Government of Zimbabwe/UNFPA 7th Country Programme 2016 – 2020 Evaluation

Final Evaluation Report
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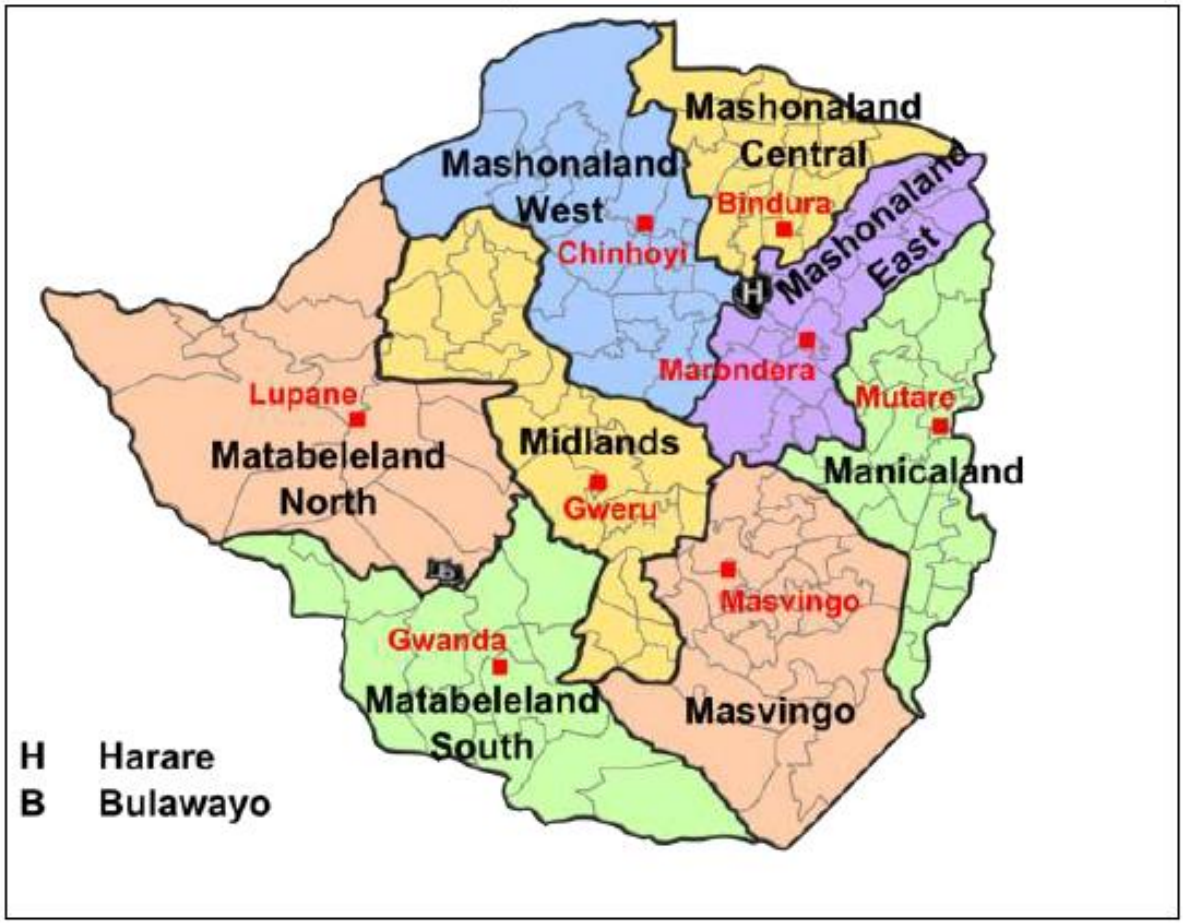
Map of Zimbabwe



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Abbreviations and Acronyms

ABR	Adolescent Birth Rate
ADVC	Anti-Domestic Violence Council
AIDS	Acquired Immuno Deficiency Syndrome
ARC	Adult Rape Clinic
AWPs	Annual Work Plans
BEmOC	Basic Emergency Obstetric and Neonatal Care
CEDAW	Convention on the Elimination of all Forms of Discrimination Against Women
CeCx	Cervical Cancer Screening
CEmOC	Comprehensive Emergency Obstetric and Neonatal Care
COH	City of Harare
CP	Country Programme
CPAP	Country Programme Action Plan
CPD	Country Programme Document
CPE	Country Programme Evaluation
CSE	Comprehensive Sexuality Education
DCT	Direct Cash Transfer
DP	Direct Payment
DVA	Domestic Violence Act
EPTCT	Elimination of Parent to Child Transmission of HIV
ERG	Evaluation Reference Group
ESARO	East and Southern Africa Regional Office
FACE	Funding Authority Certificate of Expenditure
FACT	Family AIDS Caring Trust
FOCASS	Forum of College Authorities on Students' Sexual and Reproductive Health
FP	Family Planning
FST	Family Support Trust
GALZ	Gays and Lesbians Association of Zimbabwe
GBV	Gender Based Violence
GBVie	Gender Based Violence in Emergencies
GBVIMS	Gender Based Violence Information Management System
GDI	Gender Development Index
GDP	Gross Domestic Product
GER	Gross Enrolment Rate
GII	Gender Inequality Index
GNI	Gender Inequality Index
GoZ	Government of Zimbabwe

HDF	Health Development Fund
HDI	Human Development Index
HIV	Human Immuno Virus
HMIS	Health Management Information System
ICDS	Inter-Censal Demographic Survey
ICPD	International Conference on Population and Development
ICT	Information Communication Technology
ILO	International Labour Organisation
I-PRSP	Interim Poverty Reduction Strategy Paper
IT	Information Technology
LEEP	Loop Electrosurgical Excision Procedure
LTA	Long Term Agreement
mCPR	Modern Contraceptive Prevalence Rate
MICS	Multiple Indicator Cluster Surveys
MMR	Maternal Mortality Ratio
MOHCC	Ministry of Health and Child Care
MPDSR	Maternal and Perinatal Deaths Surveillance and Response
MWACSMED	Ministry of Women Affairs, Community, Small and Medium Enterprise Development
NIDI	Netherlands Interdisciplinary Demographic Institute
NMR	Neonatal Mortality Rate
ODA	Overseas Development Aid
OECD	Organisation for Economic Cooperation and Development
OMT	Operational Management Team
OSC	One Stop Centre
PPE	Personal Protective Equipment
PCC	Parent to Child Communication
PGER	Primary School Gross Enrolment Ratio
PMTCT	Prevention of Mother To Child Transmission
PoA	Programme of Action
PR	Proportional Representation
PSI	Population Services International
PSZ	Population Services Zimbabwe
RG	Registrar General
SADC	Southern Africa Development Community
SDGs	Sustainable Development Goals
SGBV	Sexual and Gender Based Violence

SRH	Sexual Reproductive Health
SOP	Standard Operating Procedure
SYP	Safeguard Young People
TFR	Total Fertility Rate
TOR	Terms of Reference
TSP	Transitional Stabilisation Programme
TWG	Technical Working Group
UN	United Nations
UNCG	United Nations Communications Group
UNCT	United National Country Team
UNDAF	United Nations Development Framework
UNEG	United Nations Evaluation Group
UNFPA CO	United Nations Population Fund Country Office
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UZ	University of Zimbabwe
VIAC	Visual Inspection with Acetic Acid and Camera
VMAS	Vital Medicines Availability and Health Services Survey
YFC	Youth Friendly Centre
YFS	Youth Friendly Service
YPNSRHH	Young People's Network on Sexual and Reproductive Health
ZDHS	Zimbabwe Demographic and Health Survey
ZimASSET	Zimbabwe Agenda for Sustainable Socio-Economic Transformation
ZIMSTAT	Zimbabwe National Statistical Agency
ZNFPC	Zimbabwe National Family Planning Council
ZUNDAF	Zimbabwe United National Development Assistance Framework
ZYC	Zimbabwe Youth Council

Key fact table for Zimbabwe

Land	
Geographical location	Southern Africa
Land area	390,759 sq. km
People	
Population	16,152,765 (ZIMSTAT 2019)
Population growth rate	2.36% (ZIMSTAT 2019)
Government	
Type	Democratic Republic
Key political events	Independence from Britain in 1980
Economy	
GDP per capita PPP USD	$2,953[1]
GDP growth rate	-8.1[2]
Main Economic Activity	Agriculture
Social Indicators	
Human development index, rank	0.563 (UNDP 2019)
Life expectancy at birth, both sexes (years)	61.2 years (UNDP 2019)
Under 5 mortality (per 1000 live births)	65 deaths per 1000 live births (MICS 2019)
Maternal mortality (deaths of women per 100,000 live births)	462 per 100,000 live births (MICS 2019)
Total Fertility Rate (TFR)	3.9 (MICS 2019)
Births attended by skilled health personnel (%)	86.5% (MICS 2019)
Contraceptive prevalence rate	67% (FP 2020)
Unmet need for family planning (% of currently married (women, 15-49 years)	8.6% (FP 2020)
Total net enrolment ratio in primary education, both sexes	67.6 (MICS 2019)
Age specific fertility rate 15-19 years	108 per 1000 (MICS 2019)
Proportion of women aged 15-19 years who have already began childbearing	19.95% (MICS 2019)
People living with HIV, 15-49 years	1.4 million[3]
HIV Prevalence rate, 15-49 years (%)	12.78 (UNAIDS 2019)
HIV prevalence rate, 15-24 years: Male/Female (%)	3.2/5.7 (UNAIDS 2019)

Sustainable Development Goals

Sustainable Development Goals	Indicator and source	Status
Goal 2: End hunger, achieve food security and improved nutrition and promote sustainable agriculture	Proportion of children under 5 years who are underweight	5.7 (MICS 2019)
	Proportion of under 5 years severely underweight	1.8 (MICS 2019)
Goal 3: Ensure healthy lives and promote well-being for all at all ages	Maternal mortality ratio (per 100,000 live births)	462 (MICS 2019)
	Births attended by skilled health personnel	86.5% (MICS 2019)
	Antenatal care coverage	93.3% (MICS 2019)
	Infant mortality rate (per 1,000 live births)	53 (MICS 2019)
	Under 5 years mortality rate (per 1,000 live births)	19 (MICS 2019)
	Proportion of adult population infected with HIV accessing ARVs	87%[4]
	TB prevalence rate (per 100,000)	199[5]
	Contraceptive prevalence rate	67%
	Unmet need for family planning	8.6% (FP 2020)
	Proportion of pupils completing primary school	88.8% (MICS 2019)

[1] World Bank data available at https://data.worldbank.org/indicator/NY.GDP.MKTP.KD.ZG?end=2019&locations=ZW&start=1961&view=chart
[2] World Bank data available at https://data.worldbank.org/indicator/NY.GDP.MKTP.KD.ZG?end=2019&locations=ZW&start=1961&view=chart
[3] HIV Spectrum estimates data 2018
[4] HIV Spectrum estimates data 2018
[5] Zimbabwe National TB programme data 2020

	Literacy rates of 15-24 year olds	87.3% men, 92.7% women (MICS 2019)
	Literacy level among men aged between 15-49 years	89.4 (MICS 2019)
	Literacy level among women aged between 15-49 years	92.1 (MICS 2019)
Goal 5. Achieve gender equality and empower all women and girls	Proportion of seats held by women in the National Assembly	31% (GII 2020)
Goal 8. Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all	Annual GDP Growth (2016)	-8.1[6]

[6] World Bank data available at https://data.worldbank.org/indicator/NY.GDP.MKTP.KD.ZG?end=2019&locations=ZW&start=1961&view=chart

Executive Summary

1. Purpose of the UNFPA/Government of Zimbabwe 7th Country Programme Evaluation

The purpose of the country programme evaluation was to provide UNFPA Country Office (CO) in Zimbabwe, national stakeholders, the UNFPA East and Southern Africa Regional Office (ESARO), UNFPA Headquarters with an independent assessment of the performance of UNFPA Zimbabwe 7th CP (2016 – 2020) and to broaden the evidence base for the design of the next programme cycle. Primary users of this evaluation include UNFPA Zimbabwe Country Office, Government of Zimbabwe (GoZ), United National Country Team (UNCT), the UNFPA ESARO and donors operating in Zimbabwe. The findings and recommendations of this evaluation are also of interest to implementing partners of the 7th Country Programme, UNFPA headquarters, divisions and branches, UNFPA Executive Board, academia and national and international NGOs and beneficiaries of UNFPA support.

2. Evaluation objectives and scope

The specific objectives of the evaluation were to: (i) Provide an independent assessment of the relevance, effectiveness, efficiency and sustainability of UNFPA 7th CP; (ii) Assess progress towards expected outputs and outcomes of the country programme; (iii) Assess the role played by UNFPA Country Office in the coordination mechanisms of the UNCT with a view to enhancing the United Nations collective contribution to national development results; and (iv) Draw key lessons from past and current cooperation and provide a set of clear and forward-looking options leading to strategic and actionable recommendations for the next programme cycle.

The evaluation assessed programme interventions implemented from 2016 to 2020, covering 3 provinces (Harare, Matabeleland North and Manicaland) and one district in each of these provinces where UNFPA is implementing interventions. The evaluation also covered interventions supported at national level. The criteria used to select the provinces and districts ensured that all CP interventions were assessed during this evaluation. The evaluation also covered all the four outcome areas of the 7th CP in addition to cross-cutting issues notably gender mainstreaming and human rights based approaches, disability, humanitarian response and transversal aspects of coordination and monitoring and evaluation

3. Methodology

The standard evaluation criteria drawn from United Nations Evaluation Group (UNEG) and the Organisation of Economic Cooperation and Development (OECD) guided this evaluation. These criteria included relevance, effectiveness, efficiency, sustainability and coordination. In addition, the evaluation assessed the coverage and connectedness (humanitarian response) aspects of the programme. In terms of process, a design report was developed detailing the methods, stakeholder selection, evaluation matrix and data collection tools. The evaluation team undertook data collection through documents review and key informant interviews. Due to the COVID 19 pandemic restrictions, interviews were conducted virtually. Data was analysed using the evaluation matrix as a guide to identify key findings, conclusions and make recommendations. The findings and recommendations are outlined below:

4. Findings of the evaluation

Relevance

(i) The 7th CP was fully aligned to UNFPA corporate strategic plans for 2014-2017 and 2018-2021 and national development plans mainly Zimbabwe Agenda for Sustainable Socio-Economic Transformation (ZimASSET) and Transitional Stabilisation Programme (TSP). It also supported interventions that contributed to national policies and strategies across the four outcome areas.

(ii) The CP took into account the needs of targeted populations through using evidence generated from assessments, consultations with Government Ministries and implementing partners but direct involvement of beneficiaries in programming was minimal.

(iii) UNFPA made adjustments to the CP to ensure relevance was maintained throughout the implementation period. The factors that triggered adjustments include political changes and humanitarian emergencies.

(iv) The 7th CP targeted 20 districts selected based on indicators relevant to UNFPA mandate. However, this geographical focus was not maintained throughout the programme period as additional districts were targeted. National level interventions such as FP, VIAC, population dynamics, coordination policy development maintained their focus.

Effectiveness

(i) The CP achieved most of the output targets in all programme areas. A few targets were not achieved due to funding challenges and change of implementation approaches. The CP also improved strategies, capacities, commodity security, increased demand and access to family planning and maternal and neonatal health services. It also built the country's capacity to provide cervical cancer screening and treatment, increased access to obstetric fistula treatment and integrated SRH/HIV prevention services. However, gains made in these programme areas are likely to be eroded if the high turnover of trained staff is not mitigated.

(ii) The CP interventions contributed to improved adolescents and young people (AYP) access to SRH services. Key interventions included comprehensive sexuality education, parent and child communication, Sista2Sista clubs. Post engagement action planning was however not well defined.

(iii) The CP focused on building capacity and providing services for survivors of SGBV as one way of increasing gender equality and women empowerment. SGBV services were provided through One Stop Centres and Shelters complimented with community awareness on GBV but there was limited focus on SGBV prevention at community level.

(iv) Under population dynamics output, the CP contributed to generation of population data and advancement of ICPD agenda. Focus was more on building capacity for production and increasing access to population data and less on the use of the data for development planning.

(v) A comprehensive and systematic gender analysis was not conducted to inform the CP design. Gender issues such as involvement of men and boys and focus on harmful gender norms and cultural practices were addressed in some programmatic areas and not in others resulting in fragmented gender mainstreaming.

(vi) Human rights-based approach to programming was well integrated into the CP. Districts and targeted populations were selected based on indicators which identified human rights barriers to access to services and also all interventions of the CP addressed the needs of targeted population to access services and exercise their reproductive health rights. On the other hand, integration of disability was not prioritised at CP design stage but interventions to address the needs of persons with disability were introduced later in the programme. However, these interventions were small scale and ad hoc.

Efficiency

(i) UNFPA financial instruments facilitated CP implementation. The modes of funds disbursement tailored to implementing partner risk, nature of activity and donor requirements enabled UNFPA to execute the CP effectively.

(ii) The process for Annual Work Plan development and approval contributed to delay in funds disbursement particularly in the start of the year and leading to the loss of quarter 1 implementation period. This impacted on efficiency of CP implementation.

(iii) The selection of Implementing Partners with technical competencies in their respective programmatic areas contributed to the implementation of the CP.

(iv) Financial policy changes especially change of currency and regulations on access to cash, affected timely implementation of activities.

(v) UNFPA human resources capacity was aligned to the CP requirements at the time of design and capacity needs emerging during implementation were also addressed. However, weaknesses were observed in some areas such as M&E and population dynamics human resources capacity as well as the need to structure staffing in a way that promotes integrated implementation of the CP across the 4 outcome areas.

(vi) Strategic partnerships that had potential to improve CP efficiency and effectiveness such as partnerships with organisations supporting youth economic empowerment and gender and women rights promotion were not well exploited.

Sustainability

(i) The capacities built among implementers and service providers will contribute to provision of quality SRH and GBV services beyond the programme period. However, high staff turnover is likely to erode the benefits of the capacity built among service providers.

(ii) Utilisation of the physical infrastructure capacity set up by CP such as Obstetric Ward in Chinhoyi and VIAC clinics will contribute to sustainability of the CP benefits, although inadequate domestic resource allocation for equipment and maintenance will limit the use of these infrastructure.

(iii) The increased awareness, knowledge, skills and change of attitude or mind-set among beneficiaries will generate demand for SRH, HIV and GBV services beyond the CP period.

(iv) Government leadership in identification of priorities and implementation of interventions supported by the CP promoted ownership of the CP and contributes to sustainability of its benefits.

(v) Other mechanisms of the CP promoting ownership and continued benefits of the programme include use of community cadres recruited from and recognised by communities, engagement of key population organisations and youth networks, advocacy at policy and use of government systems and structures for production of population data.

Role of UNFPA in coordination within the UN

(i) UNFPA role in UN coordination mechanisms is robust and visible. UNFPA is a member and actively participated in all key ZUNDAF coordination structures (UNCT, PMT, Outcome Cluster Groups), other UN coordination groups (OMT, UNCG, M&E TWG), technical coordination mechanisms where UNFPA co-leads the Gender Working Groups, convenes the Social Protection cluster ad interim and leads the GBV sub-cluster.

(ii) UNFPA advanced the UN delivering as "one" strategy through participation in several joint programmes including Spotlight Initiative, Health Development Fund, 2gether4SRH, Joint HIV programme and Tariro youth Centre development, gender equality and access to justice.

Coverage and connected

(i) UNFPA played a major role in bringing to the fore (at policy and programming levels) the sexual and reproductive health needs and protection of women in humanitarian emergency settings. As a result, the Government of Zimbabwe prioritised SRH and GBV as part of the humanitarian response and UN also included these services in its support to government.

(ii) UNFPA response to droughts, Cyclone Idai and COVID 19 contributed to continuity of provision of SRH (particularly maternal health) services and services for SGBV survivors during emergencies.

(iii) UNFPA humanitarian response demonstrated its emergency preparedness capacity which includes utilisation of fast track procurement procedures and financial management systems.

5. Strategic conclusions

Relevance: The CP selected target districts based on an analysis of indicators relevant to UNFPA mandate but this geographical focus was to some extent lost during implementation as districts coverage was expanded partly to align to donor priorities, due to requests from government and in response to humanitarian emergency needs. UNFPA also did not adequately involve youth networks in programming.

Effectiveness: Service providers' capacity was developed to improve quality of services provided but the high staff turnover was a threat to delivery of services common across all programmes. Further, UNFPA is the main source of funding for some programmes such as cervical cancer and obstetric fistula and without UNFPA support the gains made will regress. The mainstreaming of gender and disability

in the CP was also not adequate which is a bottleneck in ensuring populations furthest behind are effectively prioritised.

Efficiency: Adequate capacity of UNFPA Country Office, effective financial instruments procurement and administrative procedures and use of IPs with technical competencies contributed to timely and effective implementation of the CP. However, delays in completion and approval of annual work plans and difficulties in accessing cash affected timely implementation of activities.

Sustainability: The capacity built among implementing partners and beneficiaries is likely to promote sustainability of CP benefits beyond its implementation period while capacity built among beneficiaries will also be utilised to sustain demand for SRH and GBV services over time. The CP also established mechanisms that promoted ownership such as ensuring government leadership in implementation, strengthening coordination structures and engaging key populations and youth networks. However, the high staff turnover and limited government funding will undermine sustainability of the CP results.

UNFPA role in coordination within the UN: UNFPA contributed to the functioning of the UNCT coordination mechanisms through meaningful participation in ZUNDAF coordination structures. There is, however, need to improve information sharing and collaboration with other UN agencies in activity implementation.

Coverage and connectedness: UNFPA CO played a key role in bringing to the fore the need to integrate maternal health and SGBV in emergency response resulting in its recognition as a key player in humanitarian response.

6. Strategic recommendations

Recommendation 1: Align the 8th CP to the UN Sustainable Cooperation Framework (UNSCF) for Zimbabwe by adapting the "cooperation framework" principles, orientation and mechanisms

- Establish a mechanism to strengthen UNFPA partnership with Government in the design, implementation and monitoring of the CP and promote government leadership and ownership of the CP.
- Conduct comprehensive orientation of CO staff on the change from "assistance" to "cooperation" framework and ensure "cooperation" principles and orientation are reflected in the CP.

Recommendation 2: Improve geographical and vulnerable populations focus and beneficiaries' participation in Country Programme to maximise its impact

- Focus CP geographical prioritisation at province level rather than districts. The focus on provinces will consolidate the CP geographical focus, allows the CP to scale up interventions to achieve greater results and makes it easier to measure the CP results.
- Ensure interventions providing a continuum of services – from demand generation to service provision are implemented in the same provinces and districts.
- Review Implementation Partners to bring on board government institutions that could strengthen the effectiveness of the CP such as the Ministry of Youth, Registrar General's Office, University of Zimbabwe Population Studies Department and Faith Based Organisations.
- Establish a mechanism for involving beneficiaries (through youth networks and KP organisations) in the programming. UNFPA could also consider training government partners (MOHCC, MoPSE MPYDIE and MoWACSMED) in participatory programming to enable them appreciate the involvement of beneficiaries.
- Introduce, on a pilot basis, client led monitoring tools to involve adolescents and young people, key populations and other beneficiaries in monitoring selected CP intervention to ensure implementation approaches are responsible to their needs.

Recommendation 3: Improve approaches for strengthening capacity of service providers and health and community systems

- Strengthen integrated SRH, HIV and GBV service delivery through building capacity of HCWs (based on existing guidelines) and strengthening monitoring of integrated service delivery. In addition, support MOHCC to establish SOPs for integrated services delivery and to develop data collection tools that track implementation of the SOPs.
- In collaboration with other development partners, support implementation of the National Community Health Strategy to align the current community level interventions with national priorities and interventions. Within this context, match the scope of integrated SRH/HIV/GBV demand generation that community cadres can undertake with their capabilities.
- Develop a comprehensive approach to integration of gender in the CP through adoption of the gender mainstreaming guidelines of the UN, developing capacity of UNFPA staff and implementing partners, conducting comprehensive gender analysis to inform the design of the CP and integrating gender into the monitoring system.
- Strengthen integration of disability onto the CP through developing comprehensive guidelines for mainstreaming disability into the CP, training UNFPA staff and implementing partners, conducting a disability analysis in the programmatic areas supported by the CP and integrate disability on to the monitoring framework of the CP.
- Support relevant line ministries (such as MOHCC and MoWACSMED) to develop and implement the disability mainstreaming guidelines to assist high level mainstreaming of disability in planning, implementation and monitoring of programmes in general.

Recommendation 4: Improve the CP annual work plan development process, UNFPA staff capacity and exploit strategic partnerships to increase programme efficiency

- Improve timeliness in approval of AWP by starting the planning process earlier and conduct half yearly review of activities to address any weaknesses in the work plan. This will allow UNFPA to accept what could be considered good instead of seeking a perfect work plans before approval.
- Review UNFPA staffing especially for M&E and population dynamics programme area to match staffing levels with expected responsibilities
- Develop strategic partnerships with organisations supporting gender and women rights, and youth economic empowerment to improve effectiveness of SRH and GBV interventions

Recommendation 5: Advocate for domestic resource allocation to health to improve sustainability of the CP results

- In partnership with other development partners, advocate to government to increase domestic resources allocated to health to sustain gains by the CP. This will mitigate staff turnover challenges, sustain provision of critical equipment and improvement of health facilities infrastructure.

Recommendation 6: Improve information sharing and joint implementation of interventions with other UN agencies

- UNFPA CO should take proactive steps to share information and involve other UN agencies in the implementation of interventions to further strengthen synergies with other UN agencies

Recommendation 7: Strengthen capacity of GOZ to integrate SRH and gender into humanitarian response and apply lessons learnt from COVID 19

- Support the GOZ to develop guidelines and SOPs for integration of SRH and SGBV into the emergency response plan. This should be followed with building the capacity of health facilities and GBV service providers in floods and droughts prone areas in implementation of these guidelines and SOPs.

7.1 Integrate lessons learnt from COVID 19 into the CP implementation approaches such as use of virtual platforms for trainings and meetings, use of hotline and mobile SGBV service delivery and integration of infection prevention and control into service providers' capacity development.

Chapter 1: Introduction

1.1 Purpose and objectives of the Country Programme Evaluation

The purpose of the country programme evaluation was to:

(i) Provide UNFPA CO in Zimbabwe, national stakeholders, UNFPA ESARO, UNFPA Headquarters as well as a wider audience with an independent assessment of the performance of UNFPA Zimbabwe 7th CP (2016 – 2020)
(ii) Broaden the evidence base for the design of the next programme cycle

The specific objectives of the evaluation included:

(i) To provide an independent assessment of the relevance, effectiveness, efficiency and sustainability of UNFPA 7th CP
(ii) To assess progress towards expected outputs and outcomes set forth in the results framework of the country programme
(iii) To assess the role played by UNFPA Country Office in the coordination mechanisms of the UNCT with a view to enhancing the United Nations collective contribution to national development results
(iv) To draw key lessons from past and current cooperation and provide a set of clear and forward-looking options leading to strategic and actionable recommendations for the next programme cycle

The primary users of this evaluation include UNFPA Zimbabwe Country Office, Government of Zimbabwe (GoZ), United National Country Team (UNCT), UNFPA East and Southern Africa Regional Office (ESARO) and donors operating in Zimbabwe. The findings and recommendations of this evaluation are also of interest to implementing partners of the 7th CP, UNFPA headquarters, divisions and branches, UNFPA Executive Board, academia and national and international NGOs and beneficiaries of UNFPA support.

1.2 Scope of the evaluation

The geographical, thematic and temporal scope of the CPE was as follows:

Geographical Scope: The evaluation covered 3 provinces (Harare, Matabeleland North and Manicaland) and one district in each of these provinces where UNFPA is implementing interventions. The evaluation also covered interventions supported at national level. The criteria used to select the provinces and districts ensured that all CP interventions were assessed during this evaluation.

Thematic Scope: The evaluation covered all outcome areas of the 7th CP namely: Sexual and Reproductive Health and Rights (which includes Family Planning, Maternal Health, Cervical Cancer Screening and Treatment, HIV Prevention); Adolescent Sexual and Reproductive Health; Gender equality and the empowerment of women and girls; and Population dynamics. In addition, the evaluation covered cross-cutting issues notably gender mainstreaming and human rights based approaches, disability, humanitarian response and transversal aspects of coordination and monitoring and evaluation

Temporal Scope: The evaluation covered interventions planned and/or implemented from 2016 to 2020.

1.3 Methodology and process

1.3.1 Methodology

The Country Programme Evaluation (CPE) followed the standard evaluation criteria drawn from the Organisation for Economic Cooperation and Development (OECD) and was conducted in accordance with the United National Evaluation Group (UNEG) Norms and Standards for Evaluation, Ethical Guidelines for Evaluation, Code of Conduct for Evaluation in the UN System and Guidance on Integrating Human Rights and Gender Equality in Evaluations. The evaluation criteria included relevance, effectiveness, efficiency, sustainability, coordination and coverage and connectedness. The evaluation also assessed cross cutting themes of gender and human rights and disability mainstreaming within the work of UNFPA. The evaluation questions developed by the Evaluation Reference Group (ERG) and the evaluation manager informed the development of the evaluation matrix which was a central guide for the evaluation (Annex 1).

Criteria and evaluation questions

Relevance
EQ1: To what extent is the country programme adapted to: i) the needs of diverse populations, including the needs of marginalized and vulnerable groups; ii) national development strategies and policies; iii) strategic direction and objectives of UNFPA; and iv) priorities articulated in the ICPD Programme of Action and SDGs, v) the New Way of Working and the Grand Bargain.

Effectiveness
EQ2a: To what extent have the interventions supported by UNFPA contributed to the achievement of the expected results (outputs and outcomes) of the country programme? In particular: i) increased access and use of integrated sexual and reproductive health services; ii) empowerment of adolescents and youth to access sexual and reproductive health services and exercise their sexual and reproductive rights; iii) advancement of gender equality and the empowerment of all women and girls; and iv) increased use of population data in the development of evidence-based national development plans, policies and programmes.

EQ2b: To what extent has UNFPA successfully integrated gender and human rights perspectives in the design, implementation and monitoring of the country programme?

Efficiency
EQ3: To what extent did the intervention mechanisms (financing instruments, administrative regulatory framework, staff, timing and procedures) foster or hinder the achievement of the programme outputs?

Sustainability
EQ4: To what extent has UNFPA been able to support implementing partners and beneficiaries (women, adolescents and youth) in developing capacities and establishing mechanisms to ensure ownership and the benefits continue beyond program termination?

Coordination
EQ5: To what extent is the UNFPA CO coordinating with other UN agencies in the country and how is it aligned to the UNDAF?

Coverage and connectedness
EQ6: To what extent has the country office been able to respond to the humanitarian emergencies and changes in national needs and priorities, including those of vulnerable or marginalized communities? What was the quality of the response?

UNFPA CO and the ERG reviewed the evaluation questions set out in the terms of reference (TOR) and reduced them from 9 to the 6 to avoid overlaps across the questions. The Country Office and

ERG also reviewed the evaluation matrix, tools and questions to ensure their relevance and appropriateness in guiding the evaluation and their recommendations were incorporated into the final design report.

Data collection and analysis

The CPE was conducted through a participatory process involving UNFPA staff, implementers and key stakeholders. To ensure in-depth understanding and analysis of the programme and its underpinning theory of change, the evaluation applied two data collection methods and systematically triangulated data from different sources.

Both quantitative and qualitative data was collected. Quantitative data included monitoring data on results achieved against set targets, data from surveys such as DHS, data from evaluation of interventions supported by the CP such as Sista2Sista (s2s), data on coverage of CP interventions particularly s2s, parent child communication (PCC), GBV one stop centres and shelters and behaviour change communication, and data on uptake of services such as cervical cancer screening and treatment, contraceptive use as well as data on maternal and perinatal deaths surveillance. On the other hand, qualitative data was collected from documents and key informant interviews.

Measures were taken to mitigate bias and any data gaps in relation to the evaluation questions. Data on each evaluation question was collected from different source including documents (programme strategic information system, annual reports, evaluation reports among others) and interviews with key informants representing all stakeholders – UNFPA staff as managers of the supported programmes, implementers, strategic partners involved in the programmes, other UN agencies who collaborated with UNFPA in implementation, frontline service providers at district, health facilities and community levels, and donors. The data from these sources was triangulated to ensure no data gaps and also to minimise bias. The data collection methods took into account issues of discrimination and other ethical consideration through interviewing each key informant individually, conducting interviews in local languages for interviewees with low English proficiency and maintaining confidentiality of the data collected.

Data was collected through:

(i) Documents review

Extensive documents review was done to understand the design and context of the 7th CP and identify issues to be addressed through key informant interviews. Documents reviewed included global and national development frameworks, programmatic strategic plans, programmatic documents such as the UNFPA CPAP, annual work plans, program and project reports, monitoring data, financial data and products developed with the CP support. Annex 2 presents the list of documents reviewed.

(ii) Primary data collection

Primary data was collected through key informant interviews. To ensure all dimensions or viewpoints on the performance of the CP were captured, data was collected (a) at national and sub-national levels, (b) from all sectors – government, civil society, academic, other development partners and UN agencies and (c) from service providers. Key informants were selected based on a comprehensive mapping of stakeholders for all output areas of the CP. National level key informants were determined based on the role they played in implementation or funding or collaboration with UNFPA. At sub-national level, key informants were selected at province, district, service delivery points and at community level. Individuals interviewed were selected in close consultation with UNFPA Country Office. A list of people interviewed is presented in annex 3.

The provinces and districts were selected for data collection based on the following criteria.

(i) Urban and rural divide to ensure differences in factors influencing the performance of the CP in urban and rural areas are accounted for in the evaluation
(ii) Languages: the country is divided into northern and southern regions where the Shona and Ndebele languages respectively are dominant. This accounted for cultural influence in the effectiveness of the programme.
(iii) Land use: Land use in Zimbabwe has an influence on availability and access to SRH and maternal health services and vulnerability to GBV and HIV infection. Key features of land use are communal farming, resettlement areas and farm lands.
(iv) Humanitarian emergencies: This criterion accounted for areas that experienced humanitarian emergencies and ensured that the evaluation assessed UNFPA humanitarian response.
(v) Type of interventions implemented in various provinces and districts were also considered to ensure that data was collected on all interventions for all CP outputs.

Based on this criteria, sub-national sites selected were as follows:

Province	District	Explanation
Harare	Harare	Selected as an urban area. Although Harare is a province, it is also being considered as a district in this evaluation and data will be collected from selected sites within Harare. All interventions are also implemented in Harare
Matabeleland North	Bubi	Bubi is a focus district in this country program and has more comprehensive GBV and SGBV services and a number of other activities being implemented in this district including the GBV 365 and the HDF supported activities
Manicaland	Chimanimani and Chipinge	This province and districts have been selected due to the humanitarian emergencies criterion. Other UNFPA supported interventions are also implemented in these districts.

Data was validated through the evaluation team meetings held regularly during the data collection phase to ensure each team member was documenting interviews effectively, exchange interview notes on cross cutting issues and continuously review the relevance of data collected vis a vis the assumptions and indicators in the evaluation matrix. The data and preliminary findings were presented to the UNFPA Country Office (CO) for staff and management for review and advise on data completeness and any issues that were not well addressed. The CO comments especially in the baselines, targets and correct representation of interventions were taken into account prior to the evaluation team commencing in-depth data analysis. The preliminary findings were also presented to the ERG for comments. The draft evaluation report was reviewed by the UNFPA CO and ERG and comments incorporated in the final evaluation report.

(iii) Data analysis

Data analysis was guided by the evaluation matrix. Data from all sources was clustered according to the evaluation questions it answered and analysis was guided by the assumptions for each evaluation question. The analysis was done using comparison and triangulation methods. Data from different documents was compared to identify common themes and the same was done for data from different categories of key informants. Quantitative data was analysed to quantify the results achieved by the CP. Having established the common themes and issues from documents review and key informants, data was triangulated to establish the findings for each evaluation question. This process ensured that the evaluation findings emerged from the evidence. The theory of change for each CP outcome and the assumptions that inform the causal relationship from output to impact level were applied to analyse the evidence that informed the findings of the evaluation.

1.3.2 Limitations encountered during the CPE

The limitations encountered during the CPE and mitigation measures taken to minimise their impact on the evaluation are described below.

Table 1: Limitations and Mitigation Responses

Limitations	Mitigation response
COVID 19 restrictions on travel and meetings impacted on data collection as focus group discussions could not be conducted.	The evaluation team collected data from service providers and community cadres involved in direct implementation of activities, who provided information on their interaction with beneficiaries including how beneficiaries benefited from the CP interventions and challenges they faced and needs not well addressed.
Face to face key informant interviews could not be held due to the risk of COVID 19 infection and associated restrictions	Key informant interviews were held through virtual platforms like Zoom and Microsoft Teams. These platforms worked well and the team was able to interview all available key informants at national, province and district levels Key informants at community and service delivery level were interviewed using the Whatsapp platform. For some of the interviews, the connection was poor and the evaluation team had to switch to telephone interviews.
Movement of staff over the programme period: Some of the staff who implemented the programme had moved to other positions or organisations creating an institutional memory gap.	UNFPA Country Office contacted these staff and arranged interviews with them.

None of the limitations was sufficient to invalidate the evaluation and the evaluation team is confident that a wide, sufficiently representative range of key informants were reached at national, provincial, district and service delivery levels. Most importantly, the validation process for the data collected and the evaluation report itself was robust and provided UNFPA and stakeholders an opportunity to review and provide comments which were taken into account by the evaluation team.

1.3.3 Evaluation process

The evaluation process followed the steps as laid out in the UNFPA CPE Handbook.

Phase 1: Preparation. Led by the CPE evaluation manager with support of Country Office management, this phase involved the development of terms of reference (TOR), set up of the Evaluation Reference Group (ERG), recruitment of consultants and compilation of key documents for this evaluation.

Phase 2: Development of evaluation design report. The evaluation team held an orientation meeting with UNFPA Country Office to understand their expectations on the evaluation and review the TOR, undertook a review of documents to understand the CP context in relation to overall socio-economic and political environment context and the challenges, policies and strategies for SRH, Adolescents Sexual and Reproductive Health, Gender Equality and Women Empowerment and Population Dynamics. Documents reviewed also provided insights into the CP design including the theory of change and the CP outcomes, outputs and interventions. The evaluation team also carried out a stakeholder mapping and stakeholder selection for interviews, selected sub-national sites for data collection, developed an evaluation matrix, finalised evaluation questions and data collection instruments and developed an evaluation work plan. These components were consolidated into an evaluation design report which was reviewed by the UNFPA CO and ERG for. The feedback received from the CO and ERG informed the final design report.

Phase 3: Field work. The evaluation team conducted virtual key informant interviews at national, provincial, district and service delivery points. The evaluation manager played a key role in setting up appointments with individual key informants while the evaluation team organised and carried out the interviews. In-depth documents review was carried out from 21st to 29th September 2020 and interviews were held from 1st to 29th October 2020.

Phase 4: Reporting. The evaluation team undertook data cleaning, collation and initial analysis to identify preliminary findings. These findings were presented to UNFPA CO on 4th November 2020. This was followed by a detailed data analysis and development of the draft evaluation report which was submitted to UNFPA CO on 20th November 2020. The findings and recommendations were also presented to the ERG on 24th November 2020. The evaluation team addressed the final comments from the UNFPA CO and ERG and submitted a final report to UNFPA Country Office.

Phase 5: Dissemination and follow up. The UNFPA Country Office will circulate the final report to stakeholders according to the corporate policy in sharing of evaluation reports.

The evaluation team collaborated throughout the evaluation period. Each team member focused on their thematic area while the lead consultant ensured the evaluation proceeded according to the evaluation guidelines and best practice. The evaluation manager ensured virtual meetings and interviews were well organised and key informants who would not have access to internet were assisted. The evaluation manager also followed up on the implementation of the evaluation work plan to ensure all tasks were completed on time. UNFPA programme specialists, as well as the evaluation manager, assisted with stakeholder mapping and identification of individuals to be interviewed and also provided key documents. The evaluation commenced on 24th August 2020 until 4th November 2020. The table below shows the timelines for key tasks of the evaluation.

Table 2: Timelines for the CPE key tasks and deliverables

Activity/Milestone	24/28 Aug	31/4 Sept	7/11 Sept	14/18 Sept	21/25 Sept	28/1 Oct	5/9 Oct	12/16 Oct	19/23 Oct	26/30 Oct	2/6 Nov	9/13 Nov	16/20 Nov	23/27 Nov	30/4 Dec
Design phase															
Desk review of background documents	X														
Development of design report		X													
Presentation of design report to ERG			X												
Revision of draft design report and approval of final design report			X	X											
Field phase (Data collection)															
In-depth review of documents					X	X									
National level key informant interviews						X	X	X							
Data collection in the selected provinces and districts								X	X	X					
Debriefing meeting with CO staff and ERG										X		X			
Reporting phase															
Data analysis								X	X	X					
Draft evaluation report											X	X	X		
Review of draft evaluation report														X	
Draft and submission of final evaluation report															X

Chapter 2: Country Context

2.1 Development challenges and national strategies

2.1.1 Country context overview

The Republic of Zimbabwe is a landlocked country in Southern Africa region with a total surface area of 390,757 square kilometres. The major tribes are Shona and Ndebele. According to the 2012 census, Zimbabwe has a total population of 13,061,239 people, with an annual average intercensal

growth rate of 1.1%. 48% of the population is male and 52% female while 61% is below the age of 25. About 67% of the population lives in rural areas[7].

Figure 1: Trend in Zimbabwe GDP, 1961 to 2019 (World Bank data)

Zimbabwe's Gross Domestic Product (GDP) was US$17.85 billion and US$ 1,079.61 GDP per capita in 2017[8]. The GDP has been fluctuating over the years starting with consistent increase from 1961 to 1970 after which the country experienced a decline in GDP up to 1979. The country also experienced a downward GDP trend from 1999 to 2008 followed by an upward trend until 2015[9]. From 2015, the economy began another phase of downward trend that saw a decline in GDP due to drought, fall of commodity prices, acute foreign exchange shortages, changing political environment and financial shocks. The UNFPA 7th CP was implemented during this phase of economic downturn.

Zimbabwe's Human Development Index (HDI)[10] was 0.563 in 2018, representing a 25% improvement between 2000 to 2018. This is explained by increased life expectancy to 61.2 years in 2018 up from 44.6 years in 2000 and an increase in expected years of schooling to 10.5 years, up from 9.8 years in 2000. Despite the gains in HDI, poverty has largely remained at the same level since 2001. The poverty headcount ratio was 70.9% in 2001, increased to 72.3% in 2011 followed by a slight reduction to 70.0% in 2017[11]. Poverty levels vary across provinces and districts underscoring the need for poverty reduction strategies targeted at the most vulnerable populations and regions.

The country faced humanitarian emergencies that had a shock on its economic growth in the recent past. Zimbabwe experienced El Nino induced drought in 2016, followed by cholera outbreak in 2017 and later the political, economic and financial crisis that started in 2017 spilling into 2020. In March 2019, Zimbabwe was hit by Cyclone Idai which caused significant loss of lives and left about 270,000 people in urgent need of humanitarian assistance. Currently, the country is experiencing an economic crisis and the COVID 19 pandemic which have hampered the provision of basic social and health services.

