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Republic of Zambia
Ministry of Finance and National Planning

SIXTH COUNTRY PROGRAMME

JOINT GOVERNMENT OF THE REPUBLIC OF ZAMBIA AND THE UNITED NATIONS POPULATION FUND

2007 – 2010

EVALUATION REPORT

December 2010

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ACRONYMS

AIDS	Acquired Immune-Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ASRH	Adolescent Sexual and Reproductive Health
BCC	Behaviour Change Communication
CBD	Community Based Distributor
CEDAW	Convention on Elimination of All Forms of Discrimination against Women
CP	Country Programme
CPAP	Country Programme Action Plan
CSO	Central Statistical Office
CT	Counselling and Testing
DC	District Commissioner
DFID	Department for International Development
DHMT	District Health Management Team
DMO	District Medical Officer/Office
EmONC	Emergency Obstetric Care
FGDs	Focus Group Discussions
FNDP	Fifth National Development Plan
FP	Family Planning
GBV	Gender Based Violence
GIDD	Gender in Development
GRZ	Government of the Republic of Zambia
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IPs	Implementing Partners
ITCP	Inter-Agency Committee on Population
KAPB	Knowledge Attitudes and Practice Baseline
LCMS	Living Conditions Monitoring Survey
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MDR	Maternal Death Review
MoE	Ministry of Education
MoFNP	Ministry of Finance and National Planning
MoH	Ministry of Health
MSc	Master of Science
MSYCD	Ministry of Sport, Youth and Child Development
NAC	National HIV/AIDS/STIs/TB Council
NGOCC	Non-Governmental Organisation Coordinating Committee
PAC	Post abortion Care
PMO	Provincial Medical Officer/Office
PMTCT	Prevention of Mother to Child Transmission (of HIV)
PPAZ	Planned Parenthood Association of Zambia
PPUs	Provincial Planning Units
PS	Permanent Secretary
RHCS	Reproductive Health Commodity Security
SMAGs	Safe Motherhood Action Groups
SPU	Social and Population Unit
SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Infections
TB	Tuberculosis
TBA	Traditional Birth Attendant
TDRC	Tropical Diseases Research Centre
TFR	Total Fertility Rate
TOT	Training of Trainers

UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNZA	University of Zambia
USAID	United States Agency for International Development
UTH	University Teaching Hospital
WILDAF	Women in Law and Development in Africa
WILSA	Women and Law in Southern Africa
YFSH	Youth Friendly Health Services
ZANIS	Zambia News and Information Services
ZAPPD	Zambia Parliamentarians on Population and Development
ZDHS	Zambia Demographic and Health Survey
ZEM	Zambia Enrolled Midwife
ZEN	Zambia Enrolled Nurses
ZPCT	Zambia Prevention Care and Treatment (Project)
ZRM	Zambia Registered Midwife
ZRN	Zambia Registered Nurse

FOREWORD

The 6th Country Programme for Zambia was approved by the United Nations Population Fund (UNFPA) Executive Board in 2006. In February 2007, The Government of the Republic of Zambia (GRZ) and UNFPA signed the Country Programme Action Plan (CPAP) 2007 – 2010. The 6th Country Programme was aligned to the United Nations Development Assistance Framework (UNDAF) and GRZ social sectors' development priorities such as reducing maternal mortality and mitigating the impact of Human Immunodeficiency Virus (HIV). The overall goal of the 6th Country Programme was to contribute to improved quality of life by achieving population growth commensurate with socio-economic development. Some interventions such as policy and programme implementation guidance were national in scope. Others were implemented in the provinces, districts and communities; with technical assistance from UNFPA. The 6th Country Programme focused on addressing pertinent bottle necks to development in Zambia. These include population, reproductive health inclusive of HIV; and gender. Expected UNDAF outcomes, expected country outputs and strategies formed the basis of programme implementation toward achieving the goal of the 6th Country Programme.

The results of the evaluation revealed that to a large extent the country outputs on reproductive health and population and development were achieved. The 6th Country Programme therefore contributed to UNDAF-Country Programme outcomes on these components and partially the gender component. A number of output indicators for gender were not achieved due to management and coordination difficulties. Adolescent health was well integrated in Behaviour Change Communication (BCC) messages in youth activities for in-school and out-of-school youths. This was supported by the publication and dissemination of the National Plan of Action for the Youth designed to operationalise the National Youth Policy 2006. The other document developed was **Empowered Engaged Encouraged** National Standards National Standards for SRH, HIV and AIDS Peer Education Programmes to standardise peer education and services for the youth in the country.

In most cases, the results in this evaluation report of the 6th Country Programme show that joint well designed and focused strategies can strengthen the capacity of government institutions to implement and achieve results. Furthermore, involving the Chiefs in the implementation of the 6th Country Programme empowered the communities to take steps to improve their own health particularly that of women, children and youths. It was also a critical contribution toward achievement of the Millennium Development Goals (MDGs) by 2015.

It is hoped that the results of the evaluation of the 6th Country Programme will strengthen not only the design of the 7th Country Programme but also capacity building of Government institutions, partners and communities to improve the provision of integrated reproductive health and HIV services and integration of gender in social sectors policies, plans and programmes. I am confident that the support from UNFPA in the 7th Country Programme will go a long way to assist Zambia to attain the MDGs by 2015.

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On behalf of the GRZ and UNFPA, I would like to thank the consultants Dr. Peggy Chibuye and Dr. Kumbutso Dzedzeke for their commitment and time to evaluate the 6th Country Programme. I have no doubt that the findings and recommendations will inform the development of the 7th Country Programme.

I would like to thank all officers the in Directorate of Public Health, Ministry of Health (MoH), Social Population Unit (SPU), Ministry of Finance and National Planning (MOFNP), Department of Youth Development, Ministry of Sport, Youth and Child Development (MSYCD), Gender in Development Division (GIDD) at Cabinet Office and the Central Statistical Office (CSO) for coordinating and managing the project components in the 6th Country Programme.

My appreciation of the successes achieved in the Country Programme would be incomplete without thanking the National AIDS Council (NAC), Demography Division, University of Zambia (UNZA), Zambia News and Information Services (ZANIS), Non-Governmental Organisation Coordinating Committee (NGOCC) and Planned Parenthood Association of Zambia (PPAZ) for their usual commitment to working with government partners on reproductive health, population and development and gender. I would also like to thank Women in Law and Development in Africa (WILDAF) and Women and Law in Southern Africa (WILSA) for adding value to the 6th Country Programme by advancing the rights of women and promoting gender equity in the country. Both organisations have been working with government on these two issues related to the welfare of women.

My special gratitude goes to Senior Chiefs Kanongesha of Mwinilunga District, Mumena of Solwezi District and Chisunka of Mansa District; and Chief Mutondolo of Kawambwa District for their interest and time in providing information to the evaluation of the 6th Country Programme. The leadership provided by the four Chiefs cannot be taken for granted. It is heartening to learn that strategic partnerships with Chiefs can contribute to reducing maternal mortality and incidence of HIV in Zambia.

I would also like to thank the people at the Provincial, District, and sub-district (health centre and community levels) that provided information for the evaluation. The Safe Motherhood Action Groups (SMAGs), parent elder educators and peer educators deserve mentioning for their contribution to creating demand and increasing access to reproductive health and HIV services. Their work further increased understanding of gender in households and among the youth. Their integrated Behaviour Change Communication (BCC) activities helped the beneficiary communities to access to reproductive health and HIV services. The time the SMAGs, parent elder educators and peer educators spent reaching women, men, youths and families in scattered villages cannot be taken for granted.

My special thanks go to the United Nations Population Fund (UNFPA) for their commitment to assisting our country to improve the socio-economic and health status of the Zambians. My wish is that the strategic relationship that has been established with Government will continue for many years to come so as to build and sustain the capacity of social sectors to improve service delivery and ultimately the well being of the people.

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EXECUTIVE SUMMARY

In February 2007, the GRZ signed an agreement with UNFPA to implement the 6th Country Programme for interventions in reproductive health, HIV, population and development and gender. Lead implementing institutions were the MoH and MSYCD on reproductive health, MoFNP on population and development, GIDD at Cabinet Office on gender and NAC on HIV.

The design of the 6th Country Programme was aligned to the UNDAF outcomes, country programme outputs, and the FNDP, which also encompassed MDGs. The 6th Country Programme, to be concluded in December 2010, was implemented at the national and provincial levels. Further, reproductive health and gender interventions were implemented in the seven districts of North-Western Province and in four (Kawambwa, Nchelenge, Mansa and Mwense) out of the seven districts in Luapula Province.

MoFNP and UNFPA hired consultants to evaluate the implementation of the 6th Country Programme. The objectives of the consultancy were to assess and review appropriateness and relevance of the entire Country Programme, its contributions to the achievement of the outcomes of the UNDAF, National Population Policy and the FNDP, integration of gender in social sectors' plans and delivery of services; and sustainability of the various components of the programme. The other objectives were to review management and coordination issues including implementation modalities, identify achievements of the financial expenditure, constraints, lessons to be learnt and emerging issues to be considered in the 7th Country Programme and make recommendations to be considered in the 7th Country Programme.

Methodology

Data was collected through document review, semi-structured and unstructured interviews, Focus Group Discussion (FGDs), observation and review of antenatal care (ANC), Prevention of Mother to Child Transmission (PMTCT) of HIV, admission, delivery and discharge registers in health centres and labour wards. The sample was selected purposively among the people directly involved in implementing the 6th Country Programme at national, Provincial, District and community levels. Others were Principal Tutors of Schools of Nursing in North-Western and Luapula Provinces and some cooperating partners. Some Cooperating Partners implementing similar activities to those supported by UNFPA were also included in the sample.

Findings

Among the main findings of the consultancy were:

1. The goal of the 6th Country Programme was consistent with that of the revised National Population Policy, the FNDP and Vision 2030. The design, outputs and strategies of the 6th Country Programme were appropriate and relevant given the status of the socio-economic indicators in Zambia where 64% of the people lived below the poverty line with 14.3% of the adults living with HIV.
2. Implementation of the 6th Country Programme started in 2008 instead of 2007. The reasons for the delay included bureaucracy related to disbursement of funds, which resulted in delays to start implementation of the 6th Country Programme by partners and delays in developing the Annual Action Plans. There was also delay in recruiting staff for UNFPA sub-offices in Luapula and North-Western Province.
3. Most of the Government partners at national, provincial and district levels participated in the finalisation of and annual reviews of the 6th Country Programme. They also wanted the joint GRZ and UNFPA programme to continue in order to reach a threshold where it would make an impact on the people. The majority of the people in the places where the reproductive health programmes were implemented were not reached.

4. With regard to the relevance and effectiveness of project components in meeting the 6th Country Programme goal, the design promoted a holistic approach to implementing integrated reproductive health, HIV and integrating gender in the Government structures at all levels. All project partners developed their own work plans but collaboration was limited on gender due to limited management and coordination capacity.
5. The 6th Country Programme contributed significantly to the UNDAF outcomes, "Increased access to a comprehensive package of HIV prevention services and increased access to HIV prevention, care and support." The national level developed national policies and strategic documents that guided programme implementation on the ground e.g. National HIV and STI Prevention Strategy and Condom Strategy.
6. Culture and human rights were embraced in the BCC messages and in reproductive and HIV service delivery in health centres and in the community. Participation of the Chiefs in the programme promoted the retaining of positive cultural practices and discouraged negative ones. ZANIS complemented the BCC messages through video shows attended by large audiences. There was no head count to give details of those in attendance. The video shows took place late evening or at night.
7. Five hundred and forty-eight (548) service providers were trained in Emergency Obstetric Care (EmONC), Post Abortion Care (PAC), Jadelle insertion, PMTCT and Maternal Death Review (MDR). However, most trainees, though the number is negligible compared to the need were from District Hospitals. This is in the background of an estimated shortage of 23,000 nurses and midwives in Zambia. Not training Zambia Enrolled Nurses (ZENs) delivering women in health centres in some of these critical maternal health interventions was a missed opportunity to improve the quality of reproductive health care for women living in hard to reach areas.
8. With financial contribution from UNFPA, CSO carried out the Zambia Demographic and Health Survey (ZDHS) in 2007. The results of the ZDHS were cited and used in developing national documents the Condom Strategy, revised National Population Policy 2007, National Strategy for Prevention of HIV and (Sexually Transmitted Infections (STIs) 2009 and the revised National Reproductive Health Policy 2008. Except for the latter Policy, the other three documents were disseminated country-wide to inform programme planning, management and service delivery of reproductive health, HIV and adolescent health services.
9. With financial and technical support contribution from UNFPA, GRZ through CSO organised and started collecting data for the 2010 Census of Population and Housing. UNFPA support included preparing enumeration area maps, conducting the Pilot Census and publicity campaign.
10. The MoFNP revised the Population Policy and disseminated it. In 2008, the MoFNP also revived the Inter-agency Committee on Population (ITCP) through which Ministries and all stakeholders from the private and non-governmental organisations (NGOs) are supposed to coordinate the implementation of the National Population Policy. More work is needed to institutionalise population issues in policy, planning, programming and monitoring and evaluation in social sectors.
11. To a large extent, gender was well integrated in BCC messages in the community services by the Chiefs, SMAGs, parent elder educators and peer educators but less so in ANC and HIV services in health centres. Staff of Government implementing partners who coordinated population and development and gender had limited knowledge in these areas. They needed to help them to do better. They were willing to get basic knowledge through short-courses but the Demography Division at UNZA was not requested to organise them for implementing partners (IPs).
12. Access to health is a basic human right. SMAGs, parent elder educators and peer educators increased access to reproductive health and HIV services. Male participation in reproductive health and HIV issues also increased.

13. Integration of population factors and gender into other programmes was hampered to some extent by the fact that staff leading the task in the Social and Population Unit (SPU) at the MoFNP and GIDD at Cabinet Office did not have core training in population or demography and gender respectively.

14. With regard to actual budget allocations, most of the expenditure rates were high and consistent with achievement of target outputs. UNFPA was also flexible to allocate more funds to areas which exhausted the initial allocation and had a need for more funds. Expenditure rates were the lowest on gender and reproductive health commodity security (RHCS). RHCS was still in draft. In Gender, most funds could not be accessed on time because the GIDD misapplied the first disbursement of funds from UNFPA. It took almost two years for the funds to be reimbursed and for the activities they were meant for to be carried out before UNFPA could disburse more funds. During this impasse period, UNFPA explored other ways to disburse funds for implementing Gender activities. The funds for gender activities to be implemented in the districts were disbursed through the Provincial Medical Offices (PMOs)/UNFPA field offices. During the impasse period, the relationship between GIDD and UNFPA and by extension between other partners in the Gender component of the Country Programme and UNFPA and GIDD was not satisfactory. In this atmosphere which was not conducive, few gender activities could be implemented. This was compounded by the fact that UNFPA did not have a comprehensive Technical Assistance Plan for Gender despite employing staff to offer technical assistance. If the plan was in place, it could have been used by UNFPA staff to bypass GIDD and implement activities with other partners.

15. UNFPA also implemented other reproductive health interventions which were not part of the 6th Country Programme. These were reproductive health commodities security, obstetric fistula and midwifery programme. Except for a very low utilisation rate of 12 per cent on obstetric fistula and midwifery programme in 2007, utilisation rates in the remaining years were high ranging from 83 per cent on obstetric fistula repair and midwifery programme to 100 per cent on procurement of contraceptives.

16. There was a mixed reaction on the ownership of the 6th Country Programme. However, it was clear from the evaluation that the Government owned the Country Programme. Almost all of the stakeholders/partners interviewed at national, provincial, district and community levels, especially in North-Western Province, spoke confidently about owning the programme. Conversely, the limited number of people interviewed at provincial level in Luapula Province gave an impression that the joint GRZ and UNFPA 6th Country Programme was owned by UNFPA and not the GRZ. During interviews, most of them referred to the joint Country Programme as a UNFPA programme.

17. On sustainability of the programme, it is unlikely that presently GRZ alone can sustain the various components of the CPAP given the state of the Zambian economy. Even resources that are budgeted for and approved by Parliament for social sectors are sometimes not fully disbursed.

18. A number of issues emerged from the 6th Country Programme but the most prominent were on population and development and gender. People need to be educated on these issues. The National Population Policy was disseminated at provincial level and not to districts. On gender, the component was not well managed and coordinated to inform effective integration in the delivery of social services. Nevertheless, led by the Provincial Planning Unit (PPU) in North-Western Province, gender was well integrated in the BCC work of the SMAGs, parent elder educators and peer education. In Luapula Province, UNFPA sub-office took the lead to integrate gender in service delivery and in community work. ZANIS complemented the efforts through screening of videos to large numbers of people in the community.

19. Monitoring and Evaluation of the three project components was minimal to non-existent. A data base had not been established to monitor the results against the indicative resources in the CPAP by output per annum. This should have enabled tracking of progress every quarter and annually. Since human resource capacity building was one of the major activities during the programme, tracking of staff and community members trained should have been systematically done. All

persons trained should have been recorded by the training they received, duration of training, workstation or community, place deployed, age and sex. With the current record keeping, it is not possible to tell where the nurses trained were deployed or whether more persons should be trained taking into account staff/community members' mobility, age and retirement. Since sex was rarely recorded, it was not possible to assess the gender balance of the trainees. It was also not practical to assess the coverage of the training activities and hence determine the scope of future scale-up.

Best Practices

1. Completing school is the means through which reproductive health knowledge is acquired with consequent improvement in reproductive health. The alternative to improving reproductive health in poor and lowly educated communities is through mass community education. In the 6th Country Programme, formation of the SMAGs, parent educators and peer groups enabled the education of members of poor communities with low educational levels, in reproductive health, gender and HIV services. This empowered families to take responsibility for their own reproductive health and the need to educate girls just as much as boys. The Chiefs provided the leadership and consistently worked with their subjects on the 6th Country Programme. They further used this platform to work with their subjects on adverse effects of other social vices such as gender violence and drug and alcohol abuse. The drawback is that this was only implemented in about 40 per cent of the communities in all the districts of North-Western and in 4 districts (Mansa, Mwense, Nchelenge and Kawambwa) in Luapula Province. It was not done in other parts of Zambia.

2. The Chiefs provided the leadership and consistently worked with their subjects when implementing interventions supported by the 6th Country Programme in the communities in North-Western Province and in the four districts in Luapula Province. As a result, there was an overwhelming sense by members of their communities that the interventions supported by UNFPA were theirs and of their Government rather than for UNFPA. The Chiefs further used the experience to work with their subjects on adverse effects of other social vices such as gender violence and drug and alcohol abuse.

3. Mobilising additional resources to support implementation of the 6th Country Programme improved further the provision of EmONC, family planning (FP) and HIV prevention services. More fistula repair camps were established thereby increasing the number of women who had fistula repairs.

4. There were no stock outs of contraceptives for three years at the national level. However, condoms were out of stock for one quarter in 2009.

Lessons Learnt

Key lesson learned included the following:

1. Technical assistance and additional financial resources provided by UNFPA enabled PMOs and District Medical Offices (DMOs), service providers and communities to provide integrated reproductive health and HIV services and made a difference to maternal health in the two Provinces.

2. Uptake of reproductive health and related health services such as on HIV can be increased even in poorer communities in which members also have low educational levels through mass sensitisation and education campaigns such as those done by SMAGs and peer groups.

3. Interventions cannot be effectively delivered if some things are missing in the package. In reproductive health, contraceptives and condoms were procured. However, the logistics system to ensure that they are always available to the end users i.e. community health worker or health facility was not fully effective such that the method of choice could in many cases not be obtained

by the users. Injectable and Implant contraceptives, which were popularised in the interventions, could sometimes not be inserted because accessories to do so were not part of the interventions.

4. Community volunteers can do a lot to implement national programmes especially those that would require mass mobilisation with little financial incentives. The work done by SMAGs, parent elder educators and peer educators in motivating community members to improve their reproductive health and prevent HIV transmission was very commendable.

5. Regarding management and coordination issues including implementation modalities of the 6th Country Programme, these were hindered by limited knowledge in population and development by the staff in SPU and GIDD in gender. At implementation level, effective management and coordination was accentuated by lack of a capacity building or transition strategy for skills transfer to PMOs, DMOs and health centres and shortage of staff. As a result, UNFPA sub-office staff assumed the role of trainers. They spent 21 days in the field at a time.

6. The way traditional leaders and other community leaders were harnessed to spearhead the implementation of reproductive health interventions in the communities in North-Western and Luapula Province was excellent. If leaders feel that they own the programmes and can see the benefit they bring to their people, the programme stands a high chance of success.

7. Similarly programmes that are led or implemented by technocrats without the core training are less likely to succeed. The essential issues might not be well appreciated and the obstacles to be tackled might seem to be too much.

8. Funds for institutions implementing related activities should not be disbursed through another partner institution. In case the recipient partner misapplies the funds or other issues cause it not to disburse the funds to the partner institutions timely, activities to be implemented by other partner institutions would be delayed.

Conclusions

To a large extent, the 6th Country Programme was a success. The design, expected country outputs and strategies including establishing UNFPA sub-offices in North-Western and Luapula Provinces respectively, were appropriate and relevant to addressing reproductive health, HIV, population and development and gender issues in the social sectors in Zambia. The successes of the 6th Country Programme contributed significantly to the UNDAF outcomes. The successes in gender integration in reproductive health and HIV services at community level were masked by limited institutional capacity to implement, coordinate, monitor and evaluate implementation of the National Gender Policy.

1. The beneficiaries were happy with the 6th Country Programme because it made a difference to the lives of the people. They spoke convincingly about the programme having reduced maternal deaths and increased male participation in reproductive health and HIV services. The communities appreciated how gender disadvantaged mainly women and children in their communities and contributed to change in attitude by parents on child rearing such as carrying heavy workloads and appreciating the importance of girl child education. However, the reported results could not be verified in the quarterly, mid-year and annual reports produced by the programme officers in UNFPA sub- offices. There was no M&E system in place hence, data was either absent or not recorded at all.

2. The 134 bonded ZEN graduates sponsored by UNFPA to serve in North-Western Province from the three Schools of Nursing Solwezi, Mukinge and Kaleni reduced the critical shortage of nurses in North-Western Province. However, only nine out of 100 graduates were deployed in Luapula Province by the MoH.

3. The expenditure rates were high for most expected country outputs and this was consistent with the quantitative and qualitative results in this evaluation report. However, the expenditure rates were low on the comprehensive framework for procurement and logistics management and gender. GIDD had limited capacity to manage and coordinate the gender component -- none of the staff were trained in gender. Allegedly, UNFPA provided inadequate technical assistance because of management and coordination problems in the Division itself.

Recommendations

Capacity building

1. In future, delays should be avoided in implementing the country programmes by developing the follow on country programme before the one being implemented ends. This could be done in the last two quarters before the end of a country programme. Implementation of the 6th Country Programme was delayed by more than a year. The implementation started in March 2008 instead of January 2007.

2. Define clearly the management and coordination roles of SPU and GIDD to strengthen the working relationships and monitoring of activities implemented by partners.

