number of YAP members needed to enhance their impact, establish a coordination mechanism that allows key departments (DOE, DOH and DSD) to have access to this panel and ensure the panel operates with a predictable work plan.
- 2g. UNFPA should consider designing annual work plans for all YAP members to ensure they are engaged to a specific plan throughout the year and are linked to each intervention. YAP members should also be trained on gender mainstreaming and human rights approach to programming so enable them address gender issues more effectively.
- 2h. Support the replication of the Low-Cost sex worker programme implemented in EC province to other districts within KZN and EC. This will also require strengthening linkage of this programme to DOH.

### **Recommendation 3: Strengthen coordination of GBV interventions and develop innovative models for GBV prevention and response**

(Based on conclusion 3)

- 3a. Strengthen GBV coordination at national and provincial levels: Build on the GBV strategic plan, currently under development, to strengthen the capacity of key institutions (Department of Women and Gender Commission among others) to establish a multisectoral GBV coordination mechanism. Improve the relations between government and civil society to strengthen coordination and implementation of the GBV strategic plan. To further strengthen coordination, establish an GBV accountability framework to enhance accountability of all relevant sectors for prevention and response to GBV.
- 3b. Assess the gender interventions supported in the 4<sup>th</sup> CP in relation to GBV and broader gender inequalities and women empowerment in South Africa and identify where UNFPA is most likely to have the greatest impact instead of supporting “event” type interventions.
- 3c. Reconsider the gender mainstreaming approach and where it is located in the new CP. Consider how to integrate gender in programmes from an analysis and design perspective, and also “mainstream” the resources for it into programmes. Develop an effective gender mainstreaming methodology, train staff and partners on how to use it for programmes and projects; adapt and improve reporting and monitoring systems; and consider an organisational culture intervention to strengthen the institutionalisation of gender mainstreaming as a practice.

### **Recommendation 4: Strengthen capacity to integrate population data in IDPs, advancement of ICPD and south-south knowledge exchange and learning**

(Based on conclusion 4)

- 4a. Review support provided to integration of population data in IDPs and develop a more comprehensive intervention/project with clear follow up and monitoring mechanisms to ensure the quality of IDPs is improving. Such a project will have a longer timeframe that allows results to be realised.
- 4b. Strengthen South Africa’s role in South-South knowledge exchange and learning. Develop a robust plan for South-South knowledge exchange to show case innovative models developed and also allow for South Africa to learn from other countries. Develop other approaches for knowledge management and dissemination such as documentation and virtual learning platforms.
- 4c. Develop a comprehensive programme with clear pre and post activities designed around key advocacy events for the ICPD agenda. This will ensure that support provided for ICPD events generates clear post event action plans.
- 4d. Leverage this programme to support improved gender disaggregated data collection across programmes, and to build the capacity of all programme partners on how to use disaggregated data for responsive programming.

## **Annexes**

[Annex 1 - FINAL Version ToR SA CPE 11 June 2019.docx](#)

[Annex 2 - People interviewed.docx](#)

[Annex 3 - Documents reviewed.docx](#)

[Annex 4 - Evaluation matrix.docx](#)

[Annex 5 - Evaluation instruments.docx](#)

[Annex 6 - Atlas projects.docx](#)

[Annex 7 - Results framework.docx](#)

[Annex 8.1 - KZN province validation meeting presentation.pdf](#)

[Annex 8.2 - Eastern Cape province validation meeting presentation.pdf](#)

[Annex 8.3 - National Coordinating Committee Validation Presentation.pdf](#)