The Government of Zimbabwe (GoZ) has in place policies and strategies that address socio-economic development challenges in the country. These includethe Zimbabwe Agenda for Sustainable Socio-Economic Transformation, (ZimASSET), 2013 - 2018[12] followed by the Interim Poverty Reduction Strategy Paper (IPRSP) covering the period 2016-2018[13]. The I-PRSP focused on promoting inclusive growth and poverty reduction through improved policies and interventions, consistent with the ZimASSET Vision of "Towards an Empowered Society and a Growing Economy". Following political changes that took place in 2017, the Government developed the

[7] Zimbabwe Population Census Report, 2012

[8] World Bank Report, 2017

[9] World Bank data available at https://data.worldbank.org/indicator/NY.GDP.MKTP.KD.ZG?end=2019&locations=ZW&start=1961&view=chart

[10] Zimbabwe Human Development Report, UNDP, 2019

[11] World Bank data available at https://data.worldbank.org/country/ZW

[12] Government of Zimbabwe. Zimbabwe Agenda for Sustainable Socio-Economic Transformation (ZimAsset) "Towards an Empowered Society and a Growing Economy" October 2013-December 2018

[13] Ministry of Finance and Economic Development, Zimbabwe Interim Poverty Reduction Strategy Paper 2016-2018, 2016.

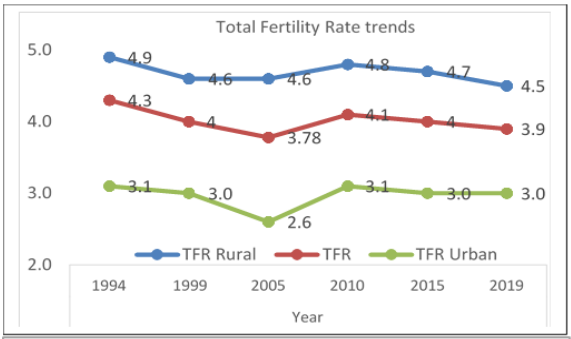
Transitional Stabilization Programme (TSP) 2018-2020[14] whose purpose was to stabilize and create a strong base for economic growth. UNFPA's supports the GOZ to achieve its national priorities as outlined in its development frameworks.

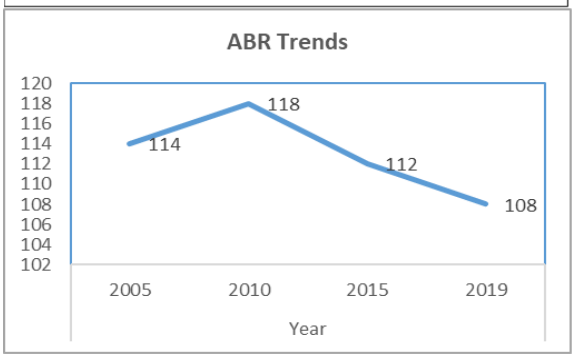
2.1.2 Sexual and Reproductive Health and Rights and HIV and AIDS

The **total fertility rate (TFR)** in Zimbabwe is 4.0 children per woman. TFR in rural areas declined from 4.9 in 1994 to 4.5 in 2019. The Adolescent Birth Rate (ABR) remains high, at 108 live births per 1000 women against a national target of 99 by 2020 and a global average of 44[15]. ABR in rural areas (136) is double that in urban areas (118). Low level of education, rural residence, poverty, sparse population (Matabeleland Central) and religious affiliation influencing health seeking behaviour (Mashonaland Central) are all associated with higher TFR and Adolescent Birth Rates (ABR)[16].

The use of modern methods of family planning (i.e. modern **Contraceptive Prevalence Rate**, mCPR) remained static at 66% from 2017-2019 against a target of 68% by 2020 while unmet need for FP declined from 12% to 8.6% in the same period falling short of the target of 6.5% by 2020. Unmet FP need varies across provinces with Matabeleland South having the highest rate at 13.3%. mCPR is also suboptimal among sexually active adolescents (15-19) at 44.9% and 38.7% respectively[17,18]. Thus, more needs to be done to achieve family planning targets.

Figure 2: Trends in TFR (graph above), ABR rates (graph below) and ABR, TRF and MCPR and unmet FO needs indicators (Table below)





	*ABR 15-19	*TFR 15-49	** mCPR 15-49	Unmet FP need
Total	108	3.9	66%	8.6%
***National Target (2020)	99		68%	6.5%
Urban	62	3.0	70.7%	6.7%
Rural	136	4.5	63.2%	8.7%
Mash. Central	150	4.3	65.2%	6.9%
Mash East	89	4.1	69.1%	6.9%
Mash West	136	4.4	71.0%	5.8%
Mat. North	161	4.2	66.3%	9.8%
Mat. South	138	3.7	59.7%	13.3%
Manicaland	97	4.3	56.7%	8.3%
Masvingo	126	4.3	60.5%	10.3%
Midlands	115	3.9	67.2%	8.5%
Harare	56	3.0	70.4%	6.7%
Bulawayo	57	2.6	70.8%	6.7%
No education	no data	no data	49.3%	18.3%
Primary ed.	175	5.3	60.7%	11.4%
Post Sec ed.	21	2.4	75.4%	3.7%
Poorest	175	5.3	61.8%	12.0%
Richest	39	2.6	72.3%	4.8%

[14] Government of Zimbabwe. Transitional Stabilisation Programme, 2018

[15] Zimbabwe National Statistics Agency (ZIMSTAT) and UNICEF (2019). Zimbabwe Multiple Indicator Cluster Survey 2019, Survey Findings Report. Harare, Zimbabwe: ZIMSTAT and UNICEF.

[16] Zimbabwe National Statistics Agency (ZIMSTAT) and UNICEF (2019). Zimbabwe Multiple Indicator Cluster Survey 2019, Survey Findings Report. Harare, Zimbabwe: ZIMSTAT and UNICEF.

[17] Zimbabwe National Statistics Agency (ZIMSTAT) and UNICEF (2019). Zimbabwe Multiple Indicator Cluster Survey 2019, Survey Findings Report. Harare, Zimbabwe: ZIMSTAT and UNICEF.

[18] Zimbabwe National Statistics Agency and ICF International. 2016. Zimbabwe Demographic and Health Survey 2015: Final Report. Rockville, Maryland, USA: Zimbabwe National Statistics Agency (ZIMSTAT) and ICF International.

Despite a reduction in the **Maternal Mortality Ratio** (MMR) per 100,000 live births from 651 in 2015 to 462 in 2019[19], the country falls short of achieving the 2020 target of 300 per 1000,000 livebirths. The major causes of maternal deaths include haemorrhage (22%), eclampsia (16%) and infections (14%). Among adolescent and young women aged 15-24 years, the major causes of maternal deaths are puerperal sepsis (16%), eclampsia/PIH (16%) and post-partum haemorrhage (14%)[20]. **Neonatal Mortality Rate (NMR)** has also remained stagnant in the last five years (between 29 deaths per 1000 live births in 2014 and 31 deaths per 1000 live births in 2019). The NMR target of 20 deaths per 1000 live births by 2020 is not likely to be achieved[21,22].

The country is implementing a national Sexual and Reproductive Health (SRH) programme through various frameworks such as the National Health Strategy, Maternal and Neonatal Health Strategy (2017-2021), the National Adolescent Sexual and Reproductive Health Strategy 2016-2020 and the Zimbabwe National Family Planning Strategy (2016-2020) to improve maternal health indicators.

Zimbabwe's incidence rate for cervical cancer, estimated at 36.7/100,000 women, is more than double the global average of 15.1/100,000 women [10]. Cervical cancer mortality rate is around 64%[11]. Despite successes in Cervical Cancer screening (80,624 screened in 2019 against a target of 75,000), the linkage to treatment has been poor. The treatment rate for VIAC positive women was 66% in 2019 against a target of 80%[23]. Unavailability of treatment options and a dearth of human resources have hindered linkage to cervical cancer treatment.

Zimbabwe's HIV prevalence of 14.1%, incidence 0.47 are among the highest in Sub-Saharan Africa[24]. However, both HIV prevalence and incidence has been on a downward trend over the past decade. Geographical disparities in prevalence exist across the country's 10 provinces, the highest being in Matabeleland North (19.5%) and South (21.7%). Of the 1.2 million people living with HIV, 60.83% are women. Majority of new HIV infections in Zimbabwe are in urban area. HIV positive individuals have a higher prevalence of active syphilis (2.9%) than those HIV-negative (0.4%)[25]. The country treatment cascade achievement is at 72.9: 86.8: 86.5 against a target of 90:90:90 by 2020 with adolescents trailing the proportion knowing HIV status (50.4%). Adolescents also have the highest rates of treatment failure, morbidity, and mortality compared with children and adults[26]. Zimbabwe developed the National HIV and AIDS Strategic Plan 2021-2025 which shifted the HIV response from a generalised centrally planned response to a geographic and population targeted response with the aim of reaching vulnerable and key populations with appropriate interventions.

2.1.3 Adolescent Sexual and Reproductive Health

About 61.1% of Zimbabwe's population is below 24 years. Adolescents aged 10-19 years constitute 23.8% of the population while young people 20-24 years constitute 9.2%. Adolescents and young people (AYP) face significant challenges to their wellbeing and health including teenage

[19] Ministry of Health and Child Care Zimbabwe (2020). 2019 Annual Family Health Programme Report

[20] Maternal Death Surveillance and Response, 2017 Annual Report

[21] Ministry of Health and Child Care Zimbabwe (2020). Annual Reproductive Health Programme Report 2019

[22] Zimbabwe National Statistics Agency (ZIMSTAT) and UNICEF (2019). Zimbabwe Multiple Indicator Cluster Survey 2019, Survey Findings Report. Harare, Zimbabwe: ZIMSTAT and UNICEF.

[23] Global Cancer Registry, Zimbabwe

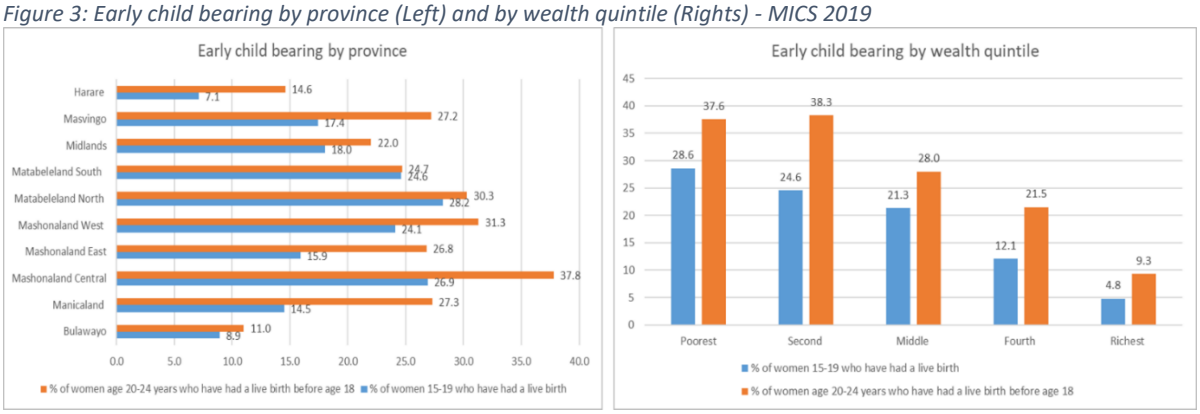
[24] UNAIDS. https://www.unaids.org/en/regionscountries/countries/zimbabwe. Accessed August 2020

[25] Ministry of Health and Child Care Zimbabwe (2019) 'Zimbabwe Population-Based HIV Impact Assessment (ZIMPHIA) 2015-2016'.

[26] Mavhu, W., et al, Effect of a differentiated service delivery model on virological failure in adolescents with HIV in Zimbabwe (Zvandiri): A cluster-randomised controlled trial. 2020;8:2 :e264-e275. DOI:https://doi.org/10.1016/S2214-109X(19)30526-1.

pregnancy, early marriages as well as challenges in accessing education. In urban areas, 2.1% of women are married before age 15 and 21.3% are married before age 18 while in rural areas 6.4% are married before age 15 and 40.0% before age 18, indicating high prevalence of early marriages[27]. Early marriage is linked to early child bearing. The percentage of women aged 15-19 years who have had a live birth is 9.5% in urban areas and 21.7% in rural areas. For women aged 20-24, this percentage increases to 15.7% in urban areas and 30.9% in rural areas. Early child bearing (teenage pregnancy) varies across provinces as shown in the figure below. Teenage pregnancy is also associated with wealth quintile with the rate being highest among the poorest women[28].

Figure 3: Early child bearing by province (Left) and by wealth quintile (Rights) - MICS 2019



Adolescents and young people (AYP) have challenges in accessing education. There are those who attend school over-age as illustrated by the Primary School Gross Enrolment Ratios (PGER) which ranges from 108.2% in Matabeleland South to 118.7% in Masvingo Province. The transition rates from primary to secondary education are also low which indicates that a significant number of AYP drop out of school after primary education. Transition rates range from 41.1% in Matabeleland North to 66.9% in Harare. Thus, interventions targeting youth out of school are critical[29].

Zimbabwe has put in place policies and strategies to ensure AYP realise their reproductive health rights and participate in the economy. These policies and strategies include the National Youth Policy, Zimbabwe School Health Policy, Zimbabwe National AIDS Strategic Plan, National Adolescent SRH Strategy and National Family Planning Strategy.

2.1.4 Gender Equality and Women Empowerment

Gender inequalities continue to persist in Zimbabwe. The country's Gender Development Index (GDI)[30] increased from 0.908 in 1995 to 0.925 in 2018 while the Gender Inequality Index (GII) declined from 0.595 to 0.525 over the same period[31,32]. The co-existence of two parallel systems of law, that is, the Roman Dutch Law and the customary law explains the status of women in the country[33]. The dual legal system in many instances contradict each other. The ZDHS (2015) data

[27] Zimbabwe Multiple Indicator Cluster Survey, 2019, ZIMSTAT

[28] Zimbabwe Multiple Indicator Cluster Survey, 2019, ZIMSTAT

[29] Poverty, income, consumption and expenditure survey report, 2017, ZIMSTAT

[30] GDI is a measure of gender inequalities in achievement of three basic dimensions of human development, namely health, education and command over economic resources

[31] UNDP, *Human Development Report. Inequalities in Human Development in the 21st Century*, 2019, p. 2, available at: http://hdr.undp.org/sites/default/files/2015_human_development_report.pdf, (accessed on 27 August 2020).

[32] GII is calculated based on percentage of parliamentary seats held by women; percentage of adult women who reached at least a secondary level of education compared to their male counterparts; the maternal mortality rate and female participation in the labour market

[33] Tsanga A, 2003;45, Taking law to the People, Weaver Press

shows that 94 per cent of Zimbabweans are Christians while 6 per cent belong to other religions such as Islam and Traditionalism. Of the 94 per cent, 41.3 per cent belong to the Apostolic Sects who are believed to fan negative gender practices through certain biblical interpretations about the position of women in society. These religious sects deny female members access to basic social services such as health care and education.

Gender Based Violence (GBV) is widespread in Zimbabwe. A GBV costing study of 2012 revealed that the country was losing close to 2 billion dollars per year towards GBV related services.[34] An increase in GBV cases has been recorded over the years for the 15-19 and 30-39 age group. 50% of women aged 15-49 years experience emotional, physical and sexual abuse committed by the current or last husband or partner[35]. Women survivors of GBV fear reporting or withdraw GBV cases due to their dependence on men in many facets of their lives and to save the family honour.

Table 3: Table 2: Percentage of Women aged 15-49 who experienced any form of violence from 2005 - 2015[36]

Age	Year		
	2005-2006	2010-2011	2015
15-19	29.4	22.7	27.9
20-24	40.3	34.9	34.8
25-29	38.3	33.3	42.4
30-39	37.4	28.7	36.7
40-49	35.4	30.7	32.7

High levels of GBV have been recorded during the COVID-19 lockdown. The national GBV Hotline recorded a total of 4,047 GBV cases between 30 March and 15 July 2020, an average increase of 70% compared to pre-lockdown trends. 94% of the cases were reported by women, with the most common forms of violence reported being psychological (55%), physical (22%), economic (15%) and sexual violence (8%) and about 90% of the cases were due to intimate partner violence[37]. Despite GBV services being recognised as an essential service within the COVID 19 lock down phase, GBV survivors continue to face challenges including movement restrictions when they do not have passes while trying to access GBV services; reduced public transport availability and closure of some health facilities[38].

The country has in place the National GBV Strategy (2015-2020), National Plan of Action Against Rape, the National Plan to end Child Marriages and the National Gender and HIV Implementation Plan (2017-2020) which guide action against GBV. The GOZ and its partners are implementing programmes aimed at improving awareness of the laws, including integration of GBV issues into the school curriculum, establishing One Stop Centres to allow survivors to access medical, psycho-social, legal and counselling services under one roof as well as establishing Victim Friendly Units across the country.

2.1.5 Population dynamics

Zimbabwe has a total population of 13,061,239.[39] The proportion of male and female population is 48% and 52 % respectively, giving a sex ratio of almost 93[40]. The Zimbabwe 2017 Inter-Censal Demographic Survey (ICDS) indicated the same male and female population disaggregation with a sex ratio of 92 as presented in Figure 10.[41] The population of Zimbabwe is relatively young with 40 percent being below age 15 years and about 6 percent age 65 years and above[42]. The youthful

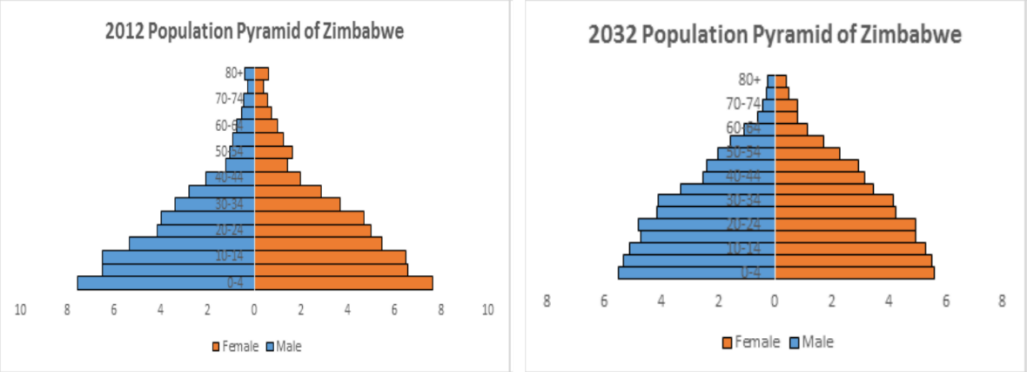
[34] SIDA, Report on GBV Zimbabwe, 2012.
[35] Multiple Indicator Cluster Survey (2019)
[36] ZDHS, 2005/6; 2010/11; 2015.
[37] OCHA, Cluster Status: Protection (Gender Based Violence) August, 2020
[38] OCHA, Cluster Status: Protection (Gender Based Violence) August, 2020
[39] Zimbabwe Population Census 2012 National Report, Zimbabwe National Statistics Agency, 2012
[40] Ibid
[41] Inter-censal Demographic Survey 2017, Zimbabwe National Statistics Agency, 2017.
[42] Ibid

age structure presents a high potential for rapid population growth as well as high dependency burden. Zimbabwe's population has grown by 74% from 1982 to 2012, registering an average annual growth of 3.1%[43].

The productive age group 15-64 years carries a high dependency burden (83 dependents per 100 persons) of young people below age 15 and older persons 60 year and above.[44] The old age dependency ratio is 9 dependents per 100 persons in the age group 15-64 years while the child dependency ratio is 74 dependents per 100 persons in the age group 15-64 years. Life expectancy at birth for both sexes was estimated at 60 years (females 61 and male 58) in 2017.[45] An increase in life expectancy implies an increase in the percentage of older persons, which increases old age dependency ratio.

The population of Zimbabwe is projected to grow to between 19 million and 20 million by 2032[46] and the development of the age-structure of the population is expected to be more bell-shaped than pyramidal. This in in line with the assumption of projected declining fertility and improved longevity.

Figure 4: Projected structure of the population of Zimbabwe by 2032



The increase in Zimbabwe's working age population creates a window of opportunity, which if effectively harnessed, can translate into higher growth and yield a demographic dividend.[47] The demographic dividend window for Zimbabwe opened in 1990 through to 2060. The potential cumulative boost in living standards emanating from the first demographic dividend between 1990 and 2060 is 33 percent (9% already accumulated between 1990 and 2015 while the remaining 24% will accrue between 2015 and 2060), assuming the country follows the Medium fertility variant of the UN population projections.[48] To harness the demographic dividend, Zimbabwe has established vocational training institutions and universities in all the ten provinces to equip young people with skills for the work market. These activities guided by the National Youth Policy 2000[49] and Constitution of Zimbabwe.

The population of Zimbabwe is mostly rural (68%) while the rest live in urban areas.[50] However, rural areas are deprived of socioeconomic services (schools, health facilities, electricity, water and sanitation) that are available in urban areas. Additionally, the land reform programme of early 2000,

[43] Zimbabwe National Statistics Agency (2013). Zimbabwe Population Censuses 1982, 1992, 2002 and 2012.
[44] IDCS 2017 - Age-Dependency Ratio: the ratio of persons in dependent ages (under15 and over 64 years) to economically productive ages (15-64 years).
[45] Inter-censal Demographic Survey 2017, Zimbabwe National Statistics Agency, 2017.
[46] Zimbabwe Demographic Fact Sheet: *Fertility, Mortality, Population Structure and Population Projections*
[47] https://www.afidep.org/key-ingredients-harnessing-demographic-dividend-africa/
[48] Government of Zimbabwe. Harnessing the Demographic Dividend in Zimbabwe, 2017
[49] The National Youth Policy, 2000.
[50] Inter-censal Demographic Survey 2017, Zimbabwe National Statistics Agency, 2017.

people moved from communal areas and resettled them in commercial farming areas where these services are not available. in commercial farming areas where these services are not available.The country has a National Population Policy developed in 1998, which guides the development and implementation of population and development strategies. The country has also been consistently carrying out national population census every ten years since 1982. In between censuses, Inter-Censal and Demographic Surveys are carried out with the most recent undertaken in 2017. Since 1988, Zimbabwe has been carrying out the Demographic and Heath Survey (DHS) every five years. As from 2009, the Multiple Indicator Cluster Surveys (MICS) have been carried out in between the ZDHS, with the most recent survey undertaken in 2019.

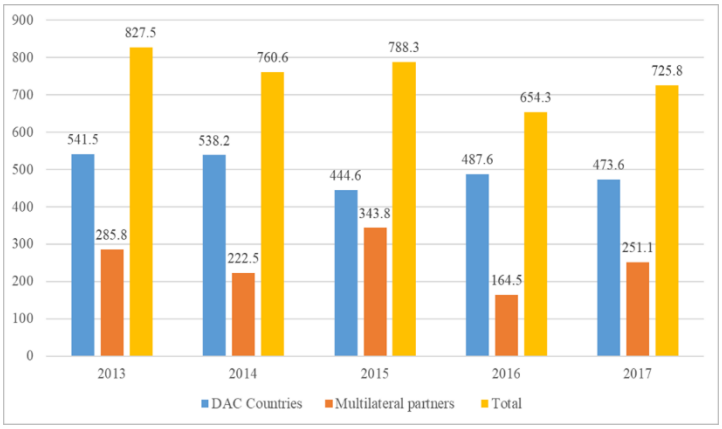
These surveys have improved the availability of reliable, comparable, age and sex-disaggregated data. The data from these surveys has been analysed and used to inform development planning, policy development, programming, and service delivery at national and local levels. However, more still needs to be done to ensure further analysis of data by age, sex, sector, and population subgroups to improve development policies, plans and programmes. There is also a gap in registration of births, which has declined in the last 20 years. According to the 2005-06 ZDHS, 74 percent of children's births were registered, but this dropped to 49 percent in the 2010-11 ZDHS, and 44 percent in the 2015 ZDHS.[51]

2.2 The Role of External Assistance

2.2.1 Overseas Development Assistance

Net Overseas Development Assistance (ODA) for Zimbabwe has been fluctuating since 2013 but points to a downward general trend. Total net ODA was US$ 827.5m in 2013 reducing to US$725.8m in 2017, a change of US$101m[52]. United States, United Kingdom, Sweden and Germany are some of the largest bilateral development partners while European Union, Global Fund to Fight AIDS, TB and Malaria, and UN Agencies are among the largest multilateral partners. Given the declining trend in ODA globally, it is unlikely that ODA to Zimbabwe will increase in the future thus exacerbate the challenges GoZ is facing in financing social services.

Figure 5:Trend in total Net ODA to Zimbabwe 2013-2017 (OECD



The commitment of the ODA received by Zimbabwe varies by sectors. 65% of the ODA is committed to social infrastructure and services. The health sector receives most of the funds (36%) followed by humanitarian emergency (13%). Despite receiving the largest share of ODA commitments, the health system in Zimbabwe faces challenges in providing quality healthcare and the country is far from achieving universal health coverage[53]. The table below shows the annual commitment of ODA to sectors since 2013[54].

Table 4: Bilateral ODA Commitments to Zimbabwe by Sector

Sector	2013	2014	2015	2016	2017	Total	% of total
Social infrastructure and services	**269.6**	**242.4**	**319.4**	**294.5**	**250.3**	**1376.2**	**65%**

[51] Zimbabwe Demographic and Health Survey, ZIMSTATS 2015.
[52] Geographical distribution of financial flows to developing countries, 2019, OECD
[53] National Health Sector Strategic Plan 2016-2020
[54] Geographical distribution of financial flows to developing countries, 2019, OECD

Education	23	14.3	62.2	17.6	13.3	130.4	6%
Health and Population	105.4	115.3	168.6	192.4	187.4	769.1	36%
Water supply and sanitation	39.4	33.4	8	6.6	4.9	92.3	4%
Economic infrastructure and services	**8.1**	**34.3**	**2.4**	**0.9**	**8.9**	54.6	3%
Energy	0.4	20.8			6	27.2	1%
Transport and communications	1	0.2	0.4	0.7	0.7	3	0%
Production sectors	**41.2**	**17.5**	**47.4**	**14.5**	**15.6**	136.2	6%
Agriculture, forestry and fishing	35.7	10.8	42.1	10.3	10.7	109.6	5%
Industry, mining and construction	3.3	4.6	4.5	3	3.9	19.3	1%
Trade and tourism	2.2	2	0.8	1.1	0.9	7	0%
Multisector	**16.9**	**12.9**	**23.9**	**10.6**	**42.4**	106.7	5%
Programme assistance	**25.8**	**27.4**	**22.6**	**48.4**	**8.6**	132.8	6%
Food aid	25.8	27.4	22.6	42.9	8.6	127.3	6%
Humanitarian aid	**81**	**23**	**25.2**	**97.3**	**41**	267.5	13%
Other and unallocated/unspecified	**5.1**	**3.8**	**5.3**	**0.5**	**19.2**	33.9	2%
Total	**447.6**	**361.3**	**446.1**	**466.7**	**385.9**	**2107.6**	**100%**

2.2.2 United National Development Assistance Framework

The UNFPA 7th CP is guided by the Zimbabwe UN Development Assistance Framework (ZUNDAF) 2016-2020 which supports the country to achieve its development objectives set out in ZimASSET (2013-2018) and TSP (2018-2020). ZUNDAF integrates cross-cutting issues (Youth, Information and Communication Technology, Resilience, Disaster Risk Management, Culture for Development and Public Private Partnerships) and UN programming principles of capacity development, environmental sustainability, gender equity, human rights-based approach and result-based management.

UNFPA CP contributes to ZUNDAF outcomes in **priority 6** (vulnerable populations have increased access and utilization of high-quality basic social services and key institutions have improved capacity to provide quality and equitable basic social services); **priority 3** (all adults and children have increased access to effective HIV-prevention services and are empowered to participate in inclusive and equitable social mobilization to address drivers of the epidemic); **priority 2** (key institutions are strengthened to formulate, review, implement and monitor laws and policies to ensure gender quality and women's rights; and **priority 5** (Government and its partners have improved capacity to generate and utilize data for development). Through these outcomes, UNFPA contributes to the collective UN effort to support Zimbabwe to achieve its overarching national development priorities in the areas of social service and poverty reduction, HIV, and public administration.

Chapter 3: UNFPA Strategic Response and Programme

3.1 The previous UNFPA Country Programme

The previous UNFPA 6th CP for Zimbabwe covered the period 2010-2015 and contributed to priorities reflected in the ZUNDAF, the National Medium Development Term Plan and the Millennium Development Goals. The 6th CP outcomes and outputs are outlined below:

Table 5: The 6th Country Programme Outputs and Outcomes

Sexual Reproductive Health and Rights
CP Outcome: Increased utilization of comprehensive gender sensitive and youth friendly Reproductive health services.
Output 1: Strengthened capacity of government and civil society partners to deliver reproductive health services

Output 2: Increased availability of reproductive health services and commodities **Output 3:** Increased demand for sexual and reproductive health services at the community level
HIV Prevention **CP Outcome:** Increased adoption of safer sexual behaviour and use of HIV prevention services **Output 1:** Increased coverage of the social and behaviour change communication programme **Output 2:** Increased availability of HIV prevention services
Gender **CP Outcome:** An improved policy and legal environment for gender equality and increased utilization of gender based violence services **Output 1:** Increased capacity of leaders to address negative social norms and practices that perpetuate gender inequities. **Output 2:** Increased availability of services to address gender-based violence **Output 3:** Increased community awareness of gender-responsive laws, mechanisms and services
Population and development **CP Outcome:** • Increased availability and analysis resulting in evidence based decision making and policy formulation around population dynamics, SRH, and gender equality • Increased availability and utilization of disaggregated data at national and sub national levels **Output 1:** Strengthened capacity of relevant government departments responsible for planning to integrate population issues into development plans and monitor sectoral policies and plans **Output 2:** Strengthened capacity of Zimbabwe statistical agency and line ministries to produce, analyse, disseminated and promote the utilization of population data **Output 3:** Strengthened capacity of ZIMSTAT to coordinate the national statistical system

The key achievements and lessons learnt from the 6th Country Programme are as follows:

Sexual and Reproductive health and Rights: The programme strengthened public health facilities capacity to provide comprehensive obstetric and neonatal healthcare services, build capacity for cervical cancer screening, expanded contraceptive use (especially implants), improved health facility infrastructure, particularly providing maternity waiting homes, established maternal death surveillance and response system, supported implementation of voluntary medical male circumcision and strengthened capacity for delivery of elimination of mother to child transmission of HIV (EMTCT) services as well as behavioural change communication among adolescents and young people 10-24 years as a key strategy for HIV prevention. A key lesson learnt from the 6th CP was the need to scale up SRHR interventions countrywide with priority given to hard-to-reach areas, intensifying integration of SRH, HIV and GBV and reconceptualising programming modalities for adolescents sexual and reproductive health service delivery.

Gender-based violence: The 6th CP raised awareness on gender laws and policies, established one-stop service centres and community shelters to serve survivors of GBV, provided survivors of GBV with legal services and trained community leaders, healthcare workers, police and court officers on GBV management and referral pathways. Despite these achievements, the programme had limited coverage, weak coordination and weak health sector response to GBV.

Population and development: the 6th CP was instrumental in supporting the 2012 population census and 2015 demographic and health survey which are key sources of date for development planning and programming; strengthened capacity in data generation and analysis and supported production of thematic reports based on the 2012 population census.

Four major recommendations emerged from the 6th CP to inform the 7th CP: i) strengthening coordination with other UN agencies to ensure complementarity in programming, ii) integrating SRH, HIV and GBV, iii) establishing a robust programme results framework and (iv) Ensuring geographical concentration of the programme to maximise its benefits. These recommendations are, to a large extent, reflected in the design of the 7th CP.

3.2 The Current Country Programme (7th CP)

Although the 7th CP maintained four outcomes as was the case with the 6th CP, the configuration of the outcomes and outputs changed. HIV prevention which was an outcome in 6th CP is an output under Outcome 1 in the 7th CP but maintained the focus on behaviour change and integrated HIV/SRH/GBV demand creation and service delivery. The CP 7 defined Outcome 2 specifically focused on adolescents and youth sexual and reproductive health with a view to reducing teenage pregnancy. Outcome 3 on gender maintained the focus on provision of services for SGBV survivors but the improvement of policy and legal environment for gender equality, increasing capacity of leaders to address harmful social norms and practices and community awareness of gender responsive laws were not carried through to 7th CP. The 7th CP Outcome 4 on population and development has one output prioritising capacity building for production of population which consolidated the 3 outputs in the 6th CP. Overall the 7th CP has more focused and consolidated output areas.

The table below outlines the 7th CP outputs and how they are linked to the UNFPA Strategic Pan, ZUNDAF and Zimbabwe national priorities.

Table 6: UNFPA Zimbabwe Response through the country programme[55]

National priority: Social service and poverty eradication, HIV, gender equality and governance and public administration **UNDAF Outcomes** 1. Vulnerable populations have increased access and utilization of high-quality basic social services 2. Key institutions have improved capacity to provide quality and equitable basic social services 3. Households living below the food poverty line have improved access and utilization to social protection services 4. All adults and children have increased access to effective HIV-prevention services and are empowered to participate in inclusive and equitable social mobilization to address drivers of the epidemic 5. Key institutions strengthened to formulate, review, implement and monitor laws and policies to ensure gender quality and women's rights 6. Women and girls are empowered to effectively participate in social, economic and political spheres 7. Government and its partners have improved capacity to generate and utilize data for development	
UNFPA strategic plan outcome	**Country programme outputs**
Outcome 1: Sexual and reproductive health - Increased availability and use of integrated sexual and reproductive health services, including family planning, maternal health and HIV, that are gender-responsive and meet human rights standards for quality of care and equity in access	**Output 1:** Increased availability of and access to voluntary family planning, especially long-acting contraceptive methods **Output 2:** Increased national capacity to deliver quality maternal health services, including in humanitarian settings **Output 3:** National cervical cancer screening programme using visual inspection with acetic acid strengthened and scaled up **Output 4:** Increased uptake of HIV-prevention services among women and men, especially young people and key populations
Outcome 2: Adolescents and youth Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education	**Output 5:** Increased national capacity to provide information and services that prevent teenage pregnancy
Outcome 3: Gender equality and women's empowerment - Advanced gender equality, women's and girls' empowerment, and reproductive rights, including for the	**Output 6:** Increased national capacity to prevent gender-based violence and enable the delivery of multi-sectoral services, including in humanitarian settings

[55] The TOR indicate that the results framework was revised to align the 7th CP to the Transitional Stabilisation Programme. The changes are not captured in this table but will be tracked during the evaluation.

most vulnerable and marginalized women, adolescents and youth	
Outcome 4: Population dynamics Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality	**Output 7:** Increased national capacity for the production and the use of disaggregated data on population, sexual and reproductive health and gender-based violence for the formulation and monitoring of evidence-based policies, plans and programmes, including in humanitarian settings

This Country Programme is operationalised through the Country Programme Action Plan (CPAP) which details the interventions under each output, a results framework with output and outcome targets and Annual Work Plans detailing activities expected to achieve the CP outputs. UNFPA CO established partnership with the GOZ, civil society, funding partners and other UN Agencies to implement the CP.

3.3 Financial structure of the 7th country programme

The 7th CP was approved for US$ 98 million, with US14.5 million from regular (core) resources and US83.5 million from other (non-core) resources. The figure below summarises the budget against expenditure from 2016 to mid-2020. During this period, the CP had a budget of US87,078,428 million and expenditure of US$73,201,555 million[56].

Budget spending was over 90% in 2016 and 2017 but there was significant under-spending in 2018 (79%), 2019 (75%) and by mid-2020 the spending level was at 75%.

Figure 6: Total annual budget and expenditure

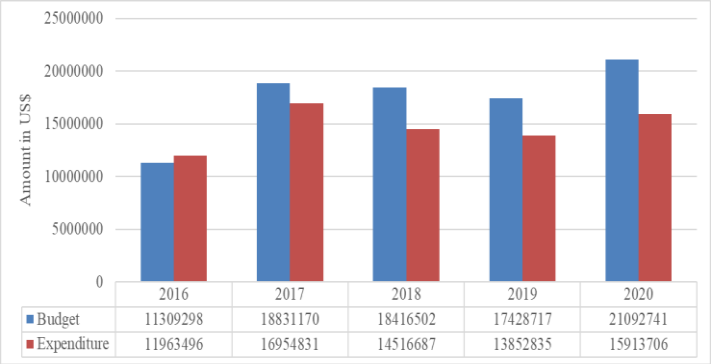
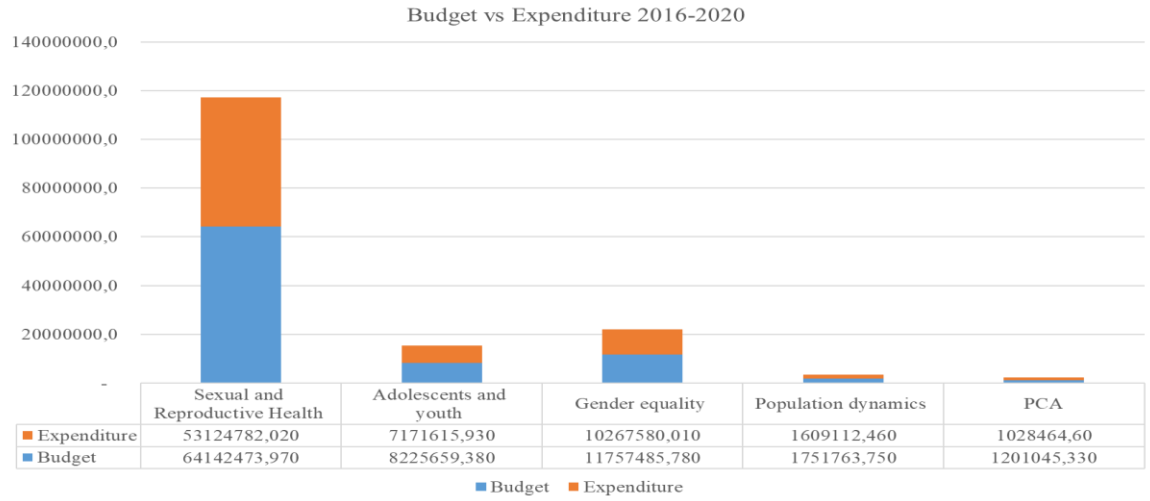


Figure 7: Total budget and expenditure by programme area



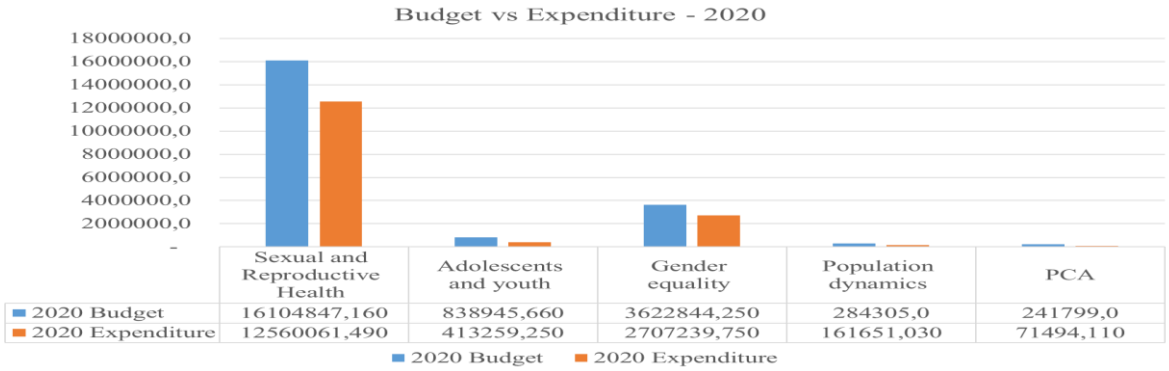
Of the total budget for 2016-2020, 74% was spent on Sexual and Reproductive Health (Outcome 1) followed by 14% on Outcome 3 (Gender Equality and Women Empowerment) and 9% on interventions for Outcome 2 (Adolescents and Youth). The Population Dynamics total budget was

[56] Atlas Projects report

2% of the total budget from 2016 to 2020, the same as the Programme Coordination and Administration budget.

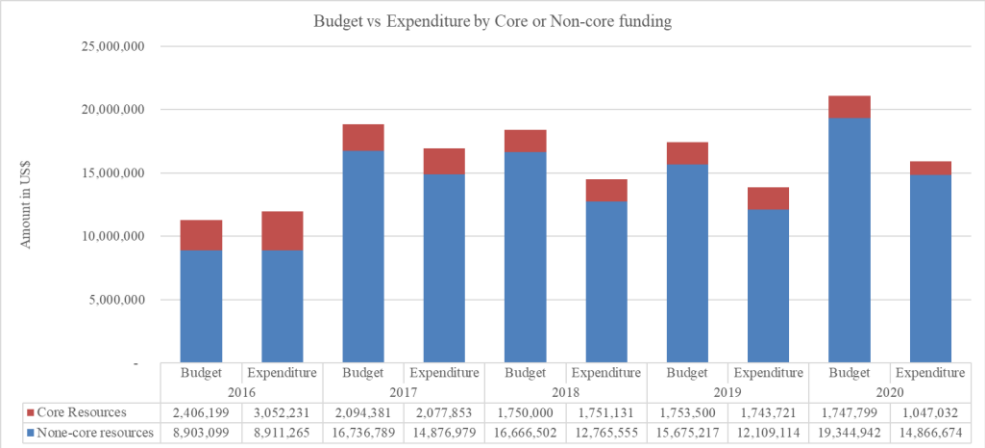
The huge disparity between funds spent on outcome 1 compared to other outcomes is because outcome 1 comprises of 4 outputs and included significant expenditure on commodities, equipment and other medical supplies as shown in the figure below.

Figure 8: Total budget by programmatic area by year



The figure below shows the successful resource mobilisation efforts from other sources. Non-core resources constituted 89% of total the CP budget. Year on year, the non-core resources constituted between 79% and 92% of the total CP resources. This shows the success of UNFPA CP implementation to a large extent depends on its ability for resource mobilisation.

Figure 9: Budget and expenditure by origin of funds (2016 to 2020)



	Budget 2016	Expenditure 2016	Budget 2017	Expenditure 2017	Budget 2018	Expenditure 2018	Budget 2019	Expenditure 2019	Budget 2020	Expenditure 2020
Core Resources	2,406,199	3,052,231	2,094,381	2,077,853	1,750,000	1,751,131	1,753,500	1,743,721	1,747,799	1,047,032
None-core resources	8,903,099	8,911,265	16,736,789	14,876,979	16,666,502	12,765,555	15,675,217	12,109,114	19,344,942	14,866,674

Chapter 4: Findings

4.1 Evaluation question 1: Relevance

EQ1: To what extent is the country programme adapted to: i) the needs of diverse populations, including the needs of marginalized and vulnerable groups; ii) national development strategies and policies; iii) strategic direction and objectives of UNFPA; and iv) priorities articulated in the ICPD Programme of Action and SDGs, v) the New Way of Working and the Grand Bargain

Summary of findings

(i) The CP was fully aligned to key development frameworks including the UNFPA strategic plans for 2014-2017 and 2018-2021, the ICPD PoA, ZimASSET and TSP. The CP was aligned to priorities set out in these plans.

(ii) The CP was fully aligned to and supported interventions that contributed to implementation of national policies and strategies relevant to the four outcome areas. UNFPA supported the development of some of the policies and strategic plans as well as implementation of the same.

(iii) The CP took into account the needs of targeted populations through using evidence generated from assessments, having consultations with implementing partners and lead Government Ministries and other institutions and through quarterly and annual reviews of work plans but direct involvement of beneficiaries in programming was minimal.

(iv) UNFPA made adjustments to ensure relevance was maintained throughout the implementation period. Factors that triggered adjustments include political changes and humanitarian emergencies.

(v) The 7th CP targeted 20 districts selected based on indicators relevant to UNFPA mandate. However, this geographical focus was not maintained throughout the programme period as additional districts were targeted during implementation.

(vi) The CP adopted the new way of working introduced in the 2014-2017 UNFPA strategic plan through aligning the modes of engagement to Zimbabwe's setting as a country with highest need and low ability to finance its programme. It also adopted the "grand bargain" in its response to humanitarian emergencies. The Country Office (CO) built capacity to adjust to the "new" modes of engagement and humanitarian response over time but capacity building requires to be sustained and continuously be improved.