3. A strategy should be devised to help the MoH, MSYCD, GIDD PMOs and DMOs to replicate the experience of the focused capacity building within the same Districts and others as well as in Chiefdoms. This should include involving Ministry of Education (MoE), other related United National (UN) agencies, and other cooperating partners based in Zambia in the design of the 7th Country Programme for buy-in and maximising utilisation of resources and information sharing on the support to Government and NGOs.

4. Support all the Districts in Luapula Province and facilities in the two Provinces rather than selected health facilities to record meaningful outcomes and for long-term impact. It will be better to provide adequate capacity building in the two Provinces rather than expanding to Western Province unless if the resources will be available to implement the 7TH Country Programme in three Provinces.

5. Increase the number of health technical staff on fixed-term contracts in UNFPA office to strengthen programme implementation, management and monitoring and evaluation. Programmes should be managed by staff trained in specific areas. It will help to retain staff. This should include assessing the capacity in UNFPA sub-offices and taking necessary steps to improve it.

6. Train implementing partners in project management, data collection, analysis and in UNPFA financial management and procedures. The purpose is to strengthen not only management and coordination of annual work plans but also to enable them to use data in decision making especially on implementation of the activities and reporting.

7. Develop comprehensive and written down technical assistance plans with strategies and goals for the SPU in the MoFNP and GIDD to improve their capacity in integrating population and gender issues in national programmes. This was done in a piecemeal way in the 6thCountry Programme.

8. Place population and development and gender technical advisors in SPU and in GIDD to support staff and strengthen institutional capacity in population and gender project components for national impact. The positions are critical to help with capacity strengthening and improving management and coordination of the two project components at national and peripheral levels.

9. Provide short-term training or recruit staff with core training in population and gender in SPU in MoFNP and GIDD respectively. Without additional knowledge or core training, staff in these units would not be able to provide effective leadership for the programmes. The difficulty and lower implementation rates of activities by these units in the 6th Country Programme was partially due to inadequate knowledge by staff in these units. This should be a priority activity in the first half of the 7th Country Programme.

Reproductive health

1. Strengthen community-based distribution of contraceptives and place emphasis on dual protection in the 7thCountry Programme. It should include establishing a data base to monitor some of the indicators against expenditure rates in the project components. Good data can show case successes and weaknesses to inform ongoing programme planning, management and indicating areas for operational research in critical interventions. It is also imperative to accelerate the undertaking of research by partners so as to support and encourage data driven revisions and application of policies in programme planning and management.

2. Increase male involvement in reproductive health and HIV services. For instance, service re-organisation such as offering HIV services to couples on a specific day can encourage men to attend ANC clinics together with their wives.

3. Advocate to partners to establish Family HIV Clinics to increase male participation in HIV prevention, care and support services and psychosocial support for families particularly women and children living with HIV. Such a clinic will also improve identification, diagnosis and treatment of HIV-TB co-existence in HIV positive pregnant women, exposed infants and children for early referral and management.

4. Procure motorbike ambulances to be placed in health centres to strengthen the referral system for maternity cases to the nearest health facilities for skilled management of complications.

5. Procure bicycles for the SMAGs, parent elder educators and peer educators. Some bicycles were bought for the programme but these were won out and the numbers of members in three groups increased.

6. Revise the ANC, maternity and children's clinic registers to strengthen integration of HIV data and follow-up of HIV positive pregnant women, mothers and HIV exposed and positive infants. This is also necessary to strengthen HIV care and support services in health facilities and in the community through development of a National Psychosocial Support Training Manual and Guidelines.

7. Work with Demography Division at UNZA to conduct an Assessment of UNFPA-funded Zambia Registered and Enrolled Nurse Training and Midwifery Training in Luapula Province as was done in North-Western Province.

Population and Development

1. Include all the activities in the 7th Country Programme, which were not implemented by SPU, GIDD, ZANIS, and Demography Division at UNZA. These are important activities in not only in capacity building but also in strengthening service delivery and empowering communities to make informed decisions on their health and well being.

2. Increase advocacy on the synergistic relationship between population and development to strengthen integration in social sectors' policies, plans, programmes and service delivery.

3. Disseminate the National Population Policy to the districts.

Gender

1. Include all the activities in the 7th Country Programme, which were not implemented in the 6th Country Programme.

2. Strengthen management and coordination of the gender component. GIDD should have quarterly meetings with partners to assess the progress being made by implementing partners and gender integration particularly in service delivery in health centres and hospitals.

3. Develop a strategy to work with partners such as NGOCC especially at district level where GIDD has no staff.

1. Introduction

1.1 Country Context

Zambia is a land locked country surrounded by eight countries. These are Democratic Republic of Congo and Tanzania in the north, Malawi and Mozambique in the east, Zimbabwe and Botswana in the south, Namibia in the south-west and Angola in the west. Administratively, the country is divided in nine provinces and 72 districts.

Zambia still faces challenges with some of the socio-economic and health indicators. Fifty-nine (59) per cent of the population in Zambia live below the poverty line (LCMS 2006). The population has risen from 3 million at independence in 1964 to 9.9 in 2000. It is projected to surpass 13 million in 2010 (CSO/MoH/National HIV/HIV/AIDS/STI/TB Council, 2009). HIV prevalence is also high with 14.3 per cent of the adult population aged 15-49 years old living with HIV (CSO/MoH/TDRC/UNZA/Measure Evaluation, 2010). Maternal mortality at 579 deaths per 100,000 live births in 2007 was quite high. Furthermore, the Total Fertility Rate (TFR) in 2007 at 6.2 was high and had increased from 5.9 in 2001-2002 despite the contraceptive prevalence rate (CPR) estimate increasing from 34% to 41% in the same period. To some extent, high fertility makes it difficult for the GRZ to provide quality social and public services. Due to the strong correlation between TFR and infant mortality, the infant mortality rate was 70 per 1000 live births and the under-five mortality rate was 119 per 1000 live births (CSO/MoH/TDRC/UNZA/Macro International Inc., 2009).

To address these social-economic and health challenges, each social sector in Zambia has been developing and implementing a number of relevant policies such health and education, strategic plans and programmes. The policies and strategic plans have been revised from time to time to align them to prevailing socio-economic and health development indicators. These have been in line with National Development Plans. It is within this existing framework that GRZ and the UNPFA signed the agreement to implement the CPAP 2007 – 2010 in two Provinces of Zambia whose evaluation results are contained in this report.

1.2 Sixth Country Progamme

The Executive Board of the UNDP and UNFPA approved a Country Programme for Zambia in 2006. In 2007, UNFPA used a participatory approach to develop with partners a joint four-year CPAP 2007-2010. The Agreement was signed in February 2007. "The goal of the 6th Country Programme is to contribute to improved quality of life by achieving population growth commensurate with socio-economic development"(GRZ/MoFNP, 2007 p.3).

The 6th CPAP was linked to the components of the UNDAF) outcomes: (1) reproductive health; (2) population and development; and (3) gender. These components are rights based and are culturally sensitive approaches. The CPAP is also harmonised with other United Nations (UN) agencies and the joint UN programme on HIV/AIDS (UNAIDS). Concurrently, the 6th Country Programme was designed to assist Zambia to achieve MDGs targets set ten years ago that are within the mandate of UNFPA -- poverty reduction, improving maternal health, combating STIs/HIV/AIDS and promoting gender equality, equity and the empowerment of women. The CPAP was implemented at the national and provincial level. Focussed activities were also implemented in seven districts in North-Western Province and four (Kawambwa, Nchelenge, Mansa and Mwense) out of seven districts in Luapula Province of Zambia.

UNFPA channelled its' support for the 6th Country Programme as the lead United Nations agency for population and reproductive health under the UNDAF. According to the country programme approved by the Executive Board of the United Nations Development Programme and of the UNPFA, the amount to be spent on respective mandates; Reproductive Health, Population and Development and Gender were US$9.1 million, US$4.1 million and US$1.5 million. The same mandates were supported in the Fifth Country Programme from 2002 to 2006 and in the Fourth Country Programme from 1997 to 2001.

Funds approved by the Executive Board are not available in advance. They are an indicator of what would be allocated if mobilisation efforts were successful.

The 6th Country Programme will be concluded in December 2010. The partners MoFNP and UNFPA recruited consultants to evaluate this programme. The objectives of the evaluation were as follows:

1. *Assess* the national population and development situation and determine the appropriateness and relevance of the design, outputs and strategies of the 6th Country Programme.
2. *Review* the relevance and effectiveness of component projects toward meeting the Country Programme goal.
3. *Assess* the extent to which the Country Programme contributed to the achievement of the outcomes of the UNDAF, National Population Policy and the Fifth National Development Plan.
4. *Assess* the extent of integration of gender, culture and human rights concerns during the implementation of the Country Programme.
5. *Identify* the achievement of substantive and financial results, successful interventions (success stories), difficulties and constraints; and lessons learned.
6. *Review* the management and coordination issues including implementation modalities, national ownership, monitoring and evaluation.
7. *Assess* the sustainability of the various components of the programme.
8. *Identify* and analyse emerging issues within the population and development domains as well as in the Country Programme that could be considered in the 7th Country Programme (Appendix 1).

It is hoped that the results will inform the development of the 7th Country Programme 2011 – 2015.

2. Methodology

2.1 Methods

The methodology for this evaluation was guided by the Terms of Reference (Appendix 1) for the consultants and the components, outputs, activities and outcomes in the 6th Country Programme. A mix of data collection methods was used to collect data for this evaluation from people involved in implementation of the 6th Country Programme in three out of seven Districts in North-Western Province, two out of four Districts in Luapula Province and at national level (Annex 4).

Review of documents related to the 6th Country Programme. The aim was to broaden understanding of the project components, outputs, strategies and activities conducted in the 6th Country Programme. Other documents reviewed were activity, quarterly and annual reports compiled by UNFPA field offices in North-Western and Luapula Provinces, annual work plans provided by UNFPA and Government annual review reports (Appendix 3).

Semi-Structured Interview Schedule was used to collect information from the staff in Provincial Government Administration, PMOs, DMOs, hospitals and health centres, UNFPA sub-offices and Chiefs. The same tool was used to collect data from national implementers of the project components in MoH, NAC, MSYCD, GIDD and sub-contractors Demography Division at UNZA, NGOCC, PPAZ, WILDAF and WILSA.

Unstructured Interviews were used to collection data from information providers who partners who did not have much information on the 6th Country Programme. The purpose was to get their suggestions and recommendations on the 7th Country Programme.

FGDs were used to collect data from members of the SMAGs, parent elder educators and peer educators and staff in UNFPA sub-offices.

The observation method was used in health facilities to assess the extent of the delivery of integrated maternal and child health and HIV services in health centres and labour wards in general hospitals. The purpose was to assess the extent to which HIV and gender were integrated in ANC, labour and delivery and post-partum care and in well child clinics.

ANC, Children's Clinic, prevention of mother to child transmission (PMTCT) of HIV and admission, delivery and discharge registers were reviewed at selected health facilities in the two Provinces. The aim was to assess the extent of integration of HIV data in the registers and quality of data recording.

2.2 Sample Size

The target group was all the partners at all levels who were involved in implementing the 6th Country Programme. The sample was selected purposively by virtue of their positions or their roles in the implementation of the 6th Country Programme. They included staff in provincial administration offices, PMOs and DMOs, doctors, nurses, midwives, Chiefs, members of the SMAGs, parent elder educators and peer educators. The others were UNFPA sub-office staff and Principal Tutors of Schools of Nursing in the two Provinces; and staff at national level who were responsible for implementing the project components (Appendix 4).

Appointments for data collection were made in advance. UNFPA staff accompanied the evaluation team to all the meetings including observations of maternal and child health service provision in health centres and labour wards. Other visits were made to four Chiefdoms to interview the Chiefs.

2.3 Data analysis

Standard participatory analysis was used to analyze qualitative data from FGDs and unstructured interviews and from activity, quarterly, mid-year and annual reports produced by UNFPA field staff. Common responses were categorized to determine the frequency a response was given by FGD discussants and interviewees. Quantitative data was analyzed manually because the sample was small.

2.4 Limitations

The first limitation was the inability to interview neither the Provincial Permanent Secretary nor the deputy and DMO staff in Luapula Province because the field visit coincided with that of the First Lady in the same week. However, adequate information was collected from the partners who were interviewed in the Province and Kawambwa District. The second limitation was inadequate quantitative data in the reports where they were available and some partners not producing reports on the activities they implemented. Third, the time was too short for this evaluation. More time was spent following up implementing partners most whom were not in their offices.

3. Findings

A total of 250 people provided information for the evaluation over a four week period. At the national level in Lusaka, 33 people provided information. In North-Western province, information was collected from Solwezi, Mwinilunga and Kasempa Districts. There were 121 people in the FGD and structured interviews. In Luapula province, information was collected from Mansa and Kawambwa Districts. There were 33 people in the FGD and structured interviews. Annex 4 contains the names of the persons contacted, designations and institutions where they were working or to which they were affiliated e.g. the SMAGs, parent elder educators and peer educators.

Implementation of the 6th Country Programme started in March 2008 and not in 2007. The delay was due to delays by UNFPA to disburse funds to the partners for them to start implementing the activities. The other delay was a result of not rehiring the staff for the sub-office in North-Western Province and

hiring staff for the sub-office in Luapula Province on time. In some cases, the partners did not submit their work plans to UNFPA on time.

To assure effective implementation of the activities in the 6th Country Programme, UNPFA procured almost all the equipment inclusive of vehicles, computers and other supplies. The procurement included equipment for health facilities for life saving procedures such as EmONC and post abortion care (PAC). The latter were distributed to North-Western only. Additionally, UNFPA mobilised additional resources to support improvement of reproductive health services in the two Provinces.

The rest of the findings from the information collected are presented by objectives of the evaluation and country outputs in the 6th Country Programme.

3.1 Appropriateness, relevance of the design, outputs and strategies of the 6th Country Programme

The goal of the 6th Country Programme was to contribute to improved quality of life by achieving population growth commensurate with socio-economic development. This goal was in line with the revised National Population Policy 2007, the objectives of the population and development section of the FNDP 2006 – 2010 and the Vision 2030. The Vision 2030 objective is, "A Prosperous Middle-income Nation by 2030 sets socio-economic development objectives necessary to achieve middle-income status." A key objective is "to decelerate the annual population growth rate from its 2005 rate of 2.9 percent to a rate of less than 1.0 percent over the next 25 years (2005 – 2030)." The National Population Policy2007 and the FNDP were designed to be implemented with Vision 2030 although more work remains to be done to make progress in translating fully the strategies into action.

The programme was implemented at the national level in Reproductive Health, Population and Development and Gender components and in all the districts in North-Western Province and in four districts in Luapula Province; namely in Kawambwa, Nchelenge, Mansa and Mwense. By national level, it is meant that the activities benefit the whole country and not a specific area. Work plans supported the goals of the Fifth National Development Plan. In fact, the duration of the 6th Country Programme was reduced to four years from the usual five years so that it could be aligned to the FNDP because it is the master plan for developmental activities in Zambia. The work plans were also aligned to the goals of the UNDAF. Lead implementation organisations were Government Ministries. NGOs and quasi Governmental Institutions were also partners.

The design, outputs and strategies of the 6th Country Programme were appropriate and relevant to Zambia as discussed below:

First, the design, outputs and strategies of the 6th Country Programme were appropriate and relevant given the state of the socio-economic indicators in Zambia. Due to high poverty levels most people did not have access to reproductive health services. Unless population factors are integrated in poverty alleviation strategies, it would be difficult for most people and society to get out of poverty. Activities in the 6th Country Programme were focussed on increasing access to reproductive health, creating demand for reproductive and HIV services and on integration of population and gender factors in service delivery.

Second, the design of the 6th Country Programme was intended to complement Government efforts to improve reproductive health and reduce the incidence of HIV in North-Western and Luapula Provinces respectively. These were among the three Provinces with high maternal, neonatal and child mortality in the country. The design was also aligned to the UNDAF outcomes: (1) The multi-sectoral response to HIV and AIDS at national, provincial and district levels scaled up by 2010; (2) By 2010, access of vulnerable groups to quality basic social services increased; and (3) By 2010, institutions in support of national development priorities are strengthened. The Country Programme outcomes: (1) Increased access to a comprehensive package of HIV prevention services; (2) Increased access to HIV/AIDS

treatment, care and support; (3) Increased access of vulnerable groups to high quality reproductive health services; (4) Institutions in support of national development priorities are strengthened; and (5) Social safety nets for vulnerable groups are strengthened were also aligned to Government priorities in the FNDP and social sectors' plans.

The UNDAF outcomes, UNDAF- Country Programme outcomes and country programme outputs were aligned to the following selected objectives in the FNDP:

- To strengthen the provision of efficient, cost-effective quality basic health care services (both preventive and curative) at all levels of the health care delivery system as defined in the Basic Health Care Package;
- To provide equity of access for all Zambians to good quality efficacious and safe essential drugs and medical supplies;
- To enhance capacity of local and national institutions delivering social protection programmes; and
- To strengthen human resource capacities and institutions delivering services to children and youth.

Third, the country outputs were based on the launched Government commitment to two development objectives in the FNDP. These are first, to attain sustained and high growth and second to improve the provision of social and public services for the purpose of reducing poverty and developing the country.

Fourth, implementation strategies of project components reproductive health, population and development, and gender were in line with Government social sector objectives in the FNDP. In the health sector, the two relevant objectives are: (1) To strengthen the provision of efficient and cost-effective quality basic health care services (both preventive and curative) at all levels of the health care system as defined in the Basic Health Care Package; and (2) To provide equity of access for all Zambians to good quality, efficacious and safe essential drugs and medical supplies. On youth development, the relevant objectives in the FNDP are: (1) to equip children and youth with relevant skills that will prepare them to cope with dynamic world and support their transition to adulthood. In relation to gender, except for one objective in the FNDP to economically empower women, the rest of the objectives were applicable to the 6th Country Programme. For example, gender streaming in national development process, contributed to creating an enabling environment for reproductive health of men and women and to build capacity in institutions to deal with gender issues effectively.

The 6th Country Programme was implemented through existing Government structures at national, Provincial, District and community levels and not through a parallel or vertical system. It had national activities to strengthen national capacity to plan, implement, manage and monitor and evaluate social sectors' programmes and programme activities that were implemented in North-Western and Luapula Provinces respectively.

In general, considerable progress was made to achieve the country programme outputs in the 6th Country Programme at national and peripheral levels. At national level, the results are presented in Tables 1, 2, 3 and 4 under each component reproductive health, population and development and gender for easy discussion of the findings.

Table 1 below indicates that four out of seven output indicators were achieved as follows:

First, The National Strategy for the Prevention of HIV and STIs was completed and disseminated through provincial meetings nation-wide in 2009. All the eight activities to achieve Country Programme Output 1 National HIV and STI Prevention Strategy developed and disseminated were implemented. This was the first time that Zambia has developed a HIV and STI Prevention Strategy. The strategy outlines priority areas for scaling-up core strategies to prevent HIV and STIs in Zambia. It includes a Logical Framework with indicators and budget to monitor implementation and achievements of expected outputs. However, the focus in the Strategy is on activities to be implemented in the health sector.

MSYCD and MoE who work with out-of-school and in-school (inclusive of universities and colleges) youth respectively were not involved in the development of the strategy. This was a missed opportunity for these two social sectors to integrate and/or strengthen HIV and STI prevention in their respective plans, programmes and service delivery. For example, the MoE has a good School Health and Nutrition programme, which includes HIV prevention, among other activities.

Second, the National Condom Strategy is being implemented. Evidently, the strategy has helped to maintain a constant supply of condoms in North-Western and Luapula Provinces respectively. Condoms are procured for the whole country using resources, which UNFPA mobilise from partners and resources from USAID/Zambia. The 134 FGD discussants (members of the SMAGs, parent elder educators and peer educators) and health workers in health centres visited in North-Western and Luapula Provinces during the field work, reported condom stock out for about one quarter in 2009. The shortage was not due to lack of condoms in the country. PMOs could not deliver them from provincial pharmacies to district pharmacies due to transport problems. Condoms were 100% available in 2007 and 2008 and three quarters of 2010. All members of the SMAGs, parent elder educators and peer educators distributed condoms during couple counselling and group education on HIV and STIs. These groups observed that condom use was on the increase in respective villages/communities but this could not be verified since condom use is best assessed through Sexual Behaviour Surveys conducted by CSO.

Table 1: CPAP Reproductive Health Results: Country Programme Outcomes, Country Programme Outputs, Output indicators, Implementing Partners and Achievements in 2010

Country Programme Outcome	Country Programme Outputs	Targets	Output indicators	Implementing partner(s) on behalf of GRZ	Achievements
Outcome UNDAF 1: The multi-sectoral response to HIV and AIDS at national, provincial and district levels scaled up by 2010					
Component: Reproductive Health					
Country Programme Outcome 1: Increased access to a comprehensive package of HIV prevention services	**Output 1**: A National HIV and STI Prevention Strategy is Developed/Reviewed by 2008	National HIV and STI Prevention document developed and disseminated	National HIV and STI Prevention Strategy is developed and disseminated	MoH, NAC	Completed and disseminated in 2009
	Output 2: Mechanisms to prevent transmission of HIV, focusing on high-risk behaviour, are in place by 2010	National Condom Strategy document being implemented	National Condom programming strategy developed and implemented	MoH PPAZ MSYCD	• Developed and is being Implemented
			National guidelines and protocols for condom programming in place		Not developed
		Life skills manual for youths and sex workers in place	Number of youth accessing youth friendly services		No data
		National Youth Network functional	Number of facilities providing adolescent sexual and reproductive health services		No data
OUTCOME UNDAF 2: By 2010, access of vulnerable groups to quality basic social services increased					
CP Outcome 2: Increased access for HIV/AIDS treatment, care and support	**Output 3:** A comprehensive framework for procurement and logistics management, with a focus on service delivery systems is developed by 2008	Procurement and logistics management framework formed	Procurement and logistics management framework is in place	MoH	Draft 4 available in 2010
			Percentage of facilities with no stock out of basic commodities in the past twelve months		• 100% for contraceptives * • 75% for condoms*

**Contraceptives and condoms were procured by UNFPA Headquarters in New York*

Five out of six activities to achieve Country Programme Output 2 "Mechanisms to prevent transmission of HIV focusing on high risk behaviour, are in place by 2010" were implemented. The Condom Strategy was developed, stakeholders meetings were held and peer educators to promote the use of sexual and reproductive health services and distribute reproductive health commodities were trained. The other two activities implemented were training of parent elder educators and traditional leaders to support adolescent sexual reproductive health. The activities not implemented were three workshops to update the training curriculum to include information on reproductive health, HIV prevention and BCC and the National Condom Programming Strategy to support implementation of the Condom Strategy was not developed.

There was no data on the number of youths accessing youth friendly services and the number of facilities providing adolescent sexual and reproductive health services. The data on the two output indicators on the youth was not recorded. An M&E system had not been established and used to monitor implementation of activities and achievement of output indicators. The MoH has a robust Health Management Information System (HMIS) but it cannot capture all the data needed to monitor various important programmes in the health sector. Therefore, it is important to collect data, which is not in the HMIS in order to monitor a programme in this case the 6th Country Programme.