4.1.1 Strategic alignment

4.1.1.1 Alignment of the 7th Country Programme to UNFPA Corporate Strategy

The UNFPA 7th CP for Zimbabwe contributes effectively to the overarching UNFPA goal – "achieving universal access to sexual and reproductive health, realisation of reproductive rights, reduction of maternal mortality to accelerate progress on ICPD agenda". The 7th CP implementation period (2016-2020) transcended two UNFPA strategic plans and the CO made adjustments to ensure consistence of the CP with these plans.

Alignment to UNFPA Strategic Plan 2014-2017: The CP adopted the UNFPA strategic direction or the "bull's eye" as defined in the 2014-2017 strategic plan through focusing on women and adolescent and youth as its main target populations and human rights, gender equality and population dynamics as key enablers facilitating effectiveness of the CP interventions. Further, the CP adopted all the four outcomes of the strategic plan and its outputs and interventions were logically linked to these outcomes[57].

Alignment to UNFPA strategic plan 2018-2021: UNFPA adjusted the CP to align it to the UNFPA strategic plan in 2018 through adopting the outcomes of the new strategic plan but maintaining its outputs and most of the interventions given that these were already relevant to Zimbabwe context and were aligned to contribute to the strategic outcomes. The CP was already designed to reach adolescents and young people and women and men furthest behind and districts with poor SRH, ASRH and gender indicators and, therefore, minimal changes were made on the programme targeting and implementation approaches. The results framework was, however, revised to refine indicators, baselines and targets. Some indicators were dropped while new ones were introduced to improve the measurement of the performance of the programme. These changes are analysed under the "effectiveness" section of this report.

4.1.1.2 Alignment of the 7th CP to SDGs and ICPD POA

Alignment to Sustainable Development Goals (SDGs): The 7th CP is most closely aligned to SDG 3 on health, SDG 5 on gender and SDG 10 on reduced inequalities. Due to the integrated and cross cutting nature of the SDGs, the CP also advanced the SDG 4 on education and SDG 16 on promoting inclusive societies and access to justice. The CP adopted SDG indicators and contributed to the attainment of SDG targets in maternal health, family planning, adolescent fertility, gender equality with a focus on reduction of violence against women.

Alignment and advancing the ICPD POA in Zimbabwe: The CP was fully aligned to and advanced the ICPD POA 1994[58,59] especially in the areas of SRHR, HIV prevention, gender equality and women empowerment and population and development. All interventions supported by the CP contributed to the implementation of the ICDP POA in Zimbabwe. More specifically, outcome 4 and Output 7 of the CP advanced the ICPD PoA in the following areas: (a) Action 3.5 on integration of population issues into the formulation, implementation, monitoring and evaluation of all policies and programmes relating to sustainable development; (b) Action 3.6 on assessing progress towards integrating population in development and environment programmes; (c) Action 3.8: Political commitment to integrated population and development strategies; and (d) Action 3.29c: Utilisation of demographic data to promote sustainable resource management. In addition, the CP supported the country preparation for and participation Nairobi ICPD 25 including advocating for prioritising the strategies in the ICPD POA.

[57] Documents review (UNFPA 7th Country Programme Action Plan, UNFPA Strategic Plan) and Key Informants Interviews

[58] Government of Zimbabwe. Zimbabwe National Population Policy. National Economic Planning Commission 1978

[59] The International Conference on Population and Development Programme of Action 1994, UNFPA.

4.1.1.3 Alignment to national development policies and strategies

Alignment to ZimASSET (2013-2018): The CP contributed to three priority areas set out in ZimASSET: (i) Social services and poverty eradication with a focus on provision of comprehensive health services. (ii) HIV prevention prioritising scale up and strengthening of high impact interventions for HIV and STI management. (iii) Governance and public administration with priority given to improved policy coordination through strengthening policy and research departments including ZIMSTAT. All interventions supported by the CP directly contributed to these priority areas of ZimASSET.

Alignment to Transitional Stabilisation Programme (2018 to 2020): The TSP was developed following the formation of a new government bringing in a new political dispensation in Zimbabwe in 2017. TSP was a short-term plan to achieve quick wins in addressing fundamental economic challenges besetting Zimbabwe's economy. The CP contributed to implementation of priorities articulated in the TSP in order to improve equitable coverage and enhance the quality of health services to address key challenges which included substandard quality of maternal health services; medicines shortages including family planning commodities; and inadequate emergency transport and communication systems which have a bearing on mortality rates.

Maintaining relevance throughout the CP period: UNFPA CO and GOZ took measures to ensure relevance of the programme throughout the implementation period given the dynamic environment in which the CP was implemented. In November 2017, the CP was adjusted to align to the new governance dispensation following the change of government. The 7th CP has also been extended to 2021 to be aligned to the new planning cycle for ZUNDAF and the national development strategic plan 2021-2025[60]. The CP also made adjustments to respond to humanitarian emergencies that took place from 2016 to 2020 (drought, Cyclone Idai and COVID 19). Given these adjustments, the CP remained relevant throughout the programme period.

4.1.1.4 CP adaptation to the New Way of Working and the Grand Bargain

UNFPA Strategic Plan for 2014-2017 introduced a new way of working (called "the mode of engagement by setting") to which the 7th CP was adapted. Zimbabwe is classified under countries with highest need but low ability to finance its programmes and, therefore, the CP deployed all the modes of engagement – Advocacy and Policy Dialogue, Knowledge Management, Capacity Building and Service delivery and supported both upstream and downstream interventions. The UNFPA CO technical capacity and structure were aligned to the four modes of engagement. Staff performance assessment was done throughout the CP implementation period and any capacity gaps addressed through staff training. The CO also taped on the UNFPA regional office (RO) and headquarter (HQ) to complement its capacity. For instance, the RO and HQ brought in technical assistance to support the development of population projections in 2017. Implementing partners recognise the ability of UNFPA staff to provide support at all level – from policy advice to service delivery (key informants).

The CP was also adapted to the "grand bargain" which involves UNFPA collaboration with other UN agencies and partners during humanitarian emergencies. UNFPA strengthened its capacity to address humanitarian emergencies through the recruitment of a humanitarian emergency coordinator and leveraged its resources to address areas of its mandate during emergencies. The CO ensured that the development agenda was not dropped at the expense of humanitarian emergency response through reprogramming the CP to ensure continuity of services and also supported implementing partners to continue implementation by adapting service delivery approaches. For instance, during cyclone Idai, UNFPA supported airlifting of pregnant women to health facilities and transferred others to maternity waiting homes while GBV services were offered

[60] UNFPA CO has developed targets

using mobile one stop services. As UNFPA CO responded to one emergency after another, it gained experience, strengthened its capacity and oriented its systems to carry out humanitarian response (Key informants).

4.1.1.5 CP responsiveness to needs of diverse populations, including the needs of marginalized and vulnerable groups

(i) Geographical coverage of the Country Programme

The 6th CP evaluation recommended that UNFPA CO should geographically concentrate its programme to maximise the impact. This recommendation was implemented through the selection of 20 target districts spread across 6 provinces based on indicators relevant to UNFPA mandate – teenage pregnancy, maternal mortality, infant mortality, HIV infection, gender based violence and school drop-out rate. However, this geographical concentration was not maintained throughout the programme period as additional districts were targeted during implementation due to the need to align the CP with donor priority districts, government requests for UNFPA to prioritise some districts and the need to response to humanitarian emergencies (key informants). In total, 38 districts were covered by at least one programme. Annex 4 lists the districts coverage by CP interventions.

The CP supported interventions reaching vulnerable populations such as adolescents and young people, women and key populations in districts with poor SRH and gender indicators. However, the evaluation found limited involvement of the beneficiaries in the programming process itself. For instance, the CP supported youth networks to undertake advocacy but the same networks were not involved in the programming processes such as design of interventions, implementation and monitoring.

(ii) Sexual and Reproductive Health and Rights

The 7th CP was aligned to and supported implementation of the following strategies:

Family planning programme: The CP supported interventions aligned to the Family Planning Strategic Plan 2016-2020 which prioritised the creation of an enabling environment for provision of family planning services, strengthening of the supply chain system and family planning commodity security, improved availability and access to quality integrated FP and related SRH services, improved demand for integrated FP services and improving monitoring, evaluation and research. The CP supported interventions and targets were also in line with the National Family Planning Costed Implementation Plan 2016-2020. The CP contributed to the country's effort to achieve the FP 2020 targets. The Family Planning needs addressed by the CP were identified through the FP forum which brought together all partners[61] and consultations held during the development of Annual Work Plans. Data from the Vital Medicines Availability and Health Services (VMAS) survey[62] conducted every quarter also informed adjustments made to FP programme in the course of implementation.

Maternal Health: The CP was aligned to and supported implementation of strategies laid out in the National Health Strategic Plan (NHSP) 2016-2020. Specifically, the CP supported strategies for increasing consistent provision of quality ANC services; ensuring availability of delivery kits and strengthening quality of maternity waiting home (MWH) services; and strengthening capacity of HCWs in life saving skills. The findings of the NHSP mid-term review also informed the revision of the maternal and neonatal care targeted. Further, the CP supported implementation of Zimbabwe Maternal and Neonatal Health Strategy (ZMNHS) 2017 to 2021. The CP were aligned to the following strategic areas: (i) Improving policy environment for provision and utilisation of quality

[61] The partners included MOHCC, ZNFPC, PSI, PSZ and UNFPA among others

[62] VMAS survey assesses availability of and uptake of FP services and tracks FP commodity stock-outs

and equitable MNH services; (ii) Strengthening capacity of health systems for planning and management of MCH programme; (iii) Increased availability and utilisation of MNH services with a focus on improving the quality of BEmONC and CEmONC at all levels. The MNH priorities addressed by the CP were identified through the maternal and perinatal deaths audits and the programme coordination and review meetings at all levels (documents review and key informants).

Cervical Cancer Screening and Treatment: Interventions supported by the CP were well in line with the Cervical Cancer Control Strategic plan 2016-2020 (which was developed with funding from UNFPA). The need to scale up cervical cancer screening and treatment was identified based on the analysis of data from the national cancer registry which revealed a high burden of cervical cancer in the country. UNFPA also made adjustments to ensure continued relevance of the cervical cancer programme based on issues emerging from the cervical cancer programme coordination meetings and support supervision missions.

HIV prevention: The CP support for HIV prevention was fully in line with the priorities set out in the National HIV and AIDS Strategic Plan and the Spectrum Modelling and ZDHS data which identified the high HIV burden districts and vulnerable and key populations. The CP contributed to the implementation of the ASRH strategic plan where SRH and HIV needs of adolescents and young people are outlined. In addition, HIV gaps addressed by the CP were identified through co-creation meeting with communities (young people, key populations and community leaders and community members).

The 7th CP took steps to strengthen and consolidate the integrated community HIV/SRH and GBV programme. UNFPA started consolidating community programmes nationally with a mapping of community of cadres in 2017/18 which found that there were more than 75 different community cadres totalling to about 70,000. As a result of the mapping, MOHCC together with its partners (UNFPA, UNICEF, WHO and CHAI) developed the National Community Health strategy (finalised in 2019) accompanied with the community essential health package. This process informed the UNFPA support to community based integrated HIV/SRH/GBV programmes.

(iii) Adolescents and Youth

CP interventions for Output 5 focusing on adolescents and youth were well aligned to various national policies and strategies. These include the National Youth Policy, 2019 [63] which promotes youth participation in socio-economic development and healthy lifestyles and personal wellbeing; the National Health Strategic Plan (2016-2020) [64] which included strategies for strengthening integrated Youth Friendly Services (YFS), inclusion of CSE in school health programme, advocacy for legislation against child marriage, enhancing community awareness of ASRH as well as strategies to reduce pregnancy related risks among women in childbearing age.

The CP supported the development and implementation of the second ASRH strategy (2016-2020) [65] whose prioritised: (i) increased safe SRH and HIV practices among AYP, (ii) increased uptake of quality youth friendly integrated SRH/HIV services and (iii) strengthening protective environment for adolescent and youth. The UNFPA CO, in collaboration with UNICEF, UNESCO and WHO, also supported the development and implementation of the Zimbabwe School Health Policy[66] (2018) which mainstreams health topics into the school curriculum, provides comprehensive school health package and strengthens of inter-ministerial linkages and coordination of all stakeholder.

[63] Ministry of Youth Development, Indigenisation and Empowerment National youth policy

[64] The National Health Strategy for Zimbabwe: 2016-2020

[65] National adolescent and youth sexual and reproductive health (ASRH) strategy II: 2016-2020: stepping up for good sexual and reproductive health outcomes for adolescents and youth in Zimbabwe

[66] Zimbabwe School Health Policy 2018

The CP took into account the recommendations of the following assessments:

(i) *Adolescent Sexual and Reproductive Health Programme evaluation*[67] which recommended (i) Strengthening of the health system to meet family planning needs of adolescent girls, (ii) Prioritising most vulnerable adolescents and youth population including HIV positive adolescents young sex workers, adolescent mothers and adolescents with disabilities, (iii) integration of peer education in other interventions and (iv) representation of MoPSE in SRH Steering Committee.

(ii) *The National Fertility study 2016*[68]*:* Recommendation of the National fertility study adopted by the CP included: (i) strengthening adolescent girls' empowerment through life skills initiatives, (ii) strengthening ASRHR in schools and out of schools, (iii) targeted demand generation to increase uptake of ASRH and (iv) strengthening a multi-sectoral approach to tackle drivers of adolescent pregnancy.

(iii) *Evaluation of the Parent to Child Communication (PCC) pilot project*[69] conducted in Hurungwe district in 2015/2016 found that PCC was an effective strategy in promoting access to SRHR information and generating demand for SRHR services. The evaluation recommended (i) provision of IEC materials appealing to adolescents, (ii) Inclusion of sessions on FP in PCC and (iii) use of community based cadres that are endorsed and trusted by the communities for community buy in and ownership. This evaluation informed the scale up of the programme to 20 districts.

(iv) *6th CP evaluation* informed the selection areas of focus in the 7th CP. The 6th CP recommendations adopted by the 7th CP included: (i) the sensitization and education for community leadership and health providers; (ii) working with youth networks to ensure engagement and participation of the youth in developmental activities; (iii) developing a mechanism to track service uptake resulting from BCF household visits and other demand generation efforts; (iv) expanding peer education in tertiary institutions and (v) supporting comprehensive sexuality education (CSE) in schools.

(v) Gender equality and women empowerment

The CP Output 6 interventions were aligned to the priorities set out in the National Gender Policy. including: setting up of institutions and mechanisms for the effective protection, care and support of GBV survivors and implementing programmes aimed at eradicating all harmful social norms, religious and cultural beliefs, attitudes and practices that legitimise the acceptance of GBV; and capacity building for the Anti Domestic Violence Council (ADVC) to ensure it operates efficiently. However, the CP did not address the need to offer correctional and rehabilitation services to GBV perpetrators.

The CP supported implementation of the National GBV Strategy (2012-2015) in the following areas: Outcome 1: Strengthening an enabling environment for non-tolerance of GBV; Outcome 2: Improved utilisation of comprehensive quality services for the protection, care and support of GBV survivors; and Outcome 4: Strengthening multi-sectoral coordination system and institutional frameworks to address GBV at all levels. The CP was further aligned to the Zero Tolerance for GBV 365 (2016-2020) whose pillars are Prevention, Service Provision, Research and M&E and Coordination.

Output 6 interventions were further informed by the 6th Country Programme Evaluation which recommended that UNFPA uses its comparative advantage to address GBV within SRH

[67] ASRH Strategic plan review 2015 -Johns Hopkins School of Public Health

[68] Ministry of Health and Child Care (2016). Zimbabwe National Adolescent Fertility Study, Harare: Technical Report

[69] SRHR Parent to Child Communications endline evaluation report, Hurungwe districts 2017

programmes; assist GOZ to develop capacity to prevent GBV in emergencies as well as support coordination at different levels to strengthen community capacity and actions against GBV.

To ensure the needs of targeted populations (survivors of SGBV) were taken into account, UNFPA held cconsultations with stakeholders in the gender sector that included the Ministry of Women Affairs, Community, Small and Medium Enterprises Development (MWACSMED) and civil society organisations (CSOs). However, there was no direct involvement of the intended beneficiaries in the identification of the needs and development of the CP to ensure that their voices are considered in the design of interventions.

(vi) Population dynamics

The population dynamics output 7 was well aligned the National Population policy[70] whose ultimate goal is to achieve higher standards of living of the people of Zimbabwe through influencing population variables and development trends in desirable directions. The specific areas of alignment of the CP to the National Population Policy included (i) Increased awareness and use of population and development data in planning, (ii) Achievement of population growth, age and spatial distribution that are more favourable to sustainable socio-economic development, (iii) ensuring that the human factor is central in all development plans at all levels of planning and (iv) Development planning integrated population and gender variables at national, provincial and district levels for all sectors.

The CP supported the implementation of the ZIMSTAT Strategy for the Development of Statistics II, 2016-2020. During the implementation, ZIMSTAT continued to engage users and producers of statistics in different platforms (including the data user/producer symposium) to discuss data for national development plans. The stakeholders engaged were government ministries, local authorities, research institutions, development partners and civil society.

The priorities supported by the CP under Output 7 were also identified through consultations with stakeholders including ZIMSTAT and potential IPs, during the development of the 7th CP. Lastly, throughout the implementation of the CP, Annual Work plans were developed, discussed and reviewed quarterly and annually to assess progress and to include any identified emerging needs.

4.2 Evaluation question 2: Effectiveness

EQ2a: To what extent have the interventions supported by UNFPA contributed to the achievement of the expected results (outputs and outcomes) of the country programme?

Summary of Findings

(i) The CP achieved most of its output targets with some being overachieved. A few targets were not achieved due to funding challenges and change of implementation approaches.

(ii) The CP improved strategies, capacities, commodity security and increased demand for family planning services, increased accessibility to quality maternal and neonatal health services, built the country's capacity to provide cervical cancer screening and treatment, increased access to obstetric fistula treatment and integrated SRH/HIV prevention services. However, gains made in these programme areas are likely to be eroded if the high turnover of trained healthcare workers is not mitigated.

(iii) The CP supported interventions which contributed to improving adolescents and young people (AYP) access to SRH services. Key interventions included comprehensive sexuality education, parent and child communication fostering a supportive environment, Sista2Sista clubs empowering girls to reduce their vulnerability to teenage pregnancy and HIV infection, support for youth advocacy and participation in decision making and provision

[70] Government of Zimbabwe. Zimbabwe National Population Policy. National Economic Planning Commission 1978

of youth friendly health services. The post engagement action planning was however not well defined.

(iv) The CP focused on building capacity and providing services for survivors of SGBV as one way of increasing gender equality and women empowerment. SGBV services were provided through One Stop Centres and Shelters complimented with awareness on GBV at community level. The number of women utilising SGBV services shows a deeper entrenchment of SGBV in the community but there was limited focus on SGBV prevention at community level.

(v) The CP contributed to generation of population and advancement of ICPD agenda. However, the CP focused more on building capacity for production and increasing access to population data and less on the use of the data for development planning.

4.2.1 Sexual and Reproductive Health

Output 1: Increased availability of and access to voluntary family planning, especially long acting contraceptive methods

Original Result Framework developed in 2016					
	Indicator	**Baseline**	**Target (2018)**	**Achievement (2018)**	**% of achievement**
1	Number of intra-uterine contraceptive device insertions among women in program supported sites	658	7,000	25,354	362%
2	Number of implant insertions among women in program supported sites	30,000	51,000	210,888	414%
3	Number of health facilities with at least one health worker trained in IUCD insertions and removals	0	34	368	1656%
4	Number of health facilities with at least one health worker trained in implants insertions and removals	0	165	397	241%
5	Number of service providers trained on insertion and removal of IUCDs	0	110	790	718%
6	Percentage of health facilities with no stock out of long acting contraceptives (Implants) for the past 3 months	98.9	99.0	99.0	100%
	Results Framework Revised in 2018	**Baseline**	**Target (2019)**	**Achievement (2019)**	**% achievement**
7	Percentage of health facilities providing LARC (by method and by level of facility)				
	b) % of hospitals providing IUCD	70	80	75	94%
	d) % of facilities (clinics and hospitals) providing implants	83	83	77	93%
8	Number of IUCD insertions among women aged 16 to 49 years	35,640	14,000	21,137	151%
9	Number of implant insertions among women aged 16 to 49 years	311,425	77,000	135,711	176%
10	Percentage of health facilities eligible to provide family planning services with no stock out of contraceptives in the past 3 months (by method and level of facility)				
	b) Combined pills	89	90	80	80%
	d) Progestogen only pills – Check with Rudo	95	95		
	f) Injectables	95	95	82	86%
	h) IUCD (facilities with trained staff)	93	93	97	104%
	j) Implants (facilities with trained staff)	98	98	71	72%

All family planning output targets up to 2018 were surpassed largely due to the training of healthcare workers, improvement of family planning service delivery, availability of family planning commodities and strong programme coordination. The CP also mobilised more funds than originally planned.

Most of the targets for output indicators revised in 2018 were also achieved although the rate of achievement was much lower. This is attributed to alignment of targets to the level of funding available and application of lessons learnt (Key Informants). Targets for 2019 for facilities reporting no stock outs were not achieved due to certain short term family planning methods being more preferred hence leading to occasional stock outs and funding challenges experienced in 2018 and 2019 (key informants).

Achievement of planned results

Capacity building: The CP supported MOHCC and ZNFPC to train healthcare workers (HCWs) on Long Acting Reversible Contraceptives (LARCs) in order to expand family planning method mix and increase choice for women. ZNFPC established a pool of trainers, trained nurses on IUCDs and Implants and conducted post training supervision leading to certification of HCWs. The trained HCWs had to conduct at least 10 supervised insertions to gain competency and confidence in order to be certified. Although the target of health facilities with at least one HCW trained in LARCs was reached, key informants and programme reports show that the trained HCWs had challenges in attaining certification due to an inadequate of number of clients, weaknesses in supervision and unavailability of ZNFPC assessors at the time HCWs needed to be assessed. Some of the trained HCWs were assisted by non-government implementers such as PSZ and FHI360 to access clients and provide LARCs in order to attain the certification threshold. However, there is high attrition of trained HCWs which accounts for fluctuation in the proportion of health facilities and hospitals offering LARCs.

Piloting of Post-Partum Intra-Uterine Contraceptive Device: The CP also supported the piloting of Post-Partum Intra-Uterine Contraceptive Device (PPIUCD) insertions in 9 facilities but, despite high acceptance rate, this method was not scaled up due the effect of Cyclone Idai on the targeted health facilities and funding limitation. The piloting of PPIUCD demonstrated that this is viable method for expanding FP coverage given that 80% of deliveries are institutional.

Commodity security: UNFPA supported procurement and supply of family planning commodities with support from Health Development Fund. To ensure effective supply of commodities to the last mile, the CP pays for operational costs of the Zimbabwe Assisted Procurement and Supply (ZAPS) system and supports supply management human resources (coordinator and logistics officers). However, the health facilities providing family planning services experience stock outs due to low levels of national stock of contraceptives resulting from inadequate funding. Some facilities also experience under-stocking and over-stocking due to lack of a harmonised family planning method specific demand and supply.

Family planning demand generation: The CP supported demand generation for family planning services, with emphasis on the IUCD and Implants. Information on family planning methods was integrated into the health education provided in health facilities while non-government implementers such as World Vision, ZiCHIRe, FACT, SAYWHAT and ZAPSO included family planning in the information pack for community cadres (Behaviour Change Facilities, S2S Mentors, Village Health Workers). These cadres delivered family planning awareness to create demand and referred clients from the community level to health facilities. However, key informants noted that although the community cadres were sensitised, they have limited knowledge of the LARCs.

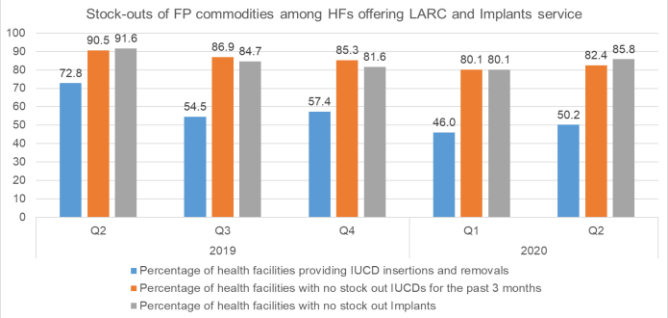
The CP also supported the development and distribution of family planning Information, Education and Communication (IEC) materials such as posters, fliers, pamphlets and braille materials and the dissemination of family planning information through community radio to generate demand. Demand generation activities targeted women of reproductive age including adolescent girls, young women and women living with disabilities. Men and boys were not adequately targeted. Key

Informants observed that demand generation contributed to the increased uptake of contraceptives although this is still skewed towards short-term methods.

Support for family planning programme coordination and planning

With support from the CP, the country developed the Family Planning Strategic Plan 2016-2020, the Costed Implementation Plan, operational guidelines and job aids. With this support, the CP was instrumental in enabling the MOHCC to develop a comprehensive and robust family planning programme. Further, the CP supported MOHCC and ZNFPC to convene coordination meetings at national and provincial levels to review progress of the family planning programme, identify bottlenecks and make adjustments to improve service delivery. The CP also supported the initial stages of restructuring of ZNFPC to clarify its role vis a vis that of MOHCC and align ZNFPC to the institutional roles outlined in the Family Planning strategic plan. However, the restructuring of ZNFPC has not been completed due to leadership changes in government including at MOHCC and at the ZNFPC board.

Figure 10: LARCs and Implants service provision and stock-outs of commodities 2019 to 2020



Interventions supported by the CP contributed to the increase in availability and access to family planning (FP) services. Figure 16 shows the target of over 90% of health facilities reporting no stock outs of FP commodities is yet to be achieved, and just about 50% of the facilities provide IUCD and Implants and this proportion is likely to reduce if the high turnover of trained HCWs is not mitigated. Thus, although there was good progress in scaling up LARCs, there is a gap in attaining universal coverage.

Output 2: Increased national capacity to deliver quality maternal health services, including in humanitarian setting

Original Results Framework (2016)					
	Indicator	**Baseline**	**Target (2018)**	**Achievement (2018)**	**% of achievement**
1	Number of strategies, protocols and guidelines developed for maternal health and midwifery services.	0	3	4	133%
2	Percentage of maternity waiting homes providing information and services as per the revised national guidelines		48		
3	Number of fistula cases repaired in UNFPA supported sites	70	260	518	199%
4	Number of health facilities with at least one health care provider trained on MVA in programme supported districts	9	120	168	140%
5	Number of districts reporting maternal deaths through the electronic maternal death notification system	15	39	130	333%
6	Number of health workers trained to provide Minimum Initial Services Package	0	200	0	0%
	Results Framework Revised in 2018	**Baseline**	**Target (2019)**	**Achievement (2019)**	**% achievement**

7	Percent of PHC facilities providing the 6 selected signal functions of basic emergency obstetric and new-born services	9.53	11	9.56	87%
8	Number of women and girls living with obstetric fistula receiving treatment with support of UNFPA	560	240	109	45%

The CP achieved and, in most cases, surpassed its targets for Output 2. Indicator 1 reflects the support provided in development of maternal health strategic plan, guidelines and protocols to improve service quality. The target for indicator 3 was also over-achieved due to increased awareness on obstetric fistula treatment through media generating more demand than expected, mini-camps conducted in Masvingo and more resources mobilised than planned. The performance against targets for indicator 4 reflects the CP investment in training of healthcare workers. With regard to indicator 5, the electronic system for reporting on maternal deaths was put in place but this is currently not functional due to technical issues and the country's upgrading to DHIS2. Minimum Initial Service Package (MISP) training was carried out in 2019/2020 hence the results are not reflected above. Targets for the indicators introduced in 2018 were not achieved. Health facilities providing all the 6 signals of BEmONC remained at 9% against a target of 11% while 240 women received obstetric fistula treatment against a target of 560 in 2019.

Achievement of planned results

Being the major funder for maternal and neonatal health in Zimbabwe, UNFPA's CP supported the following flagship interventions aimed at building capacity to deliver quality maternal and neonatal health services.

Establishment and implementation of a countrywide mentorship programme: UNFPA supported the conceptualisation of the maternal and neonatal health mentorship programme, development of mentorship guidelines and specialist mentors' visits to province, districts and facility levels. HCWs were trained on BEmONC and CEmONC and post training follow ups and mentorship undertaken. Key informants noted that the mentorship approach was more cost efficient compared to workshop based training. The mentorship programme improved HCWs' knowledge and skills and changed their attitudes. Key informants credited the mentorship programme for improving the quality of BEmONC and CEmONC services. However, mentorship has not been standardised across provinces (although new guidelines tools have been developed to support such standardisation); basic M&E tools to assess the performance of the mentorship programme are lacking and mentors face logistical challenges such as lack of fuel and vehicles, with mentors relying mainly on pool vehicles or use of their personal vehicles.

Midwifery training: The CP provided extensive support for midwifery training in the country in order to improve the quality of maternal and neonatal health services. Midwives in Zimbabwe tended to have better knowledge of theory but lacked practical competency and confidence therefore the CP was instrumental in supporting the transition from 1 year to a 2-year midwifery training curriculum in line with international standards. The second year of the curriculum was introduced to address the competency and confidence gap through attaching trainees to experienced mentors. The programme procured teaching materials including mannequins training models and other teaching aids, developed logbooks to track student performance and supported infection prevention and control in all 22 midwifery training schools. As a result, 412 students were enrolled in the new curriculum in 2019 and 193 enrolled in 2020. Enrolment for 2020 was low due to the impact of COVID 19 pandemic. However, orientation of tutors and mentors was not carried out especially on the year 2 aspects of the curriculum causing confusion in the schools. The CP is supporting MOHCC to embarked on the process of orienting tutors and mentors to remedy this gap. Nurses are also reluctant to enrol for the midwifery course due to its extended training period, lack of recognition of midwifery as a cadre and lack of improved remuneration after training. A review of the midwifery career path and establishment as a cadre in public service has been done but

recommendations are yet to be implemented. There is also no guarantee for health facilities to deploy midwives in the maternity ward. Some are deployed to the general ward hence not well utilized. These challenges limit the effect of improved midwifery training on the quality of maternal health services in the country. Further, to improve the midwifery programme, the CP supported the MOHCC to develop a Midwifery Strategic Plan and review training policies and regulations.

Delivery kits and medicines: The CP provided life-saving delivery kits (including medicines) which were procured and put into the national pool for delivery to facilities. The need for improvement of infrastructure for maternal health services is much higher given that equipment needed to improve quality of maternal care in some facilities are outdated and some are not well maintained (due to lack of a maintenance plan).

Despite the CP investment in capacity building and maternal health kits, the data below on selected EMOC indicators shows the need to scale up capacity strengthening for maternal health service delivery. A comparison of 2017 Q1 and 2020 Q2 data shows a decline in performance of three indicators while performance for two indicators remained at the same level with fluctuations in performance being recorded in between these two periods.

Table 7: Capacity to provide EMOC services at primary and secondary levels

	2017				2018				2019				2020	
EMOC Indicator	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
Proportion of PHCs providing 6 selected signal functions of BEmONC services	39.7	32.1	28.2	19.9	7.6	9.7	11.5	9.5	7.8	6.3	7.4	9.6	9.3	16.3
Proportion of PHCs providing 5 selected signal functions of BEmONC services							91.1	91.3	89.1	89.2	89.2	91.8	92.1	83.0
Proportion of district hospitals with fully functional operating room to perform emergency obstetric surgery	78.3	70.4	84.6	78.3	75	81	83.3	81.6	86.7	85.0	80.0	75.0	98.3	78.3
Proportion of health facilities with fully functioning communication equipment for emergency referral	82.0		78.2	79.1	79.1	64.6	77.4	74.1	75.6	77.0	71.2	72.0	71.3	66.1
Proportion of district hospitals performing C/S on pregnant women who require it	94.4	93.4	91.3	91.7	91.7	89.7	91.7	91.7	90.0	90.0	93.3	85.0	93.3	93.3

Data source: VMAS Survey 2020 Q2 report

Maternity Waiting Homes: Another key aspect of the CP support was the improvement of maternity waiting homes (MWH) which aimed at reducing the "second delay". MWHs target high risk women such as first time mothers, those with history of obstetric challenges and those residing far from health facilities. Health facilities assign nurses to manage these homes as an extension of ANC. The programme provided supplies to MWH such as food packs (in collaboration with WFP). Challenges facing MWHs including the poor quality of care due to shortage of HCWs (nurses and midwives) and congestion in the facilities making it difficult to meet the needs of resident women while the women are often idle waiting for the delivery date. Some women have other conditions such as malnutrition that need to be attended. These challenges notwithstanding, the MWHs contributed to equitable and timely access to obstetric and neonatal care and eventual reduction of maternal and neonatal deaths. The MWHs also played a key role in ensuring maternal health service continuity during emergencies like Cyclone Idai as noted under the humanitarian response section.

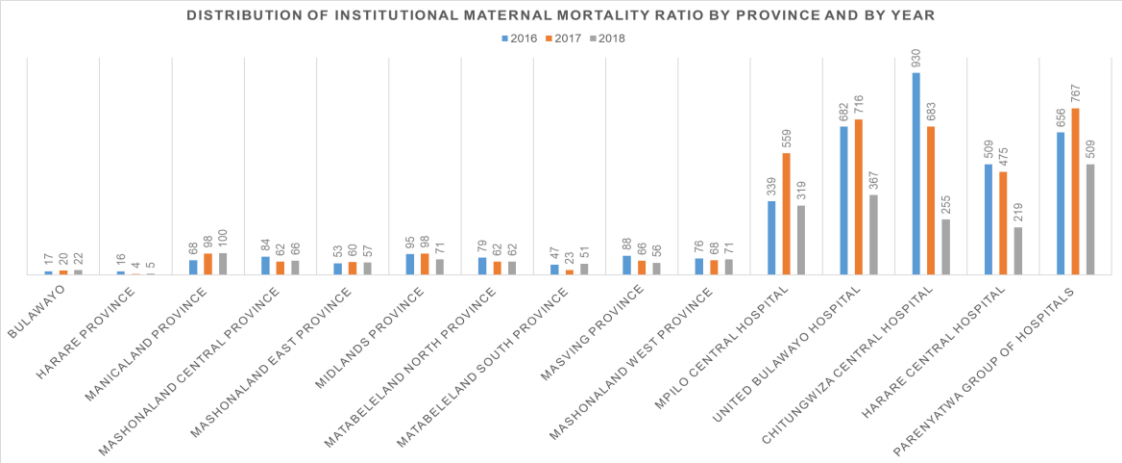
Maternal and Perinatal Deaths Surveillance and Response (MPDSR): The MPDSR system was strengthened through the CP support for the national, provincial and district MPDSR audits. The national and provincial MPDSR committees conducted maternal and perinatal deaths audit meetings quarterly. These audits were also cascaded to district level. Root causes of maternal and perinatal deaths were identified and recommendations made for corrective action. This process was linked to the mentorship programme whereby mentors supported facilities to implement audit recommendations. However, some issues identified by the audits were beyond the capacity of provinces and districts and needed to be addressed at national level. These include structural weaknesses in the health system, lack or outdated equipment such as anaesthetic machines and lack of blood banks, inadequate transport (ambulances) to facilitate timely inter-facility referrals and policy and legislation gaps. Less attention was given to implementation of these systems and policy challenges.

Post-abortion care (PAC) capacity development: The CP supported the training of HCWs in manual vacuum aspirations (MVA) to improve post abortion care and reduce maternal deaths. 281HCWs were trained in Manicaland and Midlands provinces and programme distributed 550 MVA kits to provinces providing this service, although these kits were not adequate. Health facilities where HCWs were trained on MVA reported an increased number of MVA procedures performance. For instance, United Bulawayo Hospital reported 685 MVAs. UNFPA also collaborated with other partners such as UNAIDS and other UN Agencies to advocate for the enactment of Termination of Pregnancy (TOP) Act to make abortions safer. Parliament has accepted to review submissions presented to the parliamentary committee on education, HIV and AIDS and health. Advocacy on the TOP Act is still on-going.

Obstetric Fistula Treatment: The CP is credited for pioneering the provision of Obstetric Fistula (OF) treatment in the country and UNFPA remains the main funding source for this service. An OF ward was established in Chinhoyi hospitals to provide treatment and serve as a training centre. The CP also supported training of doctors and nurses on OF, established a toll free line for women and health facilities to report cases and schedule treatment. The programme conducted demand generation through integrating OF in the community cadre information pack, raising awareness through radio and conducting outreaches. Given the wide dissemination of information on OF, clients are drawn from all provinces in the country. The programme supports all costs associated with OF treatment including transport and medical costs but it does not meet costs of other illnesses or conditions the women may be suffering from. By 2019, 627 women had successful gone through obstetric fistula repair surgery. In 2020, the scheduling of OF patients for treatment was stopped between March and June due to the COVID 19 pandemic but services have resumed with observance of COVID 19 infection prevention measures.

The support provided by the CP and other partners in capacity development to Maternal and Neonatal Health services has contributed to a reduction maternal mortality ratio from 182/100,000 births in 2013 to 102 in 2018. There is also a general decline of institutional maternal deaths from 2016 to 2018 but the number of deaths remain high in central hospitals as shown in the figure below.

Figure 11: Distribution of institutional maternal mortality ratio by province and by year (NHSP Mid-Term Review)



Output 3: Increased national capacity to provide quality cervical cancer screening and treatment services for precancerous lesions

	Original Results Framework developed in 2016				
	Indicator	**Baseline**	**Target (2018)**	**Achievement (2018)**	**% achievement**
1	Number of health facilities supported providing LEEP	7	24	23	96%
2	Number of public health facilities (tertiary and secondary) providing cervical cancer screening services using VIAC	83	298	298	100%
3	Percentage of visual inspection with acetic acid positive women with lesions eligible for cryotherapy treated	56%	66%	57%	86%
4	Number of women screened for cervical cancer in supported public and private facilities	164,013	297,000	461,658	155%
	Results Framework Revised in 2018	**Baseline**	**Target (2019)**	**Achievement (2019)**	**% achievement**
5	Number of women screened for cervical cancer	484,739	100,000	80,824	81%
6	Percent of public health facilities (hospitals) supported to provide VIAC services	58%	58%	58%	100%
7	Percent of VIAC positive women with lesions eligible for cryotherapy treated	60%	65%	80%	123%

The CP achieved most of its targets for building capacity to deliver cervical cancer screening and treatment. The achievement of indicators 1 and 2 reflect the CP support for increasing the number facilities providing cervical cancer screening and treatment services up to 2018. In 2019, the programme stopped supporting the setup of new VIAC clinics in order to focus in improving the quality of services in existing clinics. Hence, indicator 6 reflects this change by having the baseline being the same as the target.

The number of women screened for cervical cancer (indicators 4 and 5) in the public and private facilities between 2016 and 2019 surpassed the target demonstrating the investment of the CP in capacity building, particularly training of nurses and doctors and provision of required equipment, strengthening coordination and supportive supervision. However, indicator 3 shows that not all VIAC positive women eligible for cryotherapy are treated. This leakage in the screening to treatment cascade is due to social cultural barriers (e.g. women need to consult their spouses before having the treatment), extended power cuts in VIAC facilities, staff movements, equipment downtime and lack of treatment for women screened during outreaches due to inability to transport the cryotherapy equipment.

Achievement of planned results

The CP is the major source of funding for cervical cancer screening and treatment in Zimbabwe starting from 2010 when UNFPA supported a study tour to Zambia, set up pilot VIAC clinics in United Bulawayo Hospital (UBH) and Masvingo provincial hospital, and scaled up services from 2012 to 2015 to 105 facilities contributing to an increase in cervical cancer screening from less than 1% in 2010 to 13% in 2015. The 7th CP built on these successes to further expand coverage and improve the quality of cervical cancer screening and treatment services. The percentage of VIAC positive women treated with cryotherapy and LEEP varies across provinces as shown in the table below. On the other hand, 34% of VIAC positive women were not offered treatment.

Table 8:Cervical Cancer Screening and treatment 2017 to 2018

Province	**2017**			**2018**		
	Clients screened	**No. VIAC Positive**	**% treated with Cryo/ LEEP**	**Clients screened**	**No. VIAC Positive**	**% treated with Cryo/ LEEP**
Bulawayo	8594	659	45.7	5849	430	56
Harare	15105	1063	62.1	13714	661	56
Manicaland	7972	401	46.9	9094	382	62
Mashonaland Central	6045	301	42.9	8556	348	53
Mashonaland East	10625	878	62.3	11401	654	60
Mashonakand West	11363	358	54.7	14441	463	68
Masvingo	11331	748	75.4	22042	973	89
Matabeleland North	1931	89	27.0	3327	150	55
Matabeleland South	4295	361	34.6	5998	288	63
Midlands	8925	688	29.5	13075	603	66
National	**86186**	**5546**	**53.0**	**107497**	**4952**	**66**
Data source: National Health Strategic Plan 2016-2020 Mid-term Review						

Interventions supported by the CP to achieve the cervical cancer screening and treatment results include:

Training of healthcare workers: The CP supported the training of nurses and doctors on the use of VIAC technology in cervical cancer screening and cryotherapy and LEEP for treatment. Nurses were trained on cryotherapy while doctors were trained on LEEP. As noted by key informants, this was a major contribution to the scale up of cervical cancer screening and treatment to the extent that other partners rely on this staff, with some of the staff moving from public service to join NGOs providing cervical cancer screening and treatment. The CP also supported the establishment of the Centre of Excellence at United Bulawayo Hospital (UBH), to provide training and mentorship on cervical cancer screening and treatment[71]. This is a viewed as an effective strategy for rolling out cervical cancer screening and treatment programme (key informants). There is a high staff turnover among those trained to provide cervical cancer screening and treatment affecting service delivery and requiring the programme to investing in continuous staff training.

Support for VIAC clinics: The CP contributed to the increase of the number of VIAC clinics in the country through procurement of VIAC, cryotherapy and LEEP equipment and other supplies to support the implementation of the "screen and treat" strategy. Some health facilities were refurbished to create space for cervical cancer screening and treatment. Patients referred for LEEP are provided with coupons to pay for laboratory tests. Despite this progress, VIAC clinics experience service interruptions due to equipment breakdowns, some equipment is old and require replacement while MOHCC does not have a maintenance plan and lacks funding for maintenance. The provision of the VIAC services, especially the screening outreaches, were also impacted by COVID 19 pandemic in 2020.

[71] UBH was one of the two hospitals where cervical cancer screening and treatment was first set up in the country in 2010 and has been instrumental in providing lessons informing the roll out of these services.

Increasing awareness and demand generation for cervical cancer treatment: The CP supported the integration of cervical cancer information in the health education offered at health facilities and in the information package offered to communities and households by community cadres. Demand generation activities contributed to an increase in the number of women screened for cancer during programme period.

Strengthening coordination: The CP also strengthened coordination and enabling environment of the cervical cancer programme. Interventions supported included the development of the cervical cancer control strategic plan for 2016 to 2020, national guidelines and protocols and coordination meetings. The coordination meetings were convened by MOHCSS and brought together all partners involved in this programme to review progress, identify challenges and also make necessary adjustments.