Third, the National Youth Network was established in 2007 and was functional. The National Youth Network Secretariat was established in Lusaka in 2010. Two youth coordinators were also appointed and placed in Provincial Offices of the MSYCD. The aim is to contribute to creating an enabling environment that is more conducive to the development of the youth socially, culturally, spiritually, politically, economically and development in general in accordance with the National Youth Policy. This is the first time that a National Youth Network, which focuses on cross-cutting development issues, has been established in Zambia. Therefore, it will require financial, technical and material support in order to be sustainable.

Fourth, 100% facilities had oral and injectable contraceptives except for condom stock out for one quarter in 2009. All facilities had condoms since 2008.

The Procurement and Logistics Management Framework, Country Programme Output 3, a comprehensive framework for procurement and logistics management, with a focus on service delivery systems in place by 2008, was in the fourth draft. Key reasons for the delay in completing this document were infrequent meetings of the RHCS Technical Working Group and resignation of UNFPA Logistics Coordinator placed in the MoH. Work on this document stopped for four months before the incumbent UNFPA Logistics Coordinator commenced work in the MoH. Nevertheless, the existing Logistics Management Information Tool was reviewed, and UNFPA provided on the spot technical assistance to MoH by placing a member of staff in MoH.

The National Guidelines and Protocols for Condom Programming and Life Skills Manual for Youth and Sex Workers were not developed. Development of these two documents was not followed up during the implementation period. Instead, (it is acceptable for partners to vary activities as necessary) led by PPAZ, MSYCD and partners developed an equally important document, **Empowered Engaged Encouraged** National Standards for SRH, HIV and AIDS Peer Education Programmes March 2010. This document is the first activity in the National Plan of Action for the Youth. It was launched but not disseminated and orientation of stakeholders on its use had not taken place by September 2010. The partners planned to disseminate it before the end of 6th Country Programme in December 2010. The **Empowered Engaged Encouraged** National Standards for SRH, HIV and AIDS Peer Education Programmes document will standardise peer education training and peer education service delivery in the country.

In addition, MSYCD printed, launched and disseminated the National Plan of Action for the Youth. The purpose is to use it as a tool for the implementation of actionable units in the Youth Policy that was launched in 2006. In the log frame, the health section contains strategies and activities, which are in the

programme and are part of peer education programme e.g. promoting youth participation in HIV and AIDS decision making programmes and support HIV advocacy among the youth.

In the two Provinces, most of the activities to support peer volunteers were implemented. Sites for peer educators' programme were identified. The following groups were trained in their respective areas in the two Provinces:

- Peer Educators and Patrons;
- Community Based Distributors (CBDs) of oral contraceptives and condoms in North-Western and Luapula Provinces;
- Refresher training for Youth and adult CBDs in Luapula Province.

Furthermore, meetings were held with policy makers, community leaders and opinion leaders to sensitise them on adolescent sexual and reproductive health (ASRH) and materials for peer educators, CBDs and Patrons in both Provinces were procured. As discussed above, the Youth Network was established and was functional even though the advocacy and capacity building plan was not developed.

All the activities on training parent elder educators, traditional leaders and initiators were implemented. They were identified, trained and were functioning. The contribution of these groups to reproductive health is discussed under other objectives below.

. Table 2: CPAP Reproductive Health Results: Country Programme Outcomes, Country Programme Outputs, Output indicators, Implementing Partners and Achievements in 2010 (cont'd)

Country Programme Outcome	Country Programme Outputs	Targets	Output indicators	Implementing Partner(s) on behalf of GRZ	Achievements
Outcome UNDAF 2: By 2010, access of vulnerable groups to quality basic social services increased					
Component: Reproductive Health (cont'd)					
CP Outcome 3: Increased access of vulnerable groups to high quality reproductive health services	**Output 4:** Strengthened provision of high quality, integrated reproductive health services, particularly emergency obstetric care	45%	Percent of facilities that can provide basic and Comprehensive Emergency Obstetric Care	MoH	19%
			Percent of hospitals that provide Comprehensive Emergency Obstetric Care		100%
	Output 5: Increased availability of culturally sensitive reproductive health behaviour change communication	KAPB document strategy Increase from baseline by 5% access to services	Percentage of facilities providing treatment for abortion complications according to set standards		100% (hospitals only)
			Percentage of facilities providing at least three modern methods of FP		100%
			Caesarean sections as a proportion of all births		2.0 – 3.4%
			SRH BCC Strategy for vulnerable groups developed and implemented	ZANIS PPAZ	Not developed
			Number of messages developed		None
			Number of listening clubs established in communities		None
			Number of staff and volunteers trained in communities in BCC and drama		None in BCC 188 in drama

Table 2 above shows the achievements under Outcome UNDAF 2, "By 2010, access to of vulnerable groups to quality basic social services increased." The two output indicators to strengthen provision of high quality reproductive health services, particularly EmONC were achieved. Nineteen (19) percent (34 out of 178 health facilities in North-Western Province) and 18% (24 out of 134 health facilities in Luapula Province) provided basic and comprehensive EmONC and 100% hospitals provided EmONC. The low percentages are a result of shortage of health staff in the two Provinces. Only midwives, clinical officers and doctors were trained in EmONC and PAC in accordance with the national training standards for these maternal health interventions in Zambia.

Three out of seven output indicators were achieved under Output 5; "increased availability of culturally sensitive reproductive health behaviour change" were achieved. First, 100 per cent hospitals provided PAC services. The structures of health centres did not meet the national standards for them to provide the life saving PAC services e.g. a room with a couch and the necessary instruments and a trained service provider. Second, 100% health facilities in both Provinces provided at least three modern methods of family FP – oral contraception, injectable and condoms for dual protection. The number of methods provided was dependent on the cadre available in a health facility to provide (FP) services.

Third, ZANIS trained 188 artists in BCC drama. Seven videos were produced in local languages -- Lunda and Kaonde for North-Western Province and Bemba for Luapula Province. The videos are as follows:

- Cultural Barriers to Reproductive Health;
- Early Marriages;
- Teenage Pregnancy;
- Wife Inheritance;
- Wife battering
- Condom Use Among the Youth; and
- Child Defilement.

The video shows contributed to Country Programme Output 5 "Increased availability of culturally sensitive reproductive health behaviour change communication." The artists were from the communities therefore, they were aware of acceptable words to use in drama and behaviours acceptable to the community. The videos could not be on public television without paying the artists for producing the drama and paying for television companies. Such expenditures were not budgeted for in the 6th Country Programme.

Furthermore, the percentages of caesarean sections in North-Western Province were 2% out 18,907 deliveries in 2007, 2% out of 16,255 in 2008 and 3.4% out of 19,961 deliveries in 2009. The percentages of caesarean sections in Luapula Province were 2.8% out of 19,089 deliveries in 2007, 3.4% out of 21,304 deliveries in 2008 and 5.4% out of 50,182 deliveries in 2009. The percentages for caesarean sections were within the national percentages: 2.8% in 2007, 2.7% in 2008 and 4.5% in 2009. Mostly likely, most women with complications of pregnancy were referred to health facilities for further management despite the limited number of ambulances in the districts. The data shows further that facility deliveries increased in both Provinces in 2009. The increase can probably be attributed to the work of the SMAGs whose activities included encouraging pregnant women to deliver in health facilities.

The four activities not conducted under Country Programme Output 5 "Increased availability of culturally sensitive reproductive health behaviour change communication" were:

- Development of the Sexual and Reproductive Health (SRH) BCC Strategy for vulnerable groups;
- Development of a number of BCC messages;
- Establishment of listening clubs; and

- Training of staff and volunteers in the communities in BCC.

On the one hand, adolescent health was more pronounced in community BCC by the peer educators than at health facilities due to lack of space coupled with most of the health workers not being trained in the provision of adolescent health services. Thus, in some cases, adolescents who sought health care from health centres mingled with adults resulting in some of them not seeking the services they needed especially FP. One youth group stated that only the Sister in-Charge (trained in the provision of adolescent health) at their health centre was friendly to adolescents. The others were not. On the other hand, collaboration on adolescent health among stakeholders helped non-health workers to gain knowledge on this health area. One Provincial Youth Development Officer said collaboration opened his eyes on adolescent health. He observed that their Ministry (MSYCD) was recognized in the Province as a result of the 6th Country Programme. Before the two Country Programmes started, he used to feel that MSYCD was known in Lusaka only. He would like to see adolescent health scaled up in youth (16 only) centres nationally.

In general, adolescent health made an appreciable impact as testified in the various FGDs. It contributed to attaining the UNDAF outcome to increase access of vulnerable groups to quality basic social services. The peer educators provided BCC to in-school and out-of school youths and assisted with service delivery at health centres. At Chisunka Health Centre in Mansa District, peer educators have a small room where they attend to the youth and assist them to seek health care from the nurse as needed. In addition, except at the Youth Centre built by MSYCD at Chief Kanongesha's Palace, information from FGDs and interviews revealed that adolescent health was not integrated in other youth centres under the MSYCD in Districts not supported by UNFPA. Nevertheless, the coverage for adolescent health was low in both Provinces to make a significant impact. The main reason was that UNFPA sub-offices did not support or work with non-health NGOs working with the youth to help them to integrate adolescent health in their programmes.

Although a BCC Strategy was not developed during the life of the 6th Country Programme, BCC was used effectively by SMAGs, parent elder educators and peer educators who comprised of men and women from the same communities. Thus, the messages were culturally sensitive given that the Chiefs participated actively and supported the implementation of the programme in their areas. BCC accorded the Chiefs the opportunity to agree with their subjects on harmful cultural practices and how to address them together. Some key agreements included stopping early marriages (a man who married a girl below 20 years old was punished by the Chief), allowing girls with babies to continue their education or return to school when their children were one-year old as per the MoE policy; and encouraging couple CT for HIV.

The above results show a general good performance in the reproductive health component except for Country Output 5 "Increased availability of culturally sensitive reproductive health behaviour change communication." The partners ZANIS and PPAZ were supposed to implement the activities but this was not done. As pointed out above, an M&E system would have helped to track the progress being made in implementing the activities and address the problems as they arose rather than waiting until the evaluation is done. A monitoring system would have helped to follow up and support the partners to implement the activities.

Table 3 below shows the achievements related to the population and development component in the 6th Country Programme.

Table 3: CPAP Population and Development Results: Country Programme Outcomes, Country, Programme Outputs, Output indicators, Implementing Partners and Achievements in 2010

Outcome UNDAF 3: By 2010, institutions in support of national development priorities are strengthened					
Country Programme Outcome	**Country Programme Outputs**	**Targets**	**Output indicators**	**Implementing Partner(s) on behalf of GRZ**	**Achievements**
COMPONENT: POPULATION AND DEVELOPMENT					
CP Outcome 4: Institutions in support of national development priorities are strengthened	**Output 1:** Strengthened institutional capacity to implement, coordinate, monitor and evaluate the national population and national gender policy	None	Number of staff trained and retained for policy implementation	SPU in collaboration with GIDD and UNZA	None
		None	Report of high-level Inter-Agency Technical Committee (ITCP) on Population		One National ITCP meeting held
		None	Number of new or revised policies and plans that have effectively addressed population and gender		National Population Policy 2007 Draft Social Population Policy
CP Outcome 5: Institutions in support of national development priorities are strengthened (cont'd)	**Output 2:** Improved capacity of institutions at all levels to collect analyse and utilise data in planning and policy making	None	Number of staff trained and retained	CSO in collaboration with UNZA	None
		None	Number of priority studies identified and undertaken		Report on the Assessment of UNFPA-funded Enrolled Nurse Training in North-Western Province, Zambia April 2010
		None	Number of results surveys disseminated		2007 ZDHS 2010

Regarding Country Programme Output 1, "To strengthen institutional capacity to implement, coordinate, monitor and evaluate the National Population and National Gender Policies", none of the staff in SPU and GIDD were trained in (locally designed or tailor made) short courses for policy implementation. The Demography Division at UNZA was not requested to develop short courses, which could have improved management, coordination and monitoring of the implementation of the National Population and Gender Policies. However, SPU together with other Government partners and NGOs such as PPAZ representatives were in the delegation, which attended the Convention on Elimination of All Forms of Discrimination against Women (CEDAW) meetings in New York in 2010. SPU further managed and coordinated the following activities: (1) One out of four planned annual national ITCP meetings; (2) Review of the integration of population and gender factors in socio-economic policies, plans and programmes in Zambia; and (3) World Population Days in all the nine Provinces. The following equally important activities were not conducted:

- Population Action Plan was not printed and disseminated;
- Population Implementation Plan was not developed;
- Biannual monitoring field visits to the Provinces;
- Baseline survey on staff profile in the social sector line ministries – GIDD, CSO, MoFNP and Provincial Planning Units. The Demography Division at UNZA was supposed to conduct this survey and SPU should have followed it up. During the data collection SPU said that UNZA was responsible for this activity;
- Development of the staff tracking tools for Planning Units of Social Sectors Ministries, PPUs, GIDD and SPU; and
- Training 100 social sector planners, including MoFNP, provincial and district planners and selected planners from NGOs in the utilisation of gender and population data for planning and policy dialogue.

The reasons for not conducting the above activities included shortage of staff in SPU and staff having limited skills in population as it is a specialised field. One staff member said,

"Population is a specialised field. Staff will require skills in demography … We cannot coordinate an area in which the department has no competencies, including in the Provincial Offices."

SPU staff (and planners in the Provinces) acknowledged that planners need skills in M&E. They lacked the capacity to progressively collect data resulting in continuous loss of information. They added that there was no monitoring framework in the 6th Country Programme but the Results Framework in the document was not used to monitor the implementation of the programme. SPU staff recommended that M&E should be strengthened in the 7th Country Programme. The majority of technical information providers for the evaluation made the same recommendation.

The other reasons why the above activities were not implemented included time taken up by the development of the Sixth National Development Plan and Demography Division at UNZA not developing tailor made short courses to strengthen data collection, analysis and utilisation. Although Government has a robust monitoring system, it was necessary to have a complementary monitoring system to track not only financial resources allocated to each activity/Country Programme Outputs in the 6th Country Programme but also outputs, which are not in the national M&E systems. Good data can show case successes and weaknesses to inform programme planning, management, implementation, coordination, M&E and indicate areas requiring operational research.

The National Population Policy was revised, printed and disseminated country-wide through provincial meetings. However, Ministries such as Health and Education were not part of the team from Lusaka that went to the dissemination meetings in the Provinces. Including these two Ministries in these meetings was important for them to be on the same wave length on the policy its implications on service delivery given that these two sectors have the highest number of institutions at the grass-root level. Furthermore, attendance or participation of the two sectors at the dissemination of the National Population Policy in the Provinces could have motivated them to devise strategies on how to incorporate and sustain population issues in their policies, plans and programmes. Additionally, Table 3 above shows that the Social Population Policy was being reviewed in September 2010.

With regard to Country Programme Output 2: "Improved capacity of institutions at all levels to collect, analyse and utilise data in planning and policy making" in Table 3 above, the 2007 ZDHS was completed and disseminated. The 2007 ZDHS data has used in development of social sectors' policies, plans and programmes. But the two output indicators training and retaining staff and number of results surveys disseminated were not achieved. Staff were not trained and retained and priority studies were not identified and undertaken to inform improved capacity of institutions at all levels to collect, analyse and utilise data in planning and policy making. As discussed above Demography Division at UNZA did not develop tailor made course for this purpose. Priority studies were needed to produce data so as to develop evidence-based policies and plans and application in service delivery but none were conducted. However, Demography Division completed the Assessment of UNFPA-funded Enrolled Nurse Training in North-Western Province, Zambia. The assessment was needed to track deployment of nurse graduates since the 5th Country Programme started in the Province in 2001. A similar study should be done for Luapula Province in the 7th Country Programme.

The organisation for the Census 2010 by CSO in collaboration with the Demography Division at UNZA was almost complete by September 2010. Field mappers were trained on the use of GIS technology and mapping was at 99%, advocacy for the Census had been done through provincial workshops, Census Committees had been in place for about one year and Publicity Committees started work in 2010. The 2010 Census is funded by UNFPA and DFID. The plan was to start data collection in November 2010.

Additionally, the Demography Division at UNZA enrolled one PhD student and two MSc students sponsored by UNFPA. The second prospective PhD student delayed to submit the proposal for review

before she could be offered a place. The numbers of sponsored students for MSc and PhD are small for UNZA to increase its own staff establishment in the Demography Division and to support improvement of the capacity of institutions at all levels in data collection, analysis and utilisation when the graduates enter the job market in the public sector. Furthermore, demography students were placed as interns in industries. The purpose was to expose them to the working world to gain experience and getting feedback or views of companies on the relevance of the demography degree programme so as to help UNZA to maintain the standards. UNZA further put a system in place to trace graduates and books. However, migration and tracer studies were not conducted because the form was inadequate. It was taking long to review the form by the Immigration Department in the Ministry of Home Affairs.

Table 4 shows limited performance to achieve the Country Programme Outputs on gender.

Table 4: CPAP Gender Results: Country Programme Outcomes, Country Programme Outputs, Output indicators, Implementing Partners and Achievements in 2010

Outcome UNDAF 3: By 2010, institutions in support of national development priorities are strengthened					
Country Programme Outcome	**Country Programme Outputs**	**Targets**	**Output indicators**	**Implementing Partner(s) on behalf of GRZ**	**Achievements**
COMPONENT: GENDER					
Outcome: Social safety nets for vulnerable groups are strengthened	**Output 1**: Strengthened responsiveness to gender concerns among institutions and providers of basic social services	Gender based violence (GBV) reduced by TBD %	Number of gender based violence reported and acted upon	GIDD WILDAF WILSA	• The target changed • Draft National Guidelines for the Multidisplinary Management of Survivors of Gender Based Violence
		Institutions strengthened for case management of GBV	Percentage of victim support unit officers, judiciary and other law enforcement officers trained in case management of GBV		• 100 (no target)
		Specific legislation reviewed and recommendations submitted with respect to domestication of CEDAW			• None
	Output 2: Strategy for meeting State party reporting obligations for international Conventions reporting obligations is in place by 2010	Framework for reporting by Government and civil society organisations in place and operational	Framework for reporting by Government and civil society organisations is developed and in place by the end of 2008	WILDAF Population Council	None
		Network of Zambian Women Ministers and Parliamentarians established			Not done

The output indicator "Number of gender based violence reported and acted upon" was dropped because it was difficult to track but it was replaced. National Guidelines for the Multi-disciplinary Management of Survivors of Gender Based Violence in Zambia was in draft. It had been circulated to stakeholders for comments a few months before September 2010 when the data for this evaluation was collected. Only one output indicator (100 people trained by WILSA) was achieved. GIDD was not aware of the number of persons trained in case management of GBV. Consultants were referred to WILSA and WILDAF to

collect this data from the two organisations. Seemingly, GIDD did not keep records on the activities implemented in the gender component. A simple monitoring tool or M&E system would have helped GIDD to coordinate better the implementation of the activities and follow up the partners and support them where necessary

However, work on GBV continued. WILSA sensitised a total I00 mix (34 in Solwezi; 66 in Mansa Districts) representatives from Government departments. They included PPUs, Ministry of Community Development and NGOs working on gender issues and GBV. The sensitization meeting included case management of GBV in one day meetings. However, trainees were not followed up to support them to consolidate the skills in this area. In addition, participants at the sensitization meeting developed a BCC brochure. It is still in draft form at the WILSA office. UNFPA reviewed the brochure and provided comments but GIDD was not aware about its existence.

Furthermore, WILDAF coordinated the following activities on GBV:

- One full day meeting for 42 persons (20 in Chieftainess Kalaba's and 22 in Kalasa's Chiefdoms) in Mansa District. The participants included the two Chiefs and head persons;
- Three BCC community meetings through drama during the day and public video shows in the evenings. Two shows were held in Chief Kalasa's Chiefdom, the third one in Mansa town. About 2,000 adults and children attended the video shows held in the evenings. The video shows were held in collaboration with ZANIS;
- Two workshops for 60 gender focal persons from line-ministries, including staff from the Office of the President and traditional head persons.
- Four community meetings in the same Chiefdoms above and one meeting in Chief Matanda's Chiefdom;
- Conducted an assessment on GBV in 2010.The report is available.

Partners working on the gender component did not collaborate well with one another on implementation of the activities due to limited coordination and management of the gender annual work plans by GIDD. This is reflected by the low number of activities implemented under this component. The following activities under Country Programme Output 1 "Strengthened responsiveness to gender concerns among institutions and providers of basic social services" were not conducted:

- Producing and disseminating guidelines/check list to Government, private sector institutions and NGOs to assist in gender mainstreaming;
- Creating/developing a gender data base;
- Conducting an intensive TOT in gender budgeting for GIDD staff, planners, programme officers of relevant sectors and NGOs;
- Conducting a baseline study on the situation of GBV in all districts in North-Western and Luapula Provinces; and
- Intensifying and expanding the work of male action groups in support of women and girls rights.

Furthermore, all the activities under Country Programme Output 2 "State Party reporting obligations for international Conventions reporting obligations" were not conducted. These are as follows:

- Working with parliamentarians and members of the judicial system, in collaboration with other UN organisations to review relevant pieces of legislation to determine their responsiveness to the CEDAW, and to use the information to rally support for the amendment of relevant laws in favour of women and girls rights for the purpose of domesticating CEDAW;
- Holding two sensitization seminars for parliamentarians at the national level on the significance of CEDAW;
- Holding consultative meeting on the formation of Inter-Ministerial Committee to facilitate state party reporting of CEDAW;

- Network with women parliamentarians and the Zambia All-Party Parliamentarian Group on Population and Development by holding two consultative meetings to establish and launch the Network of Zambian Women Ministers and Parliamentarians to advocate for women's and adolescents' rights; and to train the network of Women Ministers and Women Parliamentary Caucus and ZAPPD in gender leadership/advocacy and resource mobilization.

Cognizant of the shortage of staff in GIDD, the gender component in the 6th Country Programme was not well coordinated. GIDD was not aware of the data, which was being collected by the partners WILDAF and WILSA coupled with not having a system in place to track and monitor implementation of the activities in the 6th Country Programme. Furthermore, Zambia has not submitted the State Report on CEDAW for 2010. There was no country format for reporting by Government and Civil Society organisations leading to the delay in submitting the State Report on CEDAW. Each stakeholder had a different format when a meeting was convened to write this State Report thus it was difficult to put the report together and submit it on time.

3.2 Relevance and effectiveness of component projects towards meeting the Country Programme goal

The project components were interrelated therefore, promoted a holistic approach to implementing integrated reproductive health, HIV and gender within the Government structures at national level and in the Provinces and Districts supported by UNFPA. The partners developed annual work plans to implement their components in the 6th Country Programme to be supported with funds from UNFPA. These were within their respective national priorities in national policies, plans and programmes.

Additionally, effectiveness of the project components was promoted by establishing strategic partnerships with institutions which were responsible for implementing them i.e., coordinating partners MoFNP, MoH, MSYCD, GIDD, NAC and CSO. The sub-contractors Division of Demography, NGOCC and PPAZ were also included in the partnership. Effectiveness was enhanced by UNPFA sub-offices building the capacity of Provinces and together providing the same to the Districts in reproductive health particularly EmONC, FP, PAC, HIV and community BCC. The work of the SMAGs, parent elder educators and peer educators (discussed in sections below) contributed to the effectiveness of the project components by increasing access to reproductive health, FP and HIV CT in health centres and hospitals.

Adolescent health was more pronounced in community BCC by the peer educators than at health facilities due to lack of space coupled with most of the health workers not being trained in the provision of adolescent health services. Thus, adolescents who sought health care from health centres mingled with adults resulting in some of them not seeking the services they needed especially FP. One youth group stated that only the Sister in-Charge (trained in the provision of adolescent health) at their health centre was friendly to adolescents. The others were not.

In general, peer educators' contribution to adolescent health made an appreciable impact as testified in the various FGDs and contributed to attaining the UNDAF outcome to increase access of vulnerable groups to quality basic social services. They provided BCC to in-school and out-of school youths and assisted with service delivery at health centres. At Chisunka Health Centre in Mansa District, peer educators have a small room where they attend to the youth and assist them to seek health care from the nurse as needed. In addition, except at the Youth Centre built by MSYCD at Chief Kanongesha's Palace, information from FGDs and interviews revealed that adolescent health was not integrated in other youth centres (16 only the whole country) under the MSYCD in Districts not supported by UNFPA. Nevertheless, the coverage for adolescent health was low in both Provinces to make a significant impact. The main reasons were that the field offices did not support non-health NGOs working with the youth to integrate adolescent health in their programmes.

Although a BCC Strategy was not developed during the life of the 6th Country Programme, BCC was used effectively by the SMAGs, parent elder educators and peer educators who comprised of men and women from the same communities. Thus, the messages were culturally sensitive given that the Chiefs participated actively and supported the implementation of the programme in their areas. BCC accorded the Chiefs the opportunity to agree with their subjects on harmful cultural practices and how to address them. Some key agreements included stopping early marriages (a man who married a girl below 20 years old was punished by the Chief), allowing girls with babies to continue their education or return to school when their children were one-year old as per the MoE policy; and encouraging couple CT for HIV.

3.3 Extent to which the Country Programme contributed to the achievement of the outcomes of the UNDAF, National Population Policy and the Fifth National Development Plan

It was evident from the results of the evaluation that the 6th Country Programme contributed significantly to the UNDAF outcomes, "Increased access to a comprehensive package of HIV prevention services and increased access to HIV prevention, care and support" as follows:

The BCC work by the SMAGs and parent elder educators in all the seven Districts in North-Western Province and in four out of seven Districts in Luapula Province can be likened to a door-to-door campaign to HIV and STI prevention. In this approach couples are provided with CT and tested for HIV in their own homes. Although HIV testing was not done in the homes in this programme, door-to-door education on reproductive health including HIV and STIs reached many people and closed a missed opportunity if BCC messages were given at community gatherings with few people in attendance. SMAGs and parent elder educators provided HIV education to adults and older children in their own homes while peer educators gave HIV and STIs education to both in-school and out of school youth. The three groups also referred people and accompanied a number of them to health facilities for CT. It is prudent for Government and UNFPA to consider including CT to be done by trained SMAG members, parent elder educators and peer education than the training done lay counsellors. This intervention increased access to CT. The support SMAG members, parent elder educators and peer education provided to communities. This intervention included encouraging those who tested HIV positive to start treatment.

Review of the PMTCT registers in health centres showed increased numbers of pregnant women (and few couples) counselled and tested for PMTCT since 2007 in North-Western Province and 2008 in Luapula Province respectively. SMAGs encourage couple CT and accompanied couples to health centres on first ANC.

Additionally, Senior Chiefs Kanongesha, Mumena and Chisunka, and Chief Mutondolo created and maintained an enabling environment to promote STI and HIV prevention in their Chiefdoms by supporting the work of the SMAGs, parent elder educators and peer educators; and working with the communities.

Despite the short time the 6th Country Programme was implemented, it contributed to four out of seven objectives in the National Population Policy and related strategies in the FNDP mainly in the health sector as discussed below:

- First, reproductive health, FP and HIV/AIDS were integrated in health policies, plans and programmes at national level. Gender was mainstreamed at community level through the BCC work of the SMAGs, parent elder educators and peer educators.
- In the health sector, gender was articulated in the National Reproductive Health Policy 2008 and in the National Strategy for the Prevention of HIV and STIs 2009. However, it has not yet been adequately mainstreamed fully in service delivery in health centres even after the

Consultancy Report on Gender Mainstreaming in the Health Sector in Zambia of 2006. Service providers in health centres seemed to equate gender to the number of spouses who accompanied their wives to the clinics for ANC and PMTCT and nothing else. A number of interviewees presented a general feeling that gender mainstreaming not only in reproductive health but in all social sectors was a challenge due to general resistance in the country. Furthermore, apart from delayed funding on gender due to an audit query in GIDD, many activities were not implemented under the gender component leading to limited integration of gender in health and youth programmes.

- Second, it appears maternal mortality was reducing in the areas supported by UNFPA especially in North-Western Province where the 6th Country Programme built on the experience from the 5th Country Programme. For instance, it was reported by Senior Chief Mumena that there was only one maternal death in his area in Solwezi District in North-Western Province during the implementation period of the 6th Country Programme (and none in the 5th Country Programme). The woman developed a complication during labour and unfortunately, transport was not available to take her to the nearest health centre or hospital for skilled management of the complication. In view of current financial constraints, one case of maternal mortality in nine years in a rural area with limited access to health care is commendable. It is a starting point in the efforts the country is making toward achieving the MDGs by 2015. The ZDHS planned for 2012 will give the result on national maternal mortality ratio.

- Third, although the TFR estimate is 6.2 per woman in 2007, the TFR is probably reducing in adolescents. All the SMAGs, parent elder educators and peer educators FGD discussants stated that teenage pregnancies reduced in their areas since the programme started in 2008 in North-Western and Luapula Provinces. The reported result could not be verified in the absence of a baseline that included the number of teenage pregnancies before the SMAGs, parent elder educators and peer educators started working in the same areas. The quantitative result will be assessed in the 2010 ZDHS. Nevertheless, teenage pregnancies were still high district or province wise because the programme covered selected facilities and communities and not an entire district. A number of information providers recommended that the programme should cover all the districts and all the facilities for impact.

- Fourth, the SMAGs, parent elder educators and peer educators played a key role to contribute to reproductive health and FP in order to encourage a manageable family size. The door-to-door BCC education approach included FP on short-term and long-term contraceptive methods. The three groups distributed condoms for dual protection and promoted long-term contraceptive methods. Meanwhile, trained SMAGs members were also distributing contraceptive pills and trained health workers provided long-term methods e.g. insertion of Jadelle implants. Review of FP registers showed that the number of women opting for long-term methods was increasing. A woman can conceal this method and tell her spouse about it. Contribution by the SMAGs, parent elder educators and peer educators was minimal compared to the need. These groups were attached to health centres, which were not supported by UNFPA.

Although DMOs were fully involved in implementing the 6th Country Programme, they did not adopt and implement the innovation to form SMAGs, parent elder educators and peer educators groups in order to improve reproductive health and HIV services district-wide. DMOs have experience working with community groups established by the health sector nationally or NGOs in selected districts some of which are still operating. Thus, it will be easy for DMOs to establish SMAGs, parent elder educators and peer educators and use them to improve delivery of reproductive health and HIV services in the facilities and in the community.

3.4 Extent of integration of gender, culture and human rights concerns during the implementation of the Country Programme

The Gender Policy has not been revised since 2000. It is an activity in the 6th Country Programme. GIDD continued to use the 2000 Gender Policy to promote gender in national plans and programmes. Apart from meetings with Parliamentarians to promote the three project components to them, little else happened at national level with social sectors. Additional reasons to the ones discussed above, which led to limited performance in gender at national level included:

- The current focal person for gender in GIDD took over in 2009 and allegedly there was no handover from the predecessor. Neither did she request the person to handover to her since he was in the same Division. Having a technical assistance plan could have address this problem;
- In 2009, the funds for gender activities from UNFPA were misapplied on other activities within GIDD;
- The activities conducted in 2008 were not documented as revealed in the results in Table 4 above;
- Funds for the first and second quarters in 2010 were received in September 2010. GIDD took long to reimburse the funds that were diverted to other activities as per agreement between Government and UNFPA;
- The results on technical assistance were mixed. GIDD felt that UNFPA did not provide the technical assistance it required -- UNFPA said this was done. According to GIDD, the person who was supposed to provide the technical assistance spent about 20 per cent of her time on assisting them because of other commitments within UNFPA office. For this reason, GIDD would like to have a full-time technical advisor working in GIDD and not operating from UNFPA office.

Members of the SMAG at the maternity waiting home awaiting completion. The group was also constructing a kitchen on the left side of the maternity waiting home.

Nevertheless, gender was well integrated in service delivery at community level by the SMAGs, parent elder educators and peer educators and less so in health facilities. ZANIS complemented the BCC messages with video shows to about 2,000 people comprising of men, women and children in the communities but the attendance at video shows could not be verified because no head counts were done because the video shows took place in the evenings when it was dark.

Meanwhile observations of service delivery and information from FGDs revealed that culture and human rights were well integrated in the work of the SMAGs, parent elder educators and peer educators. The members of the three groups were aware of both the positive and negative cultural practices because they live within the same communities. Participation of the Chiefs in the programme promoted retaining positive cultural practices and discouraged negative ones. For example, the Chiefs agreed with their subjects to end early marriages. Meanwhile, observations of service delivery in health centres found that service providers upheld human rights when offering CT for PMTCT and when offering contraceptive methods to clients.

3.5 Achievement of substantive and financial results, successful interventions (success stories), difficulties and constraints and lessons learnt

3.5.1 Substantive Results

With financial and personnel assistance from UNFPA, the project components were implemented and managed by the PMOs and DMOs together with the staff in health centres and the Chiefs in the catchment areas where the health centres were situated. The PMOs managed the discrete (separate from Government) accounts of the joint GRZ/UNFPA programme. Senior Chiefs Kanongesha, Mumena and Chisunka, and Chief Mutondolo played a pivotal role in moving reproductive health and HIV

services and integrating gender in these services. They spoke favourably of the progress the programme was making to improve the health of their subjects especially of mothers and children.

The coverage of interventions supported by UNFPA was higher in North-Western Province than in Luapula Province. This would be expected. The interventions in North-Western Province started in the 5th Country Programme but in the 6th Country Programme in Luapula Province. However, coverage in reproductive health was about the same in the two provinces. Medical equipment was provided in North-Western Province but not in Luapula Province. In fact, coverage of medical equipment was the highest among the support given by UNFPA to the facilities in North-Western Province with 100% coverage in Chavuma and Kabompo Districts. The disparity in support to Luapula and North-Western Province does not augur well with the principles of capacity building in the 6th Country Programme. National and provincial programmes are supposed to be equitable. This disparity has to be redressed if the programmes are continued.

All FGD discussants and interviewees stated that the 6th Country Programme in their catchment areas:

- Reduced maternal deaths;
- Increased the number of couples testing for HIV (although the numbers were small, it was a starting point to increasing male involvement in reproductive health and HIV services);
- Increased the number of facility deliveries and uptake of FP. The SMAG at Kalombe Health Centre in Kasempa District collected K5,000.00 (about US$1.10) from each household and constructed a maternity waiting home at the health centre shown in the photograph on the right hand side. They wanted pregnant women staying far from the health centre to wait and deliver at the health centre;
- Reduced teenage pregnancies and increased the number of girls with children returning to school;
- Reduced the heavy workload of children -- parents started carrying heavy workloads e.g. 25 litres of water from the streams and not children; and
- Reduced alcohol and drug abuse among the youth.

It was evident from the qualitative data that the above anecdotal results had been achieved. Unfortunately, despite that the SMAGs, parent elder educators and peer educators produced reports and sent them to health centres, there was still a paucity of data to support the above stated results due to a lack of an effective M&E system to track activity implementation and outcomes such as the number of people who received a given service.

With technical, equipment and material support from UNFPA, CSO printed and disseminated 2007 ZDHS nation-wide. The results of the ZDHS were cited and used in developing the national documents National Condom Strategy, National Population Policy 2007, the National Reproductive Health Policy 2008 and the National Strategy for Prevention of HIV and STIs. CSO further organized the Census, conducted the field mapping and counting of the population started in 2010. However, the technical assistance and training in HMIS was not done.

Table 5: Types of in-service training, targets and numbers trained in Luapula and North-Western provinces

In-service trainings	North-Western Province (started in 2007)		Luapula Province (started in 2008)		Total trained
	Target	Number trained	Target	Number trained	
EmONC	30	24	32	42	**66**
PAC	40	30	-	-	**30**
FP (Jadelle insertion)	60	63	42	57	**120**
PMTCT	60	74	-	-	**74**
MDR	250	152	76	106	**258**
Grand Total	**440**	**343**	**150**	**205**	**548**

Table 5 above shows the in-service trainings, targets and the numbers of health workers trained in core interventions in maternal health (reproductive health).

A total of 548 service providers were trained in EmONC, PAC, Jadelle insertion, PMTCT and MDR. Most targets were met, and in some cases e.g. Jadelle insertion and PMTCT trainings in North-Western Province and EmONC, Jadelle insertion, and MDR trainings in Luapula Province surpassed the targets respectively. Luapula Province did not train service providers in PAC and PMTCT separately. The 42 service providers were trained in EmONC, PAC and PMTCT in the same training session.

In-service trainings were not uniform in the two Provinces although the programme was the same. Mostly likely, the two UNFPA sub-offices did not have targets for their trainings. The targets in the above table were provided by field programme officers via e-mail or through the telephone but these were absent in activity, quarterly, mid-year and annual reports. UNFPA sub-offices did not conduct baseline assessments before training health workers although this was important for follow up of trainees and monitoring the quality of service delivery such as EmONC, PAC and Jadelle implant insertions.

Nevertheless, the trainees contributed to the provision of high-quality integrated reproductive health. Although the numbers of service providers trained in the above core maternal health interventions were low compared to the need in the two Provinces; there was no doubt that those trained saved the lives of some mothers and babies. In addition, the trainees increased the number of midwives providing long-term contraceptive method in both Provinces. Review of FP registers at three health centres revealed an increase in the number of women opting for long-term and injectable contraceptive methods compared to oral contraceptive pills. However, almost all trainees worked in District Hospitals. In view of the estimated shortage of 23,000 nurses and midwives in Zambia, not training ZENs conducting deliveries in health centres in the above in-service courses was a missed opportunity to improve labour and delivery services at this level. The ZENs education and training curriculum includes theory in basic midwifery and hands on experience in labour wards.

Table 6 below shows the numbers of people trained in relevant courses in order to promote provision of integrated reproductive health and HIV services and promote behaviour change in relation to reproductive health, HIV and gender.

Table 6: Types of training and numbers of people trained in both Luapula and North-Western Provinces disaggregated by gender

Type of training	2008			2009			2010			Cumulative Totals	
	M	F	Total	M	F	Total	M	F	Total	M	F
Peer educators	53	36	89	108	83	191	72	68	140	233	187
Parent elder educators	44	42	86	52	48	100	40*	35*	75*	136	125
SMAGs	46**	38**	84**	479**	416**	895**	101**	103**	204**	2,846+	
Service providers in YFHS	11**	10**	21**	12**	8**	20**	14**	7**	21**	37**	25**
Traditional initiators in ASRH and gender	-	-	-	30**	30**	60**	15**	15**	30**	45**	45**
Youth psychosocial counsellors	-	-	-	9**	7**	16**	12**	8**	20**	21**	15**
Orientation DHMTs in YFHS	-	-	-	16**	5**	21**	-	-	-	16**	5**
Youth and adult CBDs				60**	20**	80**	23**	13**	46**	691++	
TOT for CBDs	-	-	-	-	-	-	7**	14**	20**	7**	14**
Community PMTCT				12**	15**	27**	7**	8**	15**	19**	23**
Maintenance of medical equipment				18**	02**	20**	17**	03**	20**	35**	5**

**Luapula Province only **North-Western Province only;*
+Luapula Province trained a total of 1,663 members of SMAGS but the figure was not disaggregated the data by gender;
++ Luapula Province trained 571 CBDs but the figure was not disaggregate the data by gender

The courses were critical to improving the delivery of reproductive health and HIV services. The 2,846 SMAG members in both Provinces helped included importance of ANC, delivering in health facilities, FP and high risk pregnancies in BCC messages in the community. The rest of the numbers of community members and health workers trained were negligible to make an impact in provision of integrated high quality reproductive health and HIV services. Nevertheless, all the groups played a pivotal role to promote reproductive health in the community. Furthermore, trained counsellors among them also helped the staff at health centres with counselling in ANC clinics on HIV and PMTCT while some of them assisted with weighing children in children's clinics. Except for Solwezi Urban Health Centre, which had three midwives and three general nurses, the rest of the rural health centres visited had only one nurse or a health environmental technologist. Thus, the assistance by SMAGs, parent elder educators and peer educators helped the overworked nurses providing services in health centres.

In addition, Luapula Province trained 53 people (32 females and 25 males) in gender mainstreaming and 74 people (28 females and 46 males) in sexual harassment and GBV. These courses helped to address gender disparities in the community as discussed above. As presented above, WILSA trained 100 people in GBV. This number is higher than 74 given by the UNPFA sub-office. This is another demonstration why a monitoring system was needed to track activity implementation and outcomes or achievements. UNFPA sub-office and WILSA worked together but they gave different numbers of people trained in GBV.

Furthermore, the numbers of ZENs, ZRNs and ZEMs were increased in the two Provinces by bonding those sponsored by UNFPA to work in the same Provinces. All the 154 ZEN graduates of 2008, 2009 and 2010 from Solwezi, Mukinge and Kaleni Schools of Nursing were posted to work in the same Province. Meanwhile, only nine out of the total 100 (31 ZRN graduates from Mansa General Hospital in 2010) nurse graduates in 2008, 2009 and 2010 from Mansa and St. Paul's Schools of Nursing were posted to work in the same Province. These numbers helped to reduce the shortage of staff but they were a drop in the ocean regarding provision of high-quality reproductive health services. For instance, Mwinilunga District had no midwives in all the health centres. Jadelle Implants were being offered in three hospitals and four health centres out of 25 health facilities in the District while nine of them were being run by untrained staff. The situation was probably the same in the other six Districts in North-Western Province. Luapula Province had positions for nurses and midwives (and other health workers) in the new civil service structure but they were not funded due to the ongoing restructuring of the civil service.

3.5.2 Financial results

UNFPA channelled funds to implementing partners SPU, CSO, NAC, GIDD and PMOs, WILDAF and WILSA. Table 5 below indicates country outputs, implementing partners, actual annual budgets, annual expenditures and percentage utilised.

As can be seen in Table 7 below, the utilisation percentages for most Country Programme Outputs were consistently high ranging from 82.7% in 2007 by MSYCD and PPAZ to 99.9% by NAC in 2010.

Table 7: Country Programme Outputs, Implementing Partners, Actual Annual Budgets, Annual Expenditures and Percent Utilisation													
Country Programme Outputs	**Implementing Partners***	**2007**			**2008**			**2009**			**2010**		
		Budget in US$	**Expenditure**	**Percentage utilised.**	**Budget in US$**	**Expenditure**	**Percentage utilised.**	**Budget in US$**	**Expenditure**	**Percentage utilised.**	**Budget in US$**	**Expenditure**	**Percentage utilised.**
A National HIV and STI Prevention Strategy is developed/ reviewed by 2010	NAC	24,900.00	9,574.44	38.45	1,199.20	1,199.20	100.00	90,223.00	10,370.34	11.49	90,000.00	89,979.51	99.98
Mechanisms to prevent transmission of HIV, focusing on high-risk behaviour, are in place by 2010	UNFPA	-	-	-	56,078.15	4,254.36	7.6	74,000.00	73,371.43	99.2	71,000.00	67,702,.46	95.4
A comprehensive framework for procurement and logistics management, with a focus on service delivery systems developed by 2010	UNFPA	41,000.00	39,471.49	96.3	146,344.56	120,427.21	82.3	31,418.19	30,822.26	98.1	30,000.00	14,639.50	48.8
Strengthened provision of high quality, integrated reproductive health services, particularly emergency obstetric care	UNFPA MoH	1,148,999.00	1,092,382.22	95	929,468.19	823,693.93	89	1,862,646.79	1,848,589.58	99.2	1,659,725..73	1,455,291.27	87.7
Mechanisms to prevent transmission of HIV, focusing on high-risk behaviour, are in place by 2010	MSYCD PPAZ	177,812.00	147,043.85	82.7	218,462.32	185,905,60	85.6	116,400.00	114,954.75	98.7	200,000.00	140,484.42	70.2
Increased availability of culturally sensitive reproductive health behaviour change communication	ZANIS	79,000.00	75,019.95	95	175,407.90	152,901.32	90.6	126,410.15	126,410.15	100	116,000.00	89,083.44	76.8
Capacity strengthening for integration	MoFNP	94,063.00	85,176.66	90.6	313,700.00	252,360.42	80.4	223,456.62	263,197.81	92.4	368,000	263,197.81	87.4
Improved institutional capacity	CSO UNZA	456,244.00	407,751.79	94.9	624,599.65	624,599.65	85.3	631,002.84	534,700.04	78.8	851,699.00	630,133.71	88.8
Strengthened responsiveness to gender concerns among institutions and providers of basic social services	GIDD	270,538	41,024.69	15.2	332,100.00	147,238.03	44.3	214,150	167,768.00	78.3	250,000.00	74,434.80	29.8
Total		**2,292,556**	**1,897,445.09**		**2,797,359,97**	**2,321,579.72**		**3,369,707.59**	**3,179,184.36**		**3,636,424,73**	**2,824,946.92**	

Despite the high utilisation percentages on capacity strengthening for integration, SPU did not implement a number of the activities, which have been discussed in another results section above. These were critical activities, which could have ensured effective institutionalisation of population issues in social sector plans and programmes. All the respondents who provided information for the review of the integration of population and gender factors in socio-economic policies, plans and programmes in Zambia emphasized the importance of knowing population factors to planning processes. Some of the factors they mentioned were population size, structure, distribution and composition, fertility, mortality, migration and morbidity (MoFNP, 2010).

The utilisation percentages were low for the RHCS framework and the gender component. The utilisation percentages for the RHCS framework dropped from 96.3% in 2007 to 48.8% in 2010. The effort to finalize the RHCS framework stalled due to infrequent meetings of the RHCS Technical Working Group. UNFPA staff based in the MoH resigned and the position remained vacant for about four months. Nevertheless, procurement of RH commodities went smoothly. There was no stock out of contraceptives for three years. One quarter stock out of condoms in the districts supported by UNFPA in the two Provinces in 2009 was due to transport problems. PMOs experienced transport problems to distribute the condoms to district pharmacies.