Output 4: Increased uptake of HIV prevention services among women and men, especially young people and key populations

	Original results framework (2016)				
	Indicator	**Baseline**	**Target (2018)**	**Achieved (2018)**	**% of achievement**
1	Number of person exposures among sex workers to SRH and HIV prevention messages in supported sites	106,248	40,000	56.846	142%
2	Number of health facilities implementing national guidelines on integrated delivery of sexual reproductive health and HIV services	0	20	560	2800%
3	Percentage of households reached by innovative and integrated social behavioural change communication and demand generation strategies in supported districts	33%	54%	57%	105%
4	Number of innovative approaches to reduce HIV infections and pregnancies among young women developed, piloted, implemented and evaluated				
5	Number of service providers trained in syndromic management of STI	1,656	2,426	0	0%
6	Percentage of antenatal care attendees positive for syphilis who received treatment	82%	91%	82%	90%
7	Number of public sector health facilities in sex work hot spots with at least two health care providers trained in key population friendly HIV and SRHR service provision.	1	22	48	218%
	Results framework revised 2018	**Baseline**	**Target (2019)**	**Achieved (2019)**	**% of achievement**
8	Percent of facilities in supported districts trained to implement SRH and HIV integration guidelines	48%	90%	102%	

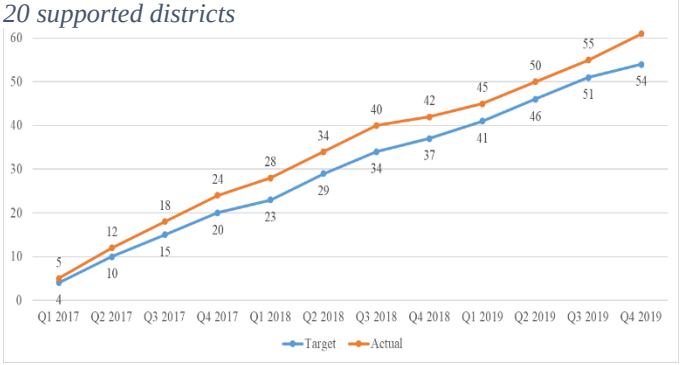
Most of the targets for Output 4 of the CP were achieved. Under indicator 1, the data on the achieved result is for cumulative for 2016 and 2017. From 2018, the Global Fund took over the support of the sex work programme leaving UNFPA covering 6 hotspots. Hence the tracking of this indicator ended in 2018. The data in indicator 2 on health facilities offering HIV and SRH integration services is not conclusive because the indicator definition changed in the course of CP implementation from health facilities with at least one HCW trained on the guidelines to facilities with guidelines. Originally the CP targeted 20 districts but these changed to include those supported by 2gether4 SRH project and further adjustments were made to include districts in other provinces. Due to this changes, the indicator was revised in 2018 from number to percentage of facilities implementing SRH and HIV integration guidelines. Indicator selection and definition needs to be consistent and an indicator should be maintained over the CP period to provide consistent performance measurement.

Indicator 3 target on households reached by behaviour change communication (BCC) and demand generation was achieved through the home visit approach adopted by BCFs. Indicator 4 was not tracked. For indicator 5, no result was achieved because of lack of funding for training and change

of the approach from classroom based training to mentorship. Indicator 6 shows that not all ANC attending testing positive for syphilis received treatment due to persistent stock out of syphilis treatment (benzathine penicillin injections) as a result of the global shortage of the drug and lack of funding to support additional procurement when the drug became available in the market. The overachievement of the target for indicator 7 is attributed to the shift to capacity building of health facilities in sex work hotspot and increased service provision by NGO implementers.

Achievement of planned results

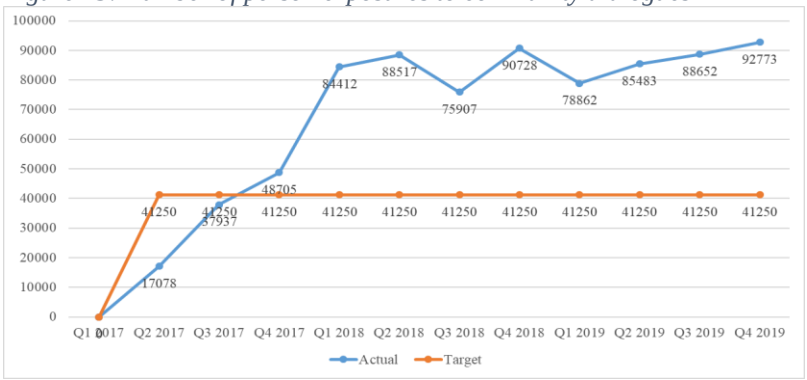
Figure 12: % of households reached by SBCC interventions in 20 supported districts



Behaviour Change Communication: Interventions that contributed to the output results of the CP include behaviour change communication and demand generation carried out by Behaviour Change Facilities (BCFs). The BCFs conducted home visits where they conducted risk assessments and tailored messages to risks identified. They also referred those who required services to health facilities using referral slips that could be redeemed at the facility. BCFs were trained to deliver HIV, SRH and GBV messages and to identify GBV survivors. In addition, specially trained BCFs also held sessions for out-of-school youth to deliver Comprehensive Sexuality Education (CSE). These sessions targeted both boys and girls and were delivered using a defined CSE curriculum. The figure below shows that the proportion of households reached for BCC were consistently surpassed from 2017 to 2019, but the link between demand generation and access to services remains a challenge. There is weak systematic monitoring of the integrated demand creation and a referral system that links individuals to services.

Community dialogue: The BCFs also played a key role in training community leaders on SRH, HIV and GBV issues. The trained leaders mobilised and held dialogue meetings with community members (men and women) on the same issues. The community engagement meetings identified locally relevant HIV, SRH and GBV issues and developed a community charter outlining actions to be taken. Targets for person exposures to community dialogue were surpassed showing the CP's success in mobilising communities but the programme lacked a clear mechanism for ensuring implementation and monitoring of the community charters resulting for community dialogue.

Figure 13: Number of person exposures to community dialogues



STI Management: The CP provided technical assistance to MOHCC to develop the condoms and STI component of the health sector HIV/STI Strategic Plan and supported the development of STI guidelines. Within the EMTCT programme, the CP supported the EMTCT of syphilis and HIV through procurement of medicines for STI, syphilis/HIV dual test kits and training of service providers on STI management based on the revised guidelines. A mentorship package for nurses was developed followed by sensitisation of district mentors. In order to improve

STI surveillance and data management, the programme supported STI data quality audits. Despite this support, not all ANC attendees testing positive for syphilis were treated due to stock outs of drugs for treatment of STIs especially syphilis at global shortage and inadequate funding.

HIV prevention among key populations with focus on Men who have sex with men (MSM): Under the Global Fund HIV grant for Zimbabwe, UNFPA was funded to implement an HIV programme for Men Who Have Sex with Men (MSM). The programme supported the set-up of Drop in Centres (DICEs) in four hotspots (Harare, Bulawayo, Marange and Mutare) providing integrated HIV/SRH/GBV services. KP peers were recruited to provide counselling, psychosocial support and referral services within the DICEs and through outreach. Suitable health facilities in the hotspot areas were also identified in consultation with KP organisations and MOHCC and their HCWs were trained to provide KP friendly services. During the COVID 19 pandemic, the DICEs were supported with Personal Protective Equipment (PPEs) to continue providing HIV services to clients.

Further, the programme addressed stigma and discrimination and reduction of violence against MSM through organising meetings for parents and family members of MSM to develop a supportive environment at family and community levels. These meetings created acceptance of MSM within the family setting (key informants). As part of high level advocacy for KP HIV services, parliamentarians were taken on a familiarisation tour to the DICEs to have first-hand experience of the challenges facing MSM in accessing healthcare. UNFPA played a key role in advocating for acceptance and adoption of the KP HIV programme in the country through engaging with high level policy makers (Key Informants). However, MSM programming is still a sensitive issue and there are occasional arrests and harassment of MSM. This programme will be scaled with funding from Global Fund for the period 2021 to 2023.

HIV Prevention: Condomize Campaign: Another key component of the HIV prevention initiative is the "Condomize Campaign" implemented to increase uptake of condoms and other HIV prevention and SRH services. The Condomize campaign is part of the national strategy for increasing uptake and use of condoms linked with other HIV and SRH services. During the campaign community members (adult men, women and young people) were exposed to information on HIV prevention, GBV and other SRH services and were provided with access to condoms and HTS.

HIV Prevention: Young Women Who Sell Sex (YWSS): The CP supported CeSHHAR to implement a project targeting Young Women Who Sell Sex. These are young women who could not be reached through child protection interventions and have weak family support system. The project sensitised the YWSS on HIV, SRH and GBV; provided them with education subsidy to enable the return to school while others were provided vocational and financial literacy training and supported to form savings groups to start income generating project. The YWSS were linked to HIV, SRH and GBV services provided in the clinics run by CeSHHAR. This project started in 2019 Q4 and in 2020 implementation was interrupted by COVID 19. Measurable results have not been realised given this short period of implementation.

Advocacy for integrated SRH and HIV services through joint programming

UNFPA, in collaboration with UNAIDS, UNICEF and WHO since 2018, supported MOHCC to strengthen integration of SRH, HIV and GBV. A baseline for integration of these services was undertaken and targets set aligned to national strategic documents. UNFPA also contributed to the development of a situation room for SRH and HIV which visualises the results of the two programmes across the country. Further, through joint programming, UNFPA supported the conceptualisation and development of the national standardised package for AGYW and a package for boys and men.

UNFPA supported the development of the HIV funding request to the Global Fund with a focus on prevention of HIV & STI, key populations, AGYW and eMTCT for the 2017-2020 grant and the new grant starting in 2021. UNFPA ensured that key populations were included in the stakeholder consultations for both grants.

UNFPA, through collaborated with UNAIDS and other agencies, supported the development of the First Lady of Zimbabwe's strategic framework for HIV and SRH, supported the First Lady's office to implement "Free to Shine Campaign" on PMTCT and developed the website for the First Lady's Foundation "Angel of Hope" which focuses on HIV and GBV. These initiatives contributed to HIV prevention especially among adolescents and young women and vertical transmission of HIV.

Further, UNFPA in collaboration with UNAIDS, successfully advocated to parliament to take up the process for amending legislation regarding "age of consent" to enhance access SRH services. Petitions were prepared by stakeholders and presented to the Speaker of Parliament and the Chairperson of the Parliamentary Committee on Health and this committee is currently engaging MOHCC to repeal the relevant legislation. UNFPA's joint programming approach was critical in leveraging resources and expertise of other UN agencies to achieve CP results in SRH and HIV prevention. This approach also enabled UNFPA to engage in high level advocacy which it would otherwise not have successfully done on its own.

4.2.2 Adolescents and Youth

Output 5: Increased national capacity to provide information and services that prevent teenage pregnancy

	Output indicators,	**Baseline**	**Target (2018)**	**Achieved (2018)**	**% of achievement**
1	Number of secondary schools with teachers training in evidence-based life-skills, sexuality and HIV and AIDS education in UNFPA supported provinces	48	200	224	**112%**
2	Number of new AYP (16-24 years) accessing contraceptives at programme supported facilities and outreach	92,278	334,000	684, 641	**205%**
3	Number of person exposures among young girls to Sista2Sista club sessions	461,414	1,943,113	2, 305,435	**119%**
4	Number of health facilities supported providing youth friendly services that meet established national standards	63	354	354	**100%**
5	Number of parent person exposure to parent child communication	0	185, 738	250, 656	**135%**
6	Number of participatory platforms that advocate for increased investment in marginalised adolescents and youth within development and health policy and programmes	7	12	12	**100%**
	Revised RF				
	Output indicators,	**Baseline**	**Target (2019)**	**Achieved 2019**	**% of achievement**
7	% of health facilities in 20 districts providing youth friendly services that meet established national standards	85	95	92.5%	97%
8	% of secondary schools with teachers trained in evidence-based life skills, sexuality, and HIV and AIDS in 20 supported districts	92	96	104	108%
9	Availability of institutional mechanism for the participation of young people in policy dialogue and programming, including in peace building processes	Yes	Yes	Yes	100%

The CP achieved and/or surpassed its targets for all the 9 output indicators as indicated in above. This outstanding performance is to a large extent attributed to more resources mobilised from various donors, the selection of implementers with capacity and technical competency on the adolescents and youth empowerment and community engagement and approaches used to mobilise and sensitise adolescents and young people.

The achievement of planned results

The CP supported the following interventions to achieve the output results outlined above:

Youth Friendly Health Services

As recommended in the 6th CP evaluation, the 7th CP moved away from supporting youth friendly corners to integrated youth friendly health facilities. The national coverage of health facilities offering youth friendly services that meet national standards remains very low at 22%. This was different in the 20 UNFPA supported districts where by mid-2020, 92.5% of the 354 facilities had been supported to provide YFS showing that the CP is on track to achieve the 95% set target. This performance is attributed to the strategies supported by the CP starting with development and adaption of the YFS standard to the Zimbabwean context by MOHCC. This exercise provided clarity on what YFS provision meant for Zimbabwe and developed clear certification guidelines. The CP supported a baseline assessment of YFS provision in all the 364 health facilities in the 20 supported districts which identified facility specific gaps and informed development of action plans. Both clinical and non-clinical staff in these facilities were trained through On the Job Training (OJT) on the nine YFS standards. The trained staff were given training materials and mandated to cascade the training to other clinic and non-clinical staff to ensure that ASRH was fully integrated in the standard of care. UNFPA supported the printing of teaching and learning materials on provision of YFS that was distributed in the health facilities for reference purposes. A total of 327 health facilities out of the 358 were certified as meeting the YFSP standards by the end of 2019[72]. Additionally, UNFPA supported ZNFPC to develop IEC materials tailored on YFS that were distributed in the health facilities. Facilities were also assisted to establish YFS committees to identify and address barriers that young people face in accessing services.

As a follow up to the development of the YFS guidelines, healthcare workers were trained to conduct internal compliance assessments. The purpose was to ensure that facilities continued to self-assess their performance against the 9 standards in order to identify areas that need improvement. Although facilities were trained on conducting self-assessments, there was no implementation plan indicating when and how often these assessments were to be conducted and whether checks and balances were in place to ensure the assessments were conducted. A mechanism involving adolescents and youth in the assessments was also not put in place.

To ensure continuity and consistency, the CP supported the incorporation of YFS in regular monitoring system of the districts and the provinces. In the 6th CP YFS were monitored as a special programme by the national head office but in the 7th CP this was incorporated in the regular monitoring visits by the provincial medical directorate.

The CP supported the integration of YFS in pre service training of 17 PCN, 22 RGN and one (1) midwifery training institutions. Training modules, teaching guides and student handouts were developed, printed and distributed in the training institutions. A total of 3 principal nursing tutors per nursing school were trained from 25 state registered nursing schools, 17 primary care nursing schools and 22 midwifery schools. Training of tutors and supportive supervision and monitoring of teaching is still on going. This approach will ensure graduating nurses are skilled in the provision of YFS.

[72] UNFPA 2019 Annual report

Challenges facing the provision of YFS include high staff turnover of ASRH trained nurses and newly recruited nurses requiring training to effect the provision of YFS in some health facilities. Secondly, although the YFS curriculum has been fully integrated in pre-service training, a number of gaps have been highlighted which include: (i) insufficient time allocation for some of the more difficult modules covering topics such as problematic deliveries (ii) less detailed content which does not adequately inform the tutors and (iii) abrupt transition to the two- years internship without adequately preparing tutors and students for the transition. Nursing training institution felt that they were left out in the curriculum development and would have provided valuable input in the structure, depth and scope of content and time allocation for each module which would have improved the quality of the curriculum.

Community engagement

The CP supported direct community engagement and transformation on SRH and HIV through 4 complementary interventions: Sista2Sista programmes, the Behaviour Change home visits (discussed under SRH), Comprehensive Sexuality Education (CSE) groups and PCC. The complimentary interventions sought to develop psycho social competences such as communication, negotiation, problem solving, decision making and increasing agency and self-esteem for young people in and out of school. Four implementing partners: FACT, World Vision, ZAPSO, and ZiCHIRe were supported to implement the 4 interventions in 20 districts. Chipinge and Chimanimani are the only UNFPA supported districts that are not implementing a full package as they don't not have the PCC and the CSE. The geographical coverage of the 4 implementing partners is shown in the map below. NAC, though the Global Fund support, is implementing these interventions in 30 non UNFPA supported districts.

Sista2Sista clubs

UNFPA and its partners developed the Sista2Sista intervention which was launched in Zimbabwe in 2013 under the 6th CP. Sista2Sista is girls-only clubs creating safe spaces for supporting and mentoring vulnerable AGYW to enable them to make informed choices regarding their sexuality. The Clubs are organized by age, grouping girls aged 10-14 years, 15-19 years, and 20-24 years and are led by female mentors. A total of 130 mentors run the Sista2Sista peer groups in 20 districts supported by the CP. There are other initiatives under the National AIDS Council also running Sista2Sista clubs in other districts. Vulnerable AGYW are selected for the program using a door-to-door approach. A risk assessment tool is administered to help identify eligible girls[73]. The girls meet weekly and undergo a 40 sessions curriculum. Those completing at least 30 of the 40 sessions are considered graduates of the programme.

The CP supported capacity building of Sista2Sista mentors and clubs with refreshments and production of materials such as handouts, manuals and videos. By the end of 2019, 36,789 girls had been tested for HIV and 88,083 girls had used a family planning method. Table 12 below shows the Sista2Sista programmme evaluation results. Between 2013-2019 a total of 91,612 AGYW were recruited in the Sista2Sista programme. Of these 58,471 (64%) AGYW completed ≥ 30 group exercises.

Table 9:Sista2Sista programme effects on participants' health and wellbeing, by level of programme exposure

Outcome indicators	**Threshold of program completion**		
	Participants who completed at least 30 exercises (75% competition)	Participants who completed at least 35 exercises (88% competition)	Participants who completed at least 40 exercises (100% competition)

[73] Effectiveness of the Sista2Sista program on improving HIV and other sexual and reproductive health outcomes among vulnerable adolescent girls and young women in Zimbabwe- manuscript near publication

Received an HIV test	2.78*** (2.52-3.10)	3.10*** (2.83-3.30)	2.41*** (2.20-2.65)
Got married (girls all ages)	0.63*** (0.55-0.73)	0.75** (0.65-0.87)	0.67* (0.51-0.88)
Got married as a child (below age 18 years)	0.64** (0.51-0.80)	0.58*** (0.45-0.75)	0.41** (0.22-0.66)
Dropped out of school	0.60*** (0.53-0.69)	0.61*** (0.52-0.70)	0.64* (0.49-0.83)
Went back to school	1.04 (0.91- 1.18)	1.33*** (1.18- 1.51)	1.41** (1.18-1.69)
Reported use of a family planning method	0.95 (0.87-1.04)	1.06 (0.97-1.15)	1.38*** (1.21-1.56)
Became pregnant (girls of all ages	1.05 (0.88-1.24)	1.16 (0.98-1.37)	0.78 (0.57-1.05)
Became pregnant as a teenager (girls aged 10-19 years)	0.88 (0.68-1.13)	1.08 (0.84-1.40)	0.38* (0.24-0.72)
Reported being sexually abused	0.92 (0.67-1.25)	1.1 (0.81-1.49)	1.76* (1.17-2.66)

The results showed that compared to those with ≤ 30 exercises, s2s graduates were more likely to take an HIV test, less likely to get married and less likely to drop out of school. Graduates who completed 40 exercises were more likely to report use of FP, more likely to report cases of abuse and less likely to become pregnant as an adolescent.

Key informants observed that the Sista2Sista programme has been instrumental in empowering young girls with diverse skills including SRH/GBV prevention and response, life skills such as budgeting and promotion for completion of secondary school education; and graduates of sista2Sista clubs impacted or shared the knowledge gained with other girls in their communities[74]. The maps below highlight the Sista2Sista reach against the set targets over from 2016-2020. The recruitment into the clubs met set targets since the rollout in 2017. Although recruitment into clubs went on as planned before the emergency of the COVID 19, exposure to group exercises was severely affected by the lockdown and travel restrictions. The detailed data on number of girls recruited against target in each province covered by the CP in the table below shows effective implementation of this intervention.

Table 10: Number of girls targeted vs those reached for Sista2Sista clubs

Adolescents recruited into S2S session

	2016			2017			2018			2019			2020		
Province	Target	Reach	Reach(%)	Target	Reach	Reach(%)	Target	Reach	Reach(%)	Target	Reach	Reach(%)	Target	Reach	Reach(%)
Mash West	1,500	1,862	124%	3,000	3,552	118%	4,000	4,456	111%	4,000	3,720	93%	4,000	3,904	98%
Mash Central	3,950	1,386	35%	3,950	4,204	106%	3,950	3,728	94%	3,950	4,093	104%	3,950	3,950	100%
Mat North				950	2,102	221%	950	1,092	115%	1,000	1,048	105%	1,000	1,056	106%
Mat South	1,250	1,064	85%	2,160	4,903	227%	2,160	2,125	98%	2,285	2,796	122%	2,400	2,161	90%
Mash East & Harare				3,375	3,628	107%	3,375	3,739	111%	3,750	3,728	99%			
Manicaland													2,000	1,950	98%

HIV test kits stock outs in some facilities hindered the uptake of HIV testing in the Sista2Sista intervention. Due to the limited stocks, health facilities conducted targeted testing which disadvantaged adolescents as they were not selected as a high priority group[75]. Stock outs of referral forms also hindered uptake as well as tracking of service uptake. Stock outs were mainly reported in Chipinge and Chimanimani districts. Sista2Sista club members, who are not HIV positive, also lacked access to free cervical cancer screening demonstrating the need for the cervical cancer

[74] In-depth interviews with Sista2Sista mentors in selected districts

[75] In-depth interviews implementing partners in selected districts

programme to collaborate with the Sista2Sista intervention. The lack of economic empowerment components was also highlighted as the major limitation in empowering the graduates of the s2s programme.

Parents Child Communication (PCC)

Zimbabwe pioneered the PCC in Hurungwe district in Mashonaland West Province to provide a platform for open communication between parents and adolescents on SRHR issues. The PCC intervention was conceived to address the gap identified in the 2015 Hurungwe teenage fertility study[76] and the 2016 national fertility study[77]. The two studies found that parents were uncomfortable to discuss ASRH issues with their adolescents and lacked information on what to say or feared providing wrong information. The PCC was therefore designed to enhance parents and adolescents' skills to initiate and maintain SRHR discussions. Parents/guardians and their adolescent children are recruited through door to door approach and met in groups facilitated by mentors. The PCC curriculum has 11 modules delivered over 2 months with the 3rd month being for support and mentoring visits to households[78].

The 7th CP supported the development of the PCC curriculum, teaching materials, handouts and the implementation plan. The Community based mentors were trained to deliver the PCC curriculum. The CP supported the pilot phase and the scale up of this project in 20 districts. 250,656 Parents were recruited in the PCC in 2019 against a target of 185,738 (135% achievement). Table below shows over achievement in almost all PCC indicators.

Table 11: Achievements against PCC targets by 2019

PCC indicators	Target	Achievement	% achievement
Number of adolescents recruited into PCC clubs	29,040	28,127	96%
Number of adolescents who completed at least 4 PCC sessions	23,232	25,037	107%
Number of adolescent person exposure to PCC	92,928	100,148	107%
Number of parents recruited into PCC sessions	21,780	20,194	93%
Number of parents who complete at least 4 PCC sessions	17,424	19,511	112%
Number of parents person exposure to PCC	19,696	18,087	104%
Number of households reached with PCC sessions	15,700	18,108	115%
Number of households with at least one SRH conversation within 2 weeks after training	6,968	9605	137%
Data source: Health Development Fund report, 2020			

The maps below show the PCC reach against the set targets in the UNFPA supported districts.

[76] Mutanana, Ngonidzashe & Mutara, Godfrey. (2015). Factors Contributing to Teenage Pregnancies in a Rural Community of Zimbabwe. Journal of Biology, Agriculture and Healthcare. 5.

[77] Ministry of Health and Child Care (2016). Zimbabwe National Adolescent Fertility Study, Harare: MoHCC Technical Report authored by Dr. Naomi N. Wekwete, Prof. Simbarashe Rusakaniko and Mr. George Zimbizi.

[78] Parent Child Communication Mentors Manual final 2017

Table 12: Recruitment of parents into PCC sessions

Parents recruited into PCC session

	2017			2017			2018			2019			2020		
Province	Target	Reach	Reach(%)	Target	Reach	Reach(%)	Target	Reach	Reach(%)	Target	Reach	Reach(%)	Target	Reach	Reach(%)
Mash West				4,140	2,438	59%	6,212	6,444	104%	6,212	7,064	114%	6,212	2,077	33%
Mash Central	1,200	2,701	225%	5,400	3,087	57%	7,200	5,058	70%	4,500	5,153	115%	4,500	1,358	30%
Mat North				1,860	1,729	93%	2,480	1,817	73%	2,180	2,135	98%	2,180	508	23%
Mat South				2,520	1,876	74%	2,970	2,450	82%	2,522	2,402	95%	1,196	396	33%
Mash East & Harare				2,250	1,522	68%	3,000	2,395	80%	2,256	2,231	99%			

Table 13: Recruitment of children into PCC sessions

Adolescents recruited into PCC session

	2017			2017			2018			2019			2020		
Province	Target	Reach	Reach(%)	Target	Reach	Reach(%)	Target	Reach	Reach(%)	Target	Reach	Reach(%)	Target	Reach	Reach(%)
Mash West				4,416	2,261	51%	8,280	8,095	98%	8,280	9,355	113%	8,280	3,072	37%
Mash Central	1,600	3,622	226%	5,760	3,972	69%	7,680	6,296	82%	6,000	6,224	104%	6,000	1,664	28%
Mat North				1,860	1,673	90%	2,480	1,730	70%	2,400	1,889	79%	2,400	416	17%
Mat South				2,688	3,067	114%	3,584	3,815	106%	3,360	3,331	99%	1,890	812	43%
Mash East & Harare				2,400	2,570	107%	3,200	3,620	113%	3,000	3,424	114%			

The achievement of set recruitment targets, high retention and completion rates of the parents and children on PCC curriculum demonstrates its relevancy and usefulness in raising SRHR knowledge. According to key informants, PCC is a very important intervention which facilitated communication between children and parents/guardians on reproductive health issues.

The 2018 presidential elections and political disruptions between in 2018 and 2019 affected recruitment of both adolescents and parents into PCC clubs. The implementation approach was adjusted to accommodate recruited groups who got disrupted. COVID19 affected the recruitment of adolescents in 2020. Cultural and religious belief hinder the participation of parents and children in the PCC programme in some communities [79].

Comprehensive Sexuality Education for out of school youth

CSE is a community-based intervention targeting out of school youths regardless of gender. The CSE programme aimed at increasing knowledge and utilisation of integrated HIV prevention, SRHR and SGBV services among adolescents and youths[80]. The intervention provides adolescents and youth with correct information, helping them to develop the skills to adopt safe sexual behaviours. Adolescents and youth are recruited through door to door approach by a trained community-based mentor. The module has 11 units delivered over 31 weeks for adolescents and youth organized by age, grouping girls ages 10-14 years, 15-24 years. These group meetings provide an environment for open dialogue and communication on issues affecting youth; the growing numbers of teenage pregnancies, school dropouts, drug abuse, social, SRH problems, SGBV, STIs and HIV.

The CSE was piloted in three districts: Mbire, Bulilima and Harare in 2018 and then was rolled out to the remaining 18 districts in 2019. The 7th CP supported the development and adaptation of the curriculum to suit the local context. CSE mentors were trained and supported to deliver the CSE curriculum. IEC materials (Posters, pamphlets, T-shirts and hats) were printed and distributed to support implementation of CSE. Output 5 currently does not have an indicator that tracks exposure

[79] In-depth interviews with PCC mentors in selected districts

[80] Comprehensive Sexuality Education for out of school young people in Zimbabwe, community facilitators manual

to CSE, however, by end of 2019, 61,000 young people had been exposed to the CSE. The table below shows the recruitment reach against targets in the UNFPA supported districts.

Table 14: Young people recruited into CSE out of school sessions by province

Young people recruited into CSE OS clubs

	2018			2019			2020		
Province	**Target**	**Reach**	**Reach(%)**	**Target**	**Reach**	**Reach(%)**	**Target**	**Reach**	**Reach(%)**
Mash West				2,500	2,274	91%	2,500	1,304	52%
Mash Central	500	492	98%	2,500	2,405	96%	2,500	2,286	91%
Mat North				1,000	917	92%	1,000	927	93%
Mat South	500	500	100%	1,500	1,426	95%	1,500	1,257	84%
Mash East & Harare	1,500	1,666	111%	2,500	2,017	81%			

Comprehensive Sexuality Education for in school youth

UNFPA, in partnership with UNESCO and UNICEF, pooled technical and financial resources and supported the Ministry of Primary and Secondary Education (MoPSE) to deliver age-appropriate CSE in schools. The CSE in schools focuses on facilitating acquisition of age appropriate knowledge of one's sexuality and health[81]. The 7th CP supported capacity building in leadership, participation and teaching of CSE; teacher trainings on Guidance and Counselling (G&C) and on the Life-skills Orientation Programme (LOP); developed learning and teaching materials and mentorship and supervision of G&C delivery in schools. There were plans to conduct teacher training through a regional online CSE platform developed by the UNFPA regional office but this did not materialise due to logistical bottlenecks which included lack of IT skills, equipment and the high costs of data bundles[82].

By the end of 2019, teachers from 224 secondary schools against a target of 200 were trained in evidence-based life-skills, sexuality and HIV and AIDS education in the 20 UNFPA supported districts. This indicator was revised to track the percentage of schools with trained teachers. Interviews with key informants highlighted that strong advocacy and joint planning, monitoring and evaluation contributed to the over achievement of this output. Monitoring the utilisation of the CSE knowledge gained by learners has been a challenge.

Integrated SRH/HIV/GBV interventions in tertiary institutions

In addressing the limited access to SRH/GBV information and services at tertiary institutions, UNFPA in partnership with SAYWHAT, implemented a programme targeting young people in tertiary institutions which included peer education, establishment of resource centres and conducting condomize campaigns. The condomize campaign is designed as a social mobilization platform for discussions and education for communities on condoms and SRHR, including HIV and STIs.

The CP supported the Forum of Colleges Authorities to serve as an accountability framework for improving the availability and access SRH/HIV/GBV information and services in tertiary institutions. 17 tertiary institutions participated in the forum in 2019 compared to 8 in 2018. In 2019, 90% of college authorities fulfilled the agreed commitments on increasing students' access to youth friendly sexual and reproductive health (SRH) services in health facilities located in institutions of higher learning through the Forum of College Authorities' on Students' Sexual and Reproductive Health (FOCASS).

The 7th CP supported the training of peer educators and training of health service providers in 14 tertiary institutions to provide comprehensive package of family planning specifically for LARC,

[81] Joint Programme for Adolescent and Youth Development in Zimbabwe (2016 – 2020)-March 2016

[82] In-depth interviews service providers

and training of tertiary institution focal persons. In 2019, SAYWHAT trained 400 peer educators while 20 peer educators were trained in 2020[83]. Tertiary institution peer educators were recruited with the universities and trained to conduct activities which included recruitment of young people into peer groups, hostel dialogues, condomize campaign, condom distribution, organising for outreach services in the institutions and registration of students on Tune Me platform. In order to promote visibility of the peer education programme within institutions, peer educators often organise events such as fun colour runs, sporting events, shows with popular personalities and they also have a snooker table mainly to attract male students. In 2019, the peer educators reached a total of 8,010 students (males 3,815, females 4,195) while in 2020 they reached a total of 1205 students (845 males and 360 females).

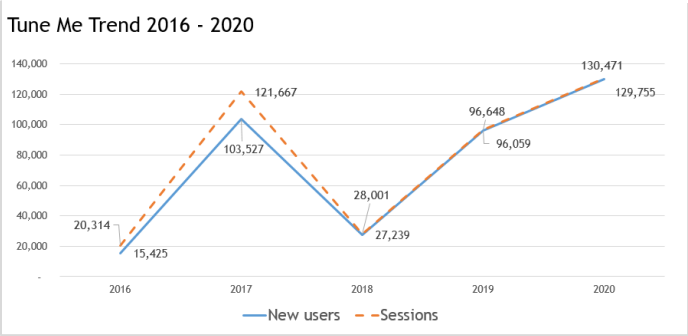
In the face of COVID 19 pandemic, UNFPA and SAYWHAT ensured limited interruption in access to SRHR information among students through establishing a virtual platform, a call centre and the Smart Choice App which is designed as a one stop shop for information on SRH, referral pathways and infographics targeting young people. One example was the successful hosting of the virtual condomize campaign which had a viewership of 31000 young people nationwide.

Challenges affecting the tertiary institutions HIV/SRH/GBV intervention include the condoms stock outs[84], constrained uptake of services from resource centres among girls due to stigma as these centres are located in boys' hostels, lack of referral for services not found in tertiary institutions and lack of funds for transport to health facilities outside of the institutions.

Use of Media – Tune Me platform

The UNFPA CO, in partnership with the regional office (ESARO), supported the adaptation and development of the content and implementation strategy for the Tune Me mobisite targeting AYP aged 15-24 years. A total of 183,303 students (97,894 females and 85,410 males) were registered on Tune Me in 2019. The backend data from the UNFPA regional office show an increase on the exposure to Tune Me in 2016 and 2017, however there was a sharp decline at the beginning of 2018 with users dropping to 27,239 from 12,667 in 2017. The number are beginning to increase with 2020 reaching a peak with 130,471 users. The Facebook platform had a reach of 358,504 students against a target of 320 000).

Figure 14: Trend in users of Tune Me mobisite in Zimbabwe



The Tune Me platform is being used not just as a digital solution but also as a tool to promote youth dialogues. Key informant highlighted two access barriers to Tune Me: language and high data costs and cost of phones. The Tune Me content is still in English and has not been translated to local languages limiting the reach especially among young people in rural communities where English is not widely spoken. High cost of data and not having phones that allow access to the Tune Me platform were noted as some of the main access challenges. Limited access to phones was mostly disadvantaging young people in rural areas.

Youth Networks/ youth participation in advocacy

Strengthening capacity of adolescents and youth networks to advocate and meaningfully participate in international, regional and national decision-making platforms was a key component of the 7th

[83] SAYWHAT quarterly report 2020

[84] Condom stock outs was due to PEPFAR 40% reduction in condom funding from October 2019

CP youth programming. The CP supported advocacy training for young people representing different networks. By end of 2019, Zimbabwe had trained a total of 350 young people[85] who included (i) 250 Junior Parliamentarians and Senators in advocacy for SRHR and Youth Development in preparation of the opening of the 10th session of parliament; and (ii) 30 Young People's Network on HIV and AIDS (YPNSRHHA) members trained on advocacy in SRH and on advocating for the inclusion of CSE in schools. In 2019 the YPNSRHHA actively participated and contributed in the youth ResulICPD@25 discussions. (iii) 50 Youth Policy Tracking Group members trained in advocacy on SRHR and youth development. This groups enables young advocates to track legislative issues with the aim of advocating for inclusion of the youth voice in policy and legislation[86]. Young People's Network members and Youth Policy Tracking Group actively participated in the 2018 Public Health Bill hearings, where they advocated lowering the age of consent to health services (currently interpreted as being 18 years although the legal age of consent to sex is 16) but was unsuccessful as the Bill was passed into law without this amendment[87].

The CP supported the operationalization of youth desks in 20 ministries to ensure young people's concerns and views were incorporated in programming. The CP supported meetings with different line ministries and engagement with Ministers in the development of Action Plans where ministries provide updates on where they are at in terms of addressing youth issues. One key activity has been the establishment of the Youth Chats where young people interfaced directly with policy makers who included ministers and city council officials. All the platforms successfully afforded young people space to share their views on key issues affecting them. The CP also supported the development of the advocacy strategy including monitoring framework the young people network advocacy.

The Youth centres

The 7th CP supported the establishment of a number of youth centres in some districts. This entailed the allocation of rooms within health facilities were young people could access services. Most youth centres have a library and internet facilities were young people access free online services for academic and social searches. Recreational and leisure activities such as in and outdoor ball games, athletics, sports, library facilities, radio listening and group discussions form part of the ASRH programmes.

Support for The Tariro youth centre

UNFPA in partnership with ILO, UNDP, Lafarge Holcim Cement Zimbabwe and the City of Harare, supported the building of the Tariro youth centre and the clinic in Hopley. Hopley is semi-formal settlement in Harare South District with a population of approximately 200,000, out of which about 65,000 are between 10-24 years[88]. The suburb is characterised by high levels of migration, poor infrastructure, weak social services, low education, early marriages and high teenage pregnancies, high unemployment and informality. Prevalence of child marriages and teenage pregnancies are at 18% and 21% respectively, while at least 70% of women are mothers by age 24 years.

The Tariro Clinic and Youth Centre were constructed to improve sexual reproductive health outcomes and reduce vulnerability through skills development and economic empowerment of young people. The facility is expected to help impart life skills and values to the 65,000 young people aged between 10-24 years, of which 18% are in child marriages and 13% are school drop

[85] Safeguarding Young People 2019 Results Matrix

[86] Zimbabwe Youth Council website

[87] Safeguarding young people programme 2018 Annual report

[88] Matamanda, A.R. Living in an Emerging Settlement: The Story of Hopley Farm Settlement, Harare Zimbabwe. Urban Forum (2020). https://doi.org/10.1007/s12132-020-09394-5

outs. The Youth Centre and the Clinic serve as a community facility and provide a safe space for young people to access youth development programs.

This initiative reached 100 vulnerable youths in Hopley with vocational skills training. The beneficiaries were selected using a multi-stakeholder approach with the involvement of the Ward Councillor, City of Harare community workers, local NGO, ZiChIRe, ILO and UNFPA. The selection also adopted a gender lens by promoting the participation of young women in traditionally male dominated areas of work, and 56% of the apprentices reached were female. Through this partnership young people were supported to get national identity documents which then gave them access to financial resources mostly through mobile money platforms. At the start of the programme, close to a third of the young people had no identity documents; mobile phones and were unbanked.

Key informants including service providers in Hopley revealed that the youth centre has become a hub which youth service organisations within Hopley are using as a meeting place for young people and in provision of SRH services. The centres have been very helpful in ensuring that young people from vulnerable communities have access to integrated SRHR services and activities that keeps them engaged and entertained. However, the scale up of such centres countrywide may not be feasible due to the cost and almost total reliance on external funding.

Strengthening coordination of ASRH programme and enabling environment

UNFPA provided funding and technical support to the multi-stakeholder coordination ASRH forum held at national level and chaired by the ministry of health. This involved supporting the secretariat of the ASRH forum to bring together stakeholders from different sectors including MoPSE and MPYDIE and youth leaders from various youth networks. The CP supports the youth to attend this forum. Further support is provided for holding the provincial ASRH forum in the five provinces. The national and provincial ASRH forums were successfully conducted in all 4 quarters throughout the year.

The evaluation found that it took time to bring together different government ministries to collaborate and participate in these coordination forums due to inadequate understanding of their role in ASRH which was largely seen as a MOHCC mandate. There is also lack of support for district level ASRH meetings which leaves a gap in coordination. Partners operating at district or ward level who lack capacity to attend provincial level meetings are often left out. Some of the districts are unable to attend the provincial meetings because of the logistical challenges (distances and funding for transport and accommodation).

The CP engaged in extensive advocacy and lobbying to address legal and policy gaps on SRH for young people through providing strategic information to inform the Education Act amendment, supporting development of the ASRH strategy 2016-2020 and supporting the review and finalization of the national youth policy (2019). UNFPA, UNICEF and UNESCO supported the development of the Zimbabwe School Health Policy launched in 2018 while the CO organised a joint media campaign on elimination of early and unintended pregnancy. The CP is also supporting the development of the national youth policy which has been validated by the youth and stakeholders at national level but final approval is still pending.

The challenge facing the CP in supporting policy advocacy and advise was the high staff turnover at the decision-making levels such as the permanent secretaries within the line ministries which derailed progress and took time as new relationships had to be built on a regular basis to get acceptance and buy in for interventions. For instance, the national youth policy has taken longer to be approved due to the changes within the ministry.

Knowledge management/ documentation

The 6th CP evaluation highlighted knowledge generation and management as lagging behind. The 7th CP supported the country to generate evidence to support ASRH programming including support for the National fertility study conducted in 2016 and the evaluation of ASRH interventions in Zimbabwe between 2009-2014 in 2015 which generated evidence that informed the selection of interventions and districts. The CP is supporting the development of the Sista2Sista journal article[89] which is being finalized for publication in peer reviewed journal. The Sista2Sista evaluation findings were presented at the 23rd International AIDS2020 virtual conference. This has increased the visibility of the CP work in Zimbabwe and to external audience at the regional and international levels.

4.2.3 Gender Equality and Women Empowerment

Output 6: Increased national capacity to prevent GBV and enable the delivery of multi-sectoral services, including in humanitarian settings

	Original results framework developed in 2016				
	Output indicators	**Baseline (2016)**	**Target (2018)**	**Result achieved (2018)**	**% Achievement**
1	Number of GBV survivors who received (access) services at OSCs.	15188	59,000	60,905	103%
2	Number of survivors who access shelters	3,268	3200	3450	107.8%
3	% of women age 15-49 ever experienced violence	45%	43%	-	
4	% of women age 15-49 who experienced violence in the past 12 months	30%	28%	-	
5	Functional national coordination forum for multi-sectoral response to GBV under the ADVC	No	Yes	Yes	Yes
6	% of public health facilities in supported districts with at least one health care provider trained in survivor centred approaches and clinical management of sexual violence	0	100	41	41%
7	Number of SGBV clients accessing health services in supported health facilities.	1036	5036	7789	154.6%
8	Number of GBV multi-sectoral team members trained on the referral pathway and service centred approaches.	5100	5400	5688	105%
	Output indicators (Results framework revised in 2018	**Baseline (2018)**	**Target (2019)**	**Result achieved (2019)**	**% Achievement**
9	Number of SGBV clients accessing health services within 72 hours in supported 20 districts	6,351	2,029	2353	115.9%
10	% of health facilities with at least two health care providers with knowledge and skills to provide clinical management of SGBV cases and refer SGBV survivors	58	80	12	15%
11	Availability of budgeted emergency preparedness and response and disaster risk reduction plan which integrate SRH	No	No	Yes	Yes

Targets for all the output indicators were achieved except for two indicators, namely, percentage of public health facilities in supported districts with at least one health care provider trained in survivor centred approaches and clinical management of sexual violence and percentage of health facilities with at least two health care providers with knowledge and skills to provide clinical management of SGBV cases and refer SGBV survivors. These indicators were not achieved due to

[89] Effectiveness of the Sista2Sista program on improving HIV and other sexual and reproductive health outcomes among vulnerable adolescent girls and young women in Zimbabwe

the change in the training and mentorship approach. No data is currently available on the status of indicators 3 and 4. These indicators measure programme outcomes and should not have been included at output level.

Achievement of planned results
This section details the interventions supported to achieve the above results.

Capacity Strengthening

The CP supported the strengthening of the capacity of institutions central to coordination of gender-based violence - Anti-Domestic Violence Council (ADVC), judiciary, the police and health service providers. An Institutional Assessment and Evaluation for the Capacity of the ADVC conducted in 2015 revealed that government had not funded the Council since inception except for irregular payments made to councillors as sitting allowances, hence the ADVC was hamstrung by limited financial resources therefore weakening its ability to promote and monitor the implementation of the Domestic Violence Act (DVA). It also compromised implementation of two of its strategic plans and restricted ADVC activities to those funded by development partners. In light of these findings, the CP supported the induction of the ADVC on its duties, development of the ADVC strategic plan (2018-2020), funding of the position of the National Coordinator for GBV, and provided transport and financial resources for monitoring visits. However, this support was not sufficient to enable the ADVC discharge its mandate effectively. For instance, the ADVC secretariat operated with the only one GBV coordinator supported by the CP.

The CP supported the revision of nurses' tutor training modules for both pre-service and continuous training to ensure integration of gender and GBV modules. The module forms part of the training of everyone going through nursing training. For police and judiciary, a GBV training module was developed which was used to train the police and judiciary.