The main reasons not only for under spending but also limited performance on the gender component were:

- The coordinating partner GIDD was overwhelmed with work due to critical shortage of staff. The Division had four staff only. As a result, there was a tendency to put aside activities in the 6th Country Programme in order to concentrate on other Cabinet activities. Partly, the problem was compounded by communication breakdown on UNFPA funding between GIDD and NGOCC. The latter got funding went through GIDD. Therefore, it took long before NGOCC could get the money to implement the activities in the 6th Country Programme. NGOCC preferred to be funded directly in the 7th Country Programme rather than through GIDD to avoid delays in implementing the activities. NGOCC has the capacity to manage the funds. It has been managing donor funds for years and has been audited several times. Furthermore, there were no gender staff in the districts;

- As discussed above, the results were mixed on technical assistance, which UNFPA was supposed to provide to GIDD on the gender component. GIDD felt that the technical assistance given was not adequate while UNPFA felt that it was. The problem was compounded by GIDD not maximising on NGOCC's long experience in gender.

Table 8 shows additional financial resources, which UNFPA mobilised from partners to enhance provision of high quality reproductive health services country-wide.

Table 8: Additional resources to support provision of integrated reproductive health

Year	Contraceptives %100 Expenditure	Obstetric Fistula and Midwifery		Reproductive Health Commodity Security	
		Budget	Expenditure	Budget	Expenditure
2007	-	US$106,830.88	US$12,508.06 (12%)	-	-
2008	US$478,561.00 EUR415,008.46	US$234,291.00	US$169,730.35 (73%)	-	-
2009	US$2,030,520.63 EUR946,014.85	US$323,750.00	US$285,704.35 (88%)	US$105,500.00	US$91,802.08 (87%)
2010	US$733,527.30	US$238,275.00	US$197,750.73 (83%)	US$205,975.00	US$205,975.00 (69%)

**RHCS: Reproductive Health Commodity Security*

The above additional resources raised by UNFPA during the 6th Country Programme had been substantial to support the provision of integrated reproductive health services. Except for a very low utilisation rate of 12% on the obstetric fistula and midwifery programme in 2007, the remaining utilisation rates were high ranging from 83% on the obstetric fistula and midwifery programme to 100% on procurement of contraceptives. There had been a continuous supply of contraceptives and condoms in Zambia since 2008. Jadelle implant was out of stock in some districts at the time of data collection but stock was available in the country. A brief shortage of condoms in North-Western Province in 2009 was due to lack of transport to deliver them from the Provincial Pharmacies to District Pharmacies.

Provision of high-quality integrated reproductive health services included empowering communities to address high-risk pregnancies inclusive of prevention of fistula. Table 9 shows the number of women who had fistula repairs from 2008.

Table 9: Number of fistula repairs done by province from 2008 to 2009

Province	Year		
	2008	**2009**	**2010***
Lusaka	48	54	36
Southern	110	90	
Eastern	4	62	98
Western	-		
Central	-		
Luapula	77	102	
Copper belt	-		
Northern	8	31	26
North-Western	9	14	
Total	**252**	**353**	

Fistula repair camps were held in six out of nine Provinces in Zambia. A group of doctors and nurses trained in fistula repair performed the surgery. The number of women who had fistula repairs increased from 252 in 2008 to 353 in 2009. The total number of fistula repairs done in 2010 will be finalized at the end of 2010. However, not all women requiring fistula repairs were reached. The team of doctors and nurses carrying out the surgery are based and work at University Teaching Hospital (UTH) in Lusaka. Hence, the waiting list for fistula repair has grown as a result of the sensitization campaign informing the public about fistula repair camps. The other three Provinces will be included in the next Country Programme. The plan is to train more teams to perform the surgery in all the Provinces.

The five centres providing fistula repair services were University Teaching Hospital in Lusaka, Lusaka Province, Monze Mission Hospital in Monze, Southern Province, St. Francis Mission Hospital in Katete District, Eastern Province, Chilonga Mission Hospital in Mpika, Northern Province and Chitokoloki Mission Hospital in North-Western Province. Fistula repair camps were also held in Mansa, Solwezi and Chipata General Hospitals respectively.

The contribution of UNFPA support to reproductive health and HIV prevention can be claimed by proxy from the HMIS in UNFPA supported districts. The data can include the number of women accepting FP, the number of pregnant women who were tested for HIV and received results and the number of HIV positive women who received antiretroviral prophylaxis and/or put on treatment etc. It was evident from the FGDs and interviews that the health facilities UNFPA supported contributed significantly to improved reproductive health and HIV services in the two Provinces. Hence, all the information providers at all levels wanted the joint GRZ/UNFPA programme to continue because it is making a different to maternal health and increasing uptake of HIV testing, among others. Furthermore, the results of the 2010 ZDHS are likely to show substantive results particularly in North-Western Province where the Country Programme had been implemented for about eight years compared to Luapula Province where the programme had been implemented for two years only.

Most of the Government partners at national, provincial and district levels participated in the finalization of and annual reviews of the progress being made in implementing the 6th Country Programme.

3.5.3 Successful interventions

A number of successful interventions were implemented in the 6th Country Programme but only two success stories are included in the evaluation to elaborate the direct and indirect affect of the programme. The first one demonstrates that strategic partnership between Government, UNFPA, Senior Chief Mumena and his subjects reduced maternal deaths in the Chiefdom. The second one is on the progress peer education made in Senior Chief Kanongesha's Chiefdom.

SUCCESS STORY 1

Strategic Partnership with Chiefs and the Community can Avert Maternal Deaths

Introduction

Before the 5th Country Programme intervention in Western Province in 2001, maternal deaths in Senior Chief Mumena's Chiefdom were high. The accepted folklore was that a pregnant woman could survive or die. People mourned and cried endlessly and agonized why this was so and were resigned to it nevertheless. But Senior Chief Mumena knew that this was not the case in many other places inclusive of the urban areas of Zambia. He said his prayers were answered by the 5th Country Programme in 2001. Men got involved and realised that it was wrong to batter women/wives. Men were no longer embarrassed to get involved in mothering issues. They dug boreholes near the villages to shorten the distance women travelled to draw water for household use.

Background

The support to North-Western Province continued in 2007. Senior Chief Mumena spoke with confidence that management of pregnancies by families and communities had improved a lot and preparation for delivery was better than before. UNFPA provided one ambulance for Solwezi District, which is tens of thousands of square kilometres. Nevertheless, Senior Chief Mumena felt that the ambulance had gone a long way to improve referrals of pregnant women in labour to health centres/hospital because of the radio messaging system, which linked some health centres and the community. People did not go far to get transport help these days.

Achievement

There had been only one maternal death in Senior Chief Mumena's area with a population of about 65,000 in Solwezi District since 2001. He stated that the maternal death which occurred in 2008 was a tragic consequence of the MoH directive barring traditional birth attendants (TBAs) from delivering mothers. He added that with the Country Programmes especially the 5th than the 6th Country Programme, virtues of good maternal health had been engrained in the culture of his subjects. Unfortunately, the 6th Country Programme scorned and threatened TBAs not to deliver women in labour. The MoH was directed by some foreign powers that TBAs should just promote safe motherhood in the community. TBAs delivered women in the community in the past and they were revered by the community. Senior Chief Mumena demanded that the mistakes of the 6th Country Programme should be corrected by reverting to the strategy and modalities of the 5th Country Programme. He asked, "Why is it that the health worker from the District tasked with implementing interventions in the 6th Country Programme by the MoH had not shown up at his Palace since? UNFPA staff were always on the ground in the 5th Country Programme. And, if it was not for the Mumena Development Trust they set up, the 6th Country Programme would not have achieved much as far as he was concerned.

Chief Mumena XI

He was installed on 1st October, 2000. He is 46 years old. Prior to his installation, he worked as a Maintenance Technician in the Post and Telecommunication Company which was later renamed Zambia Telecommunications Company (ZAMTEL). He is married to one wife with four children. They have been married since 1992. One child is a boy and there is one set of twins among the girls. The twins were born by caesarean section. He witnessed the potential perils in the lead-up to the caesarean section. His wife is a teacher at Mumena Basic School. She has helped him a lot to crusade for the improvement of maternal health in his Chiefdom

Conclusion

Strategic partnership with Chiefs and communities can avert maternal deaths. Senior Chief Mumena believes that the maternal death that happened in his Chiefdom in 2008 was because the TBAs folded their arms not by desire but by some foreign directive.

Recommendation

Senior Chief Mumena recommended that the MoH should embrace rural conditions and not bend to foreign dictates and MoH staff should get on the ground as UNFPA staff did in the 5th Country Programme.

SUCCESS STORY 2

Reaching out and Making a Difference to Adolescent Health

Introduction

Christabel Makunka, a niece to Senior Chief Kanongesha in Mwinilunga District, is 22 years old. She was born on 30th September 1987 and leaves with her uncle at the Palace. She sat for Grade 9 examination and passed to go to Grade 10 but could not continue school in Grade 10 in 2004 because she was pregnant. She delivered a set of twins (girls) in 2005. The twins' father did not marry her. Christabel did not know anything about adolescent health until she became a peer educator in 2009.

Background

The joint GRZ/UNFPA support to North-Western Province started with the 5th Country Programme in 2001. The implementation modalities included training peer educators to educate fellow youths on adolescent health inclusive of HIV, FP, gender, early marriages and adverse effects of alcohol and drug abuse. The peer educators were attached to health centres and had a Matron to support them. They delivered BCC messages to communities and to in-school and out of school youths. The peer educators in Senior Chief Kanongesha's Chiefdom operate from a youth centre built (very close to the Palace) by the MSYCD and equipped by UNFPA. The group added to adolescent health agriculture, sport such as football and netball, and a pool table donated by UNFPA. The aim was to attract and educate more young people on adolescent health, HIV, FP, gender and alcohol and drug abuse. UNFPA purchased a generator for the youth centre to enable the youths to use television and video, for training their peers.

Christabel with her uncle Senior Chief Kanongesha

Motivation

Christabel was encouraged by the Youth Coordinator at the Palace to attend peer education workshops in Mwinilunga District (56 kilometres from the Palace). The subjects learnt included adolescent health, FP, early marriages and girl child education, among others. Motivated by the information from the workshops, Christabel decided to become a peer educator in 2009. With support from her uncle Senior Chief Kanongesha, she decided to go back to school in Grade 10 in 2010. Christabel wanted to be a role model to other girls with children in the area not to shy away to return to school as MoE policy allows them to do so. As a peer educator, Christabel enjoys teaching the youth (boys and girls) on issues of abstinence, alcohol and drug abuse, early marriages, girl child education and FP. She added that what she likes best about being a peer educator is sharing adolescent health information with peers and helping them to change their behaviour for their own health, and other general developments.

Outcome

The peer education programme in Senior Chief Kanongesha's area has created an enabling environment for the rural youth on adolescent health. Christabel stated that a significant number of the youth have changed their behaviour. She observed that before the GRZ/UNFPA programme, some boys used to drink beer at night, a habit they have stopped. This is because they realised that there was more to life than beer drinking and some boys and girls also dropped bad companies. This statement was collaborated with the information given by Chief Senior Kanongesha during the interview and other peer educators during the FGD respectively.

Conclusion

Christabel concluded that, "UNFPA has been great. They have given us important information to help us change our lives. I would like to thank them for this good intervention." She requested that UNFPA should not stop this programme. They should continue, and May God Bless the organisation not to relent with this programme."

3.5.4 Best practices, constraints and lessons learned

3.5.4.1 Best practices

The well thought out and designed project approach to a great extent built the capacity of SPU and strengthened the capacity of MoH, MSYCD, NAC and CSO by implementing the project components through Government structures at all levels. Even GIDD and the Demography Division at UNZA learnt something from the experience of the 6th Country Programme, which could be used to improve the annual plans, implementation, management and monitoring of the 7th Country Programme. The partners would like the programme to continue in order to build and strengthen the capacities of social sectors and to improve provision of social and public services.

The new approach to engaging communities in reproductive health and HIV services inclusive of gender integration by formation of the SMAGs, parent educators and peer educators increased access to reproductive health and HIV services. It also empowered families to take responsibility for their own health and appreciation of the importance of girl child education. The Chiefs and all FGD discussants also wanted the programme to continue in order to reach more people in their communities.

Recognising the important role of traditional leadership in the community in Zambia, involving the Chiefs in programme implementation was catalytic to the qualitative results reported above. The Chiefs provided the leadership and consistently worked with their subjects on the 6th Country Programme. They further used the experience to work with their subjects on adverse effects of other social vices such as GBV and drug and alcohol abuse.

Mobilising additional resources to support implementation of the 6th Country Programme improved further the provision of EmONC, FP and HIV prevention. Furthermore, additional resources improved the self esteem of women who had successful fistula repairs.

3.5.4.2 Constraints

A number of constraints have been used in preceding results sections to support or highlight some issues on the results. In general, there were no major difficulties and constraints, which could have jeopardized implementation of the 6th Country Programme. However, the constraints presented below could have hindered effective programme implementation in one way or another:

- Critical shortage of staff across the board from national to District levels inclusive of health centres, affected the pace at which the three components were implemented at peripheral level. For example, there was only one ZEN or an environmental technologist at the rural health centres visited in the two Provinces. Although these cadres provided ANC and FP services and conducted deliveries, they lacked knowledge and skills to provide quality integrated reproductive and HIV services. The deliveries conducted by these categories of staff did not meet the WHO definition of skilled attendant at birth i.e., a delivery conducted by a midwife or doctor;

- The funds available were inadequate to ensure sustainable capacity building of the PMO and DMO staff, service providers and empowering communities to address risk pregnancies in the 14 Districts in the two Provinces. Communities leaving far from health centres were not reached. There were no SMAGs and sub-SMAGs, parent elder educators and peer educators in these areas so as to reduce the long distances these groups covered to reach communities living in hard to reach villages;

- There was no reproductive health programme officer in UNFPA sub-office in Luapula Province who could have focused on this component like it was in North-Western Province. Although the implementation of the 6th Country Programme started in 2008, FGDs and interviews indicated

limited coordination with Government and other partners supporting or working in the same Districts;

- The absence of data to monitor some of the output indicators in the 6th Country Programme made monitoring reproductive health, population and development and gender difficult. All the information providers recognized that this problem. A significant number of information providers recommended establishment of a strong M&E system in the 7th Country Programme.

- Psychosocial support to HIV positive men and women helps them to live positively with HIV, adhere to treatment and adopt positive prevention practices such as condom use. Observations in three health centres (Solwezi Urban in Solwezi District, Kasempa Urban in Kasempa District and Senama in Mansa District) showed that service providers did not provide psychosocial support to HIV positive pregnant women and FP clients. ANC Cards were checked for HIV status to check for example, CD4 results or whether or not the women got the ARV prophylaxis and nothing. Women were not asked about disclosure of HIV status to one's confidants and adherence to treatment.

- Furthermore, service provision was still traditional i.e., provide the services in the morning and use the afternoon to enter the data in the registers. Due to shortage of staff, time was taken up attending to large numbers of clients in the mornings. Those requiring psychosocial counselling and support were not identified and did not get the service. Service providers can reorganise service provision and use the afternoons to provide psychosocial support to HIV positive pregnant women and their spouses and couple CT. Introducing an appointment system can help to reduce the workload of nurses/midwives. Psychosocial support was not institutionalised in service delivery. The psychosocial officer in Luapula Province spent his time assisting the adolescent health officer with trainings in adolescent health;

- The design of the 6th Country Programme did not include a capacity building framework or transition strategy to assist the PMOs and DMOs to replicate district-wide the lessons learned from the health facilities supported by UNFPA. This means using the experience gained to expand the services to other facilities and communities in the same district and to other districts in the same Province.

- The lack of Family HIV Clinics closed a missed opportunity to provide psychosocial support to pregnant women and their spouses.

3.5.4.3 Lessons learnt

Technical assistance and additional financial resources from UNFPA enabled PMOs, DMOs, service providers and communities to improve provision of quality reproductive health and HIV services. This made a difference to maternal health and improved the health of the people.

Access to health is a basic human right. The formation of the SMAGs, parent elder educators and peer educators increased access to reproductive health and HIV services in the two Provinces. Strategic involvement and training of these community groups increased male participation and institutionalisation of gender in reproductive and HIV in health centres and community health services. Communities were empowered to address reproductive health issues in their areas.

Involving the Chiefs in programme planning and management empowered them to take and provide leadership for reproductive health, HIV and gender in their Chiefdoms. The 6th Country Programme brought the Chiefs and their subjects closer.

Empowering communities through BCC messages by SMAGs, parent elder educators and peer educators on reproductive health, HIV and gender to address risk pregnancies anecdotally reduced

maternal deaths, increased male participation in service provision at health centres and in the community and motivated them to address gender disparities among women and men. Communities were further empowered to recognise the importance of girl child education. A number of girls who dropped out of school because of teenage pregnancies went back to school.

Establishing UNFPA sub-offices in the Province ensured continuous technical support to DMOs, health centres and community groups. However, sub-offices will require strengthening in the 7th Country Programme for example in programme management, monitoring and evaluation and report writing.

Improving the skills of health workers in core maternal health interventions (EmONC, PAC, FP, MDR) contributed significantly to improving the health of women (and children). It is likely that the 2010 ZDHS will reveal reduced maternal mortality especially in North-Western Province where the assistance started in 2001.

Strategic involvement of relevant Government ministries and Chiefs promoted ownership of the programme at all levels inclusive of the community. Information providers' averred that the partnership did a lot in the 6th Country Programme under the Country Representative Mr. Owusu-Sarfo. He was described as committed to implementing the joint programme, understanding, hard working and supportive to the partners.

Mobilising additional resources contributed to sustaining contraceptive commodities, improved provision of integrated reproductive health and HIV services and rolling out fistula repair camps nation-wide.

3.6 Management and coordination issues including implementation modalities, national ownership, monitoring and evaluation

3.6.1 Management and coordination issues

A number of management and coordination issues have been discussed in preceding results sections. These limited management and coordination of the activities, which were supposed to be implemented by sub-partners Demography Division at UNZA, PPAZ, NGOCC, WILSA AND WILDAF. The main management and coordination issues in this section include the following:

1. Key cooperating partners UNICEF, UNAIDS, WHO and USAID based in Zambia were not involved in the design of the 6th Country Programme despite that they collaborate with UNFPA on the support to the health sector. However, three of them were aware of the 6th Country Programme. The third partner knew about it through another source a few months before the interview. Collaborating with key partners supporting national reproductive health, population and gender programmes in the design of the 6th Country Programme could have maximised the utilisation of financial resources and technical expertise. UNICEF supports a programme in Luapula Province and USAID's projects implemented by Cooperating Agencies such as the Zambia Prevention Care and Treatment (ZPCT) Project managed by Family Health International work and support Government institutions on HIV and AIDS in the two Provinces. UNFPA sub-offices in North-Western Province collaborated with ZPCT Project which ended in 2009. The staff is yet to establish collaboration with the new project. The opportunity exists to maximise the collaboration with other projects working on similar or related health sector programmes in the two Provinces for the benefit of the clients. Such collaboration can assure provision of comprehensive reproductive health holistic care to pregnant women, mothers, children and their families.

2. Two of the partners perceived the focus of the programme in selected provinces as strength of the 6th Country Programme approach. Two of them however, preferred UNFPA to step back from the project approach and work within the bilateral agreement and put money in the basket because UN is not a donor. The partner added that the project approach did not fit in the UN mandate.

3. According to one of the partners, the intent to integrate HIV and gender was good but this is difficult to do. It is compounded by limited capacity within UNFPA to effectively support this big programme. The office has few staff and most of them do not have fixed-term contracts. She gave an example of the staff member who had had worked on HIV for five years and decided to leave since she was not on fixed-term contract, which has benefits.

4. A number of activities especially in population and development and gender were not conducted or implemented as discussed in the above results sections. The staff in SPU and GIDD have post graduate qualifications in various disciplines but had limited knowledge or expertise in population and gender to effectively manage and coordinate the partnership, implementation activities and monitor the achievement of relevant country programme outputs and indicators. SPU staff said that population is a specialised area. They were keen to have basic knowledge in this area through short courses to improve the management and coordination of the two components. But the Demography Division at UNZA was not requested to commence/offer the course, which would have strengthened programme planning, implementation and monitoring of the three components in the 6th Country Programme. A course in M&E will commence as soon as the building funded by CDC is completed and the course is designed and approved by UNZA. The plan is to have UNZA as the regional centre for M&E training.

5. At national level, the MSYCD started implementing their activities in 2008. It took over the plan on adolescent health from MoH but it did not receive the support it required to integrate or strengthen adolescent health in the Youth Development Programme. Adolescent health is also a specialist area for MSYCD. Therefore, a mechanism should have been devised to assist MSYCD to integrate adolescent health in its Youth Development Programme for the whole country and not just in the two Provinces. Nevertheless, the Provincial Youth Development Officers were trained in adolescent health by UNFPA sub-offices. The Provincial Youth Development Officer in North-Western Province was actively involved in training peer educators and monitoring the services together with the PMO and UNFPA sub-office staff. The one in Luapula Province participated in the activity infrequently due to other commitments. Besides, the programme was new in that Province.

6. MSYCD launched the Youth Network on Population and Development 1n 2007. As presented above, Provincial Youth Coordinators were appointed and placed in Provincial Offices in the two Provinces. But the Provincial Youth Development Officers were not clear on how to work with and support the two partners. One of them said that he was not aware of what the provincial youth coordinator was doing because he did not inform him of his whereabouts. Guidelines will be needed to help the partners to collaborate and work together. Hopefully, the Youth Network Secretariat established in 2010 will provide the leadership needed to strengthen the participation of youths in population and development, reproductive health, HIV and gender activities at all levels.

7. While it was imperative that partners implementing the same or complementary areas worked together for effectiveness, the financial disbursement modality seemed to have created problems for most partners, MoH, MSYCD and NAC, excepted. Reportedly, sub-contract partners Demography Division, PPAZ and NGOCC on population and development and gender respectively, experienced difficulties to access funds when they were ready to implement their activities because of bureaucracy. The requests for funds by sub-partners were required to go through the coordinating partners CSO and GIDD instead of directly to UNFPA. The process contributed to the delay in disbursing the funds resulting in most activities in the 6th Country Programme not being implemented. Regarding GIDD, it took long for Cabinet Office to approve the requests for funds. It is hoped that the delays would be minimised in the future. The Permanent Secretary for GIDD is now the controlling officer.

8. Nevertheless, some sub-partners also delayed to submit the expense reports to coordinating partners such as CSO. The problem was addressed though late to accelerate activity

implementation. UNFPA funded Demography Division at UNZA, WILSA and WILDAF directly. However, it is unlikely that the Demography Division will complete the remaining activities it was responsible for in the 6th Country Programme by the end of December 2010. The same gesture of disbursing funds directly to implementing partners was not extended to NGOCC and PPAZ despite that the two organisations have been managing donor funds for decades and they are audited regularly. Furthermore, PPUs had challenges as well to get money for GIDD to conduct gender activities in the two Provinces.