The CP also supported in-service training for service providers focusing on: (i) Training of multi-sectoral service providers including police officers, health care workers, community-based counsellors and paralegal officers on the referral pathway and survivor centred approaches in the supported districts. (ii) Training of health care workers in survivor-centred approaches and clinical management of sexual violence: This training used a three-tier model comprising of theory sessions, an attachment component at either Family Support Trust or Adult Rape Clinic and a mentorship component. During the course of the attachment trainees were expected to have dealt with at least 20 GBV survivor cases. However, the MOHCC is no longer sending doctors and nurses for attachment hence FST and ARC have since stopped being involved in the attachment component of the training. (iii) Training of stakeholders that include MWACSMED and CSOs in management of GBV in emergency (GBVie) came out of the realisation that there were gaps on GBV in emergency programming in a country that was experiencing frequent emergencies. This training covered the 12 districts under the Spotlight initiative.

The challenges the CP faced in this capacity strengthening initiative included the high staff turnover in government institutions, which saw a sizeable number of those trained leaving government thus reversing the gains registered by the CP. Lack of funding from government has also forced the ADVC to rely mainly on UNFPA, which has been funding the position of National Coordinator since inception.

Strengthening GBV coordination

The 7th CP supported MoWACSMED to coordinate multi-sectoral GBV prevention and response forums at national and sub-national levels. Guidelines for coordinating these forums were developed for use by MWACSMED officers and other stakeholders. Coordination meetings were held quarterly at both national and sub-national levels, with UNFPA support, during which

stakeholders shared experiences, mapped GBV prevention and response, identified gaps and areas for synergies.

Although, all districts are supported to hold coordination meetings, training of GBV coordination forums on GBV in emergencies had only covered the 20 CP supported districts. In addition, resource constraints, both human and financial, in the MoWCSMED have continued to affect GBV coordination platforms. For example, the gender unit in the Ministry has only three officers responsible for GBV programming, coordination of the national gender machinery, capacity building, and monitoring of the national gender equality policies and programmes. This Ministry is one of the poorly funded ministries in government as since 2016, it has been allocated less than 1% of the total budget.

The CP also supported the development of the Zero Tolerance GBV 365 Programme; and the review, update and harmonisation of GBV service provision protocols, guidelines and Standard Operating Procedures and tools in line with international standards. The "Protocol on multi-sectoral management of sexual abuse and violence" was revised to align it to the revised legal framework on sexual violence. The CP also supported the development of Standard Operating Procedures (SOPs) for OSCs and Safe Homes for GBV survivors to improve quality of services offered. The CP offered technical support for the development of GBV Information Management System. However, this system has not been operationalised due to inadequate infrastructure and capacity in government.

Support for GBV Prevention

The CP supported GBV prevention through roadshows, media campaigns and home visits by BCFs. However, it emerged that the BCFs have a wide portfolio of issues which they deal with, hence adding GBV to their portfolio was not an effective way to promote the prevention of GBV. The involvement of men in GBV prevention was promoted through community dialogues as well as Comprehensive Sexuality Education designed for out of school youth, particularly boys but the scope of issues discussed in these platforms was wide and the focus on GBV prevention was not sufficient.

Padare, one of the CP implementing partners, which is a member of the Gender and Faith Network in Zimbabwe, was engaged on a six-months contract to tap into this network to promote the involvement of faith leaders who are mostly men in the fight against GBV. The approach was to sensitise and enlist faith leaders to be part of the referral pathway and to challenge negative masculinities. Due to the short period of implementation, from April to September 2020, a period that coincided with the COVID 19 lockdown, the planned training and dialogue sessions with faith leaders did not take place. Instead Padare relied on Bulk Short Messaging Solution (SMS), call in radio programmes, Facebook messages, as well as over the phone counselling. Thus, the gap in the male engagement has not been sufficiently addressed. Furthermore, traditional leaders who are also very influential at community and policy level, given that they sit in Senate, were left out.

SGBV Service delivery: One Stop Centres

The CP supported post SGBV service provision to survivors through One Stop Centres. One Stop Centres (OSCs) provide multi-sectoral case management for GBV survivors including health, psycho-social support, gathering of evidence by the police and issuance of form 234 (request for medical examination) and legal assistance under one roof and free of charge. Where the services could not be provided under one roof, partners providing services were coordinated to support the survivors. UNFPA supported 10 OSCs in 4 provinces with high demand for such services.

All OSCs have an administrator or coordinator. For OSCs located at government hospitals, the MOHCC provides staff to manage the health section, Zimbabwe Women Lawyers Association provides legal personnel, Family Support Trust provides counselling services while the Zimbabwe Republic Police handles investigations and arrest of perpetrators. At the Musasa OSCs which are not located at government hospitals, only legal advice and psychosocial support services are offered and other services (medical and police services) are accessed through referrals. The CP supported GBV survivors with transport, medical examinations and legal representation among other services. UNFPA support contributed to the strengthening of SGBV referral pathway and improved service utilisation

The utilisation of the OSCs varies by location and implementer. The Harare OSC (run by Musasa) surpassed its targets while OSCs in Gwanda and Gweru run by the MWACSMED did not meet their targets. The Gweru OSC managed by Musasa also missed its target for 2017 and 2019. The low performance was attributed to the criteria for targets setting which did not consider the dynamics of communities where OSCs are located and limited community level interventions supporting survivors to overcome stigma, trauma and fear to seek services.

Table 15: Utilisation of OSCs supported by UNFPA: target vs achieved results 2016 to 2020

Implementer	**OSC Location**	**SGBV Survivors Utilising Services**									
		2016		**2017**		**2018**		**2019**		**2020**	
		Target	Result	Target	Result	Target	Result	Target	Result	Target	Result
Musasa	Gweru	2800	2919	2800	2475	2800	3651	2800	1422	2500	1979
Musasa	Harare	4000	7865	4000	5635	4000	5970	4000	7096	3700	8085
MWACSMED	Rusape	1200	542	1200	1262	1200	2076	1200	1025	1200	928
MWACSMED	Chinhoyi									600	689
MWACSMED	Gwanda	800	74	800	479	800	488	800	514	800	328
MWACSMED	Gweru	1200	718	1200	515	1200	1049	1200	1157	1200	599
Total		**10000**	**12118**	**10000**	**10366**	**10000**	**13234**	**10000**	**11214**	**10000**	**12608**

To ensure wider access to services including during emergencies, UNFPA supported the rolling out of Mobile OSC services by district and multi-sectoral teams and toll free hotline services in 2018. The mobile OSC teams raise awareness about the services available to GBV survivors. The mobile OSC approach was described as effective, especially during the COVID 19 lockdown period, in ensuring that psycho-social support was readily available (Key informants). However, the gap with this model is the lack of protection services to GBV survivors. The national GBV hotline recorded a total of 5,306 GBV calls from the beginning of the COVID 19 induced lockdown in March until October 2020, with an overall average increase of over 60% compared to the pre-lockdown trends[90].

A major challenge related to OSCs relates to the cost incurred to support GBV survivors. A 2016 Musasa annual report states that "medical treatment and care remains a critical and costly GBV response with implications on the budget. For example, antenatal care registration fee varies from $25 to $50 while X ray cost is $2"[91]. This makes it difficult for government to sustain the running of OSCs.

GBV Service delivery: Shelters

The Domestic Violence Act provides for 'the establishment of safe houses for purposes of sheltering survivors of domestic violence, including their children and dependents". A safe home is an alternative home to house GBV survivors away from any further potential harm from the perpetrator[92]. Unlike at OSCs where GBV survivors access these services from their homes, GBV

[90] OCHA 26 October 2020 Cluster Status: Protection (Gender Based Violence)

[91] Musasa 2016 Annual Workplan Progress Report

[92] MWAGCD, 2012 Standard Operating Procedures for Safe Homes for GBV Survivors, Zimbabwe

survivors in safe homes access these services while accommodated at the shelter. Despite this being government policy, there is no government run shelter hence CP support is covering a critical gap in the protection of GBV survivors.

The CP supported 15 shelters spread in 8 provinces. Of these, two are urban, namely Gweru and Harare shelters while the rest are rural and community based. The community shelter model is meant to ensure some of the hardest to reach women get access to support. The rural shelters were established through the involvement of community leadership who provided land and labour for the construction of the shelter. Similar to urban shelters, community shelters receive referrals from courts, hospitals, clinics and police. The IPs' work with the communities and local leadership also created a strong community referral system. Community leaders were trained in GBV management for them to provide basic counselling and make referrals to the shelter. Urban shelters on the other hand are situated in an undisclosed location for security reasons, thus they serve as safe houses. Overall, the shelters are located in GBV hotspots, except in Gokwe North and Mwenezi where shelters were established to accommodate survivors of cyclone Idai in 2019. FACT and Caritas shelters in Hurungwe and Muzarabani respectively are still at inception stages.

Support from UNFPA consists of allowances for staff, legal and medical support for GBV survivors, transport for GBV survivors to access services, upkeep of the survivors at the shelter and their skills building, administrative support. Through UNFPA support, GBV survivors who require medical care are referred to hospitals or clinics and have costs of medical care covered. Those with children are also catered for. GBV survivors at shelters go through empowerment sessions to support them to recover from the violence and gain technical skills to enable them become independent to overcome vulnerability to GBV. However, there were no starter income generating packs for GBV survivors who received such training at shelters.

Utilisation of shelters has been high in Harare, Gweru and Marange. The rest of the shelters did not meet their targets. The setting up of the same targets for all shelters should be revisited to take into account the dynamics in the communities where shelters are located. The level of utilisation also points to the gaps in demand generation and to some extent the reluctance for report SGBV cases.

Figure 15: Shelter Targets and Achievements by Implementing Partner, 2016-2020

IP	**OSC Location**	**SGBV Survivors Utilising Services**									
		2016		2017		2018		2019		2020	
		Target	Result	Target	Result	Target	Result	Target	Result	Target	Result
FACT	Mutasa	-	-	100	3	400	115	400	362	400	306
FACT	Makonde	-	-	100	9	400	111	400	188	400	161
Musasa	Harare	400	453	400	492	400	555	400	578	400	500
Musasa	Marange	400	240	400	298	400	570	400	653	400	507
Musasa	Chikomba	400	342	400	266	400	307	400	587	400	397
Musasa	Bubi	400	392	400	336	400	399	400	477	400	294
Musasa	Gutu	400	461	400	279	400	362	400	417	400	341
Musasa	Gweru	400	291	400	430	400	590	400	531	400	430
Musasa	Umzingwane									160	64
Total		**2400**	**2179**	**2600**	**2113**	**3200**	**3009**	**3200**	**3793**	**3360**	**3000**

As a sustainability measure shelters have introduced income generating projects such as poultry and horticulture to support running costs. To enhance the role of community involvement especially the role of religious leaders in GBV prevention and response, UNFPA is piloting two community shelters in Hurungwe and Muzarambani districts in partnership with Caritas and FACT. These are surrogate shelters based at Catholic mission centres which make use of already existing church infrastructure and are designed to promote localised referral pathway within the community. This model was considered to be cost efficient because of the community contributions and management by the faith based organisation and offers a model for sustainability of shelters.

A key challenge with shelters is the lack of clarity in the standard operating procedures as to who accesses the shelters and how long the person can stay. Gaps also remain on termination of pregnancy after rape. A majority of women failed to access termination within the stipulated time period, due to failure to get the right personnel at the police stations, time taken by the police to finalise the investigations, time taken by the doctors to finalise medical tests as well as the costs that come with these steps, in light of the fact that a majority of these doctors are not found at the same place. A documented case is a client who went through this tedious process and finally got a termination of pregnancy order at the 6th month of her pregnancy when it was no longer safe to perform the abortion (Key informants).

GBV in Emergencies

UNFPA leads the Protection Cluster and the GBV sub-cluster ensuring GBV is addressed during emergencies. During emergencies, UNFPA provided dignity kits to women and girls, bicycles to community cadres to ensure easy mobility; training of IPs on GBV in emergencies, provision of Personal Protective Equipment (PPE) during COVID 19 and airtime and data bundles to IPs. There was intensified radio and online programmes during COVID 19 and support to the Mwenezi and Gokwe North shelters to cater for Cyclone Idai survivors. The Safe Space initiative was also supported to educate women and girls on GBV and promote dialogue among them on the same issues. However, there is only one expert in humanitarian emergencies within UNFPA which may affect swiftness of the response during emergencies.

4.2.4 Population dynamics

Output 7: Increased national capacity for the production and the use of disaggregated data on population, sexual and reproductive health and gender-based violence for the formulation and monitoring of evidence-based policies, plans and programmes, including in humanitarian settings

	Original results Framework for 2016	**Baseline 2015**	**Target 2018**	**Result achieved 2018**	**% Achieved**
1	Number of in-depth census and demographic health survey thematic analysis reports produced and disseminated	0	14	16	**114%**
2	Number of web-enabled database systems operationalized	0	2	2	**100%**
3	Number of civil service training centres and university institutions offering population and development curricula	0	0	0	**0**
	Results Framework Revised in 2018	**Baseline 2018**	**Target 2019**	**Result achieved 2019**	**% Achieved**
4	Number of in-depth census and demographic health survey thematic analysis reports produced and disseminated	3	4	4	**100%**
5	Number of web-enabled database systems operationalized	2	2	2	**100%**
6	Number of civil service training centres and university institutions offering population and development curricula	0	1	0	0
7	Availability of a national system to collect and disseminate disaggregated data on the incidence and prevalence of gender-based violence	No	No	Yes	

Achievements of planned results

Support for the National Population Census

Zimbabwe holds the national population census every 10 years, with the last one held in 2012 and the next one planned in 2021. The 7th CP provided financial and technical support to ZIMSTAT to undertake in-depth analysis of the 2012 census data, producing 6 thematic area reports and

disseminating them to the public in hard copy and on the ZIMSTAT website. Some of the reports produced in 2016 were (i) Women and Children; (ii) Labour Force Characteristics; (iii) Living Conditions; (iv) Older Persons; and (v) Updated 2012 Population Census Projections Report produced in March 2019.

In support of the next population census, UNFPA is leading resource mobilisation through reaching out to traditional and non-traditional funders. With support from UNFPA, preparations (meetings and trainings) for the next census started in 2017. UNFPA supported the updating of the ZIMSTAT cartography database and acquired servers for the census. Standardization of enumeration areas for the GIS database is about 67% complete mainly for rural areas that use the 1:50,000 scale while urban areas which use cadastral sheets is yet to be developed.

Capacity development of staff to undertake the census was on-going through the 7th CP support. Key members of the census management team visited Malawi's National Statistical Office to learn about the use of CAPI which Malawi had used in her 2018 population census. Two ZIMSTAT IT staff were trained on CAPI as a mode of data collection and CSPro for use in census data processing while another staff member participated in a SADC regional training on census operations (including planning, management, mapping and data processing). Critical contract staff was recruited in December 2019, including 4 demographers, 2 IT experts and 96 cartographers. Census mapping fieldwork commenced in December 2019 but was derailed due to the COVID-19 lockdown. The 14 mapping teams resumed their work after the lifting of the COVID 19 lockdown. An application for additional resources (to procure tablets and vehicles) in order to increase the number of mapping teams from 14 to 57 was awaiting approval at the time of the evaluation. ZIMSTAT expects to have completed census mapping by May 2021. To a large extent, UNFPA support for census preparatory activities contributes to ensuring the census is conducted as planned to avail data to support the next phase of national development planning.

Two gaps were identified in the process of carrying out the census:

(i) Limited funding: Resource mobilisation is continuing to secure adequate financial support for the population census and UNFPA is contributing to this effort.
(ii) Limited ZIMSTAT capacity to collect migration statistics, especially international migration data. ZIMSTAT acknowledge that capturing migration data is difficult as some migrants use unofficial entry and exit points especially to and from South Africa. ZIMSTAT has consulted with IOM to build their capacity on international migration. Meanwhile, a proxy migration module that was added in the ICDS 2017, will be used for the migration data collection in the population census.

Support for the ZDHS

UNFPA provided financial and technical support to ZIMSTAT for the production of 14 ZDHS 2015/16 in-depth analysis reports. The findings were disseminated, with one research paper published in a peer-reviewed journal in 2018. The CP supported the development and sharing of media briefing materials with both electronic and print media houses to disseminate further the findings of the in-depth analysis reports. However, support for 2020 ZDHS was put on hold to pave way for the population census taking place in 2021. This will have a negative impact on the 8th UNFPA CP as SRHR and GBV baseline indicators based on ZDHS data will not be available.

Two gaps were identified with regard to the design of ZDHS. Firstly, some implementing partners noted that they would benefit more from the ZDHS data if the survey could go beyond national and provincial level to include a district level sample. Secondly, there is no evidence of who used which in-depth analysis report for planning and programming purpose to bring meaningful change that would not have been achieved if the in-depth analysis were not undertaken. It was not possible to

ascertain the added value of in-depth analysis from the user perspective as such information is not being tracked.

Support for ICDS

With support from the Government and UNFPA, ZIMSTAT conducted the ICDS 2017 which used CAPI for data collection for the first time. Two editions of the report were produced and disseminated and the data was uploaded on the ZIMSTAT website for accessibility to the public. The Master Sample for the 2021 census was developed based on the ICDS 2017. The ICDS findings were further disseminated at national level as well as in three out of the ten provinces in 2019. Dissemination of the remaining 7 provinces and district population projections is yet to be carried out. The second edition of ICDS 2017 has new data on variance estimates of additional demographic variables. SDG indicators were derived from the ICDS 2017 and disaggregated by sex, place of residence and disability status. A summary sheet with 43 SDG indicators was produced and published as part of the 2nd edition of the ICDS report.

Support for other Studies

UNFPA supported other studies that included the Demographic Dividend (2017), the Zimbabwe Vulnerability Assessment (2020), and the Resources Flow Survey (2017). The findings of the Demographic Dividend Study were disseminated at the National Youth Investment Conference held in October 2017. UNFPA also produced a policy brief on the Demographic Dividend results which was shared with the government, and subsequently used as reference document for the preparation of a chapter on population and development in the TSP. The findings of the Demographic Dividend Study were also utilised by the Ministry of Finance and Economic Development in the development of the National Development Strategy I 2021 - 2025.

The Zimbabwe Vulnerability Assessment was conducted in 2018. UNFPA participated and provided technical assistance in developing tools, conducting the assessment, and the creation of dashboards adjusted to the Zimbabwe context. Also successfully conducted was the Resources Flow Survey in 2017 which collected data on expenditure on family planning.

ZIMSTAT and UNFPA collaborated to provide population data for the Cyclone Idai affected areas. However, ZIMSTAT capacity to provide data to support humanitarian emergencies is limited. The data provided during Cyclone Idai was not adequately disaggregated. The agency also lacked expertise in producing GIS maps to international standards to support mapping of area in need of humanitarian response. During COVID 19 pandemic, the agency is not involved in data management and dissemination and does not participate in the COVID 19 task force where it could support the use of population data to assess the pandemic effect on livelihood, employment and social impact.

Support for Vital Registration

The Vital Registration Report was not produced during the 7th CP as planned. A Vital Statistics Report to cover the period 2010 to 2016 was expected to be produced in 2020. The last report was done in 2010. Efforts aimed at strengthening the country's vital registration and vital statistics system were for the greater part hampered by the reluctance of the Department of the Registrar General to supply ZIMSTAT with complete data on births and deaths. ZIMSTAT successfully re-engaged the RG's Office in the third quarter of 2019 and 4 trained clerks started manually extracting vital statistics data on births and deaths while extraction of data on marriages and divorces was to follow. The data on deaths shows that more of the deaths recorded and computerised were institutional deaths while deaths outside of institutions were recorded on paper files. At the time of the evaluation ZIMSTAT was working on 2015 mortality data, targeting to develop a 2015

Mortality Report by January 2021, then Births Report will follow by December 2021. The vital Statistics Report, encompassing births, deaths, marriages and divorces, will be developed when all data is computerised.

Even though data extraction on births and deaths has commenced, a number of challenges beset this activity: (i) Difficulties in accessing data from the Department of the Registrar General, as the office is not forthcoming to share data deemed as confidential individual records. Notwithstanding that ZIMSTAT and the RGs Office are both bound by the same rules and regulations for confidentiality and secrecy, the RGs Act does not allow external staff to access its data while ZIMSTAT Act is silent on what is expected of providers of data in line ZIMSTAT mandate. (ii) The electronic database shared was incomplete as it had fewer cases. It did not capture deaths outside of institutions or those without a birth certificate or national identity card. (iii) Data for most of the deaths is still paper-based mainly for those who die without a birth certificate and/or national identification record. (iv) Some causes of death are not classifiable as diseases. (v) Limited manpower to retrieve data from the files as ZIMSTAT was working with 4 clerks. Thus, if the vital registration report is to be produced, it is likely to have data quality and completeness gaps.

Support for Web-enabled Databases

This indicator was achieved as 2 web-enabled database systems (Zimbabwe Statistical Database (ZIMDAT) and REDATAM), were established in 2016 and operationalised for archiving of national indicators and allow for access to users on-line. UNFPA, UNDP and UNICEF supported maintenance and updating of the database online through the 7th CP support. The 2002 and 2012 population census datasets and MICS 2014 were cleaned and uploaded onto REDATAM while ICDS 2017 data, PICES and administrative/routine sources were uploaded on ZIMDAT.

UNFPA supported the development of an SDG data inventory matrix in 2017, housed at ZIMSTAT, which was updated using recent data from surveys and routine data systems. This was shared with the SDG coordinating Ministry of Finance and Economic Development. Seventeen officials drawn from key ministries of macro-economic planning and investment promotion, health and childcare, and environment, water and climate were trained on the use of ZIMDAT to monitor SDG indicators. To date 43% of the SDG indicators prioritized by Zimbabwe have data.

To strengthen the skills and capacity of staff, 2 ZIMSTAT staff members were trained in 2016 on how to develop and maintain the database systems. Staff received further training in 2017 on the use of ZIMDAT to monitor SDG indicators. A user training workshop on ZIMDAT and REDATAM was conducted. ZIMSTAT received additional capacity and support through the recruitment of one international and two national consultants contracted in December 2019. For guidance and oversight, an Inter-Ministerial Technical Committee was established and was functional through the 7th CP period. In 2019, for example the Committee held two meetings which discussed data gaps and meta data for SDGs 14 and 17. ZIMSTAT also held web related meetings, as necessary.

The challenges encountered included the intermittent functionality of the ZIMSTAT website which sometimes hampered access to ZIMDAT and REDATAM databases. The internet platform software has not been upgraded hence not robust enough to host the website. Secondly, there are some indicators with no definitions that need to be defined to enable archiving. There is, therefore, need to strengthen ZIMSTAT IT overall, technical knowledge, and continued refresher trainings in-line with trends in technology.

Support for Civil Service Training Centres and Universities to offer Population Curricula

There was no civil service training centre or university institution offering population and development studies that was supported by UNFPA during the 7th CP. Nonetheless, a capacity assessment of the University of Zimbabwe (UZ) Centre for Population Studies was successfully

conducted in 2019 using an adapted tool from the US Census Bureau, and a report of the findings was produced. Based on these findings, a draft strategy to meet identified training needs of senior staff from government and stakeholder organisations was developed. In 2020, UNFPA was to engage the Centre for Population Studies to convene two policy dialogues but this activity did not take place due to lack of adequate financial resources.

Another area with weak coordination is the National Statistical System. Currently, there is no National Statistical System Sector Committee. This is a critical area in the development and utilisation of population data and vital statistics. Overall, the interventions of the population dynamics thematic area cannot be achieved without close collaboration with all stakeholders and partners (United Nations entities, private sector companies, civil society and academics, inter alia).

Evaluation question 2: Effectiveness

EQ 2b: To what extent has UNFPA successfully integrated gender and human rights perspectives in the design, implementation and monitoring of the country programme?

Summary of findings

(i) A comprehensive gender analysis was not conducted to inform the CP design. Gender issues such as involvement of men and boys and focus on harmful gender norms and cultural practices were addressed in some programmatic areas and not in others resulting in fragmented mainstreaming

(ii) Human rights-based approach to programming was well integrated into the CP. Districts and targeted populations were selected using indicators which identified human rights barriers to access to services and also all interventions of the CP addressed the needs of populations left behind and those furthest behind.

(iii) Integration of disability was not prioritised at CP design stage but interventions to address the needs of persons with disability were introduced later in the programme. However, these were still at a small scale and ad hoc.

Gender integration in the CP

A comprehensive gender analysis was not conducted to inform the design of the CP, yet effective gender integration should consider how gender norms and relations affect the achievements of CP results. The framing of the CP did not comprehensively address the critical power dynamics linked to access to and uptake of SRHR, adolescents sexual and reproductive health and gender based violence services.

Gender mainstreaming varied across the CP outcomes. Under outcome 1 (SRH), all interventions addressed the needs of girls and women but there was a gap in the involvement of men in family planning, maternal and neonatal health and cervical cancer treatment. Male involvement could have enhanced the effectiveness of these interventions. For instance, one of the reasons some women who tested VIAC positive were not offered treatment is because they needed to consult with their spouses. Use of family planning methods was also, in some instances, hindered by men's attitudes to contraceptives. For example, migrant men living in South Africa suspect their wives to be unfaithful if found using contraceptives and this tends to lead to gender-based violence (key informants). There was also no clear approach to involving men in supporting women in maternity waiting homes. On the other hand, HIV prevention education and demand generation conducted

through home to home approach reached over 40% males and addressed challenges facing men and women in accessing HIV services such as HIV testing and access to condoms.

Under outcome 2 on adolescents and youth, strategies used incorporated both females and males except the Sista2Sista clubs. The parent child communication (PCC), strengthening of Youth Friendly Services, Youth desks and youth centres provided information and services and empowered both males and females. These interventions strengthened a supportive environment for both the girls and boys.

Outcome 3 focused mainly on the response to gender based violence. There was an attempt to sensitise men during community dialogue meetings to enable them support survivors of GBV and report such cases to relevant institutions. However, the focus of the CP was more on provision of post SGBV services than on address harmful cultural norms and practices that account for most GBV cases. The involvement of men did not go far enough to effectively address the underlying gender inequalities inherent in communities (Key informants).

Outcome 4, data from the census and demographic and health survey generated with UNFPA support was disaggregated by selected characteristics including age, sex, location, education and health quintile, race, ethnicity, disability and religion. This data informed the selection of districts to be covered by the CP but deeper analyses to bring out underlying inequalities between men and women was not done to inform the design of interventions.

The capacity of implementing partners in gender integration varied. Some of the implementers including such as MOHCC and ZNFPC observed that they would appreciate training in gender mainstreaming in their interventions. Other implementing partners, especially those implementing interventions in output 6 (outcome 3) had technical competency to mainstream gender given that this is part of the mission of their organisations. This variation show that gender issues were not comprehensive addressed.

The CP indicators were also not disaggregated by gender. There was an attempt though during monitoring to collect data disaggregated by sex, age but this was not done for all indicators. Thus, the gender dimensions of the interventions supported by the CP was not adequately covered in the monitoring system.

Human rights integration in the CP

The CP integrated human rights perspectives through a consideration of populations from diverse backgrounds including women, adolescents and young people, people with disabilities, sex workers and other key populations. These populations have been considered as rights holders with rights to health. Human rights based approach to programming was adopted right from the CP design stage. UNFPA applied criteria for selection of districts and target populations which effectively identified those left behind and furthest behind. As a result, the 20 focus districts selected were those where key indicators (teenage pregnancy, school drop-out rates, maternal mortality ratio and infant mortality rates, contraceptive prevalence rates, HIV prevalence etc.) were poorest and where there was a funding gap.

The CP supported interventions that promoted human rights of women and adolescents and youth. For instance, under Outcome 1, support for family planning promoted the right of women to exercise their reproductive health rights through expanding choice of family planning methods and increasing access to family planning services. The CP support for cervical cancer and obstetric fistula treatment removed barriers women face in accessing these services. Obstetric fistula treatment in particular was not prioritised prior to UNFPA advocacy and support. This intervention

promoted the dignity of the women affected. Support for the provision of maternal and neonatal health service prioritised interventions removing barriers to timely access to these services by addressing the second and third delays. Under Outcome 2, the CP promoted the rights of adolescents and youth, especially adolescent girls in accessing SRH services through providing them with information and skills to minimise vulnerability to HIV infection and teenage pregnancy. The CP supported the development of a supportive environment within the household and in the community for AYPs to exercise their reproductive health rights.

The response to SGBV played a key role in protecting the rights of the survivors. The CP empowered them to have access to livelihoods as one way of promoting their rights. There was less emphasis on addressing underlying harmful cultural practices that cause GBV and following up on perpetrators as deterrence for GBV. The CP supported the production of population data but there was limited specific focus on human rights analysis.

Mainstreaming disability in the CP

The CP did not adequately integrate disability at the time of design. However, during implementation, interventions addressing the needs of persons with disability were introduced. For instance, young people with disability were represented in ASRH multi-stakeholder coordination meetings and FP forums. This representation brought out the needs and challenges of persons with disabilities which included infrastructure not being friendly and limited access to IEC materials. UNFPA, with support from Australian Embassy, revamped GBV shelters and the Hopley youth centre to make then disability friendly. HCWs were also trained on how to provide services to persons with disability while some IEC materials were developed in Braille. A disability module was also added to the second edition of the ICDS 2017 in line with the SDG data disaggregation requirements (Key informants). These efforts demonstrate the integration of disability in the CP during the course of implementation. The CP lacks a comprehensive analysis of persons with disability among its targeted populations and a comprehensive approach towards integrating disability in implementation approaches.

4.3 Evaluation question 3: Efficiency

EQ3: To what extent did the intervention mechanisms (financing instruments, administrative regulatory framework, staff, timing and procedures) foster or hinder the achievement of the programme outputs?

Summary of key findings

(i) UNFPA financial instruments facilitated CP implementation. The modes of funds disbursement tailored to implementing partner risk, nature of activity and donor requirements enabled UNFPA to execute the CP effectively.

(ii) The process for Annual Work Plan development and approval contributed to delay in funds disbursement particularly in the start of the year and led to loss of quarter 1 implementation period. This impacted on efficiency CP implementation.

(iii) The selection of Implementing Partners with technical competencies in their respective programmatic areas contributed to the implementation of the CP.

(iv) UNFPA procurement procedures including during humanitarian emergencies ensured timely procurement of commodities that were critical for health service delivery (e.g. for family planning commodities and delivery kits and PPEs required during the COVID pandemic). This also facilitated timely implementation of the programme.

(v) The financial situation in the country, especially change of currency and regulations on access to cash, effected timely implementation of activities.

(vi) UNFPA human resources capacity was aligned to the CP requirements at the time of design and capacity needs emerging during implementation were also addressed. However, weaknesses were observed in M&E and population dynamics human resources capacity as

well as the need to structure staffing a way that promotes integrated implementation of the CP across the 4 outcome areas.

(vii) Strategic partnerships that had potential to improve CP efficiency and effectiveness such as partnerships with organisations supporting youth economic empowerment and gender and women rights promotion at community level were not well exploited.

UNFPA has in place financial instruments which facilitated implementation of the country programme. The Country Office applied four modes of financial management tailored to the risk level of implementers, nature of activity and requirements of donors. These included (i) Direct Cash Transfer (DCT), (ii) Direct Payment (DP) disbursement mode, (iii) Reimbursement mode, and (iv) UNFPA direct execution mode which was applied to cases where UNFPA procured commodities and equipment for the MOHCC. The application of these modes of funds disbursement minimised risk, enabled UNFPA to effectively manage financial regulations in the country and to meet donor requirements while facilitating implementation of the programme.

The process for development and approval of Annual Work Plans (AWPs) was, however, identified by most implementing partners as a major bottleneck hindering timely implementation of the programme. The development of AWPs commences in October and is expected to be completed by December for activity implementation to start in January of the following year. Due to several reasons including instances of late submission of first drafts of AWPs by implementers, quality of AWPs and the iterative process between IPs and UNFPA Country Office, it takes time for the AWPs to be completed on time. This process, by account of most key informants, ends in March of the following year, leading to implementers losing the first quarter of the AWP before funds are disbursement and activities tend to commence in the second quarter. This leads to acceleration of activity implementation in other quarters. Key informants at province and district levels observed that they are often under tight schedule to complete activity implementation towards the end of the year and this affects the quality of activities.

The financial situation in the country affected timely activity implementation. Key issues include challenges in access to forex especially where implementers need cash to pay for activities in the field and the change of currency from US$ to Zimbabwe dollar. UN Agencies, with support from Resident Coordinator's Office (RCO), came together and held consultations with the Reserve Bank and were able to have the Reserve Bank change some of the restrictions. This notwithstanding, challenges in paying suppliers still prevail. For instance, Government restricts payment of suppliers in US dollars and has also come up with restrictions in the use of mobile money payment platform "ECOCASH".

UNFPA procurement procedures are well laid down and followed by the country office. The use of UNFPA procurement processes, especially for family planning and maternal health commodities, ensured timely delivery of the commodities in-country[93]. Fast track procurement procedures were activated in times of humanitarian emergencies such as Cyclone Idai and COVID 19. On the other hand, implementing partners use their own procurement procedures which are reviewed by UNFPA at the time of assessment of implementers.

Administrative procedures of UNFPA are well established and understood by staff. For instance, procedures for vehicle and hotel booking and travel to the field, request and acquittal of DSA among others are predictable and do not present a bottleneck in programme implementation (Key Informants). Implementing partners are allowed to apply their own administrative procedures in implementation of programme activities.

[93] Stock outs for family planning commodities were due to challenges in funding and supply chain challenges rather than UNFPA procurement procedures

UNFPA participation in the UN Operational Management Team (OMT) contributed to efficiency of the CP. Through participation in OMT, UNFPA recorded efficiency gains from cost savings/ cost avoidance through use of UN Common Service contracts for travel, security, courier, internet services, banking, security and office maintenance. Most of the local procurement is done using the UN established Long Term Agreements (LTAs) through the common service unit and other UN agencies specific LTAs which contributed to timely activity implementation.

The selection of implementing partners (IPs) with technical competencies and capacity to implement the CP also facilitated implementation and achievement of results. The IPs are selected through a well laid down procedure which includes assessment of their capacities to identify risk levels and any capacity gaps to be addressed. However, some institutions with a mandate relevant to UNFPA programmatic areas were not involved as IPs such as Ministry of Youth, Registrar General's Office, Ministry of Primary and Secondary Education, University of Zimbabwe (department of population studies) and Faith Based Organisations with infrastructure to run GBV shelters.

UNFPA CO, to a large extent, has adequate human resources capacity to implement the CP. Human resources capacity was assessed and aligned to the requirements of the 7th CP and staffing needs arising during implementation were addressed such as the recruiting a humanitarian coordinator. However, some challenges were noted which affected programme efficiency. The programme staff tend to rely on the M&E staff for data analysis, target setting, progress review which adds to the M&E staff's roles in monitoring and reporting of overall CP, supporting country HMIS and production of strategic information. In addition, the M&E staff positions do not match the responsibilities they are expected to carry out. Further, the population dynamics programme area is inadequately staffed with only one programme officer. The CO is structured in a way that each programme staff is focused on a particular programmatic area. Although this ensures the provision of specialised technical expertise to government, it has limitations in delivering the CP through integrated approaches across all the 4 outcome areas (Documents Review and Key Informants).

Support provided by the UNFPA Regional Office also played a critical role in facilitating the CP implementation. This included support for procurement of goods especially from South Africa where certain items such as IT equipment have competitive prices, hiring of consultants and provision of technical support (such as in preparation for population census) to the country office on need basis.

Monitoring and evaluation

Monitoring and Evaluation requirements and procedures for the CP are also well established. The M&E requirements and tools were disseminated to implementers and all implementers interviewed have a clear understanding of the M&E requirements. Implementers were also supported to conduct field monitoring of their interventions to assess progress and address any arising challenges. UNFPA also undertook field monitoring to support implementers.

The evaluation found that the development of the CP results framework needs improvement especially in identification of indicators and setting targets. The definitions of some of the output indicators (as mentioned under effectiveness) would not be operationalised consistently and effectively while some indicators had to be dropped when the results framework was revised in 2018. The criteria for setting targets was also not clear resulting in huge overachievement of some targets during implementation.

Innovation

Most of the interventions supported by the 7th CP were continuing from the 6th CP although the implementation strategies for some interventions were modified. Two interventions that would be considered as innovations include:

(i) The Tariro Youth Centre which demonstrates how economic empowerment can be used as a strategy for addressing vulnerability to HIV infection and teenage pregnancy among other SRH issues. However, the cost of setting up this centre hinders the scale up of this model.
(ii) Set up of FBO shelters for GBV survivors: This model which is being piloted with the CP support demonstrates how shelters for GBV survivors could be sustained through anchoring them in faith based organisations (churches) to leverage existing infrastructure and management systems to reduce cost and sustain their operations.

Strategic partnerships

UNFPA forged strategic partnerships to facilitate implementation of the CP. These include: (i) Strategic partnerships with other UN Agencies to undertake joint programming which enabled UNFPA to leverage the capacities and resources of other UN agencies to implement specific interventions such as the set-up of Tariro Youth Centre and also to carry out advocacy and policy level initiatives such as support for school health policy and support for the First Lady's Office; and (ii) Partnership with training institutions for nurses, midwifery, judicial officers and police to integrate midwifery, youth friendly services, and SGBV in pre-service training.

However, UNFPA strategic partnerships with government ministries such as MOHCC and MWACSMED as well as ZIMSTAT could be improved. Although these institutions were expected to lead implementation of the CP in areas of their mandate, these institutions viewed UNFPA as donor whose requirements they needed to adhere to rather than a partner.

UNFPA had opportunities to utilise strategic partnerships to strengthen the CP supported interventions but these were not well exploited. For instance, UNFPA could utilise strategic partnerships with other development partners and implementers in GBV prevention programmes to create linkages with its support for SGBV survivors to ensure that harmful cultural practices partly contributing to SGBV are addressed even as it focuses on SGBV response. Another opportunity was to link the interventions providing information and education to adolescents and young people on SRH, financial literacy and entrepreneurship (e.g. Sista2Sista and CSE) to partners implementing economic empowerment programmes.

4.4 Evaluation question 4: Sustainability

EQ 4: To what extent has UNFPA been able to support implementing partners and beneficiaries (women and adolescents and youth) in developing capacities and establishing mechanisms to ensure ownership and the benefits continue beyond programme termination?

Summary of findings

(i) Capacity building was integrated into the interventions supported by the CP as one of the modes of engagement. The capacities built among implementers and service providers will contribute to provision of quality SRH and GBV services beyond the programme period. However, high staff turnover is likely to erode the benefits of the capacity built among service providers.
(ii) The utilisation of the physical infrastructure capacity set up by CP such as Obstetric Ward in Chinhoyi and VIAC clinics will contribute to sustainability of the benefits beyond the CP period. However, inadequate domestic resource allocation for maintenance and equipment will limit the use of these infrastructure.
(iii) The benefits of the awareness, knowledge, skills and the change of attitude or mind-set among beneficiaries (adolescents and young people, parents, key populations, SGBV survivors, women, community leaders and community members) will generate demand for

SRH, HIV and GBV services beyond the programme period. The community cadres are also likely to continue providing information on SRH, HIV and GBV.

(iv) Government leadership in identification of priorities and implementation of interventions supported by the CP promoted ownership of the CP and contribute to sustainability of the benefits of the programme

(v) Other mechanisms of the CP promoting ownership and continued benefits of the programme include use of community cadres recruited from and recognised by communities, engagement of key population organisations and youth networks, advocacy at policy level to improve enabling environment for health services especially for key populations and use of government systems and structures for production of population data.

Capacity development was integrated in the support provided by UNFPA to implementers and beneficiaries, as one of the key "modes of engagement". Critical aspects of capacity development supported by the CP to ensure that ownership and benefits continue beyond the programme include:

(i) Training of healthcare workers (doctors and nurses) to improve skills and knowledge in family planning, maternal health, cervical cancer, obstetric fistula treatment among others was a key support by the CP to ensure continued provision of quality healthcare beyond the programme. The CP supported the MOHCC and ZNFPC and non-government implementers to carry out workshop based training, on the job training and mentorship. This notwithstanding, the contribution of capacity building to sustainability of CP results has been grossly undermined by the high turnover of trained staff from public service. For instance, in one province, Matabeleland North, 15 nurses left the public service in one week.

(ii) The CP support the improvement of pre-service midwifery training and integration of GBV and YFS training in the pre-service training of the police, nurses and judicial officers to ensures that personnel graduating from these institutions will continue providing services and hence sustain gains made by the CP. The integration of CSE into the school curriculum will also ensure learners have knowledge of SRH and HIV upon leaving school. The CP also supported the MOHCC mentorship programme as a sustainable approach for "in-service" training of HCWs given the high staff turnover.

(iii) The CP support to MOHCC and some NGOs to establish physical infrastructure capacity will also contribute to sustainability of programme gains. This infrastructure includes the Obstetric Fistula ward in Chinhoyi hospital, VIAC clinics, Drop in Centres and Youth Centres. Some of these facilities like the DICEs and Youth Centres are run by the key populations and youths. The challenge these structures face is inadequate funding to support their operations.

(iv) The CP also built capacity of government human resources, structures and systems particularly for producing population data which ensured ownership of the population census and surveys, enabling the government to produce and analyse population data going forward. The trained staff would subsequently train their peers and the databases established will continue ensuing access of data to users. Notwithstanding the capacity developed, ZIMSTAT, like other government institutions, has experienced high staff turnover of key staff at the level of statistician and above which undermines the sustainability of gains made through UNFPA support.

(v) The CP also supported beneficiaries' capacity development which is critical for sustainability. This included training of community cadres (Behaviour Change Facilitators and Village Health Workers) on SRH/HIV and SGBV and capacity development of Key Population organisations such as GALZ. With the skills and knowledge gained, these cadres are likely to continue sensitising the community beyond the programme as volunteers.

(vi) The CP sensitised beneficiaries on SRH, HIV and GBV through various community based interventions (CSE, Sista2Sista clubs, PCC, Community Dialogue). The increase in awareness, knowledge, skills and the change of attitude or mind-set among beneficiaries (adolescents and young people, parents, key populations, SGBV survivors, women, community leaders and community members) will continue generating demand for SRH, HIV and GBV services beyond the programme period.

The mechanisms supported by the CP to ensure ownership and benefits continue beyond the programme are as follows:

(i) Government leadership in the interventions supported by UNFPA promoted government ownership. For instance, UNFPA supported government to develop policies (such as the national youth policy and school health policy) as well as strategic plans for various programmes such as family planning, cervical cancer control, adolescent reproductive health and gender strategy which established national priorities. Interventions supported were also drawn from national plans hence ensuring that the CP supported priorities set out by government. Implementation of some of the interventions was equally led by government using its own systems, structures and staff. The Non-Government implementers also developed linkages and engaged with government in implementation of their interventions. This planning and implementation approach promoted national ownership of the CP.

(ii) Engagement of key populations through support for key populations led organisations such as GALZ and supporting establishment of the National Sex Workers Association also promoted ownership and will contribute to sustainability of the gains made. For instance, the programme also engaged KP peers deployed to DICEs and youth peers in tertiary institutions which promoted ownership and sustainability.

(iii) Selection of community cadres from their own communities where they are trusted and viewed as community own resource persons. These cadres are consulted by the community even outside of the programme (Key informants) and will continue providing volunteer service beyond the programme. It is notable that there has been very limited attrition of the BCFs and S2S mentors during the period of the programme.

(iv) UNFPA advocacy for the key population programme among policy makers at MOHCC and parliamentarians has improved the enabling environment for provision of healthcare services to MSM and other KPs. The enabling environment will endure and ensure the KPs continue accessing services beyond the programme.

(v) Strengthening MOHCC leadership and coordination of the SRH/HIV programmes through development of strategic plans and guidelines and supporting coordination structures to ensure government ownership. However, inadequate funding will most likely affect the functioning of the coordination structures going forward.

(vi) Networks, linkages and coordination platforms were established for national ownership of population data. These included inter-Ministerial Technical Committees, ZIMDAT Inter-Ministerial Technical Committee, chaired by ZIMSTAT, the SDG Cluster chaired by three different ministries under the overall coordination of the Ministry of Public Service, Labour and Social Welfare. These mechanisms promote ownership and use of population data beyond the CP period.

4.5 Evaluation question 5: Role of UNFPA in Coordination within the UN

EQ 5 To what extent is the UNFPA CO coordinating with other UN agencies in the country and how is it aligned to the UNDAF?

Summary of findings

(i) UNFPA role in UN coordination mechanisms is robust and visible. UNFPA is an active member in ZUNDAF coordination structures (UNCT, PMT, Outcome Cluster Groups), other UN coordination groups (OMT, UNCG, M7E TWG), technical coordination mechanisms where UNFPA co-leads the Gender Working Groups, convenes the Social Protection Groups and leads the GBV sub-cluster.

(iii) UNFPA advances the UN delivering as "one" strategy involving joint programming through participating in several joint programmes including Spotlight Initiative, the Health Development Fund, 2gether4SRH, Joint HIV programme and joint programming for Tariro youth Centre development, gender equality and access to justice.

(iv) In humanitarian response coordination, UNFPA leads the Protection Cluster, the gender sub-cluster, contributes to the UN reports and works jointly with other UN agencies to support the government response.

UNFPA is extensively involved in UNCT coordination mechanisms and contributes significantly to ZUNDAF which is the overarching strategic guide for UN Support to the Government of Zimbabwe. The UNFPA Country Representative is a member of the UNCT and reports on UNFPA programme contribution to ZUNDAF and provides strategic advice on areas relevant to UNFPA mandate during these meetings. On an Ad hoc basis, the Representative rotates with other UN agency Heads to act as Resident Coordinator in the absence of the Coordinator. Key informants observed that UNFPA contributions to the UNCT have been insightful and meaningful.

The Deputy Country Representative for UNFPA is a member of the Programme Management Team responsible for overseeing implementation of ZUNDAF. The team reviews reports form the ZUNDAF outcome clusters and identifies strategic and policy issues to be presented to UNCT. The Team also addresses challenges facing ZUNDAF implementation. This inter-agency team ensures coherence in the implementation of ZUNDAF by all agencies.

Another structure that UNFPA participates in is the ZUNDAF Results Cluster for outcome 3 which reviews progress in implementation of interventions. Outcome Results Groups are instrumental in ensuring coordinated planning and implementation across agencies and alignment of the CP to ZUNDAF. UNFPA M&E Officers represent UNFPA in the M&E Working group which is responsible for developing the ZUNDAF results framework and providing data to track ZUNDAF indicators. It was not noted that the M&E staff from UNFPA are not at the same level as those from other agencies in the M&E working group. Within these coordination structures, UNFPA ensures that issues of adolescents and young people and women empowerment are integrated across relevant results areas. Given its support for ZIMSTAT, UNFPA also plays a key role in ensuring that data is available for planning not only at national level but also within the UN.

UNFPA staff are members of other groups that play critical roles in UN operations. These include the Operations Management Team (OMT) which comprises of 5 working groups – common services, procurement, human resources, ICT and finance. UNFPA is represented by the Finance and Operations Officer. The chair or leadership of OMT rotates and UNFPA was the chair in 2018. UNFPA has also chaired the finance, ICT and procurement TWGs in the past. This committee is instrumental in supporting agencies including UNFPA to gain cost efficiencies by utilising common services. UNFPA is also a member of the UN Communication Group (UNCG) which coordinates UN-wide communication activities. This group facilitates information sharing especially in areas of joint programming and helps the UN to deliver as "one".

At programmatic level, UNFPA is a co-lead (with UN Women) of the Gender Working Group within the UN which facilitates gender mainstreaming, it plays a key role in the steering committee for Protection Against Sexual Exploitation and Abuse, leads the GBV sub-cluster and coordinates (in the interim) the Protection Cluster. UNFPA is a member of the Health Cluster focusing in SRHR issues. Participation of UNFPA in these groups has increased its visibility and promoted the

integration of SRHR, adolescents and young people and women empowerment issues across programmes. It also provides technical expertise on these issues during these meetings (Key Informants).

Another layer of UNFPA participation in coordination mechanism is the joint programming. UNFPA participates in the following joint programmes:

(i) Spotlight Initiative established by the UN Deputy Secretary General and is funded by European Union. This programme support gender equality and women empowerment and is implemented jointly by UNFPA, UNICEF, UNDP, UN Women and UNICEF.

(ii) Health Development Fund set up by multi-donors to support healthcare services in Zimbabwe. UNFPA and UNICEF are jointly implementing this programme.

(iii) Joint programming with ILO to establish the Tariro Youth Centre and Clinic as a centre of excellence for provision of SRH, HIV and GBV services to young people.

(iv) 2Gether4SRH programme supported by Sweden which is jointly implemented by UNFPA, UNICEF, UNAIDS< and WHO in 13 districts spread across 7 districts in the country.

(v) UN joint programme on AIDS coordinated by UNAIDS where UNFPA is involved with other UN Agencies in implementing UN support to the national HIV response. UNFPA is a member of the Joint Team on AIDS which leads the HIV outcome of ZUNDAF.

(vi) Gender equality joint programming with UNDP, ILO and UN Women

(vii) Joint programming on Access to Justice with UNDP, UNICEF and UN Women

With regard to humanitarian response, UNFPA leads the GBV sub-cluster, contributes to the bi-weekly Zimbabwe STI Report on social protection and GBV and humanitarian response SITREPS and COVID 19 SITREPS submitted to OCHA. UNFPA is also a co-lead with WHO in the UN Clinic Management. Since COVID 19, UNFPA has taken the role of the national COVID Coordinator (within UN) to ensure duty of care for UN Staff in Zimbabwe.

4.6 Evaluation question 6: Coverage and connectedness

EQ 6: To what extent has the CO been able to respond to changes in national needs and priorities during the humanitarian emergencies and crisis e.g. drought, floods and cyclone? What was the quality of the response?

Summary of findings

(i) UNFPA played a major role in bringing to the fore (at both policy and programming levels) the needs for sexual reproductive health and protection of women during humanitarian emergency settings. As a result of the UNFPA evidence-based advocacy, the Government of Zimbabwe prioritised SRH/GBV as part of the humanitarian response and UN also included these services in its support to government.

(ii) UNFPA response to both Cyclone Idai and COVID 19 contributed to continuity of provision of SRH (particularly maternal health) services and services for SGBV survivors. Lessons learnt can be applied to improve programme efficiency and effectiveness.

(iii) UNFPA humanitarian response demonstrated its emergency preparedness capacity which includes utilisation of fast track procurement procedures and financial management systems.

Major humanitarian emergencies that took place during the period of the 7th CP include the El Nino induced drought in 2016, cholera outbreak in 2017, political, economic and financial crisis started in 2017 spilling over to 2020. The economic crisis resulted in an industrial strike from September to December 2019 and accelerated movement of healthcare workers from public service. The country also experienced Cyclone Idai in 2019 which affected the eastern region of the country leaving about 270,000 people in urgent need of humanitarian assistance and COVID 19 in 2020

which has affected the provision and access to healthcare services and deepened the economic crisis in the country.

UNFPA is typically not viewed as a humanitarian agency. However, it played a key role in bringing to the fore the effects of humanitarian emergencies on SRHR and GBV among other forms of violence against women and girls.

During cyclone, UNFPA worked with the UN Joint Team to assess the impact of Cyclone Idai on HIV, maternal health services and GBV and provided data which informed the UN to include these services in its support to government. ZIMSTAT and UNFPA collaborated to provide data on populations affected by Cyclone Idai, but as mentioned under effectiveness section, the data was not adequately disaggregated.

UNFPA contribution to the UN response to Cyclone Idai included the provision of vehicles to support transportation of commodities, establishment of safe spaces for adolescent girls and women affected by GBV, airlifting pregnant women to health facilities, supporting maternal waiting homes in unaffected health facilities to take up pregnant women from the cyclone affected areas, provision of delivery kits to health facilities in affected areas, training of HCWs in the health facilities on Minimum Initial Service Package (MISP) in the affected areas and provision of dignity kits to women and girls. The UNFPA support ensured continuity of maternal health and GBV services during the Cyclone Idai emergency and also helped to raise awareness among policy makers in the MOHCC on the need to integrate maternal health and GBV services into the humanitarian response. The response to Cyclone Idai increased UNFPA capacity and preparedness to respond to humanitarian emergencies.

During the COVID 19 pandemic which started in Zimbabwe in March 2020, UNFPA was better prepared to ensure continuity of SRH and GBV services. Measures taken included collaboration with implementing partners to re-programme the CP to adjust implementation approaches. This involved halting some interventions and changing implementation approaches for others. For instance, more focus was put on continuity of maternal health services, attending to GBV survivors using the mobile One Stop Service to ensure access to services during the lockdown and moving training and mentorship to virtual platforms.

UNFPA advocated to Government to prioritise GBV as an essential service and waive travel restriction to allow survivors to access shelters, One Stop Service centres and health facilities. Implementing partners were trained on GBV in humanitarian emergency settings. The programme also introduced the safe space initiative as a response to increasing cases of violence against women and to ensure girls get to the Sista2Sista clubs. To ensure continuity of maternal health services, UNFPA provided transport to HCWs in the City of Harare. HCWs workers were also trained in the provision of Minimum Initial Service Package which includes maternal health services.

Implementing Partners were provided with data bundles to facilitate communication with UNFPA and community cadres and to hold of virtual meetings. Community cadres were also provided with airtime to enable them communicate with Implementing Partners and to continue community sensitisation. In addition, UNFPA provided personal protective equipment to allow safe delivery of SRH and GBV services. It was observed that community cadres assessed the SRH and GBV needs at community level and identify persons in need of service such as transport, emergency maternal health and GBV services and disseminated the information to Implementing Partners. Non-Government implementers supported by UNFPA such as ZICHIRE and ZAPSO among others used the community cadres to conduct GBV surveillance and link survivors to SGBV services. UNFPA support also enabled the Drop in Centres for MSM to continue providing services given that Wilkins Hospitals where a specialised KP clinic is located was more focused on addressing COVID 19.

UNFPA utilised organisational procedures and tools such as the KOBO tool (a virtual reporting system) to allow timely reporting by Implementing Partners, the fast track procurement procedures and humanitarian emergency financial management guidelines to respond to the impact of the pandemic on programme implementation. As a result of UNFPA CO involvement in humanitarian emergencies, it was appointed to mead the Protection Cluster and GBV Sub-Cluster. The Country Office recruited one humanitarian emergency expert to lead its response efforts.

Chapter 5: Conclusions and Recommendations

5.1 Conclusions

5.1.1 Strategic conclusions

Conclusion 1: Relevance of the CP to national policies and strategies
Based on EQ1

1.1 The 7th CP was well aligned to the national policies and strategies (ZimASSET and TSP), UNFPA strategic plans, ZUNDAF and Sustainable Development Goals; and advanced the ICPD Programme of Action. It was also well aligned to the national policies and strategies for maternal and child health, family planning, cervical cancer control, gender as well as the youth policy and population policy. The 8th CP will need to adapt the UN shift from the "assistance framework" to a "sustainable cooperation framework" which emphasises working with the country/government as a partner while promoting government leadership and ownership of the programme.

Conclusion 2: Relevance of the CP to the needs of targeted populations
(Based on EQ1)

2.1 The CP selected targeted geographical areas (districts) and populations through analysis of data for indicators relevant to UNFPA mandate. While the CP selected 20 districts where its interventions were to concentrate in order to maximise its impact, additional districts were targeted during implementation partly due to the need to align to donor programme coverage, requests from government and humanitarian emergency needs. As a result, the districts in which individual CP interventions are implemented tend to differ affecting approaches such as integrated service delivery and continuum from demand generation to SRH, HIV and GBV service delivery.

2.2 UNFPA recognises that Adolescents and Youth are a major target population for the CP and supported youth networks to participate in advocacy and decision making processes. However, there was inadequate involvement of these youth networks in UNFPA programming processes.

Conclusion 3: Effectiveness of the CP in achieving outputs
(Based on EQ2a and 2b)

3.1 Capacity building was one of the major approaches for delivering results across all programmes. Service providers' capacity was built to enable them deliver quality services and also to increase service availability. This notwithstanding, the high turnover of trained staff from public service is a common threat to delivery of services across all programme areas.

3.2 There is no other immediate funding source for some of the programmes supported by the UNFPA (OF, Cervical Cancer Treatment, Family Planning commodities, Maternal Health audits and capacity building, etc). Without the UNFPA support, gains made are likely to regress.

3.3 The CP adopted integrated SRHR/HIV and GBV programming to a large extent where community cadres provided an integrated package of information and demand creation and

health service providers were also expected to provide integrated SRH/HIV/SGBV services. The integrated approach reinforced synergies across the four outcomes of the CP. However, the variations in the districts where each CP intervention was implemented undermined the smooth continuum from demand generation to access to services in the health facilities, OSC and Shelters among other service points. The integrated approach also stretched the capability of community cadres who were expected to provide information and generate demand for several services.

3.4 The CP mainstreaming of gender was not comprehensive and systematic. Commitment to gender mainstreaming is demonstrated in the UNFPA CO but this was not followed through to ensure strong gender analysis to inform the CP design and monitoring. There was good progress in integrating gender in some of the interventions such as those under outcome 2 and 3, but integration of gender in outcome 1 was relatively weak. Further, the capacity of some of the implementing partners, such as MOHCC, in gender mainstreaming was inadequate.

3.5 Integration of disability in the CP took place later in the programme during implementation and attempts to address the needs of persons with disability were localised in specific interventions. A holistic approach to addressing the needs of persons with disability was lacking.

Conclusion 4: Efficiency of CP implementation

(Based on EQ3)

4.1 High performance of the CP, demonstrated by the achievement of most output targets, can be attributed to adequate capacity of UNFPA CO and Implementing Partners, effective financial instruments and administrative procedures deployed for execution of the programme. UNFPA has an adequate number of skilled staff while implementing partners have technical competency in their programing areas.

4.2 UNFPA staffing especially for M&E and population dynamics programme area and the CO staffing structure could be improved in increase efficiency in CP implementation

4.3 The process of AWP development, though well laid out, presented a major bottleneck in CP implementation resulting in late start-up of activity implementation.

4.4 Opportunities for strengthening and developing strategic partnerships to improve effectiveness of the CP were not adequately exploited. For instance, through strategic partnerships, the CP could ensure adolescents and young people reached with information and skills developed are linked with partners providing economic empowerment opportunities. There was also potential for UNFPA to partner with other players implementing gender and women rights programmes to address causes of SGBV prevention as the CP focused on the response to SGBV.

Conclusion 5: Sustainability of the country programme

(Based on EQ4)

5.1 Capacity building of implementing partners and service providers contributed to sustainability of benefits achieved through the CP but, as mentioned under conclusion 3, the high turnover of trained staff undermines the sustainability of the gains of the CP.

5.2 The approach adopted by the CP to provide capacity development through pre-service training programmes and mentorship was a cost efficient and sustainable strategy for continuous capacity development in a context where the need for skills development is significant and continuous.

5.3 Government leadership, policy level advocacy, engagement of key populations and youth networks and community leaders was critical in promoting ownership of the programme.

However, the involvement of the youth and other beneficiaries in the programming processes was inadequate

Conclusion 6: Role of UNFPA in coordination

(Based on EQ5)

6.1 UNFPA participated meaningfully in the coordination mechanisms of UN including the coordination structures for ZUNDAF and UN technical groups in line with its mandate. UNFPA was also involved in joint programming with other UN agencies. However, there is a need to improve information sharing and involvement of other UN agencies in implementation of the CP interventions.

Conclusion 7: Coverage and connectedness

(Based on EQ6)

7.1 Over time, the role UNFPA CO for Zimbabwe in humanitarian response has been recognised both within the UN and by government. The CO also succeeded in ensuring maternal health and GBV are included as essential services during emergencies and there is a need to ensure these services are fully integrated into national emergency planning.

7.2 UNFPA response to COVID 19 brought out important lessons in ensuring continuity of service delivery in the context of pandemics such as use of virtual platforms in training and programme review, improvement of infection control to ensure service continuity and management of SGBV cases through mobile/outreach services and telephone counselling. Some of these lessons have potential of being integrated into the CP to improve efficiency.

5.1.2 Programmatic conclusions

(All conclusions are based on EQ2a)

Conclusion 1: Sexual and reproductive health

1.1 CP investments in capacity building especially on provision of LARCs, procurement and supply of FP commodities, demand generation and institutional strengthening and coordination contributed to increased uptake of FP services, but coverage of IUCD and implants is still too low compared to other contraceptive methods.

1.2 Although the CP supported improvement of maternal and neonatal health services and contributed to improved quality of EmONC services, there was inadequate support for implementation of recommendations of maternal and perinatal deaths audits particularly those touching on policy, legislation and systems strengthening (equipment and infrastructure).

1.3 The CP was the only funding source for obstetric fistula treatment and without UNFPA support; gains made in OF service delivery are likely to be lost if UNFPA support is withdrawn. OF treatment is available in one centre in the country and there is a need to provide this service in additional central hospitals to improve access.

1.4 Although there was increased uptake of cervical cancer screening and treatment services with the CP support, challenges remain in having the services available countrywide and closing the gap between VIAC screening and treatment to ensure all women testing VIAC positive are offered treatment.

1.5 The CP supported several interventions to generate demand for and increase uptake integrated SRH, HIV and GBV services – BCC, STI management, condomize campaigns, community dialogues and interventions targeting MSM and YWSS. The referral systems from demand generation to service delivery was not well structured and monitored. The capacity of

community cadres to provide information on some of the topics such as GBV and LARCs was also limited,

Conclusion 2: Adolescents and youth

2.1 The 7th CP supported national and subnational adolescents sexual and reproductive health multi-sectoral coordination meetings and various thematic groups. however, this support did not cover all districts.

2.2 The empowerment of adolescents and young people through multiple approaches (Sista2Sista clubs, CSE, PCC and community engagement) was effective in increasing access to SRH information as well as in increasing the uptake of services such as HIV testing. Despite this achievement, post engagement planning and monitoring or follow up of graduating adolescents and youth is weak.

2.3 Although the UNFPA supported districts performed well in meeting YFS standards, the national coverage remains very low and the youth themselves are not adequately involved in monitoring the services.

Conclusion 3: Gender equality and women empowerment

3.1 One Stop Centres and Shelters addressed a critical gap in responding to the needs of GBV survivors. The high level of utilisation of the services in some OSCs and shelters is testimony to this. However, the CP set similar targets across all facilities without taking into account community dynamics in the areas where the OCS and Shelters are located. The level of OSCs and shelters utilisation may be a reflection of the reporting of GBV cases including awareness and demand generation, cultural norms, fear and stigma.

3.2 The setting up and running of OSCs and shelters is resource heavy and relies on donors. Government did not allocate resources to these centres despite being part of the Domestic Violence Act. Reliance on donors is not sustainable and a long term sustainability strategy is required.

3.3 Capacity for coordination was strengthened at national level (ADVC and Ministry of Women Affairs and the national coordination forum) and at province and district levels but gaps remain as not all districts are covered, the capacity of ADVC remains insufficient and the GBVIMS has not been operationalised.

3.4 The CP prioritised support for SGBV survivors (response to SGBV) while GBV prevention was not comprehensive or well defined. It was assumed that integration of SGBV into community cadres work would increase awareness and generate demand yet different skills and processes are required to address SGBV. Male involvement in prevention and response to GBV was not sufficiently integrated into the CP support.

3.5 GBV in emergencies has become a very critical intervention considering the frequencies of emergencies in the country.

Conclusion 4: Population dynamics

4.1 The Population Dynamics component of the 7th CP is highly relevant and well aligned to the Zimbabwe National Population Policy, and to the ICPD POA. It comprehensively addresses the needs and requirements of the GoZ and ZIMSTAT in integrating population and development into planning and implementation of programmes. The GoZ commitments in the

ICPD POA@25, highlight the need to review the 1998 Zimbabwe National Population Policy, which UNFPA can advocate for and support the process.

4.2 Staff capacity was developed in data collection, analysis and dissemination using various platforms including meetings, web-based platforms and by hard copies. A lot has been done to improve the quality and disaggregation of data. However, there are still gaps in the capacity for collection of migration statistics and reporting on vital registration statistics.

4.3 Assessments have shown that there is a need for not only human resources development, but also for knowledge sharing and a strong and supportive technological base and infrastructure to efficiently produce and disseminate statistics.

4.4 There is limited evidence of data utilisation at national, provincial and district level for planning and programming due to the fact that there is no systematic assessment of data use and its effectiveness for change (in-depth analysis reports, web-based databases, population based studies).

4.5 Funding for Population Dynamics has been on the decline and some activities in the 7th CP were not achieved due to limited funding.

4.6 The UZ Centre for Population Studies is positioned to support in-depth data analysis of thematic areas from surveys and to build the capacity of staff from government ministries in integration of population data in their work.

5.2 Recommendations

5.2.1 Strategic recommendations

Recommendation 1: Align the 8th CP to the UN Sustainable Cooperation Framework (UNSCF) for Zimbabwe by adapting the "cooperation framework" principles, orientation and mechanisms
(Based on conclusion 1)

1.1 Establish a mechanism that will strengthen UNFPA partnership with Government in the design, implementation and monitoring of the CP and promote government leadership and ownership of the CP. One option is to set up a steering committee for the CP co-chaired with Government and UNFPA and with a high level (preferably permanent secretary) official as a focal person. This will facilitate cooperation between UNFPA and Government. A second option is to use a mechanism that UN in Zimbabwe will set up to coordinate the UNSCF with government. This option duplication of UN-Government coordination structures but has potential for diminishing visibility and focus on the CP.

1.2 Given that the UNSCF has not been developed, it is advisable that UNFPA conducts a comprehensive orientation of the CO on the change from "assistance" to "cooperation" and ensure "cooperation" principles and orientation or way of working are reflected in the CP.

Recommendation 2: Improve geographical and vulnerable populations focus and beneficiaries' participation in Country Programme to maximise its impact
(Based on conclusion 2)

2.1 To improve the geographical concentration of the 8th CP, prioritise CP geographical targeting at province rather than district level. The focus on provinces will allow the CP to scale up interventions in districts within the province to achieve greater results and makes it easier to measure the CP performance.

2.2 Ensure interventions providing a continuum of services – from demand generation to service provision - are implemented in the same provinces and districts. For instance, demand generation for SRH, HIV and GBV as well as support for service delivery (e.g. capacity

building of service providers, provision of commodities and equipment, mentorship, strengthening referral mechanism, OSC and Shelters for GBV survivors and training of GBV service providers) should be implemented in the same provinces to ensure both demand and supply interventions are interlinked to maximise the CP impact.

2.3 Review implementation partners to bring on board other institutions that could strengthen the effectiveness of the CP. These include the Ministry of Youth which coordinates the implementation of the youth policy, Registrar General's Office in charge of civil registration, University of Zimbabwe Population Studies Department to strengthen capacity building in population and development and Faith Based Organisation which have infrastructure to run GBV shelters.

2.4 Establish a mechanism for involving beneficiaries in the programming – during design, implementation and monitoring of the CP. Some of the quick wins include the involvement of the youth (through their networks) and the key populations (from MSM organisations) in the programming processes. UNFPA could also consider training government partners (such as MOHCC, MoPSE and MPYDIE MoWACSMED) in participatory programming to enable them appreciate the involvement of beneficiaries.

2.5 Introduce, on a pilot basis, client led monitoring tools to involve adolescents and young people, key populations and other beneficiaries in monitoring selected CP intervention to the CP is responsible to their needs.

Recommendation 3: Improve approaches for strengthening capacity of service providers and health and community systems

(Based on conclusion 3)

3.1 Strengthen integrated SRH, HIV and GBV service delivery through building capacity of HCWs and strengthen monitoring of the integrated service delivery. The CP should support MOHCC to develop SOPs on integrated services develop and a tool to track implementation of the SOPs.

3.2 In collaboration with other development partners, support implementation of the National Community Health Strategy to align the current community based interventions with national priorities. Within this context, match the scope of integrated SRH/HIV/GBV demand generation that community cadres can undertake with their capability.

3.3 Develop a comprehensive approach to integration of gender in the CP through adaptation of the gender mainstreaming guidelines of the UN, developing capacity of UNFPA staff and implementing partners, conducting comprehensive gender analysis to inform the design of the CP and integrating gender into the monitoring system.

3.4 Strengthen integration of disability onto the CP through developing comprehensive guidelines for mainstreaming disability, training UNFPA staff and implementing partners, conducting a disability analysis and integrate disability on to the monitoring framework of the CP.

3.5 Support relevant line ministries (such as MOHCC and MoWACSMED) to develop and implement the disability mainstreaming guidelines at ministry level to assist high level mainstreaming of disability in planning, implementation and monitoring of programmes in general. This will advance disability mainstreaming within the Universal Health Coverage agenda.

Recommendation 4: Improve the CP annual work plan development process, UNFPA staff capacity and exploit strategic partnerships to increase programme efficiency

(Based on conclusion 4)

4.1 To improve timeliness in development of AWPs, start the planning process earlier and conduct half yearly review of activities to address any weaknesses in the work plan. This will allow UNFPA to accept what could be considered good enough instead of seeking to achieve perfect work plans.

4.2 Review staffing especially for M&E and population dynamics programme areas to match staffing levels with expected responsibilities.

4.3 Develop strategic partnerships especially with organisations supporting gender and women rights, and youth economic empowerment programmes in order to improve efficiency and effectiveness of the CP.

Recommendation 5: Advocate for domestic resource allocation to health to improve sustainability of the CP results

(Based on conclusion 5)

5.1 In partnership with other development partners, advocate to government to increase domestic resources allocated to health to sustain gains made by the CP. This will mitigate the staff turnover, provide critical equipment and improve health facilities infrastructure.

Recommendation 6: Improve information sharing and joint implementation of interventions with other UN agencies

(Based on conclusion 6)

6.1 UNFPA CO should take proactive steps to share information and involve other UN agencies (involved in joint programming) in the implementation of interventions to further strengthen synergies with other UN agencies

Recommendation 7: Strengthen capacity of GOZ to integrate SRH and gender into humanitarian respond and apply lessons learnt from COVID 19

(Based on conclusion 7)

7.1 Support the GOZ (MOHCC) to develop guidelines and SOPs for integration of SRH and SGBV into the national emergency response plan to ensure continuity of these services in cases of emergencies. This should be followed with building the capacity of health facilities and GBV stakeholders in areas prone to floods and droughts in implementation of these guidelines and SOPs.

7.2 Integrate key lessons learnt from COVID into the CP implementation approaches such as use of virtual platforms for training and meetings, use of the hotline and mobile SGBV service delivery and integration of infection prevention and control into service providers' capacity development.

5.2.2 Programmatic recommendations

Recommendation 1: Improving and scaling up sexual and reproductive health services

(Based on conclusion 1)

1.1 Scale up coverage and uptake of LARCs through increasing capacity of MOHCC/ZNFPC to train HCWs on LARCs in additional health facilities, supporting MOHCC to certify qualifying HCWs, introducing a mentorship programme for HCWs on LARCs replicating mentorship programme for maternal health. UNFPA should also consider developing a partnership between ZNFPC and NGOs providing FP services to utilise their capacity to mentor HCWs on LARCs. UNFPA should continue supporting procurement and supply of FP commodities in the medium term as it advocates to government to allocate funds for FP commodities in the medium to long term.

1.2 Expand the reach (access, availability and utilisation) of comprehensive FP services for vulnerable groups such as the youth, and people with disabilities.

1.3 Support MOHCC to develop a comprehensive approach to implementation of maternal and perinatal deaths audit recommendations, especially those touching on policy, legislation, systems and infrastructure gaps. UNFPA should also continue advocating for government to allocate resources for maternal health equipment and infrastructure requirements.

1.4 Expand obstetric fistula treatment infrastructure to attain adequate geographical coverage. This can be achieved by building the capacity of provincial hospitals to provide OF treatment.

1.5 Strengthen the capacity for provision of Cervical Cancer treatment services countrywide through establishing additional VIAC clinics, providing new treatment technology to be used during VIAC outreaches to close the screening to treatment gap and integrating male involvement in the VIAC screening and treatment.

1.6 Strengthen implementation of the M&E systems for the National Community Health Strategy (referred to in strategic recommendation 2.2. This will include development of guidelines and data tools for the referral pathway between SRH, HIV and GBV demand generation at community level and service delivery points including health facilities.

Recommendation 2: Improving and scaling up sexual and reproductive health services
(Based on conclusion 2)

2.1 Strengthen coordination of ASRH programme through supporting coordination of ASRH interventions at district level given that districts are closer to the interventions implemented at community level. At the national level, continue to support the three-line ministries (MoHCC, MoPSE, MYSAR) and other stakeholders such as City of Harare to jointly plan and coordinate activities to ensure consistency and smooth implementation.

2.2 Develop a robust post engagement (post s2s, PCC, CSE and community engagement) plans to ensure skills, knowledge and attitude changes are translated into SRH/HIV/Gender outcomes. Strengthen these interventions by incorporating basic livelihood (income generation) activities as a way of providing a holistic intervention that addresses both the information and economic vulnerabilities that put young people at risk.

2.3 Scale up Youth Friendly Health Services through the approaches deployed in the current CP districts where YFHS has over 90% coverage. In addition, include a component of youth-led monitoring of YFHS at health facilities.

2.4 Develop the linkage between community-based interventions (Sista2Sista, PCC, CSE) and basic livelihood (income generation) and lifesaving skills to enhance the effectiveness of community based SRH/HIV/GBV interventions.

2.5 Develop resources materials for Facebook and Tune me platforms in local languages to broaden reach to the those left behind and furthest behind through eliminating language barriers. Support the development of social media platforms that can work well with those with limited data to reduce on the costs of data

Recommendation 3: Improving the response to gender based violence
(Based on conclusion 3)

3.1 Consolidate the response to GBV initiative through strengthening the referral pathway to ensure timeous access to services. Focus should be on training and deploying community level paralegals and social welfare cadres to support SGBV survivors to report to OSCs and prioritise supporting hospital based OSCs because government is already providing healthcare support, law enforcement and judicial services to SGBV survivors. There is need to build the capacity of the government's Legal Aid directorate in GBV with the intention to link the hospital based OSCs to this directorate for free legal services to GBV survivors. Legal Aid directorate staff can be seconded to government OSC to provide legal advice.

3.2 Set targets for OSCs and shelters to taking into account community dynamics, demand generation and awareness efforts and the extent of deployment of community cadres (especially paralegals) to support SGBV survivors to overcome stigma and fear and report cases.

3.3 Develop a coordination framework defining countrywide GBV planning processes, M&E and accountability. This framework should include a component for community level coordination.

3.4 Develop comprehensive and inclusive SGBV prevention interventions, including strengthening male engagement and community leaders' awareness and participation in women rights protection and reporting of SGBV cases. The CP should strengthen partnerships with other programmes focusing on women empowerment, including women economic empowerment and engagement of men and boys.

3.5 Strengthen GBV in emergency programming through establishing appropriate guidelines and building capacities within UNFPA, government and implementing partners

3.6 Invest in infrastructure and capacity of stakeholders to collect, store, analyse and share data using the GBVIMS. This will ensure availability of reliable GBV data in the country to guide programming.

Recommendation 4: Improving population dynamics

(Based on conclusion 4)

4.1 Strengthen the capacity of the MoFED to coordinate the integration of population issues in national and sectoral policies and plans and building the capacity of Parliamentarians and Parliament Committees on the interlinkages between population and development, for the Government of Zimbabwe to fulfil its ICPD POA commitments.

4.2 Build the capacity of ZIMSTAT on approaches to capture migration and vital registration statistics and bring on board Partners such as the International Organisations on Migration and the Ministry of Foreign affairs for migration statistics.

4.3 Strengthen ZIMSTAT IT systems and infrastructure, re-tooling of the server, renew hardware and software, including Computer Consumables, accessories and supplies.

4.4 Build the capacity of ZIMSTAT carry out in-depth analysis of population data, develop policy briefs and dissemination of these products.

4.5 Provide financial and technical support to the Department of Registrar General to improve its data quality as from 2021 onwards by addressing gaps and errors already identified in the extraction of the 2015 data by ZIMSTAT. Additional funding is required to support data extraction and computerisation of all records (staff, computers, internet connectivity to access online soft copies of the International Classification Book for causes of death as hard copies are deemed voluminous for everyday use.) The MOHCC can support the RG's Office with a more robust method for the classification of cause of death.

4.6 Develop a systematic methodology to profile data users, their expectations, frequency of data use, level of data use, and accessibility of data from ZIMSTAT.

4.7 Bring on board non-traditional development partners to add to the traditional funders and mobilise for domestic resources from the private sector to fund population dynamics interventions.

4.8 Establish a Research Component/Unit within the Centre for Population Studies to coordinate and facilitate in-depth analysis of population data and dissemination of policy briefs by MSc and PhD students as part of their programme requirements; and introduce short-term capacity development courses for staff from government ministries and institutions, other stakeholders on integration of population and development and how to utilise demographic data in their ministries and/or organisations.

Annexes

Annex 1: Evaluation Matrix	Evaluation Matrix.docx
Annex 2: List of Documents Reviewed	List of documents reviewed.docx
Annex 3: Stakeholder mapping	Stakeholder Mapping.docx
Annex 4: People Interviews	People Interviewed.docx
Annex 5: UNFPA District Coverage by Programme	UNFPA districts coverage by program
Annex 6: Interview guides	Key Informants Interview Guides.docx
Annex 7: Terms of Reference for the Country Programme Evaluation	**Final CPE ToR Zimbabwe.pdf**
Annex 8: Evaluation Reference Group Terms of Reference and note on involvement in the evaluation	TORs for ERG and Process of Establishin
Annex 9: UNFPA 7 CP Status of Outcome Indicators	UNFPA 7th CP Status of Outcome Indicators

Annex 1: Evaluation Matrix

Relevance
EQ 1: To what extent is the country programme adapted to:
i) the needs of diverse populations, including the needs of marginalized and vulnerable groups
ii) national development strategies and policies
iii) strategic direction and objectives of UNFPA
iv) priorities articulated in the ICPD Programme of Action and SDGs
v) the New Way of Working and the Grand Bargain

Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
Needs of diverse populations (including marginalised and vulnerable populations targeted by the programmed) were taken onto account in the 7th CP	• Evidence of systematic identification of the country's needs prior to programming of each thematic area of the CP • Extent of which UNFPA CO has taken into account priorities of GOZ and stakeholders • Selected interventions are consistent with identified needs of targeted populations and national priorities in the CPD and AWPs	• CPD, CPAP and AWPs • National policies and strategy documents relevant to each thematic area • Surveys and assessment reports relevant to each thematic area • Key informants drawn from UNFPA staff, implementers, and service providers partners at all level (national, provincial, district among others)	• Documents review • Key informant interviews
The 7th CP is adapted/ aligned to national strategies and policies	• Programme outcome and strategies are consistent with relevant government policies • Country programme strategies and interventions are discussed and agreed with national partners	• CPD and CPAP • National policies and plans (ZimASSET; Interim Poverty Reduction Strategy Paper (IPRSP); Transitional Stabilization Programme (TSP); Vision 2030; Population Policy; Youth Policy; and Health Sector Investment) • Reports/ minutes of meetings with national partners • AWPs • Interviews with national UNFPA staff, partners, implementers and other stakeholders	• Documents review • Key informant interviews
SP objectives and strategies are consistent with priorities put forward in UNFPA	• CP objectives and strategies are in line with core strategy of UNFPA and SDGs • ICPD POA goals are	• CPD, CPAP and AWPs • UNFPA strategic plan, SDGs and ICPD POA, ICDP Annual Report,	• Documents review • Key informant interviews

strategic plan, ICPD POA and SDGs	reflected in the CP components especially the population dynamics component	ICPD@25 • Key informant interviews – UNFPA staff, national partners and implementers and national stakeholders	
The business model for CP is consistent with Zimbabwe country classification	• UNFPA CO mode of engagement is consistent with business model relevant to Zimbabwe • Business model adopted for 7th CP is reflected in the implementation approaches adopted by UNFPA country office	• UNFPA Strategic Plan • CPAP and AWPs • Key informants – UNFPA staff, national partners, implementers and stakeholders	• Documents review • Key informant interviews

Data collected from the field to be filled

Consistency and alignment to national policies and strategies

- CP contributed to ZimASSET focusing on 2 priority areas – social services and poverty reduction, HIV and governance and public administration. Transitional Stabilisation Programme – Oct. 2018 to Dec 2020 – established following formation of new government (and new dispensation), short term quick wins to address fundamental economic challenges besetting the economy in the immediate term. CP planning cycle has been aligned to the national planning cycle which starts in 2021.

Consistency with UNFPA Strategic Plan, ICPD PoA and SDGs

- CP aligned to UNFPA Strategic Plan 2014-2017 – has consistency with the strategy outcomes and selected outputs relevant to Zimbabwe. CP made adjustments to its results framework to align to UNFPA strategy of 2018-2021 and also maintained the four outcome areas.
- The CP is fully aligned to and advancing the ICPD agenda especially in the areas of sexual and reproductive health and reproductive health rights including family planning, HIV prevention, maternal health; gender equality and women empowerment and population and development.
- CP aligned to SDG3, (health), SDG 5 (Gender), SDG 10 (reduction of inequalities), SDG 4 (education) and SDG 16 (inclusive societies and access to justice)

Geographical targeting

- Selection of districts based on key indicators (geographical consolidation) based on key indicators: Teenage pregnancy, child marriages, HIV infections, secondary/high school drop-out rates, maternal mortality, poverty and infant mortality. This analysis resulted in the selection of 20 districts spread across 6 provinces. Some districts were added during implementation such as Chipinge and Chimanimai to address humanitarian emergencies.

Sexual and Reproductive Health and Rights

- CP support for Family planning service delivery aligned to the family planning strategic plan 2016-2020 and the family planning costed implementation plan. It was also guided by the Zimbabwe commitment to FP2020 targets. The CP also took into account issues arising from FP coordination meetings at national and provincial levels and the findings of the VMAS survey.
- CP support to maternal health aligned to national strategies including the National Health Strategic Plan (2016-2020), Maternal Health and Neonatal Strategy 2017-2021 and the National Health Strategic Plan midterm review findings. The needs addressed by CP were also identified through the Maternal and Perinatal Deaths Surveillance and Response (MPDSR) audits. The CP took into account other partners support to maternal health such as UNICEF and World Bank to ensure synergy.
- Support for Obstetric Fistula (OF) treatment was triggered by hospital based survey done in 2008 which reviewed data on women with OF and found 88 cases. High MMR also points to high maternal morbidities including OF.
- Cervical Cancer Strategic Plan sets out national priorities supported by the CP. Cervical Cancer support was also informed by data from cancer registry.
- The priorities set out in the National HIV Strategic Plan (ZNASP IV) and Adolescent Sexual and Reproductive Health (ASRH) strategy also informed the CP support to HIV prevention. in addition, recommendations of the CP6 evaluation to have HIV/SRH integration were taken into account in CP7. HIV prevention needs were also identified through co-creation meetings with communities and key populations.

Adolescents and youth

- The CP was aligned to the government of Zimbabwe's strategic priorities as enunciated in the Zimbabwe Agenda for Sustainable Socio-Economic Transformation, Transitional Stabilisation Programme, the National Youth Policy and the second ASRH strategy. It was further aligned to UNFPA's strategic objectives, SGDs and the needs of vulnerable adolescents and youths. The CP took into account the SRH health needs of adolescents and youth in its programming, identified through consultative meetings and evaluations with young people and other key stakeholders.

Gender equality and women and girls' empowerment

- The CP was aligned to the government of Zimbabwe's strategic priorities as enunciated in the Zimbabwe Agenda for Sustainable Socio-Economic Transformation, Transitional Stabilisation Programme, the National Gender Policy and the National Gender Based Violence Strategy. It was further aligned to UNFPA's strategic objectives, SGDs and the needs of diverse populations on gender equality. However, there was minimal direct involvement of the intended beneficiaries in the identification of the needs and in the development of the CP to ensure that their voices are considered in the design of the interventions.

Population dynamics

- The Population Dynamics component of the 7th CP (Outcome 4 and Output 7) was well aligned the National Population policy94 whose ultimate goal is to achieve higher standards of living of the people of Zimbabwe through influencing population variables and development trends in desirable directions.
- Needs of ZIMSTAT were identified through a consultative process during the development of ZUNDAF. UNFPA then identified the ZIMSTAT needs they were to support from the ZUNDAF work plan, including the implementation of the ZIMSTAT Strategy for the Development of Statistics II 2016-2020. During the CP implementation, ZIMSTAT continued to engage users and producers of statistics in different platforms (including the data user/producer symposium) to discuss data for national development plans.
- Priorities supported by the CP under Population Dynamics were also identified through two consultative meetings with stakeholders during the development of the 7th CP. Lastly, throughout the implementation of the CP, Annual Work plans were developed, discussed and reviewed quarterly and annually to assess progress and to include any identified emerging needs.

Effectiveness

EQ 2a: To what extent have the interventions supported by UNFPA contributed to the achievement of the expected results (outputs and outcomes) of the country programme? In particular:

i) increased access and use of integrated sexual and reproductive health services
ii) empowerment of adolescents and youth to access sexual and reproductive health services and exercise their sexual and reproductive rights
iii) advancement of gender equality and the empowerment of all women and girls
iv) increased use of population data in the development of evidence-based national development plans, policies and programmes.

Assumptions to be assessed	• **Indicators**	• **Sources of information**	• **Methods and tools for the data collection**
Planned outputs were successfully achieved and contributed to outcome results in all thematic areas, with robust theory of change underlying the results chain	• Evidence of achievement of programme outputs • Extent to which outputs in the CP and results framework are likely to have contributed to outcome results	• M&E documentation • AWPs • Programme, project and institutional reports of stakeholders • UNFPA CO staff • GOZ partners, implementing partners and other stakeholders	• Documents review • Key informant interviews

Data collected from the field to be filled

Sexual and Reproductive Health and Rights

CP support to Family Planning services included:

- Training of HCWs on LARC as a flagship intervention to improve access to contraceptives which is a core mandate of UNFPA. Training HCWs in IUCD, PPIUCD and Implants insertions and those trained are required to undertaken a certain number of integrations to be certified. Certification done by ZNFPC. FP was skewed to oral contraceptives

[94] Government of Zimbabwe. Zimbabwe National Population Policy. National Economic Planning Commission 1978

and this training aimed at increasing uptake of LARCs. ZNFPC has trainers drawn from various institutions (PSZ, SNFPC, MOHCC) who train HCWs on LARCs (IUCD, PPIUCD and Implants). Didactic training methodology is used in the facilities with clients until the HCWs reach a threshold of inserts to be certified. District level supervisors and assessors from ZNFPC supervise and assess and certify HCWs who have attained recommended proficiency for certification.

- Piloting of PPIUCD - Through training, introduction of PPIUCD approach given that over 80% of deliveries are institutional and there was a missed opportunity for PPIUCD
- UNFPA major funding source for FP commodities and procured and supported FP commodities supply countrywide. UNFPA also supports quantification and forecasting of FP commodities. However, FP commodity quantification is done based on trends and when demand increases, there is a likelihood of shortage (stock outs) of the respective method in demand. Secondly, when UNFPA procurement delays, there tends to be a stock out of FP commodities especially in rural health facilities.
- Demand development and awareness undertaken though community mobilisation, IEC and media engagement. Training of community volunteers (BCFs and VHWs) to generate demand for FP (especially LARCs) through integrated demand generation. Creating awareness on FP methods mix, referral pathway and mobilising the community during FP outreaches (FACT, ZICHIRE). This is done using BCF home visit approach
- CP support to maternal health
- Capacity building using cost efficient, effective and sustainable approach of mentorship and on the job training to improve. Previously, training was done through face to face workshops but under the CP, this has changed to using a new approach involving mentorship and OJT using a pool of mentors
- Support for improvement of pre-service midwifery training curriculum increasing training from 1 to 2 years with year 2 covering attachment/ mentorship to improve practical skills and confidence.
- MPDSR – support for MPDSR committee at national, provincial up to district level to conduct deaths audits to identify root causes of deaths and what should be rectified and using mentors to support implementation of corrective actions which include mentoring HCWs.
- Supporting commodity security - procurement of life saving medicines/ delivery kits and putting this into a national pool
- Support for MWHs - These homes are targeting high risk women and those staying in far distances from health facilities. MWHs address the second MH delay
- Electronic Maternal and Perinatal Deaths Reporting System – this system was working before the DHIS system was upgraded. Since DHIS2 upgrade, the system has faced functionality problems. The system was conceptualised to use the DHIS platform.