9. Regarding gender and BCC materials, ZANIS effectively complemented the BCC work by the SMAGs; parent elder educators and peer educators with video shows on reproductive health and gender, which were screened to large numbers of people in the communities. The video shows were attended by about 2,000 men, women and children. It was not possible to record and disaggregate the attendance by gender. The video shows were screened in the evening or at night.

10. ZANIS involved provincial technicians in shooting and screening video shows but not provincial technical staff. ZANIS said that provincial offices had no equipment to shoot and show video shows therefore the equipment from the headquarters was to be returned to Lusaka to be used for upcoming assignments. The justification for passing ZANIS provincial technical staff to shoot and screen video shows in the communities seemed weak and did not augur well with the capacity building intentions of the 6th Country Programme. ZANIS could have devised other ways of ensuring that the equipment was returned to Lusaka after shooting and screening the video shows. For example, the officer from Lusaka can work with the provincial colleague and the latter can return the equipment to Lusaka.

11. The design of the 6th Country Programme enabled ZANIS to reach many people at one video show. The institution should have taken advantage of other important meetings to sensitise people on HIV and STI through video shows. These were not funded in the 6th Country Programme but should be taken into account and funded in the 7th Country Programme. One such gathering is traditional ceremonies. A high level information provider said:

> *"You are aware of the HIV prevalence in various districts in our Province. I know people are saying that you have done enough preaching on HIV and AIDS. But there are a number of traditional ceremonies in the Province where people from many places within the country and from other countries mingle but sensitisation on HIV is not done."*

He recommended that ZANIS should go to the sites five days before the ceremonies to sensitise people on HIV. The recommendation should be taken into account and funded in the 7th Country Programme to close missed opportunities to further promote HIV prevention.

12. UNFPA sub-offices were established to assure consistent on the ground technical assistance or support to the PMOs and DMOs, selected health centres, SMAGs, parent elder educators and peer educators in each District. This included having trainers of trainers (TOTs) in place for technical components of reproductive health development (EmONC, FP, PAC and adolescent health) and mainstreaming population and gender issues in training programmes and in service delivery. There were no TOTs trained. Selected provincial and District staff were only oriented on technical areas. Resultantly, UNFPA field staff took the lead in training SMAGs, parent elder educators and peer educators. It was not uncommon for UNFPA field staff to be in the field conducting training for about 21 days at a time. Yet they were supposed to build the capacity of DMOs to conduct the training themselves, thereby leaving UNFPA programme officers to monitor the quality of the training especially in Western Province where the 5th Country Programme started in 2001. Meanwhile, the field office in Luapula Province did not have a reproductive health officer on the team. Although the staff in the office implemented this component, it was evident that a reproductive health officer was needed to focus on this component.

13. The PMOs and UNFPA teams in the Provinces have the capacity to maintain medical and other equipment such as radios at health facilities. They have a programme for servicing the equipment. However, the spare parts required for the repairs are seldom readily purchased. Batteries for radios and kerosene for refrigerators were in many periods reported to be unavailable. Without the batteries, there were delays to refer and transport women in labour who developed complications for skilled management in District or general hospitals. Without kerosene, refrigerators for storing vaccines and medicines and other supplies would lose the potency thus rendered useless to recipients of the vaccines. The supply chain for batteries and kerosene should be strengthened.

3.6.2 Implementation modalities

Implementation modalities were excellent. The programme was implemented through existing Government structures at all levels. Most importantly, Government managers for reproductive health, population and development and gender in respective social sectors managed the 6th Country Programme at all levels. The Chiefs and communities were empowered through training to identify the problems and take steps to address them. The approach used to integrate reproductive health and gender in social sector policies, plans and programmes promoted integration of the two components in service delivery although more work is needed to strengthen this. And, more work is needed to increase understanding of population issues in relation to service delivery in social sectors and at family level.

Another important implementation modality was the training and retention of nurse graduates to save the provinces for two years after graduating. Bonding is not new in Zambia. The Government has had this mechanism in place since independence in 1964 but few graduates saved the bonding period. The mechanism in place was weak to ensure that the graduates saved the bonding period because it was highly centralised. The new bonding agreement between Government and UNFPA had worked because it was implemented within the decentralisation policy and it involved key stakeholders in the Provinces and Districts. In North-Western Province, all the nurse graduates were deployed to work in the Province. However, Government (MoH) did not honour the agreement to deploy all the nurse graduates for two years in Luapula Province. All the interviewees in this Province expressed disappointment with this development in the face of critical shortage of staff and the fact that North-Western Province retained all the nurse graduates. MoH should deploy the nurse graduates from the two Schools of Nursing (one school has midwifery as well).

3.6.3 National ownership of the country programme

Most of the people interviewed spoke confidently about owning the 6th Country Programme. They were happy with the programme and their relationship with UNFPA except on issues of delayed funding for the programme. Most of them including the Chiefs and SMAGs added that more work was done in the 6th Country Programme compared to the 5th Country Programme because of the new Country Representative. They all described him as committed, understanding and hard working. The District Commissioner (DC) for Kawambwa District said, "The programme added value to health services in Kawambwa District." He added that the communities who were involved in the programme were excited about it and traditional rulers were also happy about it. He noted that sensitisation and education can change negative attitudes and wanted the programme to continue.

Nevertheless, the DC was concerned about the shortage of nursing staff in the province and in Kawambwa District in particular. He stated that only 10-15% of graduates originate from Luapula Province. These are likely to stay and save their people while those from other provinces might want to move else after saving the two-year bonding period. The DC recommended an increase in the number of student nurses in the two schools of nursing in the Province and reopening of Mbereshi School of Nursing. The recommendation to increase the number of student nurses was made by almost all the health workers who provided information for the evaluation such as DMOs, doctors, nurses and the Principal Tutors.

The Provincial Deputy Secretary for North-Western Province appealed further for more Schools of Nursing in to reduce the shortage of nurses in the Province. Government acknowledges that human resources for health will be needed for the country to attain MDGs and recognised:

> *"… the need to retain and maintain adequate numbers of heath workers to provide quality services to the population. In doing so, there is need to increase the number of training places for health workers, expand the retention scheme to cover all workers and construct more staff houses" (*MoFNP, 2009 p. 87).

There is no doubt that improvement of the health of the people will require adequate numbers of health workers especially to attain the MDGs by 2010.

The reasons why people were happy about the 6th Country Programme included developing annual plans to support service provision with additional resources, technical support from UNFPA and good working relationship with the organisation. Other people spoke with confidence on how the 6th Country Programme has contributed to improving maternal and adolescent health in their Province. In North-Western Province, UNFPA field staff were taken on board as members of the team in the health sector, in population and development and gender. Unfortunately, it was not possible to assess the opinions on programme ownership in Luapula Province. Provincial policy makers and DMO staff in Mansa District were not interviewed due to conflicting schedules of the field work for the consultants and the visit of the First Lady to the Province. Enough information to inform the evaluation was collected from people who were available.

3.6.4 Monitoring and evaluation

Monitoring and evaluation of the 6th Country Programme was minimal to non-existent. The CPAP contains a Results Framework, which could have been used or adapted to monitor the performance of the 6th Country Programme but this was not done. Neither was a data base developed to monitor implementation of the programme. As a result, a significant number of activities were not followed up and implemented. The activity, quarterly, bi-annual and annual reports were not uniform even if they written by the same person. A reporting format was not provided. The data reported by SMAGs, parent elder educators and peer educators was not compiled, analysed and used to monitor the outcomes. For example, the number of pregnant women counselled for HIV and referred to health centres, the number of couples counselled in their own homes and the service provided etc.

Above all targets were not set in terms of the number of people to be reached for each activity annually. The HMIS and other Government monitoring frameworks monitor national indicators and not programme specific indicators. This was why it was important to have an M&E system for the 6th Country Programme. Other projects using discrete funding to Zambia set up M&E systems to monitor the achievements of the project including utilisation of the funds while at the same contributing to national health outputs.

The technical assistance should have included assisting the district especially nurses, midwives and clinical officers to appreciate the importance of why data is collected. For instance, data recording in ANC, FP and Children's Clinic Cards and various registers was neat and accurate in health centres but the Admission, Delivery, PMTCT and Discharge registers in maternity wards in Solwezi and Mansa General Hospitals respectively were incomplete. A lot of information needed to measure the trends of pregnancy outcomes was missing. This can be attributed to shortage of staff and heavy workload on the skeleton midwives who were also not oriented on the registers in labour wards. It is also possible that staff were inadequately supervised to diligently record the data/information in the registers. Yet data is needed to monitor the uptake of services and monitor the trends accordingly.

3.7 Sustainability of the various components of the programme

It is unlikely that presently Government alone can sustain the various components of a Country Programme given the state of the Zambian economy. The situation has been compounded by cooperating partners withholding budget support to some sectors due to financial mismanagement of the funds.

Despite additional resources from UNFPA, not all prerequisites for effective management of the programme were met. For instance, one ambulance per district was insufficient to assure timely and efficient referral of all pregnant women in labour with complications for further management to District or General Hospitals. It can further not meet all the requests to pick up and take pregnant women to health centres from the scattered communities in a district. Evidently, transport was not available to take the woman in labour that died from complications of pregnancy in Senior Chief Mumena's area in 2008. More ambulances will be needed to strengthen the referral system and contribute to the achievement of the MDGs by 2015.

The SMAGs, parent elder educators and peer educators also lacked transport to reach the people living in hard to reach areas or go to the health centres for assistance as needed. Some of them stayed about 48 kilometres or more to the nearest health centre. This means a pregnant woman who develops a complication is expected to walk or be transported on a bicycle if available. Women will continue to deliver at home if transport is not available to transport them to nearest health facilities for further management of complications. The alternative is to construct maternity waiting homes where women can wait to deliver to assure skilled attendant at birth. Maternity waiting homes can further ensure that all pregnant women using the opt-out approach are tested for HIV and ARV prophylaxis is given or treatment is commenced is positive.

3.8 Emerging issues

The main emerging issues which should be considered in the 7th Country Programme are the following:

1. The Country Outcome 2: Increase access to for HIV/AIDS treatment, care and support did not include activities for HIV positive women (and spouses and children) in service delivery. Although antiretroviral therapy (ART) is not one of the mandates of UNFPA, it would make sense if UNFPA collaborated with the partners supporting the health sector on ART and develop strong linkages to ensure that HIV positive women who need treatment receive it. A midwife is the first contact for all pregnant women and FP clients therefore, she/he can save as the lynch pin to the provision of comprehensive quality HIV prevention, care, treatment and support for HIV positive pregnant women and FP clients. Moreover, integration of reproductive health and HIV would be incomplete without supporting HIV positive pregnant women who need treatment to receive it. It is more efficacious compared to single dose ARV and dual prophylaxis in reducing the risk of HIV transmission to the unborn baby in utero. Furthermore, establishing a Family HIV Clinic will increase adherence to treatment, disclosure of positive HIV status to partners and enhance psychosocial support for women.

2. There was no national strategy on adolescent health resulting in limited technical assistance to integrate this intervention in the MSYCD Youth Development Plan and programme and strengthening service delivery in the health sector. Other sectors such as the MoE, Ministry of Community Development and Social Welfare and NGOs dealing with the youth would have benefited from such a strategy.

3. Despite that HIV-TB co-existence is common in HIV positive people including pregnant women and mothers; it was not part of service delivery in ANC and FP services. Observations revealed that midwives did not ask HIV positive pregnant women the four key questions to rule out suspicion of TB. It is recognized that TB is not a mandate for UNFPA but it makes sense to address it in service delivery in collaboration with the partners supporting TB services. It is the

same HIV positive woman who can also have TB. Such small interventions can contribute to improving the quality of reproductive health services. As stated above, a midwife is the first contact for pregnant women in health care settings therefore an effective referral system starts with the midwife. This is an opportune moment for early detection of TB and early referral for investigation and management of TB if the pregnant woman has this disease.

4. Most partners and beneficiaries had limited understanding of the relationship between population and development and the delivery of social services. This was to be expected because the provinces who were involved in the dissemination of the National Population Policy 2007 did not disseminate it to the districts. To some, population was equated with available empty land which could be filled up with inhabitants. More work is needed to create awareness and educate people on population and development issues and their impact on socio-economic and health development.

4. Conclusions

To a large extent the 6th Country Programme was a success. The design, expected country outputs and strategies including establishing UNFPA sub-offices in North-Western and Luapula Provinces respectively were appropriate and relevant to addressing reproductive health, HIV population and development and gender issues in social sectors plans and programmes in Zambia. The successes of the 6th Country Programme contributed significantly to the UNDAF outcomes of increased access to a comprehensive package of HIV prevention services and increased access to HIV prevention, care and support as evidenced by the above qualitative results. Furthermore, persons contacted at all levels were happy with the 6th Country Programme and implementation modalities. The successes however, were constrained by management and coordinating issues as discussed below:

1. At national level, substantial work was done to create an enabling environment to increase access to a comprehensive package of HIV prevention services, HIV prevention, care and support services; and access of vulnerable groups to high quality reproductive health services. Furthermore, most of the output indicators were achieved but more work is needed to strengthen institutions in support of national development priorities. Specifically, the capacities to manage, coordinate, implement and monitor and evaluate the National Gender Policy. More work is needed regarding the National Population Policy and the National Gender Policy so that people at the grass-root level understand the relationship between population and development and impact of gender in health. This will help people to make informed decision to utilise especially reproductive health and HIV services for their own health and that of their families.

2. Substantial work is needed to strengthen responsiveness to concerns among institutions and providers of basic social services. A framework is needed to ensure that State Reporting obligations for International Conventions are met timely.

3. The partners MoH, NAC, MSYCD, SPU/GIDD and CSO in collaboration with Demography Division at UNZA were delegated the responsibility to manage and coordinate the three components and varied activities in the 6th Country Programme. The other sub-partners NGOCC, PPAZ, WILDAF and WILSA (the latter was not mentioned in the Country Programme) also participated in conducting the activities in their own remits. The components were well managed and coordinated by MoH, SPU and MSYCD at national and provincial levels. However, a lot more work is needed to strengthen management and coordination of the gender component particularly at national level.

4. SPU in MoFNP implemented a number of activities on population and development but could not effectively facilitate institutionalising these issues in social sectors plans and programmes. The staff had no training neither in population nor demography. They were actively and passively exposed to these fields in the course of their careers. This was not good enough to provide technical and management leadership for institutionalising population and development issues in

the social sectors in Zambia. The problem was compounded by the Demography Division at UNZA not commencing the short courses at UNZA to improve knowledge and skills of national coordinators in population and development issues and influence integration of the same in Provincial and District Plans and programmes.

5. The four officers in GIDD at Cabinet Office had no training in gender but had been actively and passively exposed to gender matters. This was insufficient for them to effectively support gender integration in national plans and programmes. The problem was accentuated by limited technical assistance to GIDD due to what seemed to be a difficult working relationship between GIDD and UNFPA and between GIDD and NGOCC coupled with not having staff in the District to spearhead integration of gender in social sectors at provincial and District levels. Neither did GIDD capitalize on NGOCC's long experience in gender and use of its staff in the Districts.

6. MoH and NAC built on their long experience in reproductive health and HIV and AIDS respectively to support improved implementation of these areas by PMOs, DMOs and health centres inclusive of empowering communities to address risk pregnancies at this level. Nevertheless, the efforts were hindered by a critical shortage of trained staff especially in health centres and small numbers of SMAGs; parent elder educators and peer educators formed compared to the need even in one catchment area of a health centre.

7. MSYCD included adolescent health in the National Plan of Action for the Youth but the activities were not implemented due to financial constraints. The sector received about 35% of its annual budget in 2010. Furthermore, MoH did not provide the technical support adolescent health needed by the Department of Youth Development to help them to understand this health area vis-à-vis the youth. Meanwhile, adolescent health was better integrated in youth programmes in North-Western Province but not in Luapula Province. The field office in Luapula Province concentrated on adolescent health only. The sub-office has the capacity in adolescent health therefore can help to integrate it in other youth programmes managed by non-health partners.

8. All the beneficiaries were happy about the 6th Country Programme because it made a difference to the lives of the people. They spoke convincingly about the programme having reduced maternal deaths, increased male participation in reproductive health and HIV services and made people appreciate how gender disadvantaged mainly women and children in their communities. However, the reported results could not be verified in the quarterly, mid-year and annual reports produced by the programme officers in UNFPA sub-offices. The reports lacked a format that could show incremental changes resulting from the delivery of interventions in the 6th Country Programme. In training reports, sex was rarely indicated and yet this is one of the most important indicators in the 6th Country Programme. In a number of cases, the sex and age of the recipients in the reproductive health interventions, such as recipients of condoms and contraceptive pills were not recorded.

9. While the success of the programme can be claimed by attribution to HMIS data in the districts supported by UNFPA, it was imperative to establish an M&E system to monitor the achievement of country programme outputs and indicator outputs in the CPAP.

10. The SMAGs, parent elder educators and peer educators were instrumental in contributing to increasing health facility deliveries, acceptance of CT for PMTCT and improved quality of reproductive health and HIV services. The Chiefs supported the work of the SMAGs, parent elder educators and peer educators. They were fully involved in the implementation of the 6th Country Programme. One case in point is the one unfortunate maternal death in Senior Chief Mumena's Chiefdom in the 6th Country Programme in 2008 and none in the 5th Country Programme.

11. In addition, the Chiefs and their subjects devised strategies to promote safe motherhood and gender equity in their areas. One of them was to charge men who impregnated girls to empower the woman. In one area the men were charged two cows as agreed by the whole community.

Furthermore, the SMAGs sensitized communities that pregnant women should go with their spouses for first ANC booking.

12. The bonded ZEN graduates sponsored by UNFPA to serve in the same Province from the three Schools of Nursing Solwezi, Mukinge and Kaleni reduced the critical shortage of nurses in North-Western Province. Only nine out of 100 graduate nurses were deployed in Luapula Province by the MoH.

13. The utilisation of the actual budgets was high for most expected country outputs and this was consistent with the quantitative and qualitative results in the 6th Country Programme. The utilisation of the actual budgets was low on the comprehensive framework for procurement and logistics management, with a focus on service delivery, which was in the fourth Draft, and worst on strengthened responsiveness to gender concerns among institutions and providers of basic social services. At national level, GIDD had difficulties to manage and coordinate implementation of the gender component. As a result, a number of activities were not conducted and most output indicators were not achieved. The problem was compounded by the shortage of staff in the Division. This is why GIDD would like a technical advisor to help with moving gender forward.

5. Recommendations

5.1 Capacity building

1. In future, delays in implementing the Country Programmes could be avoided by overlapping the winding up of a Country Programme with the follow on Country Programme. This could be done in the last two quarters before the end of a Country Programme. Implementation of the 6th Country Programme was delayed by more than a year. The programme should have been implemented from 2007 but the earliest activity to be implemented was from March 2008.

2. In order to avoid delays in implementation, all implementing institutions should be funded separately even if they have a joint work plan that works to achieve a common outcome. This will eliminate delays in implementation of activities by allied institutions caused by factors peculiar to the lead institution which disburses funds it obtains from UNFPA, such as industrial action, misapplication of funds, management and leadership shortcomings etc.

3. Involve UN partners and other cooperating partners based in Zambia in the design of the 7th Country Programme to maximise utilisation of resources, expertise and enhancing buy in into the 7th Country Programme.

4. Conduct objective assessments of the capacities of staff in the implementing institutions. Improving their capacities might be necessary before they can be in a position to spearhead the implementation of the activities.

5. UNFPA should hold regular training programme of Project Staff on the rules and procedures for management, procurement and accounting. This training should be done depending on the need during the annual review meetings because administrative, accounting and audit staff in Public institutions are frequently rotated. Those that were trained could be replaced by those that have not been trained.

6. Place technical advisors in SPU and GIDD to strengthen management and coordination of population and development and gender at all levels.

7. UNFPA should procure items whose specifications have been made by the user institution or are equivalent to those made by the user institution. And, the procurement should be done timely.

8. Devise a strategy to help the MoH, MSYCD, GIDD PMOs and DMOs to replicate the experience of the focused capacity building within the same District and other Districts and Chiefdoms/communities.

9. The current mode of providing technical assistance for Gender is not appropriate and should be changed in future. It is important that the staffs providing Technical Assistance are imbedded full time in the premises of the Gender in Development Division.

10. Support all the Districts in Luapula Province and all the facilities in the two Provinces rather than selected health facilities for impact. Not all the health facilities and communities were covered within the Districts and Chiefdoms. In such a situation, the potential impact of the interventions could be ameliorated by resistance and infiltration of bad practices from the "neighbours" or be watered down by those that were not reached. Typically more than half of the potential targets should be reached for an intervention to have an impact. It will be better to provide adequate capacity building in the current two Provinces rather than expanding to Western Province unless if the resources will be available to expand to Western Province.

11. Increase the number of staff on fixed-term contracts in UNFPA office to strengthen programme planning, management, coordination, implementation and M&E. This should include assessing the capacity in UNFPA sub-offices and taking necessary steps to improve it.

12. Increase the number of scholarships for student nurses in both Provinces and student midwives in St. Pauls School of Midwifery. This should include working with MoH to honour the agreement with UNFPA to bond graduate nurses and midwives to work in Luapula Province for two years.

13. All project implementation partners have to be trained in report writing. Training of say two to three weeks would improve report writing of the project implementation staff so that meaningful and useful reports about project implementation can be archived for posterity.

14. Strengthen M&E by establishing a data base to monitor some of the indicators in the 6th Country Programme against the budget expenditures. UNFPA can claim relevant reproductive health and HIV results by attribution from the MoH and NAC in the Districts supported by UNFPA.

15. Take advantage of the M&E training centre funded by CDC at UNZA and sponsor partners to undertake the courses to improve data collection, analysis, utilisation to improve planning, programme management and coordination. Systematic data can show case successes and weaknesses to inform ongoing programme planning, management and areas for operational research.

16. Accelerate the conduct of research by partners so as to support data driven policies.

5.2 Reproductive health

1. Train trainers (TOTs) for each district so that the DMOs will manage and coordinate the trainings with minimal support from the UP sub-office. This should include devising work plans from the district plans to allow the DMOs to accommodate the activities supported by UNFPA in their busy schedules.

2. Nurses trained with UNFPA support in Luapula Province should be deployed in the same Province after graduation as per the agreement between GRZ and UNFPA just as in North-Western province. The reasons advanced for not doing that cannot hold. The bottom line should be that all health facilities should have trained personnel. If there are personnel trained for specific health facilities, they should be deployed there by all means and not excused to work elsewhere

3. A number of intervention activities were introduced whose effectiveness should be assessed. There should be an evaluation or research study to assess the effectiveness of SMAGs in improving coverage of antenatal care, institutional deliveries, postnatal care, and vaccination coverage etc. Similarly the effectiveness of peer groups such as youth peer educators should be assessed.

4. Conduct baseline site assessments as per MoH procedures before commencing the trainings to ensure that sites are ready to start offering the services immediately after training in the core maternal health interventions. This will further help in monitoring the process of implementation as well as increase in the uptake for example of FP and HIV services in health facilities and in the community.