Obstetric Fistula Treatment

- UNFPA support OF as a matter of sexual right for women. safeguarding the dignity of women and needs to be prioritised. The next DHS should include OF module.
- UNFPA support for establishing a 30 bed facility at Chinhonyi hospital for OF repairs. UNFPA supported the medical commodities needed to perform the repairs and also paid incentives to the doctors and nurses.
- Supported training of doctors and nurses on OF through mentorship from expert doctor.
- Women supported with transport, food and accommodation but other ailments not covered
- Outreaches conducted to increase awareness, identify OF patients (Masvingo) and refer cases for repair at Chinhonyi. Awareness activities covered all provinces except Manicaland. Awareness also done using radio, social media and toll free number to publicise the services. Also utilised other maternal health activities such as MVA and health education at facilities to integrate the message on OF. This has attracted women from all provinces.

Cervical cancer treatment

- CP supported capacity building for provision of cancer screening and treatment services through development of a training manual and training of nurses and doctors on cervical cancer screening and treatment. The training has been very useful as other partners such as OPHID indicated that they rely on HCWs trained with UNFPA support to provide cervical cancer screening and treatment services. Established UBH as a centre of excellence (CoE) where HCWs are able to learn and UBH also provides mentorship to other facilities. A CoE is a good strategy assisting the roll out of cervical cancer programme
- Support for commodity security - Procurement of equipment and consumables for cervical cancer screening and treatment. CP introduced VIAC technology for screening in the country.
- Expansion of health facilities providing cervical cancer screening and treatment, although this was halted to prioritise improvement of quality of services. Expansion entailed: provision of equipment procurement such as cryotherapy,

trained doctors and nurses- these are screening and treatment sites; integration of cervical cancer screening and treatment: Cervical cancer screening and treatment is part of the HCWs routine work and no additional incentives are paid. incentives are only paid when the HCWs undertake outreach to lower level facilities and catchment areas.

- Support for the "see and treat" approach – cryotherapy is used or patients referred for LEEP. They are given coupons which are supported by UNFPA to cover costs such as lab tests. The purpose of this approach is to minimise loss of patients between screening and referral to treatment for precancerous lesions. This approach has largely worked well despite the occasional breakdown of machines and attrition of nurses
- Demand generation – using outreaches and integrating cervical cancer services in Health Education and in community cadres information - BCF, VHWs and s2s mentors to sensitise communities. Demand generated has led to an increase in the number of women screened during the programme period. Except for COVID effect which halted or had some activities postponed. Interventions resumed from May/June 2020.
- Strengthening the enabling environment through development of cervical cancer control strategic plan which provides guidance to the MOHCC and all partners; development of new cervical cancer screening and treatment guidelines and national protocols; and strengthening of collaboration with other partners through bringing together partners under MOHCC leadership to ensure interventions of various partners are well coordinated.

HIV prevention (integrated HIV/SRH and GBV)

- CP supported integrated HIV/SRH/GBV service delivery – Behaviour Change Communication (BCC) demand generation and referral/linkage. Support included sensitisation of communities on HIV prevention, SRH and GBV. UNFPA is using a community engagement approach which has transitioned to demand generation for service update; training of BCFs on integrated information/sensitisation on SRH/HIV and GBV case findings and youth engagement; supporting BCFs to conduct home to home visits – once in the home, conducted risk assessment and tiolors message to the risks and made referrals for those in need to various services including HTS, FP, Cervical Cancer screening, SGBV services; referral of couples and individuals for HTS.
- Support for CSE for out-of-school youth – designed for boys having realised the boy child is being left behind – engages AYP in SRH issues
- Community dialogue – training leaders who in turn run community dialogue meetings focusing on SRH, HIV and SGBV issues and coming up with solutions/ charters

Support for STI management through

- Development of STI strategic plan and STI guidelines in line with WHO guidance
- Support for development of HIV/STI strategic plan 2020-2015 for the health sector. UNFPA supported an STI consultant.
- Support for EMTCT of HIV and Syphilis – procurement of medicines for STI and syphilis/HIV dual test kits and training of service providers on STI management
- Mentorship of nurses (HCWs) – development of mentorship package and sensitising district mentors on the package
- STI Surveillance and data management – support for data quality audits.
- Capacity building and scale up of key population programme – focusing on Young Women who Sale Sex (YWSS) and MSM

Support for MSM programme

- UNFPA played a pioneer role by creating an enabling environment for provision of HIV/SRH services to MSM in the country even before becoming an SSR for Global Fund grant. This involved supporting policy level advocacy where UNFPA engaged in high level advocacy with parliamentarians and MOHCC to have MSM programme in place and at community level where it brought together community leaders and families of MSM to create community and family level support system. Programming for MSM has built on this enabling environment.
- Establishment of Drop In Centres – those supported by UNFPA in Harare, Masvingo and Mutare.
- Support for referral for services through linkages established with several service providers – PSI, HFs where staff are trained; and using referral slips to make referral and then follows up to ensure the clients reach the referred facilities
- Mobilisation through individual MSM – Individual MSM brought parents and friend who they were comfortable with to a meeting for sensitisation on challenges facing MSM community. Individual MSM also reached out to friends. The next step is to have a meeting with parents (brothers and sisters) only. The aim is to establish a family and community support system for the MSM community to reduce stigma and discrimination and improve access to health services.

Young Women Who Sell Sex (YWSS)

- Capacity building and scale up of key population programme – focusing on Young Women who Sale Sex (YWSS) and MSM. Young Women who Sale Sex (YWSS) – project implemented by CeSHHAR for only 6 months. sensitised the 4 KP led CBOs, providing education subsidy, training the YWSS on vocational training, forming savings groups which starts IGPs projects, training on financial literacy and linking YWSS with HIV and SRH and GBV services. Paralegals trained within the 4 CBOs to address GBV issues as they know have to handle GBV. Project affected by COVID (halted activities) but has nor restarted

Adolescents and youth

- The CP supported the migration from youth friendly corners to integrated youth friendly health facilities and this facilitated provision of integrated ASRH services. This necessitated a baseline assessment of YFS provision in 364 health facilities in the 20 supported districts which identified facility specific gaps and informed development of action plans. Both clinical and non-clinical staff in the facilities were trained through On the Job Training. Direct community engagement and transformation on SRH and HIV interventions were implemented.
- The four complimentary interventions: Sista2Sista programmes, the Behaviour Change home visits, Comprehensive Sexuality Education and Parent to Child Communication successfully generated demand for SRH services. Interview with Implementing partners shows that all the four interventions managed to surpass the set recruitment and retention targets. However, stock outs of essential commodities such as the HIV testing kits limited uptake at facility level. Youth engagement through social media platform such as the Tune Me and Facebook was highly successful reaching out to 130, 471 and 358, 504 users respectively. This increased adolescents and youth's access to SRH information and dialogues. Despite achieving the set targets, high cost of data and language were noted as key barriers that disadvantaging young people in accessing the platforms.

Gender Equality and Women and Girls' Empowerment:

- The CP supported the strengthening of the capacity of institutions central to coordination of gender based violence - Anti-Domestic Violence Council (ADVC), judiciary, the police and health service providers and provided services for survivors of SGBV as one way of increasing gender equality and women empowerment. SGBV services were provided through One Stop Centres and Shelters complimented with awareness on GBV at community level. The increased number of women utilising SGBV services shows a deeper entrenchment of SGBV in the community but there was limited focus on SGBV prevention at community level. The CP also offered technical support for the development of GBV Information Management System to facilitate accurate GBV data capturing. However, due to inadequacies in the infrastructure and capacity in government and partners to operate the GBV IMS, the programme has relied on data from community cadres gathered through community surveillance which is not comprehensive.

Population dynamics: The 7th CP provided financial and technical support to ZIMSTAT and achieved the following:

- **Support for the National Population Census -** in-depth analysis of the 2012 census data, producing 6 thematic area reports and disseminating them to the public in hard copy and on the ZIMSTAT website. On the forthcoming 2021 Population Census, the CP had supported the updating of the ZIMSTAT cartography database, acquired servers, and standardization of enumeration areas for the GIS database
- **Support for the ZDHS –** Produced and disseminated 14 ZDHS 2015/16 in-depth analysis reports
- **Support for ICDS** - conducted the ICDS 2017 which used CAPI for data collection for the first time. Two editions of the report were produced and disseminated and the data was uploaded on the ZIMSTAT website for accessibility to the public
- **Support for other Studies** – Three studies were conducted, namely, the Demographic Dividend (2017), the Zimbabwe Vulnerability Assessment (2020), and the Resources Flow Survey (2017) whose findings were widely disseminated. The findings of the Demographic Dividend Study were used as reference document for the preparation of a chapter on population and development in the TSP and the development of the National Development Strategy I 2021 – 2025
- **Support for Vital Registration** - ZIMSTAT successfully re-engaged the RG's Office in the third quarter of 2019 and 4 trained clerks started manually extracting vital statistics data on births and deaths. At the time of the evaluation ZIMSTAT was working on 2015 mortality data, targeting to develop a 2015 Mortality Report by January 2021, then Births Report will follow by December 2021
- **Support for Web-enabled Databases** - Two web-enabled database systems (Zimbabwe Statistical Database (ZIMDAT) and REDATAM), were established in 2016 and operationalised for archiving of national indicators and allow for access to users on-line. UNFPA, UNDP and UNICEF supported maintenance and updating of the database online through the 7th CP support. The 2002 and 2012 population census datasets and MICS 2014 were cleaned and uploaded onto REDATAM while ICDS 2017 data, PICES and administrative/routine sources were uploaded on ZIMDAT

- UNFPA supported the development of an **SDG data inventory matrix** in 2017, housed at ZIMSTAT, which was updated using recent data from surveys and routine data systems. To date 43% of the SDG indicators prioritized by Zimbabwe have data.
- Strengthened the **skills and capacity** of ZIMSTAT staff
- **Civil Service Training Centres and Universities to offer Population Curricula -** a capacity assessment of the University of Zimbabwe (UZ) Centre for Population Studies was successfully conducted in 2019 using an adapted tool from the US Census Bureau, and a report of the findings was produced. Based on these findings, a draft strategy to meet identified training needs of senior staff from government and stakeholder organisations was developed.

Effectiveness

EQ 2b: To what extent has UNFPA successfully integrated gender and human rights perspectives in the design, implementation and monitoring of the country programme?

Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
Gender and rights based approaches are explicitly integrated into the implementation of the CP	• Evidence of systematic integration of human rights based approach and gender within the programme and project plans documents of UNFPA • Evidence of integration of gender and rights based approach in interventions implemented under each thematic area • Evidence of integration of rights based approaches and gender in CP monitoring	• CPD, CPAP and AWPs • CP Results framework • Programme and project reports • UNFPA CO staff • GOZ and key partners • Implementing partners • Stakeholders including other UN agencies	• Documents review • Key informant interviews

Data collected from the field to be filled

- A comprehensive and systematic gender analysis was not conducted to inform the CP design. Gender issues such as involvement of men and boys and focus on harmful gender norms and cultural practices were addressed in some programmatic areas and not in others resulting in fragmented mainstreaming.
- Interviews with implementing partners and key stakeholders highlighted that the rights of adolescents and youth, especially adolescent girls in accessing SRH services were met through the provision of information and skills to minimize vulnerability to HIV infection and teenage pregnancy. An enabling and supportive environment within the household and in the community for AYPs to exercise their reproductive health rights was created. The CP did a good job in addressing the needs of young people with disabilities. For instance, young people with disability were represented in ASRH multi-stakeholder coordination meetings and FP forums. Although there was representation of young people with disabilities in the ASRH forums there were no set indicators to track the inclusion and participation of young people with disabilities in the community-based interventions hence they were not adequately incorporated and they continued to be left.
- In SRHR, no systematic gender analysis of UNFPA focuses on women's health and it is assumed that gender issues are addressed. However, some aspects of gender mainstreaming included: Men/boys are involved in the programme e.g. community engagement includes men/boys; and BCF home visits reached about 45% if men; the SRH service package included needs for boys e.g. male condoms and specific programmes such as OF address sexual rights and dignity of women and are prioritized in the CP.
- Maternal Deaths – Data on age and socio-economic status of the women is needed to identify those most affected. The focus of the CP has been on women and less on men
- In addition, integration of disability was not prioritised at CP design stage but interventions to address the needs of persons with disability were introduced later in the programme. However, these were still at a small scale and ad hoc.
- Human rights-based approach to programming was well integrated into the CP from the design stage. Districts and targeted populations were selected using relevant indicators which identified human rights barriers to access to services and also all interventions of the CP addressed the needs of targeted population to access services and exercise their reproductive health rights.

Efficiency **EQ3: To what extent did the intervention mechanisms (financing instruments, administrative regulatory framework, staff, timing and procedures) foster or hinder the achievement of the programme outputs?**			
Assumptions to be assessed	• **Indicators**	• **Sources of information**	• **Methods and tools for the data collection**
Administrative and financial procedures and a mix of implementation modalities allowed for smooth (timely) execution of the CP	• Appropriateness of UNFPA financial instrument and administrative regulatory framework for implementation of the Programme • Evidence of resources combined to facilitate gender responsive and human rights based approaches to be implemented across the CP • Appropriateness of approach and criteria for selection of implementing partners and interventions • Evidence of transparent selection of implementing partners	• Reports from implementing partners • Audit reports • Financial utilization data • UNFPA CO staff • Implementing partners	• Documents review • Key informant interviews
Implementers received resources that were planned, to the level foreseen and in a timely and consistent manner	• Financial resources were received as planned in AWPs • Financial resources were received in a timely manner • Evidence of adequate human resources to delivery CP interventions at UNFPA and implementers levels	• AWPs and Annual Programme Reports and Implementers reports • UNFPA CO financial reports • UNFPA CO staff, GOZ and IP staff	• Documents review • Key informant interviews •
Data collected from the field to be filled - IPs reported that the process for Annual Work Plan development and approval contributed to delay in funds disbursement particularly in the start of the year and led to loss of quarter 1 implementation period. This impacted on efficiency CP implementation. - The selection of Implementing Partners with technical competencies in their respective programmatic areas contributed to the implementation of the CP. - Strategic partnerships that had potential to improve CP efficiency and effectiveness such as partnerships with organisations supporting youth economic empowerment and gender and women rights promotion at community level were not well exploited. - Human resources – UNFPA has adequate number and skilled staff to implement the CP. o Adequate resources and capacities in place o CP development is accompanied with an assessment of HR requirements. This was the case with 7th CP –some posts were added. HR structure is approved at HQ. o There could be changes in the case of CP. CO Representative has authority to make certain changes. For current CP, there is adequate staff as shown in the implementation rate. o UNFPA CO has well qualified staff to deliver the CP. The challenge is in the resources to carry out the UNFPA mandate as funding has been declining – RO Focal Person o IPs also have adequate human resources and other capacities to implement the CP. The IPs capacity is assessed during the selection stage and capacity weaknesses are addressed during implementation. - Administrative procedures of UNFPA are also well defined and known to staff and facilitate implementation. o Procedures for travel – fill in a request, security clearance and get allowances and stay in UN cleared accommodation.			

- SOPs are specific to UNFPA CO and shows number of days needed to prepare for travel. Funds have to be acquitted after return from the field.
- COVID has restricted travel tit he field. OMT has developed guidelines for travel during COVID.
- UNFPA came up with country specific procedures and HQ has approved them exceptions for Zimbabwe.
- IPs use their own guidelines

- UNFPA procurement policies and procedures are well defined and also contribute to efficient implementation of the programme.
  - Programmes submit goods and services request form to trigger procurement process.
  - Procurement thresholds include: Below 5000 USD – quotations; 5000 – 49999 – Local Procurement Committee made up of programmes and finance staff assesses the bids and recommends suppliers and country representative approves; 50,000 to 99,999 – Procurement goes through the CAP comprising of all UN Agencies (Inter-Agency); Above 100,000USD – Contract Review Committee (CRC) at HQ
  - To facilitate implementation, all the committees issue their schedule of meetings communicated to all programme staff at beginning of the year and can also have extraordinary meetings to address urgent procurement.
  - Challenges in 2020 are associated with COVID – HQ came up with Fast Track Procurement for COVID. This gas fast tracked the procurement process.
  - OMT – all operations managers in the UN agencies are members. It also has sub-groups e,g. procurement working group and have come up with a common items using Long Term Agreements to fast track procurement.
- Support from the regional office – ROSC- also facilitates implementation. Enables UNFPA to access items at competitive prices in South Africa while the same items cost more in Zimbabwe.
  - Meant to cover small countries and now open to other countries
  - It supports Zimbabwe in procurement
  - Some items are cheaper in South Africa and ROSC assists in the procurement of such goods/commodities – ICT commodities, printing and communication
  - Sometimes they procure on time and sometimes not. UNFPA CO have to follow up and remind them and often they are responsive.
  - Support that UNFPA CO requested from the RO includes: Review of TORs, data collection tools; Census preparation; Hiring of consultants; Implementation of intervention – reviewing reports, documentation, situational analysis; RO also disseminates lessons from other UNFPA offices/countries – south to south cooperation

Sustainability

EQ 4: To what extent has UNFPA been able to support implementing partners and beneficiaries (women and adolescents and youth) in developing capacities and establishing mechanisms to ensure ownership and the benefits continue beyond program termination?

Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
UNFPA CO has contributed in all four programme areas to sustainable capacity development in GOZ, implementing partners and beneficiaries	• Evidence of capacity development initiatives supported by the UNFPA CO and of likelihood of sustaining results • Evidence of on-going benefits after interventions have ended • Evidence of mechanisms (networks, linkages, coordination platforms etc)	• AWP and Annual Programme Reports • UNFPA CO Staff • GOZ and Implementing Partners • Other stakeholders	• Documents review • Key informant interviews •
UNFPA CO has contributed to establishing mechanisms to ensure ownership and benefits continue beyond the programme period	• Evidence of UNFPA CO involvement in development of policy, strategy and plans in its programmatic areas • Evidence of mechanisms (networks, linkages, coordination platforms etc.)	• AWP and Annual Programme Reports • UNFPA CO Staff • GOZ and Implementing Partners • Other stakeholders	• Documents review • Key informant interviews

	that foster national ownership of UNFPA supported interventions		

Data collected from the field to be filled

- Capacity building was integrated into the interventions supported by the CP as one of the modes of engagement. The capacities built among implementers and service providers as well as development of SOPs, manuals and modules for use by service providers will ensure continuation of quality GBV service provision beyond the programme period. However, high staff turnover is likely to erode the benefits of the capacity built among service providers. The benefits of the awareness, knowledge, skills and the change of attitude or mind-set among beneficiaries SGBV survivors, women, community leaders and community members will generate demand for GBV services beyond the programme period. The community cadres are also likely to continue providing information on GBV. The costs of running OSCs and shelters makes them an unsustainable model in the absence of government support.
- Capacity building of community-based cadres to deliver most of the intervention and bringing in different government ministries and quasi government organisations to participate in multi-stakeholder coordination forums will ensure continuation of ARSH service provision. The integration of YFS in pre service training and the in-service training, production of YFS manuals and SOPs will ensure continuity of the provision of YFS in facilities as healthcare workers will have the skills and printed materials to use beyond programme funding. High staff turnover is however likely to threaten sustainability.
- The CP also build capacity of government human resources, structures and systems particularly for producing population data which ensured ownership of the population census and surveys by government and will enable the government to produce and analyse population data going forward.
- Networks, linkages and coordination platforms were established for national ownership of population data. These included inter-Ministerial Technical Committees, ZIMDAT Inter-Ministerial Technical Committee, chaired by ZIMSTAT, the SDG Cluster chaired by three different ministries under the overall coordination of the Ministry of Public Service, Labour and Social Welfare. These mechanisms promote ownership and use of population data beyond the CP period.
- UNFPA contribution to sustainable capacity development of GOZ/Implementers and beneficiaries
  - Capacity of MOHCC has been built but movement of staff undermines this capacity
  - Sustainability at MOHCC may be more fragile that at community level
  - Where we have been able to change mind set, sustainability is likely to be achieved
  - Capacity building has been done at various levels e.g. mentorship of HCWs, midwifery training provincial and district teams providing OJT. Given the economic climate, there is no guarantee of sustaining the capacity developed. Government is not providing letters of good standing to allow HCWs to move outside the country.
  - Government should to do more to fund health services and not to depend on donors but government is yet to do so.
  - Community/ beneficiaries capacity. This capacity has been developed through training of BCFs, VHWs e.g. on CeCx, MWHs management etc.
- UNFPA contribution to establishment of mechanisms to ensure ownership of the programme
  - Engaged KP organisations e.g. Sex Workers (National Sex Worker Association) which promoting ownership
  - MSM=TG groups are engaged in the programme implementation hence increasing ensuring ownership
  - Engagement of parliamentarians on KP programme – visited MSM programme sites to realise the needs of the MSM community first hand. This has promoted acceptance of the programme at policy level.
  - Also KP and young people engaged with parliamentary committee on Health providing visibility to key health issues

Coordination

EQ 5 To what extent is the UNFPA CO coordinating with other UN agencies in the country and how is it aligned to the UNDAF?

Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
UNFPA has actively contributed to UNCT working groups and coordinated with other UN agencies in joint	• Evidence of participation in UNCT working groups and exchange of information • Evidence of the leading role	• Minutes of UNCT cluster or working groups • Minutes of joint programme meetings	• Documents review • Key informant interviews

programming in alignment to the ZUNDAF	played by UNFPA in UN working groups • Evidence of UNFPA involvement in join programming • Evidence of joint implementation of programmes • Evidence of UNFPA participation in ZUNDAF implementation processes as defined in the ZUNDAF mode of engagement	• Reports submitted to joint programme focal points by UNFPA • UNFPA CO Staff and UN Agencies	

Data collected from the field to be filled

- UNFPA involved in ZUNDAF coordination structures – UNCT, ZUNDAF Result Monitoring Groups, Programme Management Team.
- Annual reviews of ZUNDAF implementation carried by high level meeting co-chaired by GVT and UN RC. Results Groups report on progress every quarter. UNFPA reports through this mechanism
- M&E working group focusing on results areas provides data for the indicators. UNFPA is represented in the M&E group
- UNFPA participation in Sector/programmatic coordination including Gender working group; Humanitarian emergency response – Social Protection Cluster chaired/hosted by UNFPA as well as GBV sub-cluster working group; High Level Humanitarian Country Team – UNFPA is a key member; Operations Management Team (OMT) – UNFPA is also member; Protection against Sexual Exploitation and Abuse – UNFPA plays a key role in the steering committee at RC level
- Participation in joint programming including Spotlight Initiative with ILO, UNICEF, UNDP, UN Women and UNFPA. HIV Joint UN programme coordinated by UNAIDS; Health Development Fund joint implementation with UNICEF. 2Gether4SRH with WHO and UNAIDS and collaboration with ILO and UNDP in Tariro Youth Centre development.

Coverage and connectedness
EQ 6: To what extent has the CO been able to respond to changes in national needs and priorities during the humanitarian emergencies and crisis e.g. drought, floods and cyclone? What was the quality of the response?

Assumptions to be assessed	**Indicators**	**Sources of information**	**Methods and tools for the data collection**
UNFPA CO made changes to respond to national needs and priorities during humanitarian emergencies in a gender responsive manner	• Evidence of changes made by UNFPA CO to CP strategies, interventions and resources allocation to respond to humanitarian emergencies • Evidence of changes made by UNFPA CO to implementation approaches (mode of engagement) to respond to humanitarian emergencies • Extent to which UNFPA response to humanitarian emergencies timeously met the need of targeted populations • Appropriateness of mode of engagement/ implementation approaches adopted for	• AWP and Annual Reports • Humanitarian emergency plans and reports • UNFPA CO Staff • GOZ, implementing partners • Other agencies UNFPA collaborated with	• Documents review • Key informant interviews

	humanitarian emergency response		

Data collected from the field to be filled

- UNFPA worked with UN Joint Team on AIDS to assess the impact of emergencies on HIV response (Cyclone Idai and COVID 19.
- UNFPA focused on GBV, SRH and HIV in humanitarian settings in line with its mandate
- Contributed to the UN support to Government e.g. providing vehicles to improve transportation of supplies as part of UN support.
- Community cadres identified the communities/persons in need of services e.g. emergency services for maternal health and GBV. The community cadres were used to disseminate information, setting up safe spaces and ensuring girls get to S2S clubs; and During COVID, UNFPA provided airtime to community cadres and data bundles to implementers to ensure effective communication
- UNFPA made changes in the CP implementation approaches to respond to national needs and priorities during humanitarian emergences in a gender responsive manner.
- UNFPA is not seen as a humanitarian response agency. It had to push its way through into this area.
- During humanitarian emergencies, issues such as GBV take a forefront and need to be addressed.
- UNFPA has evolved to show it is capable of responding to issues related to its mandate.
- It has taken leadership of the Protection Cluster and also leading a the GBV sub-cluster
- It takes a while to develop capacity for humanitarian response and the humanitarian and development nexus should be firmed up in the 8th Country Programme.

Annex 2: Documents Reviewed

African Union. Addis Ababa Declaration on Population and Development in Africa Beyond 2014. October 2013

Government of Zimbabwe. Memorandum to Cabinet on the Zimbabwe Specific Commitments for the Twenty-Fifth Year Commemoration of the International Conference on Population and Development (ICPD) 25 at the Nairobi Summit 12– 4 November 2019.

Government of Zimbabwe. The Transitional Stabilisation Programme over October 2018 to December 2020.

Government of Zimbabwe. Zimbabwe Agenda for Sustainable Socio-Economic Transformation (Zim Asset) "Towards an Empowered Society and a Growing Economy" OCTOBER 2013- DECEMBER 2018.

Government of Zimbabwe. 1998. Zimbabwe National Population Policy.

Internal Peer Review of the UNFPA/GoZ 7TH Country Programme 2016-2020

Micro Assessments of Zimstat. UNICEF; Baker Tilly Chartered Accountants (Zimbabwe) 17 July 2017

Regional Interventions Action Plan for East and Southern Africa 2018-2021

UNFPA Strategic Plan, 2018-2021 Annex 1. Integrated results and resources framework

UNFPA Strategic Plan, 2018-2021 Annex 2. Theory of change

UNFPA Strategic Plan, 2018-2021 Annex 4 Business model

The UNFPA Strategic Plan, 2014-2017

2019 UNFPA Annual Report – Zimbabwe Draft 20 January 2020.

2018 UNFPA Annual Report – Zimbabwe Finalized 03 February 2019.

2017 UNFPA Annual Report – Zimbabwe Finalized 14 February 2018.

2016 UNFPA Annual Report – Zimbabwe Finalized 17 March 2017.

Revised CPAP Results Framework 2018-2020

UNFPA. The Report on the Nairobi Summit on ICPD25. Accelerating the Promise

UNFPA Country Programme Action Plan 2016-2020

Zimstat. National Strategy for the Development of Statistics II 2016 -2020

Zimbabwe United Nations Development Assistance Framework 2016-2020 Supporting Inclusive Growth & Sustainable Development

National Youth Policy 2013

National Health Strategy for Zimbabwe 2016-2020

The Mid-Term Review of the Zimbabwe National Health Strategy 2016-2020

National Adolescent and Youth sexual and reproductive health (ASRH) strategy II 2016-2020

Zimbabwe School Health Policy 2018

ASRH Strategic plan review 2015 -Johns Hopkins School of Public Health

Zimbabwe National Adolescent Fertility Study, Harare: Technical Report

The 2019 Zimbabwe Multiple Indicator Cluster Survey (MICS)

Effectiveness of the Sista2Sista program on improving HIV and other sexual and reproductive health outcomes among vulnerable adolescent girls and young women in Zimbabwe- manuscript near publication

The Zimbabwe Health Development Fund 2019 Annual Report

Zimbabwe Population Census Report, 2012

Nuptiality and Fertility Thematic Report August 2015

Joint Programme for Adolescent and Youth Development in Zimbabwe (2016 – 2020)

Mortality Thematic Report August 2015

Zimbabwe Service Delivery Point Survey Report 2017

Updated 2012 Population Census projections report

Zimbabwe demographic and Health Survey

Zimbabwe demographic and Fact Sheet

Zimbabwe Human Development Report, UNDP, 2019

FACT Sheet: Abortion in Africa

Ministry of Health and Child Care (2016). Zimbabwe National Adolescent Fertility Study

Comprehensive Sexuality Education for out of school young people in Zimbabwe manual

Joint Programme for Adolescent and Youth Development in Zimbabwe (2016 – 2020)-March 2016

Safeguarding young people programme 2018 Annual report

Annual workplans 2016-2020

Ministry of Finance and Economic Development, Zimbabwe Interim Poverty Reduction Strategy Paper

2019 Annual Family Health Programme Report

UNDP, Human Development Report. Inequalities in Human Development in the 21st Century

Annual Reproductive Health Programme Report 2019

Labour Force and Child Labour Report, 2019

Harnessing the Demographic Dividend in Zimbabwe, 2017

The International Conference on Population and Development Programme of Action 1994

OCHA 26 October 2020 Cluster Status: Protection (Gender Based Violence)

MWAGCD, 2012 Standard Operating Procedures for Safe Homes for GBV Survivors, Zimbabwe

Zimbabwe National Family Planning Strategy (ZNFPS) 2016-2020

Zimbabwe National Family Planning Costed Implementation Plan 2016—2020

Zimbabwe Maternal and Neonatal Health Strategy (ZMNHS) 2017 to 2021

National HIV and AIDS Strategic Plan

Revised CPAP Results Matrix

Zimbabwe Health sector investment case

Statistical Review of progress towards the mid-term targets of the Zimbabwe Health Sector Strategic Plan

National Cancer Prevention and Control Strategy for Zimbabwe 2014-2018

Zimbabwe Cervical Cancer Prevention and Control Strategy 2016-2020

Service Guidelines on SRHR and HIV Linkages

National Child Survival Strategy (2016 – 2020)

Zimbabwe Youth Development report

Evaluation of the UNFPA support to the HIV response (2016-2019)

Annex 3:
Stakeholder Mapping

All outcome areas and other evaluation criteria (coordination, efficiency, humanitarian emergencies)						
Government	**Donors**	**International NGOs**	**Local NGO**	**UN agencies**	**WRO**	**Academia**
	EU USAID DFID Sweden			UNFPA Representative, Deputy Representative Assistant Representative UN Resident Coordinator		
Outcome 1 and 2: SRH and ASRH						
Government	**Donors**	**International NGOs**	**Local NGO**	**UN agencies**	**Professional boards**	**Academia**
Ministry of Health and Child Care, Family Health department and AIDS AND TB department; Ministry of labour and social welfare ZNFPC NAC ZIMSTATS	EU DFID Sweden	FHI360 PSI Leonard Cheshire	PSZ OPHID I-TECH Centre for Sexual Health and HIV Research (CeSHHAR) Family AIDS Caring Trust (FACT) Students and Youth Working on Reproductive Health Action Team (SAYWHAT) Zimbabwe AIDS Prevention and Support Organisation (ZAPSO)	UNICEF UNAIDS WHO	Zimbabwe Confederation of Midwives Midwifery Association of Zimbabwe	UZ

			Zimbabwe Community Health Intervention Research project (ZiCHIRE) Padare			
Outcome 3: Gender equality						
Government	**Donors**	**International NGOs**	**Local NGO**	**UN agencies**	**WRO**	**Academia**
Ministry of Women Affairs, Community, Small and Medium Enterprises Development- Gender Department; Anti-Domestic Violence Council Ministry of Health and Child Care, Family Health department; Judicial Service Commission	EU Irish Aid Sida	World Vision Leonard Cheshire	Musasa Project Adult Rape Clinic Family Support Trust Students and Youth Working on Reproductive Health Action Team (SAYWHAT) Family AIDS Caring Trust (FACT) Zimbabwe AIDS Prevention and Support Organisation (ZAPSO) Zimbabwe Community Health Intervention Research project (ZiCHIRE) Padare	UN Women UNICEF	Zimbabwe Women Lawyers Association Women's Coalition of Zimbabwe	University of Zimbabwe, Department of Community Medicine
Outcome 4: Population dynamics						
Government	**Donors**	**International NGOs**	**Local NGO**	**UN agencies**	**WRO**	**Academia**
Ministry of Finance and Economic Development - Population and Development Unit Ministry of Local Government, Public Works & National Housing - Civil Protection Unit Central Registry ZIMSTAT National Statistics System (ZIMDAT, RREDATAM) ZIMSTAT – Director Census and Surveys				UNFPA Programme specialist, Pop and development, Planning and M&E Officer UNICEF		University of Zambia

Annex 4 - People interviewed

Organisation	Interviewee (Key Informant) name	Position
MOHCC	Dr. Christine Gabaza	A/Director - RH Unit/ Person in charge of MPDSR and eMPDNS system
MOHCC	Sandra Murwira	Programme Officer VIAC and OF
MOHCC	Anna Machiha	CCP/STI coordinator
MOHCC	Dr Davidzoyashe Makosa	Former D/Director RH Unit
MoHCC	Aveneni Mangombe	ASRH Coordinator
MoHCC	Margret Nkomo	Midwifery school tutor
MOPSE	Ms KRL Nyanungo	Chief Director, Learner Welfare, School Psychological Services and Special Needs Education
MWACSMED	Vaida Mashangwa	Director-Women Affairs and Gender
MWACSMED	Magdalene Chavhunduka	Coordinator-Anti-Domestic Violence Council
MoFED	Innocent Madziva	Deputy Director National Planning, Modelling and Forecasting
ZIMSTAT	Godfrey Matsinde	Director – National Statistical System
ZIMSTAT	Aluwisio Mukavhi	Director - Census and Surveys
ZIMSTAT	Rodgers Sango	Manager Vital Registration
ZIMSTAT	Leonard Katova	Systems Developer
Registrar General Department	Takuranawo	Provincial Registrar – Harare
ZNFPC	Dr Murwira	Executive Director
ZNFPC	Dr Noni Zwangobani	Programme Director
Natpharm	Mr. Zealous Nabadza	Acting MD
NAC	Mrs B Nyamwanza	National Youth AIDS Coordinator
NAC	Tonderai Mabamba	GF Coordinator
ZYC	Mr Nyoni	Executive Director
FCDO	Tapiwanashe Hoto	Health advisor
USAID	Lucia Takundwa	Integrated Health Specialist
USAID	Ruth Bulaya Tembo	HIV Specialist
EU	Beatrrice Ndarugirire	Health Advisor
Swedish Embassy	Henrik Olsson Selerud	Bilateral Associate Expert
Switzerland (SYP)	Fouad Amir	Assistant Regional Director Head of Domain HIV/SRHR
Irish Aid	Paula Nolan	Development Specialist
UNCT	Maria Ribeiro	UN Resident Coordinator
UNAIDS	Martin Odiit	Strategic Information Advisor
UNDP GFTAM	Emmanuel Boadi	Project Manager/Coordinator
UNFPA	Esther Muia	Country Representative
UNFPA	Gulnara Kadyrkulova	Deputy Country Representative
UNFPA	Abbigail Msemburi	Assistant Country Representative
UNFPA	Raghu Vibhavendra	Technical Specialist FP & MH
UNFPA	Edwin Mpeta	SRH Programme Specialist
UNFPA	Dagmar Hanisch	Technical Specialist HIV Prevention & SRH
UNFPA	Pennelope Kasere	Program Analyst - Adolescent Sexual and Reproductive Health

UNFPA	Isabel Jolt	Program Analyst - Adolescent Sexual and Reproductive Health
UNFPA	Loveness Makonese	Programme Specialist -Gender
UNFPA	Verena Bruno	Technical Specialist GBV
UNFPA	Choice Damiso	Former UNFPA Gender Specialist
UNFPA	Piason Mlambo	UNFPA CO - Programme Specialist: Population and Development
UNFPA	Bertha Shoko	Communications
UNFPA	Jesilyn Dendere	Communications
UNFPA	Rudo Mhonde	M&E
UNFPA	Sunday Manyenya	M&E
UNFPA	Farai Guvakuva	Operations Manager
UNFPA RO	Renata Talarico	SYP Regional Coordinator
UNFPA RO	Tamisayi Chinhengo	Special Assistant to the Regional Director
UNFPA RO	Frederick Okwayo	Regional Adviser Population and Development
UNFPA RO	Sunkuntu Kanyanta	CO Focal Point
UNFPA ESARO	Mark Hutchinson	Former Operations Manager at ESARO
UNESCO	Lucas Halimani	National Program Officer
UNESCO	Masimba Nyamucheta	Education Specialist
UNICEF	Ms Laylee Moshiri	UNICEF Country Representative
UNICEF	Lovemore Magwere	Education Specialist
UNICEF	Shelly Chitsungo	Health Specialist - Maternal Health
UNICEF	Rumbidza Tizora	Surveys - MICS
UN Women	Delphine Serumaga	Country Representative
OCHA	Wouter De Cuyper	Humanitarian Affairs Officer
WHO	Dr Gasasira	WHO Representative
WHO	Trevor Kanyowa	Family and Reproductive Health
Crown Agents	Muchaneta Mwonzora	Country Director
FHI360	Dr. Gladman Muchena	
Judicial Service Commission	Bianca Makwande	Deputy Chief Magistrate
PSZ	Rumbidzai Matewe	Programme Director
OPHID	Sarah Page Mutongwiza	Director of Programs
ZAPSO	Thomas Kazonda	Director
ZiCHIRe	Walter Chikanya	Programmes Director
SAYWHAT	Vimbai Mlambo	Programmes Manager
FACT	Moses Nyamasoka	Programme Manager
CeSHHAR	Primrose Matambanadzo	Programme Director
World Vision	Sifiso Ndlovu	BC Programme Manager
MUSASA	Precious Taru	Director
Adult Rape Clinic	Memory Kadau	Program Coordinator
Family Support Trust	Tamburayi Muchinguri	Director
Leonard Cheshire Disability Zimbabwe	Greaterman Chivandire	Director
Padare	Walter Vengesai	Director

Health Times	Michael Warisa	Journalist Population and Development
The Herald	Roselyne Sachiti	Features, Health and Society Editor
Alpha Media	Phylis Mbanje	Senior Health Reporter/Supplements Editor
Midlands State University	Amon Chaka	Dean's Forum Chairperson
University of Zimbabwe - Centre for Population Studies	Prof. Marvellous Mhloyi	Head of Department
Harare Province		
City of Harare	Dr. Masunda	Acting Director Health Services
City of Harare	Matron Chitando	Matron
City of Harare	Last Mutandwa	SIC Maternity
City of Harare	Edward Kadiyo	YF Centre focal person
GALZ	Samuel Matsikure	KP led organisations (Sex Worker Association, MSM etc)
Wilkins Infectious Disease Hospital	Dr Hilda Bara	Medical Superintendent, Lead HIV programme
Cervical Cancer servive providers (HCWs)	Dr Madembo	HCW worker involved in CeCx services including outreach
MOHCC	Mbiri	RHO
ZiCHIRe	Priscilla Romgoti	Sista2Sista Mentor
ZiCHIRe	Babra Farashishiko	PCC Mentor
ZiCHIRe	Tracey Njenje	CSE Mentor/ Peer
MUSASA	Sharon Matingwina	Shelter Coordinator
Musasa	Tinashe Chitunhu	Legal Advisor
Musasa	Dinah Sisipenzi	Senior Counsellor
Musasa	Tsungai Gadaga	Counsellor
Musasa	Pennyluther Mundida	SGBV Nurse
Musasa	Prisca Ferretti	Shelter administrator
SAYWHAT	Fadzai Musenda	Peer Educator
SAYWHAT	Munashe Mhaka	Peer Educator
SAYWHAT	Tsitsi Masarira	Peer Educator
SAYWHAT	Sydney Gumbo	Peer Educator
ZYC	Princess Mharire	Youth Policy Tracker
ZYC	Joseph Mhasvi	Youth Policy Tracker
Zimbabwe Republic Police, Victim Friendly Unit	Superintendent Jessie Banda	Victim Friendly Unit Coordinator
Manicaland Province		
MoHCC	Admire Maravanyika	PMCHO
MoHCC	Simon Nyadundu	PMD
MoHCC	Jane Mandimutsira	RHO
MoHCC	Brian Makumbe	DMO Chipinge
MoHCC	Plaxedes Mandevhana	DNO
MoHCC	Martha Femai	FP nurse
MoHCC	Farai Mhlanga	EMNoC nurse

MoHCC	Tambudzai Mlambu	WMS SIC
MoHCC	Lorraine Gobiye	VIAC nurse
MoHCC	Takunda Matereke	Youth Friendly nurse
NAC	London Makwanya	District AIDS Coordinator
MWACSMED	Munyaradzi Rubaya	Provincial Development officer
MWACSMED	Gabriel Jaji	District Development Officer, Chipinge
MWACSMED	Rudo Marange	District Development Officer, Chimanimani
ZNFPC	Dyson Masvingise	Provincial Manager
Mashonaland West Province		
FACT	Tonderayi Gonye	Provincial Manager
FACT	Makaita Madyise	Sista2sista Mentor
FACT	Hygiene Mukumba	PCC Mentor
FACT	Chapinga Nyatwa	CSE Mentor
FACT	Edmore Muruvi	BFC Mentor
Village head	Bowen Sibanda	Traditional leader
Ward Councillor	Mr Siwela	Councillor
Matabeleland North Province		
MOHCC	Dr. Munekayi Padingani	PMD/ PMCHO Matabeleland North
MOHCC	Freeman Sibanda	RHO
MoHCC	Tafadzwanashe Gwera	DMO
MoHCC	Todd Ngwenya	DNO
MoHCC	Eric Sithole	SIC Maternity
MWACSMED	Masauso Phiri	Provincial Development Officer
NAC	Dingaan Ncube	Provincial Manager - Matebeleland North
MWACSMED	Davison Mawarire	District Development Officer
ZNFPC	Blessed Gumbi	Provincial Manager
Sexual Rights Centre	Pillippa Mhike	Director
Musasa	Silobile Moyo	Shelter Administrator
Village head	Reuben Ngwenya	Village head, Maqaqeni village
Religious Leader	Dubilizwe Khanye	Religious leader, Seventh Day Adventist Church
Religious Leader	Desire Ncube	Religious leader, Zion Christian Church
Ward Councillor	David Siwela	Councillor, Ward 11
Ward Councillor	Meluleki Sibanda	Councillor, Ward 15
World Vision	Ntandoyenkosi Mpofu	Sista2sista
World Vision	Florence Sibanda	PCC Mentor
World Vision	Nolita Nkala	CSE Mentor
World Vision	Bekezela Ncube	BCF Mentor

Annex 5 -UNFPA District Coverage by Programme

	Provinces and districts	CPAP (All program	Spotlight (Community,	HDF (all program	2gether4 SRHR	ASRH	GBV- Shelters	GBV - OSC	Humanitarian	Current sex work
	Manicaland									
1	**Mutasa**		**X**						**X**	
2	**Chimanimani**		**X**						**X**	
3	**Chipinge**		**X**							
4	**Buhera**				**X**				**X**	**X**
5	**Makoni**				**X**			**X(HDF/365)**		
6	**Mutare rural**						**X (hdf/365)**			
	Mash Central									
7	**Bindura**	**X**		**X**		**X**				
8	**Centenary/ Muzarabani**	**X**	**X**	**X**		**X**				
9	**Mbire**	**X**	**X**	**X**	**X**	**X**			**X**	
10	**Mt Darwin**	**X**	**X**	**X**		**X**				
11	**Shamva**	**X**	**X**	**X**	**X**	**X**				
	Mash East									
12	**Marondera**	**X**		**X**		**X**				
13	**UMP**	**X**		**X**	**X**	**X**			**X**	
14	**Mudzi**	**X**		**X**	**X**	**X**			**X**	**X**
15	**Chikomba**						**X (HDF/365)**			
	Mutoko									**X**
	Mash West									
16	**Mhondoro/Ngezi**	**X**		**X**		**X**				
17	**Hurungwe**	**X**	**X**	**X**	**X**	**X**	**X (Spotlight)**		**X**	

18	**Sanyati**	**X**		**X**		**X**				
19	**Makonde**	**X**	**X**	**X**		**X**	**X(HDF/365)**	**X(HDf/365)**	**X**	
20	**Chegutu**	**X**		**X**	**X**	**X**				
21	**Kariba**								**X**	
	Masvingo									
22	**Gutu**						**x (HDF/365)**			**X**
23	**Mwenezi**								**X**	
24	**Chivi**								**X**	
25	**Chirumhanzu**									**X**
	Mat North									
26	**Bubi**	**X**		**X**		**X**	**X (Hdf/365)**			
27	**Tshlotsho**	**X**		**X**		**X**				
28	**Hwange**				**X**					
29	**Lupane**				**X**					
30	**Binga**								**X**	
	Mat South									
31	**Bulilima**	**X**		**X**	**X**	**X**				
32	**Mangwe**	**X**		**X**	**X**	**X**				
33	**Beitbridge**	**X**		**X**		**X**				
34	**Umzingwane**		**X**				**X (Spotlight)**			
35	**Gwanda**							**X(HDf/365)**		**X**
	Midlands									
36	**Gweru shelter and OSC**						**x (hdf/365)**	**x (hdf/365)**		
37	**Gokwe North**								**X**	
	Harare									

38	**Epworth**	**X**	**X**	**X**		**X**				
	Harare South	**X**		**X**		**X**				
	Harare (Hopley)		**X**		**X**					
	Harare						**X (Spotlight/365)**			
	Total	**20**	**12**	**20**	**13**	**20**	**9**	**4**	**11**	**6**
Notes										
1. RH and family planning are national programs (63 districts)										
2. UNFPA is working in the above 38 districts for specific programs and donors. Harare south, Hopley and Epworth are considered to be one district.										
3. Those shaded green we are only supporting the interventions shown										
4. These are our major programs										
	Summary of districts covered by the country programme									
	CP Programmes	**Number of districts covered**								
1	**CPAP (All programs)**	**20**								
2	**Spotlight (Community, Gender, P&D)**	**12**								
3	**HDF (all programmes)**	**20**								
4	**2gether4SRHR (HIV)**	**13**								
5	**ASRH**	**20**								
6	**GBV-Shelters**	**9**								
7	**GBV - OSC**	**4**								

8	**Humanitarian response**	**11**								
9	**Current sex work sites**	**6**								

Annex 6: Interview Guides

My name is…..(we) are evaluating the 7th CP between the Government of Zimbabwe and UNFPA on reproductive health, adolescents and youth, gender and population dynamics. I would like to ask you a few questions about your involvement in the implementation of the programme. I greatly appreciate your taking time to speak with me (us). Do you have any questions before we start?