5. Strengthen community-based distribution of contraceptives and give more emphasis to dual protection in the 7th Country Programme. Only some of the SMAGs and peer educators were trained as CBDs and no other. Therefore, few women (and men) received contraceptive methods. In addition, explore the possibility of introducing injectable contraceptives to be given by trained CBDs and promoting or popularising vasectomy as an FP method for men. This should include establishing an effective M&E system inclusive of introducing a village register. The village register is needed given the new cadre of community health workers to be deployed in the system by the MoH soon.

6. Increase male involvement in reproductive health and HIV services. For instance, service re-organisation such as offering HIV services to couples on a specific day can encourage men to attend ANC clinics together with their wives. Observations in health centres showed that they were virtually empty in the afternoons. Thus, one afternoon can be assigned for couple counselling and testing.

7. Advocate for establishment of Family HIV Clinics to increase male participation in HIV prevention, care and support services and strengthen psychosocial support for families particularly women and children living with HIV. These family-centred care clinics can increase adherence to prophylaxis and treatment, support for each other in households and promote positive prevention of HIV in households and communities.

8. Procure motorbike ambulances to be placed in health centres to strengthen the referral system for maternity cases to the nearest health facilities for skilled management of complications. This should include bicycles for SMAGs, parent elder educators and peer educators. Devise a system together with the Chiefs on utilisation of the two modes of transport inclusive of maintenance.

9. Revise the ANC and maternity (and children's clinic) registers to strengthen integration of HIV data and follow-up of HIV positive pregnant women (and HIV exposed and positive infants).

10. Strengthen HIV care and support services in health facilities and in the community. Thus, develop a National Psychosocial Support Training Manual and Guidelines and train service providers.

5.3 Population and development

1. Include in the 7th Country Programme all the activities, which were not implemented in the 6th Country Programme. These are critical activities that will popularise population issues in social sectors' plans, programmes and service delivery as well as the population at large.

2. MoFNP being the lead institutions, SPU should strengthen management and coordination of the three components to ensure that all the partners implement the activities.

3. Establish an M&E system and monitor the implementation of the activities in the Country Programme.

5.3 Gender

1. Priority should be given to ensuring that the State Report for CEDAW is written and sent on time in 2011.

2. Include in the 7th Country Programme all the activities, which were not implemented in the 6th Country Programme. These are critical activities that will popularise population issues in social sectors' plans, programmes and service delivery as well as the population at large.

3. Develop strategic partnerships with implementing partners taking into account their comparative advantages on gender. They can help GIDD to implement the activities while GIDD monitors and provides the necessary support.

4. Establish an M&E system and monitor the implementation of the activities in the Country Programme.

APPENDIX 1

Terms of Reference for the Evaluation

EVALUATION OF THE 6TH UNFPA/GRZ COUNTRY PROGRAMME

1.0 Background

UNFPA Executive Board approved the Government of the Republic of Zambia (GRZ)/ United Nations Population Fund (UNFPA) Sixth CP in June 2006 in the amount of US$15.3 million over a 4-year period from 2007-2010. The duration of the CP was reduced by one year in conformity with the United Nations Development Assistance Framework (UNDAF) so that the UN programme cycles would be aligned with the National Development Plan. The overall goal of the 6th CP is to contribute to improved quality of life by achieving population growth commensurate with socio-economic development. The programme was developed with the participation of Government, NGOs, UNFPA and Academia. The CP outcomes contribute to the UNDAF outcomes and consist of three components: reproductive health; population and development; and gender. The CP was also formulated within the context of UNFPA Strategic Plan, 2008-11. The programme is being implemented at both national and sub-national levels by public institutions and civil society organisations.

In 2009, mid-term reviews of the UNDAF and the Basic Social Services component of the UNDAF were conducted which also covered the 6th CP. Therefore, no separate mid-term review was conducted of the programme. Since 2010 marks the end of the UNDAF as well as the 6th CP, an independent evaluation of the 6th CP is proposed to be undertaken in accordance with UNFPA policies and procedures.

2.0 Evaluation purpose and specific objectives

The evaluation will assess the extent to which the CP goal and outputs have been achieved. Furthermore, it will identify the constraints that inhibited the implementation of the programme and also highlight the lessons learned in order to contribute to the improvement of the design and implementation of the components of the next CP (7CP).

2.1 Specific Objectives

More specifically, the evaluation will:

- *Assess* the national population and development situation and determine the appropriateness and relevance of the design, goal, outputs and strategies of the 6th CP
- *Review* the relevance and effectiveness of component projects toward meeting the CP goal.
- *Assess* the extent to which the CP contributed to the achievement of the outcomes of the UNDAF, National Population Policy and the Fifth National Development Plan.
- *Assess* the extent of integration of gender, culture and human rights concerns during the implementation of the CP.
- *Identify* the achievement of substantive and financial results, successful interventions (success stories), difficulties and constraints; and lessons learned.
- *Review* the management and coordination issues including implementation modalities, national ownership, M&E.
- *Assess* the sustainability of the various components of the programme.
- *Identify* and analyse emerging issues within the population and development domains as well as in the CP that could be considered in the next CP.
- *Make* recommendations based on the findings of the evaluation and recommend interventions that should form the basis of the next CP.

3.0 Scope of the evaluation

The evaluation will be implemented at both national and sub-national (Luapula and North-Western Provinces) levels.

4.0 Methodology and Sources of data

The findings and conclusions of this evaluation shall be based on:

- Literature or desk reviews/ analysis of various reports, review exercises, surveys etc as detailed below
- Interviews with implementing partners, programme managers and beneficiaries
- Site visits to sample of Districts; and
- Focus Group Discussions

(i) The Country Programme Document (CPD) 2007- 2010.
(ii) UNDAF Document
(iii) The CPAP (2007 – 2010) Programme document
(iv) The Annual Work Plans (AWP)
(v) Quarterly project Reports
(vi) Annual co-ordination and review meeting
(vii) Country Office Annual Reports
(viii) Standard Progress Reports
(ix) National RH Strategy
(x) Audit reports (2007-2010)
(xi) Field monitoring reports
(xii) Studies conducted during the period 2007-2010
(xiii) UNFPA Guidelines for Monitoring and Evaluation
(xiv) National statistics and data management information systems
(xv) Other relevant materials (to be proposed by consultant)

5.0 Deliverables/output

The final 6th CP evaluation report providing quantitative and qualitative analysis on achievements, constraints and emerging issues as well as evidence based clear recommendations. The following will be the outline of the report:

- Executive summary:
- Introduction
- Findings and conclusions
- Best Practices and lessons learned
- Emerging issues
- Recommendations
- *Annexes*
  - ToR (for the evaluation).
  - List of documents reviewed (reports, publications).
  - List of persons/institutions contacted

6.0 Duration

The evaluation will be conducted over a period of six weeks. The process will begin from 15 August and should terminate on 4 October, 2010.

7.0 Evaluation team composition

The team will comprise of up to 3 evaluators. The evaluation will be managed by one team-leader supported by two thematic (RH and PD/Gender) experts. The evaluators will be selected by UNFPA Zambia in consultation with the Ministry of Finance and National Planning. The team-leader is responsible for the final report (which should include an overview of the results of the 6th CP) and is to

provide technical support and overview to the two experts during the field-research and writing of their respective reports. The evaluators should all possess interview skills, analytical skills, facilitation skills and possess excellent English writing skills.

7.1 Profile of Evaluation team-members

1. **Team Leader**

Key tasks:
- Elaborate an analytical framework for the evaluation
- Lead in translating analytical framework into data collection and analysis tools
- Lead in proceeding analysis works
- Lead in undertaking basic activities to support the evaluation
- Guide other team members in order to complete the work in accordance with the Terms of Reference in timely fashion
- Continuously review the work of individual members, provide guidance and ensure a coordinated analysis
- Settle any disagreement and disputes among the evaluation team, if any, and find the best solutions
- Be the spokesperson of the team in relation to UNFPA Country Office, Government partners and other counterparts
- Ensure that field visits and meeting schedules are adequate to fulfil the terms of reference
- Consolidate the team members' contributions into a final evaluation report
- Prepare evaluation report and serve as principle presenter in front of key audiences

Qualification
- Post graduate degree in social sciences, public health or any related field to UNFPA's mandate
- At least 5-10 years work and/or research experience
- Experience as an evaluation team-leader
- Proven analytic, communication/presentation skills and evaluation skills
- Excellent writing skills
- Excellent capacity in English (both writing and speaking)

2. **Public Health specialist**

Key tasks:
- Assess the design, implementation and results of the RH programme
- Develop evaluation tools
- Prepare a conceptual and practical framework for the comprehensive assessment of quality of health care services
- Provide assistance to the evaluation through analysis of UNFPA's programme and national priorities
- Provide assistance to the team leader in preparing the evaluation report through the preparation of chapters evaluating the 6th CP RH component

Qualification:
- Post graduated degree in Public Health
- At least 10 years in health field
- Proven skills on evaluation of health projects
- Familiarity with health care system of Zambia
- Excellent capacity in English
- Prove ability to work within multi-disciplinary teams

3. **Demography/Gender specialist**

Key tasks:
- Assess the design, implementation and results of the PD/Gender components
- Develop evaluation tools

- Provide assistance to the evaluation through analysis of UNFPA's programme and national priorities
- Prepare a conceptual and practical framework for the comprehensive assessment of quality of GBV management services
- Provide assistance to the team leader in preparing the evaluation report through the preparation of chapters evaluating the 6th CP PD/Gender components

Qualification:

- Ph.D or Masters degree in public administration, demography, social science or another related study Health or related field
- At least 10 years work and/or research experience
- Proven analytic and evaluation skills
- Proven communication/presentation skills
- Previous experience in working in the area of collecting and utilizing data for planning
- Excellent capacity in English is required.

9.0 Evaluation Management and reporting

The evaluation team will work under the direct supervision of UNFPA Country Office Representative for Zambia who will provide necessary information and guidance for planning the evaluation. UNFPA Zambia will provide relevant documents and information for pre-reading upon signing the contract between UNFPA office and evaluators.

UNFPA will provide logistical support and arrange meetings and field visits as per the agreed plan. Evaluators will be expected to work 6 days a week. Travel to field visits will be arranged. UNFPA will also make available office space; the evaluators are however expected to bring their own laptops.

In order to secure involvement by the relevant authorities in the management and implementation of the 6th CP Evaluation the Ministry of Finance and National Planning represented by the Department of National Planning - Government co-ordinating institution will coordinate the smooth implementation of the evaluation exercise.

The Lead consultant will be expected to debrief UNFPA CO at the end of the evaluation. He/ She will also present the findings of the evaluation in a workshop for implementing partners and other stakeholders and clarify issues. The Consultants shall reflect the comments, feedbacks and recommendations of the workshop in the final report. The daily management of the evaluation will be the responsibility of UNFPA M&E focal point person in close coordination with the Ministry of Finance and National Planning represented by the Department of National Planning.

Annex 1 Thematic Research Questions

I. UNFPA's Reproductive Health Component

RH Programme design, management and implementation

a) To what extent was the RH component aligned and/or contributed to national and sub-national priorities? Were the proposed and implemented interventions evidence-based? What were the main assumptions and risks identified which could impact foreseen results?)
b) To what extent did the programme design assure mechanisms to reach the poor and marginalized?
c) To what extent was the participation of policy makers in ensuring the sustainability of RH component?
d) To what extent were UNFPA's and its partners (financial, technical and management) capacity in the development and management of the RH programme considered?
e) Were all strategic stakeholders included in the development and implementation of the RH?

f) To what extent was there flexibility in addressing emerging issues experienced during the course of the CP?
g) To what extent was the RH component intertwined with other UNFPA 6th CP outputs?
h) To what extent was results-oriented programming and monitoring taken into consideration during the development and implementation of the component?
i) Were the monitoring mechanism appropriate and were the results of monitoring appropriately used to make necessary adjustments?
j) To what extent has the Provinces and District RH activities contributed to the promotion of reproductive health and rights?
k) To what extent has the SMAGS working group contributed to address family planning needs of the people
l) To what extent has RH effectively integrated, young people and human rights?

Effectiveness and efficiency

a. To what extent have the expected results been achieved?
b. What factors have played facilitating and constraining roles in achieving the expected results?
c. How have efforts of other Outputs contributed towards the achievement of the results made on providing integrated essential reproductive health services
d. What is the opinion of stakeholders (policy makers, service providers, clients) about the results?
e. To what extent were management decisions based on the progress reported in two Province?

Sustainability and component replication

a. Did the local governments allocate sufficient resources to guarantee achieved results will be sustainable?
b. Did the component design and implementation include strategies to ensure sustainability?
c. To what extent can it be expected that lessons-learned, good practices and innovative interventions provide inputs into the GRZ's initiatives to increase the quality of access and services?

What are the facilitating and constraining factors that affect the sustainability and component rolling over to another Province?

II. UNFPA's Population and Development /Gender Components

PDS Programme design, management and implementation

a) To what extent has the PD/Gender components (improvement of database, and support to the conduct of large survey i.e. 2007 Zambia DHS, and 2010 Population and Housing Census, Policy studies and 2007 DHS) been aligned and/or contributed to national and provincial priorities?
b) What were the main assumptions and risks identified which could impact foreseen results?
c) To what was the PD/Gender components (improvement of database, and support to the conduct of large survey i.e. 2007 DHS, and 2010 Population and Housing Census, Policy studies and 2007 ZDHS) expected to contribute to the outcomes and outputs of the United Nations Development Assistance Framework (UNDAF)
d) To what extent were UNFPA's and its partners (financial, technical and management) capacity in the development and management of the PD/Gender components considered?
e) Were all strategic stakeholders included in the development and implementation of the components?
f) What were the expected results of the PD/ Gender components?
g) To what extent was there flexibility in addressing emerging issues experienced during the course of the CP?
h) In what way did the components design respond/took into consideration specific local and or national needs and conditions?
i) To what extent was results-oriented programming and monitoring taken into consideration during the development and implementation of the components?
j) Were the monitoring mechanism appropriate and were the results of monitoring appropriately used to make necessary adjustments?
k) Did the components design and implementation include strategies to ensure sustainability?

Effectiveness and efficiency

a. To what extent have the expected results been achieved through the attainment of indicators?
b. Have the allocated budget sufficient to ensure achievement of the outputs?
c. What factors have played facilitating and constraining roles in achieving the expected results?
d. How have efforts of other Outputs contributed towards the achievement of the results made on increasing the utilisation of data
e. What is the opinion of stakeholders (policy makers, planners, data users and data collectors/processors) about the results?
f. Were financial and human resources used in the most efficient way?
g. How have efforts of other Outputs contributed towards the achievement of the results made on increasing the quality of GBV management services?
h. Is there a difference in quality and range of GBV management services in areas where UNFPA had its interventions and those that did not benefit from UNFPA's support?

Sustainability and programme replication

a) Are the achieved results sustainable?
b) Will the Government allocate sufficient resources to guarantee achieved results will be sustainable?
c) To what extent can it be expected that lessons-learned, good practices and innovative interventions provide inputs into the GRZ's initiatives to increase the quality and utilisation of data for planning and policy making?
d) What are the facilitating and constraining factors that affect the sustainability and programme replication?

Timeline

An important consideration in deciding the timeline is the fact that in September 2010, UNFPA Zambia should submit the 7th CP to UNFPA Executive Board for approval. Once approved the implementation of the 7th CP is expected to start being implemented early 2011. Therefore the evaluation reports should be available to accommodate the main recommendations, built forward on good practices and address identified obstacles and challenges.

Date	Activity
16 25 August	Initial orientation of team, interviews in Lusaka with government and non-government stakeholders
26th August – 4th September	Fieldwork
6-15 September	Supplemental interviews at central level, joint team analysis and drafting report
17 September	Presentation initial findings to stakeholders
18- 23 September	Report writing and submission of first draft
27 September	Reply on first draft by UNFPA and Government of Zambia
29-30 September	Editing of report and submitting final report

Remuneration

Payment will be made based on individual evaluator's previous salary history and work experience. The expected number of working days is 33.

Submission of application

Please provide us with an update CV **before 10 of August 2010.**

UNFPA provides a work environment that reflects the values of gender equality, teamwork, respect for diversity and integrity.

If you have any questions regarding the terms of reference, please contact:

Mr. Duah Owusu-Sarfo: owusu@unfpa.org

Mr. Charles Banda: cbanda@unfpa.org

APPENDIX 2

FOCUS GROUP DISCUSSION QUESTIONS

My name is ______________________. I will ask my colleagues to introduce themselves. We are here to evaluate the joint 6th Country Programme between the Government of The Republic of Zambia (GRZ) and the United Nations Population Fund (UNFPA) on reproductive health, population and development and gender. We will be grateful if you if you could kindly share with us the information we seeking to help us evaluate the performance of this programme. This is not a test; there are no right or wrong answers.

1. What are the successes of the reproductive health and HIV programmes in your Province/District?
2. What are the main reasons for these successes?
3. To what extent were you involved in developing the Provincial/District work plan that included support from UNFPA?
4. To what extent have the additional resources from UNFPA benefited service provision of reproductive health and PMTCT services in your Province/District?
5. To what extent have the provincial and District offices integrated the activities in the current CP?
6. Can you please share your opinions on coordination and collaboration with UNFPA on reproductive health and gender?
7. Which activities in the 6th CP would like to continue and why?
8. Is there anything you would like to improve regarding the additional financial support from UNFPA?
9. Would you like to make any recommendations to strengthen collaboration with UNFPA on reproductive health, HIV services and gender?
10. Do you have any recommendations on how UNFPA can improve the support on reproductive health and gender in your Provinces/District/community services?

THANK YOU FOR YOUR TIME

APPENDIX 3

SEMI-STRUCTURED INTERVIEW SCHEDULE

1. **District**:--

2. **Name of health facility**: ____

3. **Location**:--

4. **Type of health facility**:--

5. **Location**:--

	Respondent no.	Qualification(s)	Position
Date			
Result			

Result codes: Completed 1; Respondent not available 2: Refused 3; Partially completed 4; Other 5.

Introduction:
My name is ______________________. I will ask my colleagues to introduce themselves. We are here to evaluate the joint 6th Country Programme between The Government of Zambia (GRZ) and The United Nations Population Fund (UNFPA) on reproductive health, population and development and gender. We would like to ask you a few questions about your involvement in the implementation of this programme. This is not a test; there are no right or wrong answers.

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

NO.	QUESTIONS	ANSWERS AND CODES	SKIP TO
1.	Were you involved in the development of the 6th Country Programme?	Yes ....1 No...2	If No, skip to Q18
2.	How were you involved?	______________________________ ______________________________	
3.	When did you officially start implementing the annual work plan?	Month ________ Year ________	
4.	When did you start implementing the work plan activities?	Month ________ Year ________	
5.	Do you perceive that you started implementing the work plan activities on time?	Yes ....1 No...2	

NO.	QUESTIONS	ANSWERS AND CODES	SKIP TO
6.	What are some of the factors that led to the delay? CIRCLE ALL THAT APPLY	Delaying 6th CP__________________ Busy with other work_______________ Shortage of staff_________________ Lack of competent staff____________ Lack of office space_______________ Counterpart funds not released on time__________________________ Delays by other partners______________ Delayed approvals by supervisors______	
7.	What do you like most about the 6th Country Programme?	______________________________ ______________________________ ______________________________ ______________________________	
8.	What are the successes of the 6th CP in your province/district/community?	______________________________ ______________________________ ______________________________ ______________________________	
9.	What are the main reasons for these successes?	______________________________ ______________________________ ______________________________ ______________________________	
10.	To what extent were you involved in developing the provincial/district work plan that included support from UNFPA?	Actively involved___________________ Not involved_______________________ NA____________________________	
11.	What were the main constraints in implementing the 6th CP?	______________________________ ______________________________ ______________________________ ______________________________	
12.	To what extent have the additional resources from UNFPA benefited service provision of reproductive health, HIV and gender services in your province/district/community?	______________________________ ______________________________ ______________________________ ______________________________	
13.	To what extent have the provincial and district offices integrated the activities in the current country programme into their work plans?	______________________________ ______________________________ ______________________________ ______________________________	

NO.	QUESTIONS	ANSWERS AND CODES	SKIP TO
14.	Can you please share your opinions on coordination and collaboration with UNFPA, MSYCD and GIDD on reproductive health, HIV and gender?	____________________ ____________________ ____________________ ____________________	
15.	Which mechanisms in the 6th CP would like to continue in the 7th and why?	____________________ ____________________ ____________________ ____________________	
16.	Is there anything you would like to improve regarding the additional financial support from UNFPA?	____________________ ____________________ ____________________ ____________________	
17.	Do you any recommendations that can strengthen collaboration with UNFPA and other partners on reproductive health, HIV and gender?	____________________ ____________________ ____________________ ____________________	
18.	Do you have any recommendations on how UNFPA can improve the support on reproductive health, HIV and gender services?	____________________ ____________________ ____________________ ____________________	
19.	If no to Q1, can you please share areas of concern that you would have liked to be included in the 6th CP even though you were not involved in its development?	____________________ ____________________ ____________________ ____________________	
20.	Do you have recommendations, which you feel can improve the delivery of the 7th Country Programme?	____________________ ____________________ ____________________ ____________________	
21.	Do you have any questions for me?	____________________ ____________________ ____________________ ____________________	

THANK YOU FOR YOUR TIME

APPENDIX 4

LIST OF DOCUMENTS REVIEWED

1. MoFNP/UNFPA/UNZA (2010) Review of the integration of Population and Gender Factors in Socio-Economic Policies, Plans and Programmes in Zambia. MoFNP. Lusaka, Zambia
2. MSYCD, NAC, MoH, ZANIS (2008), (2009) and (2010) Annual Work Plans. UNFPA. Lusaka, Zambia
3. UNFPA Field Offices Activity, Quarterly and Annual Reports (2008), (2009). UNFPA. Lusaka, Zambia
4. UNZA/UNFPA (2010) *Report on Assessment of UNFPA-funded Enrolled Nurse Training Programme in North-Western Province, Zambia*. Lusaka. UNZA. Lusaka, Zambia
5. GRZ (2010) *Empowered, Engaged, Encouraged: National Standards for SRH. HIV and AIDS Peer Education Programmes*. MoH. Lusaka, Zambia
6. MoFNP (2009) Annual Report of the Fifth National Development Plan. MoFNP. Lusaka, Zambia
7. ZANIS (2009) Country Programme Annual Report. ZANIS. Lusaka, Zambia
8. CSO/MoH/TDRC/UNZA/Macro International Inc. (2009) *Zambia Sexual Behaviour Survey*. Lusaka, Zambia. CSO and MEASURE Evaluation.
9. CSO/MoH/TDRC/UNZA/Macro International Inc. (2007) *Zambia Demographic and Health Survey 2007*. Calverton, Maryland, USA: CSO and International Inc.
10. ZANIS (2008) Country Programme Annual Report. ZANIS. Lusaka, Zambia
11. MoH (2008) *National Training Operational Plan: Field Assessments, Analysis and Scale-up Plans for Health Training Institutions*. MoH, Lusaka, Zambia
12. GRZ/UNFPA (2007) *CP Action Plan (CPAP) 2007 for the Programme of Cooperation between the Government of the Republic of Zambia and the United Nations Population Fund. GRZ/UNFPA*. Lusaka, Zambia
13. MoFNP (2007) National Population Policy. MoFNP. MoFNP
14. CSO (2006) Living Conditions Monitoring Survey. CSO. Lusaka
15. UNFPA (2006) *Executive Board of the United Nations Development Programme and the United Nations Population Fund. United Nations Population Fund CP for Zambia. UNFPA*. New York, UN, USA
16. MoH (2008) *National Reproductive Health Policy*. MoH, Lusaka, Zambia
17. MoH (2006) *Consultancy Report on Gender Streaming in the Health Sector in Zambia*. MoH. Lusaka, Zambia
18. MSYCD (2006) Minimum Standards Guidelines for Youth Development in Zambia. MSYCD. Lusaka, Zambia
19. MSYCD (2006) *National Plan of Action for the Youth. MSYCD*. Lusaka, Zambia
20. NAC (2009) *National Strategy for the Prevention of HIV and STIs. National HIV/AIDS/STI/TB Council*. Lusaka, Zambia
21. Annual co-ordination and review meetings
22. Country Office Annual Reports
23. Audit reports (2007-2010)
24. UNFPA Field Trip Reports
25. UNFPA Guidelines for Monitoring and Evaluation

APPENDIX 5

LIST OF PERSONS/INSTITUTIONS CONTACTED

No.	Name	Position	Institution
North-Western Province			
Solwezi District			
1.	Mr. Nkolola Hazeemba	Deputy Permanent Secretary	Provincial Administration
2.	Dr. George Liabwa	Provincial Medical Officer	Provincial Health Office
3.	Mrs. Clara Mwala	Team Leader/Youth Programme Officer	UNFPA-NWP
4.	Mrs. Garnet Mwenya	Safe Motherhood Programme Officer	UNFPA-NWP
5.	Mary Kate Bwalya	Reproductive Health Programme Officer	UNFPA-NWP
6.	Christopher Malisopo	Acting Provincial Youth Development Coordinator	MSYCD
7.	Wesley Ng'andu	Provincial Information Officer	MIS, ZANIS
8.	Stephen Chibesa	Chief Planner	MOFNP
9.	Rodney Machila	Principal Planner	MOFNP
10.	Pride Kabuswe	Principal Planner	MOFNP
11.	Peter Chinungwe	Medical Equipment Officer	MOFNP
12.	Mrs. Liabwa	In-Charge	UNFPA-NWP
13.	Mrs. A. Chanda	Registered Nurse	Solwezi Urban Clinic
14.	Mrs. P. Mseteka	Registered Nurse	Solwezi Urban Clinic
15.	Mrs. J. Kaseya	Registered Nurse	Solwezi Urban Clinic
16.	Mrs. J. Nkumba	Enrolled Nurse	Solwezi Urban Clinic
17.	Mrs. A. Sichalwe	Lay Counsellor	Solwezi Urban Clinic
18.	Mrs. L. Kapaya	Lay Counsellor	Solwezi Urban Clinic
19.	Mrs. Chinyembu	Lay Counsellor	Solwezi Urban Clinic
20.	Ms. Konselio	Lay Counsellor	Solwezi Urban Clinic
21.	Mr. Mutanya	Lay Counsellor	Solwezi Urban Clinic
22.	Mr. Rogers	Lay Counsellor	Solwezi Urban Clinic
23.	Esther Mwachisaka	Lay Counsellor	Solwezi Urban Clinic
24.	Kapondola Peter	Lay Counsellor	Solwezi Urban Clinic
25.	Dr. E. K. Chisenga	DMO	Zambezi DHMT
26.	Dr. S. Shajanika	DMO	Kambopo DHMT
27.	Dr. W. Mumba	Acting Medical Superintendent	Solwezi General Hospital
28.	Fanwell Mususu	Acting DMO	Solwezi Zambezi DHMT
29.	Bernadette Mukanzu	Acting PNO, RH/MCH	Provincial Health Office
30.	C. M. Likando	Acting DMO	Chavuma DHMT
31.	Sikota Lutangu	CCO	Kasempa DHMT
32.	P. Kambangu	CCO	Mufumbwe DHMT
33.	Aaron Banda	Acting Principal Tutor	Kaleni School of Nursing
34.	Masiye Pumulo	Acting Principal Tutor	MukingeSchool of Nursing
35.	Seleji Chinyama	Acting Principal Tutor	Solwezi School of Nursing
36.	Senior Chief Mumena	Chief	Chief Mumena Area

No.	Name	Position	Institution
North-Western Province			
Mwinilunga District			
37.	Ernest Mutwave	CCO	Mwinilunga DHMT
38.	Akabana Yamboto	DHIO	Mwinilunga DHMT
39.	Senior Chief Kanongesha	Chief	Chief Kanongesha Area
40.	Kusaluka R. Wisdom	Youth Chairperson	Chief Kanongesha Area
41.	Victoria Kakisa	Main SMAG, Treasurer	Chief Kanongesha Area
42.	Ene Penseh	Sub-SMAG member	Chief Kanongesha Area
43.	Dorothy Chibembe	Sub-SMAG member	Chief Kanongesha Area
44.	Ridah Samuuska	Sub-SMAG member	Chief Kanongesha Area
45.	Sabrina Chilongwe	Main SMAG member	Chief Kanongesha Area
46.	Maidan Robbine	Main SMAG member	Chief Kanongesha Area
47.	Patrick Lufunda	Sub-SMAG member	Chief Kanongesha Area
48.	Crispin Sitali W.	Head Teacher, Mulumbi Basic School	Chief Kanongesha Area
49.	Kasanga Alexon	Radio Reporter, Local Media	Chief Kanongesha Area
50.	Annice Mutelu	Matron	Chief Kanongesha Area
51.	Christabel Makunku	Peer Educator	Chief Kanongesha Area
52.	Catherine Manjombi	Peer Educator	Chief Kanongesha Area
53.	Oliga Chilongu	Youth Club Member	Chief Kanongesha Area
54.	Bridget Sawila	Youth Club Member	Chief Kanongesha Area
55.	Sam Mafulu	Youth Club Member	Chief Kanongesha Area
56.	Greysworth Kusana	Youth Club Member	Chief Kanongesha Area
57.	Geddson Kamboyi	Youth Sports Chairman	Chief Kanongesha Area
58.	Stanley Kamusengi	Youth Sports Organizer	Chief Kanongesha Area
59.	Kenneth Kamocha	Youth Treasurer	Chief Kanongesha Area
60.	Ackim Kachiza	Peer Educator	Chief Kanongesha Area
61.	Alex Maini	Vice Chairperson	Chief Kanongesha Area
62.	David Samuhela	Youth Club member	Chief Kanongesha Area
63.	Anne Sakufwela	Youth Club member	Chief Kanongesha Area
64.	Screven Dikashi	Youth Club member	Chief Kanongesha Area
65.	Gypsy Kusanah	Youth Club member	Chief Kanongesha Area
66.	Hendrix Besa	Youth Club member	Chief Kanongesha Area
67.	Justine Kawaya	Youth Club member	Chief Kanongesha Area
68.	Clement Makiku	Youth Club member	Chief Kanongesha Area
69.	Happy Sawila	Youth Club member	Chief Kanongesha Area
70.	Crispi Kapumba	Youth Club member	Chief Kanongesha Area
71.	Cledia Chakamisha	Sub SMAG Publicity	Mwinilunga DHMT
72.	Jean Yowanu	Main SMAG Vice Secretary	Mwinilunga DHMT
73.	Crispin Makhinta	Main SMAG Vice Chairman	Mwinilunga DHMT
74.	Grace Kamulosu	Main SMAG Vice Treasurer	Mwinilunga DHMT
75.	Softy Katumoya	Main SMAG Publicity	Mwinilunga DHMT
76.	Bosweu Kanema	Main SMAG Secretary	Mwinilunga DHMT
77.	Joyreen Chilandi	Main SMAG Secretary	Mwinilunga DHMT
78.	Timothy Sikasuema	Sub SMAG Chairperson	Mwinilunga DHMT
79.	Freddy Lambakasa	Main SMAG Member	Mwinilunga DHMT
80.	Anthony Kambunga	Sub SMAG Member	Mwinilunga DHMT
81.	Reeb Sangunga	Sub SMAG Traditional Birth Attendant	Mwinilunga DHMT
82.	Roy Kashinakati	Sub SMAG Chairperson	Mwinilunga DHMT
83.	Richard Mtonga	Main SMAG Chairperson	Mwinilunga DHMT

No.	Name	Position	Institution
North-Western Province			
Kasempa District			
84.	Joyce S. Kamwana	IRH Focal Person/Acting DMO	Kasempa Urban Clinic
85.	Evans Kamwana	District Education Officer/Acting DC	District Education Board
86.	Florence Mukoma	ZRN/ZRM	Kasempa Urban Clinic
87.	Christine K. Samanjomba	ZRN/ZRM	Kasempa Urban Clinic
88.	Majory Mtonga	ZEN/ZEM	Kasempa Urban Clinic
89.	Mubanga Kazembe	CO	Kasempa Urban Clinic
90.	Mulonda Lubinda	EHT	Kalombe Health Centre
91.	Kyaba Kangay	SMAG Secretary	Kalombe Health Centre
92.	Marry Muzhile	SMAG Treasurer	Kalombe Health Centre
93.	Mainess Shindwami	SMAG member	Kalombe Health Centre
94.	Milliam Phiri	SMAG Vice-Chairperson	Kalombe Health Centre
95.	Tony Sopasopa	SMAG Top Secretary Sub-Committee	Kalombe Health Centre
96.	Subakanya Kabila	SMAG Vice Top Chairperson	Kalombe Health Centre
97.	Elika Amon	SMAG member	Kalombe Health Centre
98.	Mizika Mushisitimwe	SMAG member	Kalombe Health Centre
99.	Mabange Benco	SMAG Chairperson	Kalombe Health Centre
100.	Steven Mutwila		Kalombe Health Centre
101.	Alex Iputu		Kalombe Health Centre
102.	Kamona Mulonda	Peer Educator	Kalombe Health Centre
103.	Memory Kambenga	Peer Educator	Kalombe Health Centre
104.	Bensoni Kebana	Peer Educator	Kalombe Health Centre
105.	Mercy Mwiya	Class Teacher (Matron, Peer educators)	Kalombe Health Centre
106.	Lime Motoka Luputa	SMAG Main Committee member	Nselauke Rural Health
107.	Joseph Winki	SMAG Main Committee member	Nselauke Rural Health
108.	Carol Chanda	Lwansununu Sub-SMAG member	Nselauke Rural Health
109.	H. N. Nkonde	Kafumfula Sub SMAG member	Nselauke Rural Health
110.	Boniface Kayuma	Lwansununu Sub-SMAG member	Nselauke Rural Health
111.	Ernest Pollen	SMAG Chairperson	Nselauke Rural Health
112.	Abiya Ngaalatiya	Lwansununu Sub-SMAG member	Nselauke Rural Health
113.	Richard Mushima	Nselauke (Psychosocial Counsellor)	Nselauke Rural Health
114.	Enelessy Anailo	Kafumfula Sub SMAG member	Nselauke Rural Health
115.	Isaac Nkanda	Kafumfula Sub SMAG member	Nselauke Rural Health
116.	Agnes Poleni	SMAG Main Committee member	Nselauke Rural Health
117.	Rachel Kasabulo	Nselauke (Youth CBD)	Nselauke Rural Health
118.	Elvis Kabandulu	SMAG Main Committee member	Nselauke Rural Health
119.	Joyce Kampukesa	SMAG Main Committee member	Nselauke Rural Health
120.	Naba Chikwanda	SMAG Main Committee member	Nselauke Rural Health
121.	Sylvester Musenge	SMAG Main Committee member	Nselauke Rural Health

No.	Name	Position	Institution
Luapula Province			
Mansa District			
122.	Dr. Elicho Bwalya	Acting Provincial Medical Officer	MoH Provincial Health Office
123.	Pascoe Salimu	Gender Officer/Team Leader	UNFPA Field Office
124.	Joyce M. Chabala	Safe Motherhood Programme Officer	UNFPA Field Office
125.	Regina C. Lungu	Adolescent Health Programme Officer	UNFPA Field Office
126.	Mr. Francis Kasonde	Psychosocial Officer	UNFPA Field Office
127.	Sicholastica Banda	Administrative Assistant	UNFPA Field Office
128.	Mr. Mpala Mambwe	Provincial Youth Development Coordinator	MSYCD
129.	Mr. Webster Chisaka	Acting Senior Hospital Administrator	Mansa General Hospital
130.	Charity Kasakula	RN/RM/Acting In-charge	Mansa General Hospital
131.	Dr. Francis Bwalya	Medical Superintendent	Mansa General Hospital
132.	Peter Chiko Bwalya	Accountant	Mansa General Hospital
133.	Astrida T. M. Hikaambo	Nursing Officer (Obs and Gynae)	Mansa General Hospital
134.	Augustine Luboya	Principal Tutor	Mansa School of Nursing
135.	Lazarus Mulenga	Senior HR Management Officer	Provincial Health Office
136.	Steven M. Ngoi	EHT	Mansa DHMT
137.	Senior Chief Chisunka	Chief	Chisunka Rural Health Centre
138.	Brian Ngandwe	Nurse in-charge	Chisunka Rural Health Centre
139.	Edwin Kabwe	EHT	Chisunka Rural Health Centre
140.	Kaoma Gladys	SMAG member	Chisunka Rural Health Centre
141.	Suzanne Chalwe	Sub SMAG	Chisunka Rural Health Centre
142.	Cephas Kapanya Chola	SMAG member	Chisunka Rural Health Centre
143.	Juliet Kabengele	SMAG Treasurer	Chisunka Rural Health Centre
144.	Jenipher Sonto	SMAG Vice Chairperson	Chisunka Rural Health Centre
145.	Mukulambulu Alex	SMAG Top Secretary	Chisunka Rural Health Centre
146.	Dorothy Kalusha	SMAG member	Chisunka Rural Health Centre
147.	Chibwe Darius Pardon	SMAG Chairperson	Chisunka Rural Health Centre
148.	Mwamba Jeomus Katongo	SMAG member	Chisunka Rural Health Centre
149.	Kaluba Jameson	SMAG member	Chisunka Rural Health Centre
150.	Mwenya Foster	SMAG member	Chisunka Rural Health Centre
151.	Singogo Maureen	SMAG member	Chisunka Rural Health Centre
152.	Mambwe Beauty	SMAG member	Chisunka Rural Health Centre
153.	Memory Katongo	SMAG member	Chisunka Rural Health Centre
154.	Kaoma Mathews	SMAG member	Chisunka Rural Health Centre
155.	Kaoma Lackson	SMAG member	Chisunka Rural Health Centre
156.	Singongo Webster	SMAG member	Chisunka Rural Health Centre
157.	Henry J. Pupe	SMAG member	Chisunka Rural Health Centre
158.	Bupe Pascal	SMAG member	Chisunka Rural Health Centre
159.	Chama Able	Parent Elder Educator Chairperson	Chisunka Rural Health Centre
160.	Dinas Kapala	Parent Elder Educator member	Chisunka Rural Health Centre

No.	Name	Position	Institution
Luapula Province			
Mansa District (cont'd)			
161.	Feliciter Nkhata	Parent Elder Educator Trustee	Chisunka Rural Health Centre
162.	Judith Nkandu		Chisunka Rural Health Centre
163.	Josephine Bwalya Kabenge	Parent Elder Educator Vice Secretary	Chisunka Rural Health Centre
164.	Joyce Mutono	Parent Elder Educator Trustee	Chisunka Rural Health Centre
165.	Catherine Chola	Parent Elder Educator Top Chairperson	Chisunka Rural Health Centre
166.	Mwape Jasper	Parent Elder Educator member	Chisunka Rural Health Centre
167.	Autorn Chibwe	Parent Elder Educator member	Chisunka Rural Health Centre
168.	Mwila Crispin	Parent Elder Educator member	Chisunka Rural Health Centre
169.	Mpunde Earnest	Youth Educator Chairperson	Chisunka Rural Health Centre
170.	Nangongo Agnes	Youth Educator Secretary	Chisunka Rural Health Centre
171.	Shamende Victor	Youth Sub-Educator member	Chisunka Rural Health Centre
172.	Mathews Mwandama	Youth Educator Vice Secretary	Chisunka Rural Health Centre
173.	Kankulileko Emmanush	Youth Educator Committee member	Chisunka Rural Health Centre
174.	Kabalika Rose	Youth Educator Treasurer	Chisunka Rural Health Centre
175.	Kaoma Grace		Chisunka Rural Health Centre
176.	Musonda Janet		Chisunka Rural Health Centre
177.	Bwanga Emmely		Chisunka Rural Health Centre
178.	Chilufya Linda		Chisunka Rural Health Centre
179.	Innocent Daka	Provincial Office - ZANIS	Provincial Officer
180.	Maureen Mubita	ZEN/ZEM	Senama Health Centre
Kawambwa District			
181.	Mr. Gershom Tanga	District Commissioner	District Administration
182.	Chilolo M. Lameck	Environmental Health Officer	Kawambwa DHMT
183.	Lackson Ndhovu	Acting Clinical Care Officer	Kawambwa DHMT
184.	Basil Mulu	Enrolled Nurse	Kawambwa DHMT
185.	Chola Chakopu	Community Development Officer, Gender	MCD
186.	Chief Mutondolo	Chief	Muntondolo Chiefdom
187.	Norryce C. Mwewa	ZEM	Mufwaya Rural Health Centre
188.	Maybin Chomba	SMAG Top Secretary	Mufwaya Rural Health Centre
189.	Brighton Chomba	SMAG Top Chairperson	Mufwaya Rural Health Centre

No.	Name	Position	Institution
Luapula Province			
Kawambwa District (cont'd)			
190.	Albert Mulenga	SMAG Member	Mufwaya Rural Health Centre
191.	Grace Mwape	SMAG Vice-Secretary	Mufwaya Rural Health Centre
192.	Grace Mwape	SMAG Chairlady	Mufwaya Rural Health Centre
193.	Annie Kombe	SMAG Treasurer	Mufwaya Rural Health Centre
194.	Webby Mucemwa	SMAG member	Mufwaya Rural Health Centre
195.	Rabon Matimba	SMAG Publicity Secretary	Mufwaya Rural Health Centre
196.	Chishala Obed	SMAG member	Mufwaya Rural Health Centre
197.	Katabwa Thomas	SMAG member	Mufwaya Rural Health Centre
198.	Musonda Derrick	SMAG Secretary	Mufwaya Rural Health Centre
199.	Katutu Davies	Parent Elder Educator Secretary	Mufwaya Rural Health Centre
200.	Musonda Clement	Parent Elder Educator member	Mufwaya Rural Health Centre
201.	Clement Bwalya	Parent Elder Educator	Mufwaya Rural Health Centre
202.	Malama Priscilla	Parent Elder Educator	Mufwaya Rural Health Centre
203.	Katai Stella	Parent Elder Educator	Mufwaya Rural Health Centre
204.	Rose Chomba	Parent Elder Educator	Mufwaya Rural Health Centre
205.	Charles Mwewa	Parent Elder Educator	Mufwaya Rural Health Centre
206.	Chilambwe Evelyn	Parent Elder Educator	Mufwaya Rural Health Centre
207.	Musonda Augustine	Parent Elder Educator	Mufwaya Rural Health Centre
208.	Melbourne Mulenga	Parent Elder Educator	Mufwaya Rural Health Centre
209.	Kalumba Bridget	Peer Educator Treasurer	Mufwaya Rural Health Centre
210.	Kangwa Mercy	Peer Educator member	Mufwaya Rural Health Centre
211.	Bwalya Euphrasia	Peer Educator Treasurer	Mufwaya Rural Health Centre
212.	Kabwe Pascalina	Peer Educator member	Mufwaya Rural Health Centre
213.	Salimu Lucy	Peer Educator member	Mufwaya Rural Health Centre
214.	Mwansa Japhet	Peer Educator Vice-Secretary	Mufwaya Rural Health Centre
215.	Misumbi Lewis	Peer Educator Vice-Secretary	Mufwaya Rural Health Centre
216.	Benny Musonda	Peer Educator Chairperson	Mufwaya Rural Health Centre
217.	Bridget Mwila	Peer Educator Secretary	Mufwaya Rural Health Centre
National level			
218.	Christine Kalamwina	Director, Social, Legal and Governance	GIDD
219.	Teddy Mulonga	Permanent Secretary	MSYCD
220.	Collins Mulonda	Director, Youth Development	MSYCD
221.	John Zulu	Director, Child Development	MSYCD
222.	Dr. Reuben K. Mbewe	Deputy Director, Reproductive Health	MoH
223.	Dr. Ben Chirwa	Director General	National HIV/AIDS/STIs/Tb Council
224.	Dr. Namunda Mutombo	Lecturer	University of Zambia
225.	Mainga Lwabelwa	Chief Planner	MoFNP
226.	Pamela Kauseni	Planner	MoFNP

National level (cont'd)			
227.	Belinda Lumbala	Planner	MoFNP
228.	Kotutu Chimuka	Programmes Manager	NGOCC
229.	Modern Maimbo	Assistant Director	ZANIS
230.	Hollo Hachonda	Acting Director	PPAZ
231.	Edford Mutuma	Director, Programmes	PPAZ
232.	W. C. Mayaka	Deputy Director – Social Statistics	CSO
233.	Charles Banda	National Programmes Officer, Population and Development/Monitoring and Evaluation Focal Person	UNFPA
234.	Dr. Sarai Malumo	National Programmes Officer, Reproductive Health	UNFPA
235.	Mwaka Siamutuwa	Programme Associate, Population and Development	UNFPA
236.	Florence Tembo-Mulenga	NPPS, HIV	UNFPA
237.	Mekia Mohammed	Gender and HIV Programme Officer	UNFPA
238.	Ruth Bweupe	Family Planning and Adolescent Health Officer	MoH
239.	Abraham Changalika	MoH/UNFPA	Logistics Coordinator
240.	Dr. Amaya Gillespie	Country Representative	UNAIDS
241.	Christine Fube Mutungwa-Lemba	Maternal and Child Health Specialist	UNICEF
242.	Dr. Ngawa Nyongani-Ngoma	Expanded Programme of Immunisation Officer	UNICEF
243.	Solomon Kagulula	WHO	NPO, NPN
244.	Dr. George Sinyangwe	Senior Health Advisor	USAID
245.	Ernest Lungu	Specialist, Economics and Finance,	GIDD
246.	Charles Habeene	Accounts and Administration Officer	WILDAF
247.	Victor Hachimbi	Senior Research Officer, Research and Information	ZANIZ
248.	Lillian Mulubwa	Accountant	ZANIZ
249.	Hope Kasese Kumalo	Acting National Coordinator	WILSA
250.	Masauso Phiri	Data Management Officer	MoH