UNFPA Programme Staff

These questions are for programme officers in-SRH, Adolescents and Youth, Gender Equality and Women Empowerment and Population Dynamics

Overall involvement in CP

1. What interventions is UNFPA supporting in your programme area?

Relevance

2. How did you identify the needs/priorities addressed by the CP interventions? (probe further)
   - Were national partners involved in identification of the needs and interventions? And how?
   - Were beneficiaries involved in identification of the needs and interventions? And how?
2. To what extent were interventions informed by substantive gender, human rights and social exclusion analysis?
3. Which provinces and districts is your programme covering? How were the districts selected? Have the districts covered changed over time and why?
4. What policies and strategies are the interventions aligned to? How do the interventions advance the implementation of these policies and strategies?
5. Were any changes made to reflect the shift from UNFPA strategic plan 2014-2017 to 2018-2021? If so, what were these changes?
6. Were any changes made in your programme area to reflect the country's shift from ZimASSET to TSP? If so, what are these changes?
7. Reflecting on UNFPA business model, what modes of engagement did you apply in implementation of your programme and why? Have you faced any challenges with the modes of engagement?

Effectiveness

8. What are the major achievements (outputs) of programme?
9. What factors facilitated the achievement of these results? (What worked well?)
10. What factors hindered the achievement of results? (What did not work well?)
11. How have the outputs been utilized?

Gender and human rights integration into the programme cycle

12. What specific measures were taken to integrate gender and human rights in the CP?
    - Does UNFPA CO have a systematic process gender integration and HR based programming?
    - Do you have sufficient skills and knowledge in this area? Were you trained?
    - Do implementing partners have sufficient skills and knowledge in this area? Were they trained?
    - Does the results framework of the intervention integrate gender equality and human rights? Does the RF contain indicators, outputs and outcomes disaggregated by gender and human rights?
    - Are women and disadvantaged groups actively involved in the CP interventions?
13. How well did these measures work? What did not work well?
14. To what extent were the CP interventions designed to transform gender relations and promote gender equality and with what outcomes?
15. What measures did UNFPA take to integrate disability in the CP? How well did these work? What did not work well?
16. What support would you require to integrate gender into your area of work?
17. What support would implementing partners require to integrate gender into their interventions?

Efficiency

18. How many staff are in your unit/programme? Do you have adequate staff strength and capacity for implementation and achievement of results of the CP?
19. How timely did you receive financial resources for implementing this programme?
    - How timely were financial resources disbursed to implementing partner? Were funds disbursed according to the AWP? Were the resources sufficient for implementing partners to complete activities? Were there activities not implemented due to lack of resources?
20. Did the IPs have adequate staff (human resources) to implement activities? Were there activities not implemented due to inadequate staff?
    - Were there delays in activity implementation? If yes, why and how did you solve the problem?
    - Were new activities added to the planed programme activities during implementation?
    - Are there occasions when the budget was not enough or you overspent?
    - Are there activities that were cancelled or postponed?
21. How did UNFPA financial and administrative regulations facilitate activity implementation? How did they hinder activity implementation?
22. Was provision made for adequate resources for integrating gender equality (human, technical and financial resources in the intervention as an investment in short-term, medium-term and long-term benefits?
23. Was the programme approach, partner and stakeholder engagement appropriate for achievement of results?
24. How is the programme monitored? (monitoring tools in place and used by IPs). How often they report on the programme? Is reporting timely?

Sustainability

25. How did UNFPA support the development of implementing partners' capacities? What type of capacity building support was provided? (probe for specific capacity building aspects – human resources, organizational development, networking, physical capacity, skills building etc)
    - How have partners utilized capacity developed through UNFPA support?
    - How did UNFPA support the development of beneficiaries' capacities? What type of capacity were built? (E.g. community leaders' skills, beneficiary networks etc)
26. Did the CP create the institutional change conducive to systematically addressing gender equality?
27. To what extent are these capacities likely to sustain the results of the programme?
28. Are national partners involved in UNFPA programming? If so, how?
    - What is the process for generating partner annual work plans and budgets?
    - What role does UNFPA and national partners play in implementation of interventions? (who plays what role?)
29. To what extent are programme results likely to be sustained beyond the programme period?
    - What measures are in place at end of the programme cycle for various interventions to continue?
    - Have programmes been integrated in government institutional plans?

Humanitarian response: Coverage and Connectedness

1. What humanitarian emergencies took place during the life of the 7th CP?
2. How did the emergencies affect your specific programme?
3. What measures did UNFPA take to response to humanitarian emergencies?
4. Which partners did UNFPA collaborate with in responding to humanitarian emergencies? What role did UNFPA play?
5. What humanitarian emergency activities were undertaken? What was the mode of delivery of the humanitarian assistance?
6. How were gender and human rights approaches integrated in humanitarian assistance?
7. How successful where these interventions? What were the major achievements?
8. How did the UNFPA humanitarian/disaster preparedness measures (SOPs and regulations) facilitate or hinder the response to humanitarian emergencies?
9. What were the weaknesses in the response to emergencies?

<u>UNFPA Staff, UNCT and other UN Agencies on UNFPA role in coordination</u>

1. What are the UNCT coordination structures and mechanisms in place for ZUNDAF?
2. What is the role of the UNFPA in the UNCT coordination structures and mechanisms? What partnerships exist? Any specific contributions to the achievement of results?

3. Any challenges? How could these be overcome?
4. To what extent has UNFPA proactively driven and supported the meaningful integration of gender equality and human rights based approaches across interventions?
5. Is UNFPA CO participating in any joint programme? If so, which joint programme? What is UNFPAs role? What is the value addition of the joint programme to achievement of UNFPA results?
6. Is UNFPA collaborating with other UN Agencies in implementation of interventions? Which UN Agencies and in which interventions? What are the roles of UNFPA and other UN Agencies? How has this contributed to achievement of UNFPA results?

UNFPA Monitoring and Evaluation Unit

1. What role do you play in the country programme as an M&E unit?
3. Did/does M&E unit play any role in identification of needs/priorities addressed by the CP identified? If so, what role?
4. Did/does M&E unit play any role in identifying provinces/districts covered by the CP selected? If so, what role?
5. What informed the development of CP results framework (indicators and targets)?
   - Are these aligned to the national M&E frameworks, UNFPA strategic plan etc?
   - What changes have been made to the RF over the programme period and why?
6. How is the M&E system for the CP designed?
   - How is data collected and reported?
   - How do you ensure data quality?
   - How is the M&E data used to inform the CP?
7. What measures have you take to support (i) gender integration in CP? (ii) human rights based programming, (iii) disability integration into CP, (iv) Effective targeting of marginalised AYP and other socially excluded groups?
8. What support do you provide to programme staff in M&E?
9. What support do you provide to implementers in M&E?
10. What action have you taken to contribute to visibility of the CP achievements?
11. What challenges do you face? Do you have sufficient staff and financial resources?
12. What challenges do UNFPA programme staff and implementers face in M&E? How would these be addressed?

UNFPA CO Communication Staff

1. What role do you play in the country programme as a communication lead?
   - What is the objective of the community unit/role?
   - What activities are you carrying out to achieve these objectives?
   - What support do you provide to programmes or Country Office?
   - How do you contribute to the implementation of the CP?

2. Do you participate in UN-wide communication groups? if so, what role do you/UNFPA play in this group?
3. What actions have you take to contribute to the visibility of the Country Programme within the country and globally?
4. What have been your key achievements?
5. What challenges do you face in implementing communication activities?
6. What type of support would you require going forward?

UNFAP CO Finance and Operations Staff

1. What is the role of the finance and operations unit?
2. How efficient is the mechanism for funds transfer from donors/UNFPA HQ to the country office? Are there instances of delays and what causes such delays?
3. How efficient is the mechanism for funds disbursement to implementing partners? Are there instances of delays and what causes such delays?
4. How efficient is the financial reporting by IPs? What is the quality of the reports received? Are there instances of iterative process due to incomplete reports or need for verification? How does this this affect implementation?

5. What type of support do you provide to programmes and IPs to ensure timely funds disbursement and financial reporting?
6. How efficient is the mechanism for procurement? Are there benchmarks on how long procurement of goods and services should take? Are there instances of the benchmarks not being met i.e instances of delays and why?
7. In your view, to what extent do financial and administrative procedures facilitate implementation of activities?
8. To what extent do the financial and administrative procedures hinder activity implementation?
9. What type of support would you require going forward?

Country Programme Donors

1. What UNFPA programme interventions are you supporting?
2. What have been the major achievement? How has this assistance helped the country to achieve its objectives (policies and strategies)?
3. Are there any challenges in implementation of the interventions? if so, what are the challenges?
4. Efficiency: Does UNFPA meet its obligations as expected (timely submission of work plans, programme and financial reports etc?)
5. Going forward, what improvements would you recommend in terms of (i) programme areas (gaps not well addressed currently) and (ii) implementation approaches

UNFPA Country Management (Country Representative, Assistance Representative)

Relevance

1. How were the needs/priorities addressed by the CP identified?
   - Were beneficiaries (MOHCC and other government institutions as well as community level beneficiaries such as the youth) involved in identification of the needs? And how?
2. How were the province and districts covered by the CP selected? Have the districts covered changed over time and why?
3. What changes were made to align the CP to UNFPA strategic plan 2014-2017 and to the strategic plan 2018-2021?
4. What changes were made to align the CP to the Transition Stabilization Plan 2018-2021?
5. To what extent were interventions informed by substantive gender analysis, human rights and disability?
6. What was done to adapt the CP to the New Way of Working (the business model)?
7. What was done to adapt the CP to the Grand Bargain?

Effectiveness

8. What in your view are the major strategic achievements of the 7th CP?
9. What factors facilitated the attainment of these achievements?
10. What factors hindered the attainment of the achievements?

Efficiency

11. How did the financial and administrative procedures of UNFPA facilitate implementation CP)?
12. How did the financial and administrative procedures of UNFPA hinder/affect implementation of the CP?
13. In your view, does UNFPA have adequate capacity to implement the CP?
14. In your view, do implementers have adequate capacity to implement the CP?

Sustainability

15. What measures were put in place to promote sustainability of achieved results?
16. What type of capacity building did UNFPA support? Is this capacity likely to contribute to sustainability of the CP results?
17. What was done to promote ownership of the interventions supported by the CP among national partners? How does this contribute to sustainability?

Coordination

18. What is the role of the UNFPA in the UNCT/ZUNDAF coordination structures and mechanisms?

19. Is UNFPA CO participating in any joint programme? If so, which joint programme? What is UNFPAs role?
20. Is UNFPA collaborating with other UN Agencies in implementation of interventions? Which UN Agencies and in which interventions? What are the roles of UNFPA and other UN Agencies? How has this contributed to achievement of UNFPA results?
21. What challenges is UNFPA facing in participating in the coordination structures?

Humanitarian response

10. What measures did UNFPA take to response to humanitarian emergencies?
11. How did the UNFPA humanitarian/disaster preparedness measures (SOPs and regulations) facilitate or hinder the response to humanitarian emergencies?
12. What were the challenges in the response to emergencies?

UNFPA Regional Office

1. What is your role?
2. What is the relationship with the Country Office?
3. What are your expectations of the Country Office?
4. To what extent the country office meets this expectations/ plays its role?
5. What support do you provide to the Country Office?
6. What in your view have been the achievements of the Country Office?
7. What can be improved?

Interview Guide for National stakeholder: Government, CSOs and NGOs

Introduction: What interventions were supported by UNFPA?

Relevance

1. How did you identify the needs/priorities addressed through UNFPA support?
    a. Did these interventions address your needs and/or needs of your target populations?
    b. Were the interventions discussed between yourselves and UNFPA?
    c. How did you identify the districts covered through UNFPA support?
2. What aspects of national policies and strategies were addressed by or guided the interventions supported by UNFPA? Or how did you ensure the interventions are aligned to national/programme policies and strategies?
    a. What specific policies informed/guided CP interventions?
    b. What specific national strategies guided the interventions?
3. To what extent were the interventions aligned with international gender and human rights instruments, national policies on gender and human rights and the different needs of men and women?
4. How appropriate were the mode(s) of engagement with UNFPA? (Probe for)
    a. Capacity building, advocacy, service delivery, technical assistance and knowledge management
    b. What were the challenges with the mode(s) of engagement?

Effectiveness

5. Looking at implementation so far, to what extent has the CP reached intended beneficiaries?
6. What are the major achievements (outputs) of the interventions supported by UNFPA? To what extent were the set targets achieved?
7. What factors facilitated achievement of the targets/outputs? (what worked well?)
8. Are there factors hindered achievement of the outputs? (what did not work well?)
9. How have the outputs been utilized?

Human rights and gender integration

10. How was gender equality, human rights and disability integrated in the CP? (Proble for)
    - Was/is an analysis of gender, human rights and disability data done at design or development of annual work plans?
    - Does your project/work plan include indicators, outputs and outcomes disaggregated by gender, human rights and disability variables?
    - Are women and people with disability and other disadvantaged groups actively involved your interventions?
11. Did/does UNFPA provide guidance on how gender, human rights and disability issues can be integrated into your project/annual work plan?

- To what extent has UNFPA proactively driven and supported the meaningful integration of gender equality and human rights based approaches across interventions?
- To what extent were the CP interventions designed to transform gender relations and promote gender equality and with what outcomes

12. Were you trained on integration of gender, human rights and disability in programmes?
    - In your view, do you and your staff have sufficient skills in this area?
    - What support would you require to integrate gender, human rights and disability issues into your programs effectively?

Efficiency

13. Explain the resources management process of the programme?
    - The process from development or the annual work plan, submission to UNFPA, review and approval by UNFPA, receipt of funds, reporting back to UNFPA (financial and programme report) and receiving further disbursement.
        - What funding modality is applied to the IP? (Direct Cash Transfer, Direct Payment, Reimbursement, Direct UNFPA execution)
        - What works well and does not work well in this process and how does this impact on implementation?
        - What has UNFPA done to address the bottlenecks in this process?
14. How timely did you receive resources for implementing this programme?
    - Were the resources sufficient to complete activities?
    - Were there delays? If yes, why and how did you solve the problem?
    - Are there activities that were cancelled or postponed?
    - Were new activities added to the planed programme activities during implementation? How is approval of work plan changes handled?
    - Are there occasions when the budget was not enough or you overspent?
15. Was provision made for adequate resources for integrating gender equality (human, technical and financial resources in the intervention as an investment in short-term, medium-term and long-term benefits?
16. How did UNFPA financial and administrative regulations facilitate activity implementation? How did they hinder activity implementation?
17. Was the programme approach, partner and stakeholder engagement appropriate for achievement of results?

Sustainability

18. How has UNFPA supported interventions contributed to your capacity development?
    - What type of capacity building support was provided? (probe for specific capacity building aspects – human resources, organizational development, networking, physical capacity, skills building etc)
    - To what extent is this capacity likely to contribute to sustainability of results achieved?
19. How did UNFPA support the development of beneficiaries' capacities?
    - What type of capacity were built? (E.g. community leaders' skills, beneficiary networks etc)
    - To what extent is this capacity likely to contribute to sustainability of results achieved?
20. Are you involved in UNFPA programming decision making process (from design, implementation, monitoring and reporting)? If so, how?
    - What is the process for generating partner annual work plans and budgets?
    - What role does UNFPA and national partners play in implementation of interventions? (who plays what role?)
21. Did the CP create the institutional change conducive to systematically addressing gender inequality?

Coverage and Connectedness

22. What humanitarian emergencies took place during the life of the 7th CP?
23. How did the emergencies affect your specific project?
24. How did UNFPA support you to response to humanitarian emergencies?
25. What humanitarian emergency activities did you undertake? What was the mode of delivery of the humanitarian assistance?
26. How were gender and human rights approaches integrated in humanitarian assistance?
27. How successful where these interventions? What were the major achievements?
28. What were the weaknesses in the response to emergencies?

Service providers at health facilities, OSCs and Shelters, Community Level implementers, Community led organisations, training institutions

1. How were/are you involved in implementation of FP/RMNCAH/SRH/GBV etc service delivery?
2. What type of services are you providing?
3. Who are you mainly targeting?
4. What approach are you using to provide the services?
5. What have been the major achievements or changes so far?
6. Have you been trained and/provided any equipment to delivery these services? Probe further
7. What other support have been provided to deliver the services?
8. Do these services meet the needs of targeted beneficiaries? If so how?
9. What other needs of beneficiaries are not met?
10. What challenges are you facing in delivering the services?
11. What challenges are beneficiaries facing in accessing services?
12. How would these challenges be solved?

Annex 7: Terms of Reference

United Nations Population Fund (UNFPA) Zimbabwe 7th Country Programme 2016 - 2020

Country Programme Evaluation

December 2019

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Acronyms

ADVC	Anti Domestic Violence Council
CO	Country Office
CP	Country Programme
CCA	Common Country Analysis/Assessment
CESHHAR	Centre for Sexual Health and HIV/AIDS Research Zimbabwe
COVID-19	Coronavirus disease 2019
CPAP	Country Programme Action Plan
CPD	Country Programme Document
CPE	Country Programme Evaluation
CPR	Contraceptive Prevalence Rate
DSA	Daily subsistence allowance
ERG	Evaluation Reference Group
EQA	Evaluation Quality Assessment
EQAA	Evaluation Quality Assurance and Assessment
ESARO	East and Southern African Regional Office
FACT	Family AIDS Caring Trust
FP	Family Planning
GBV	Gender-based Violence
GoZ	Government of Zimbabwe
ICPD	International Conference on Population and Development
I-TECH	International Training and Education Center for Health
KP	Key populations
LARC	Long Acting and Reversible Contraceptives
LEEP	Loop Electrosurgical Excision Procedure
MISP	Minimum Initial Services Package
MOHCC	Ministry of Health and Child Care
MOPSE	Ministry of Primary and Secondary Education
MWACSMED	Ministry of Women Affairs, Community, Smal and Medium Enterprise Development
MWH	Maternity Waiting Home
M&E	Monitoring and Evaluation
NAC	National AIDS Council
OECD/DAC	Organisation for Economic Co-operation and Development's (OECD) Development Assistance Committee (DAC)
OPHID	Organisation for Public Health Interventions for Development
OF	Obstetric Fistula
PHC	Primary Health Care
PSI	Population Services International
PSZ	Population Services Zimbabwe
REDATAM	Retrieval of DATa for small Areas by Microcomputer
RO	Regional Office
SAYWHAT	Students and Youth Working on Reproductive Health Action
SDGs	Sustainable Development Goals

SGBV	Sexual and Gender Based Violence
SRHR	Sexual and reproductive health and rights
ToR	Terms of Reference
TSP	Transitional Stabilisation Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNEG	United Nations Evaluation Group
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNPDF	United Nations Partnership for Development Framework
UNSDCF	United Nations Sustainable Development Cooperation Framework
UZ	University of Zimbabwe
VIAC	Visual Inspection with Acetic Acid and Cervicography
WHO	World Health Organisation
WRA	White Ribbon Alliance
ZAPSO	Zimbabwe AIDS Prevention and Support Organisation (ZAPSO)
ZIMASSET	Zimbabwe Agenda for Sustainable Socio-Economic Transformation
ZIMDAT	Zimbabwe Statistics Database
ZNFPC	Zimbabwe National Family Planning Council
ZUNDAF	Zimbabwe United Nations Development Assistance Framework

1. Introduction

The United Nations Population Fund (UNFPA) is the lead United Nations agency for delivering a world where every pregnancy is wanted, every childbirth is safe and every young person's potential is fulfilled. UNFPA expands the possibilities of women and young people to lead healthy and productive lives. The strategic goal of UNFPA is to "achieve universal access to sexual and reproductive health, realize reproductive rights, and reduce maternal mortality to accelerate progress on the agenda of the Programme of Action of the International Conference on Population and Development (ICPD), to improve the lives of women, adolescents and youth, enabled by population dynamics, human rights and gender equality".[95] In pursuit of this goal, UNFPA works towards three transformative and people-centred results: (i) end preventable maternal deaths; (ii) end the unmet need for family planning; and (iii) end gender-based violence and all harmful practices, including female genital mutilation and child, early and forced marriage. These transformative results will contribute to the achievement of the Sustainable Development Goals (SDGs), in particular good health and well-being (Goal 3), the achievement of gender equality and the empowerment of women and girls (Goal 5), the reduction of inequality within and among countries (Goal 10), and peace, justice and strong institutions (Goal 16). In line with the vision of the 2030 Agenda for Sustainable Development, UNFPA seeks to ensure that no one will be left behind and that the furthest behind will be reached first.

UNFPA has been operating in Zimbabwe since 1982. The support that the UNFPA Zimbabwe Country Office (CO) provides to the Government of Zimbabwe (GoZ) under the framework of the 7th Country Programme (CP) 2016 - 2020 builds on national development needs and priorities as articulated in the UNFPA Strategic Plan 2018 – 2021; ZIMASSET (2013 – 2018); the Transitional Stabilisation Programme (TSP) 2018 – 2020; the United Nations Common Country Analysis/Assessment (CCA); the Zimbabwe United Nations Development Assistance Framework (ZUNDAF), 2016 – 2020, the UNFPA Country Programme Action Plan (CPAP), 2016 – 2020; the National Health Strategy 2016 – 2020; and the Interim Poverty Reduction Strategy Paper (I-PRSP) 2016 – 2018.

The 2019 UNFPA Evaluation Policy requires CPs to be evaluated at least once every two programme cycles. The country programme evaluation (CPE) will provide an independent assessment of the relevance and performance of the UNFPA 7th CP 2016 to 2020 in Zimbabwe, and offer an analysis of various facilitating and constraining factors influencing programme delivery and the achievement of intended results. The CPE will also draw key lessons and provide a set of actionable recommendations for the next programme cycle.

The evaluation will be implemented in line with the *Handbook on How to Design and Conduct Country Programme Evaluations at UNFPA* (UNFPA Evaluation Handbook), which is available at: https://www.unfpa.org/EvaluationHandbook. The handbook provides practical guidance for

[95] UNFPA Strategic Plan 2018-2021.

managing and conducting CPEs to ensure the production of quality evaluations in line with the United Nations Evaluation Group (UNEG) norms and standards and international good practice for evaluation. It offers step-by-step guidance to prepare methodologically robust evaluations and sets out the roles and responsibilities of key evaluation stakeholders at all stages in the evaluation process. The handbook includes a number of tools, resources and templates that provide practical guidance on specific activities and tasks that the evaluators and the Evaluation Manager perform in the different evaluation phases.

The main audience and primary users of the evaluation are: (i) The UNFPA Zimbabwe CO; (ii) GoZ; (iii) the United Nations Country Team (UNCT) in Zimbabwe; (iv) East and Southern Regional Office (ESARO); (v) and donors operating in Zimbabwe. The evaluation results will also be of interest to a wider group of stakeholders, including: (i) Implementing partners of the UNFPA Zimbabwe CO; (ii) UNFPA headquarters divisions, branches and offices; (iii) the UNFPA Executive Board; (iv) academia; (v) local civil society organizations and international NGOs; and (vi) beneficiaries of UNFPA support (in particular women and adolescents and youth). The evaluation results will be disseminated to these audiences as appropriate, using traditional and new channels of communication and technology.

The evaluation will be managed by the Evaluation Manager within the UNFPA Zimbabwe CO, with guidance and support from the Regional Monitoring and Evaluation (M&E) Adviser at the ESARO, and in consultation with the Evaluation Reference Group (ERG) throughout the evaluation process. A team of independent external evaluators will conduct the evaluation and prepare an evaluation report in conformity with these terms of terms of reference.

2. Country Context

The Republic of Zimbabwe is a landlocked country in Southern Africa with a total surface area of 390,757 square kilometres. The major tribes are Shona and Ndebele. According to the 2012 census, Zimbabwe has a total population of 13.1 million people, with an annual average intercensal growth rate of 1.1%. 48% are males and 52% are females, with 67% below the age of 25. About 67% of the population lives in rural areas. Life expectancy, which declined between 1992 and 2002, is on the upward rebound from 45 years in 2002 to 58 years in 2012 to 61 years in 2018 according to the World Health Organization latest published data[96].

The economy of Zimbabwe is mainly made of tertiary industry which makes up to 60% of the total GDP as of 2017. Zimbabwe's **Gross domestic product is** 17.85 billion USD **and** 1,079.61 USD **GDP per capita** (2017 World Bank Report). The **GDP growth rate is** 3.4% annually. The average gross cash income for households in 2017 was US$2,401 of which primary income was US$1,591. Zimbabwe's HDI value for 2018 is 0.563, which puts the country in the medium human development category with a lower middle income economy.

[96] https://data.worldbank.org/indicator/SP.POP.TOTL?locations=ZW

The maternal mortality ratio (MMR) increased from 695 per 100,000 live births in 1999 to 960 per 100,000 live births recorded in 2010. However, the MMR declined to 651 per 100,000 live births in 2015 (ZDHS, 2015) and further to 462 (MICS, 2019). Total fertility rate declined from 4.29 in 1994 to 4 in 2015 (ZDHS) and 3.9 (MICS, 2019). Adolescent fertility remains high at 110 live births per 1000 live births (ZDHS, 2015). Contraceptive Prevalence Rate (CPR) for currently married women was at 67 in 2015 (ZDHS). The skilled birth attendance at delivery was at 78% in 2015 and increased to 86% (MICS 2019), 76% of pregnant women had 4 or more ANC visits and 73% of newborns received a postnatal check-up in the first 2 days after birth. The under-5 mortality rate is 69 deaths per 1,000 and about one in 15 children in Zimbabwe dies before his or her fifth birthday, with 70 percent of these deaths occurring during infancy.

Two percent of women and 3% of men reported an STI or symptoms of an STI in the 12 months preceding the ZDHS 2015 survey. The crude incidence rate of cervical cancer was 36.7 per 100,000 women (Human Papillomavirus and Related Diseases Report Zimbabwe, 2018).

According to the 2015 ZDHS, twenty two percent of girls aged 15 - 19 years have begun child bearing. The adolescent fertility rate is 110 live births per 1000 women aged 15-19 years, up from 99 in 2010 with a striking rural-urban differential of 138 versus 63. HIV prevalence for women and men 15 to 24 years is at 6.7% and 4.2% respectively. Unmet need of family planning (FP) for 15 - 19 years is 12.6% compared to 10.4% which is the national value. 65.7% of young men who had more than one partner in the last 12 months used a condom at last sexual intercourse. 29.8 % and 19.4% of young men and women (15 – 19 years) were tested for HIV and received results respectively. Forty six percent of young women and 47% of young men aged 15 to 24 years have "comprehensive knowledge" about the modes of HIV transmission and prevention.

In the 2015 ZDHS, unmet need for family planning among currently married women has decreased from 15 percent in 2010-11 to 10 percent in 2015. Sixty-seven percent of currently married women report current use of a family planning method, and 66 percent use a modern method. The most popular contraceptive method is the pill, currently used by 41 percent of currently married women. Demand for family planning satisfied by the use of modern methods among currently married women is 85 percent.

Thirty five percent of women have experienced some form of violence in their lifetime, with 14% of women having experienced sexual violence at least once in their lifetime. Thirty-nine percent of women and 33 percent of men age 15-49 believe that a husband is justified in beating his wife in at least one of five specified circumstances.

The following policies/strategies are available and relevant to UNFPA mandate:

1. National Health Strategy (2016 – 2020)
2. National Reproductive Health Policy;
3. National Adolescent Sexual and Reproductive Health Strategy (2016- 2020)
4. Zimbabwe National Family Planning Strategy (2016 – 2020)
5. Zimbabwe School Health Policy
6. National Youth Policy
7. Reproductive Maternal Newborn Child and Adolescent Strategy (draft)
8. National Gender Policy (2018 – 2022)

In June 2018 Zimbabwe held harmonized elections and the new Government developed the Transitional Stabilisation Programme (2018 to 2020). Over the past years, the United Nations had to shift its focus to humanitarian emergency response; first in 2016 during the El Nino induced drought, then during the cholera outbreak in 2017, and later the political, economic and financial crisis that started in 2017 spilling into 2018 and 2019. In March 2019, Zimbabwe experienced cyclone Idai which caused significant loss of lives and left about 270,000 people in urgent need of humanitarian assistance, causing widespread property and infrastructure destruction. The economic crisis has affected most basic and social services provision. Some health care providers employed by the Government went on a strike from September to December 2019, worsening the situation on service provision. The 7th CP therefore took into consideration the devastating consequences of these disasters with a focus of ensuring that women access SRHR and GBV prevention services.

In 2018, a mid term peer review of the programme was conducted and its recommendations were utilised to shape the alignment of the programme to the new UNFPA strategic plan (2018 – 2021).

While the current programme is due to end in 2020, an extension of the programme by another year will be submitted for approval by the Executive Board in September 2020. This is to ensure alignment with the ZUNDAF (extended by one year to 2021) as well as to the Transitional Stabilisation Programme (TSP) and the vision "To be a middle income country by 2030". UNFPA evaluation policy (2019) stipulates that at least one CPE should be conducted every two programme cycles" unless the quality of the previous country programme evaluation was unsatisfactory and/or significant changes in the country contexts have occurred". While the 6th CP received a "good" rating, the country office saw it fit to conduct an evaluation of the 7th CP given the one year extension and the need to use the results to align with the national priorities.

3. UNFPA Country Programme

UNFPA has been working with the Government of Zimbabwe since 1982 towards enhancing sexual and reproductive health and rights (SRHR), advancing gender equality, realizing rights and choices for young people, and strengthening the generation and use of population data for development. UNFPA is currently implementing the 7th CP in Zimbabwe.

The 7th CP (2016 - 2020) is aligned with UNFPA Strategic Plan 2018 – 2021, ZIMASSET (2013 – 2018), The Transitional Stabilisation Programme (TSP), The United Nations Common Country Analysis/Assessment (CCA), Zimbabwe United Nations Development Assistance Framework (ZUNDAF), 2016 – 2020, UNFPA Country Programme Action Plan (CPAP), 2016 – 2020, The National Health Strategy 2016 – 2020, Interim Poverty Reduction Strategy Paper (I-PRSP) 2016 – 2018. In 2018, the UNFPA Zimbabwe CO undertook the process of aligning the 7th CP to the 2018-2021 Strategic Plan. It was developed in consultation with Government, civil society, bilateral and multilateral development partners, including United Nations organizations, the private sector and academia.

The UNFPA Zimbabwe CO delivers its country programme through the following modes of engagement: (i) advocacy and policy dialogue, (ii) capacity development, (iii) knowledge management, (iv) partnerships and coordination, and (v) service delivery]. The **overall goal** of the UNFPA Zimbabwe 7th CP (2016 - 2020) is **universal access to sexual and reproductive health**

and reproductive rights and reduced maternal mortality, as articulated in the UNFPA Strategic Plan 2018-2021. The CP contributes to the following **outcomes** of the UNFPA Strategic Plan 2018-2021

- **Outcome 1.** *Every woman, adolescent and youth everywhere, especially those furthest behind, has utilized integrated sexual and reproductive health services and exercised reproductive rights, free of coercion, discrimination and violence*.
- **Outcome 2.** *Every adolescent and youth, in particular adolescent girls, is empowered to have access to sexual and reproductive health and reproductive rights, in all contexts.*
- **Outcome 3.** *Gender equality, the empowerment of all women and girls, and reproductive rights are advanced in development and humanitarian settings.*
- **Outcome 4.** *Everyone, everywhere, is counted, and accounted for, in the pursuit of sustainable development*.

The UNFPA Zimbabwe 7th CP (2016 - 2020) has 4 thematic areas of programming with distinct **outputs** that are structured according to the 4 outcomes in the Strategic Plan 2018-2021 to which they contribute.

- **Outcome 1**: Every woman, adolescent and youth everywhere, especially those furthest behind, has utilized integrated sexual and reproductive health services and exercised reproductive rights, free of coercion, discrimination and violence.

Output 1: Increased availability of and access to voluntary family planning, especially long acting contraceptive methods This will be achieved through: a) revising and updating relevant family planning policies, guidelines and protocols; b) building capacity of service providers, especially those at primary health care level, for quality family planning, counseling, and services, including intra-uterine contraceptive device insertion and removal; c) conducting integrated community-based behavioral change interventions to generate demand for family planning; d) providing essential reproductive health commodities to enhance the country's reproductive health commodity security and diversify choices of contraceptives. e) Strengthen the institutional capacity of Zimbabwe National Family Planning Council to effectively lead, regulate and coordinate family planning programmes for achieving the FP2020 goals of Zimbabwe.

Output 2: Increased national capacity to deliver quality maternal health services, including in humanitarian setting

This will be achieved through a) support national coordination mechanisms for maternal health; b) support midwifery association, regulation, and education; c) scale up maternal death surveillance and response; d) further integrate reproductive health indicators in the health management information system; e) scale up support to clinical mentorship; f) scale up integrated quality sexual reproductive health information and services for pregnant women, especially young pregnant women, in maternity waiting homes; and g) support fistula prevention, treatment, and re-integration interventions. h) support the Ministry of Health and Child Care to conduct contingency planning based on minimum initial service package for sexual reproductive health in emergencies.

Output 3: Increased national capacity to provide quality cervical cancer screening and treatment services for precancerous lesions. This will be achieved through a) development of national policy, guidelines, and protocols on cervical cancer screening and treatment; b) expansion of cervical cancer centers in public health facilities; c) training of service providers in public hospitals; d) enhancement of referral mechanisms to advanced care at tertiary hospitals.

Output 4: Increased uptake of HIV prevention services among women and men, especially young people and key populations. This will be achieved through a) continue to enhance the national integrated demand generation programme on sexual reproductive health, HIV and gender-based violence services with a focus on young people; b) roll out the sexual reproductive health and HIV service integration model in public health facilities at the district level; c) support civil society partners to provide equitable and acceptable sexual reproductive health and HIV services to key populations, especially in hard to reach communities, based on existing hot spot mapping and through scaling up pilot interventions under the sixth country programme for young key populations; d) advocate for and support capacity building interventions in public sector facilities to deliver integrated HIV prevention services to key populations using innovative service delivery approaches; e) support national programme coordination and policy development for selected HIV prevention services based on emerging evidence

Outcome 2: Every adolescent and youth, in particular adolescent girls, is empowered to have access to sexual and reproductive health and reproductive rights, in all contexts.

Output 5: Increased national capacity to provide information and services that prevent teenage pregnancy. This will be achieved through strengthening youth friendly health services, community engagement through Sista2Sista programmes, Comprehensive Sexuality Education and Parent Child Communication, development of the Adolescent Sexual Reproductive Health policy to provide an enabling environment for implementation services and programmes, support to the Zimbabwe Youth Council which provided an opportunity for youth participation.

Outcome 3: **Gender equality, the empowerment of all women and girls, and reproductive rights are advanced in development and humanitarian settings.**

Output 6: Increased national capacity to prevent gender-based violence and enable the delivery of multi-sectoral services, including in humanitarian settings. This will be achieved through: a) Support to the Ministry of Women Affairs, Gender and Community Development to coordinate a multi-sectoral gender-based violence prevention and response programme; b) Technical assistance and capacity building for national institutions, mechanisms and civil societies in GBV prevention and response; c) Technical support for the development of data/information management systems; d) Capacity building in health response to GBV; e) Building of capacity in referral pathway mechanism and f) Establishment of safety nets.

Outcome 4: **Everyone, everywhere, is counted, and accounted for, in the pursuit of sustainable development.**

Output 7: Increased national capacity for the production and use of disaggregated data on population, sexual reproductive health and gender-based violence for the formulation and monitoring of evidence-based policies, plans and programmes including in humanitarian

settings. This will be achieved through: a) conducting of surveys and application of modern technologies, including the Zimbabwe Demographic and Health Survey and Inter-Censual Demographic Survey; b) subsequent in-depth analysis of surveys in partnership with Zimbabwe National Statistics Agency, universities and national statistical offices; c) web-enabled demographic and socio-economic database systems to improve data access, including in humanitarian preparedness and response; d) strengthening administrative data systems in the areas of health, HIV and gender; and e) Ministry of Economic Planning to coordinate the integration of population issues in national and sectoral policies and plans.

In addition, the UNFPA Zimbabwe CO takes part in activities of the UNCT under the leadership of the United Nations Resident Coordinator, with the objective to ensure inter-agency coordination and efficient delivery of tangible results in support of the national development agenda and the SDGs.

The **theory of change** that describes how and why the set of activities planned under the CP are expected to contribute to a sequence of results that culminates in the strategic goal of UNFPA is presented in Annex A. The theory of change will be an essential building block of the evaluation methodology.

The UNFPA Zimbabwe 7th CP (2016 - 2020) is based on the following results framework presented below:

Goal: Achieved universal access to sexual and reproductive health, realized reproductive rights, and reduced maternal mortality to accelerate progress on the ICPD agenda, to improve the lives of adolescents, youth and women, enabled by population dynamics, human rights, and gender equality			
UNFPA Thematic Areas of Programming			
I. Sexual Reproductive Health	**II. Adolescents and Youth**	**III. Gender equality and women's empowerment**	**IV. Population and Development**
UNFPA Strategic Plan Outcomes			
Increased availability and use of integrated sexual and reproductive health services, including family planning, maternal health and HIV, that are gender-responsive and meet human rights standards for quality of care and equity in access	Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health	Advanced gender equality, women's and girls' empowerment, and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth	Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality
UNFPA Zimbabwe 7th CP Outputs			
Output 1: Increased availability of and access to voluntary family planning, especially long acting contraceptive methods. Output 2: Increased national capacity to deliver quality maternal health services including in humanitarian settings Output 3: Increased national capacity to provide quality cervical cancer screening and treatment services for precancerous lesions Output 4: Increased uptake of HIV prevention services among women and men, especially young people and key populations	Output 5: Increased national capacity to provide information and services that prevent teenage pregnancy	Output 6: Increased national to prevent gender based violence and enable the delivery of multi-sectoral services including in humanitarian settings.	Output 7: Increased national capacity for the production and use of disaggregated data on population, sexual reproductive health and gender-based violence for the formulation and monitoring of evidence-based policies, plans and programmes including in humanitarian settings.
UNFPA Zimbabwe 7th CP Intervention Areas			
1.1 Support ZNFPC transformation 1.2 Support FP coordination at national and subnational levels to enhance programme accountability and efficiency 1.3 Create enabling environment for FP programme 1.4 Support Reproductive Health Commodity Security in Zimbabwe (Integrate RH commodities). 1.5 Build capacity of health service providers to provide LARC (IUCD, Implant) 1.6 Generate demand for FP	5.1 Support to policy advocacy on youth empowerment 5.2 Support ASRH coordination 5.3 Roll out Adolescent and Youth Friendly Health Services (AYFHS) programme in public health facilities. 5.4 Support CSE programme in school and tertiary institutions 5.5 Roll out CSE for out of school young people beyond the 3 pilot districts	6.1 Support MWACSMED and ADVC to strengthen coordination of GBV prevention and response. 6.2 Implement multi-layered multi media social and behaviour change communication and community mobilisation interventions (Integrated) 6.3 Support GBV community based shelters 6.4 Support GBV One Stop Centers	7.1 Support to REDATAM and ZIMDAT based information management systems at ZIMSTAT 7.2 Support to population census 7.3 Support to the 2020 ZDHS 7.4 Support to strengthen vital registration 7.5 Support to SDG monitoring and reporting 7.6 Support work on integration of population dynamics in national policies and plans

1.7 Support availability of quality information and data to guide FP programme 2.1 Support clinical mentorship using the revised guidelines (focus Mat N, Midlands, Mash West and "the 3 priority districts") 2.2 Facilitate continuous quality improvement and RMNACH integration 2.3 Support to strengthen quality and timely referral with focus on obstetric and neonatal emergencies 2.4 Strengthen implementation of maternal and perinatal death surveillance and response. 2.5 Support to Health Management Information Systems 2.6 Support Human Resource for Health (HRH) 2.7 Support to strengthen MWH services based on the revised national guidelines (2018) 2.8 Support obstetric fistula programme 2.9 Support orientation, sensitization of MOHCC senior managers on MISP 3.1 Support screening of women for cervical cancer using VIAC 3.2 Strengthen treatment for VIAC positive women in supported facilities (cryotherapy, thermocoagulation and LEEP) 3.3 Provide integrated SRHR/CaCx/HIV/GBV outreach services by public health facilities (start in 2 districts) 3.4 Support national cervical cancer control steering committee, technical working group and quality assurance meetings 4.1 Support to Comprehensive Condom Programming, 4.2 Implement 2Gether4SRHR joint programme 4.3 Support KP programme 4.4 Support to national STI programme 4.5 Support integrated demand generation and behaviour change programme for SRHR/GBV/HIV in communities	5.6 Implement Sista2Sista (S2S) Programme in 20 Districts 5.7 Implement Parent to Child Communication (PCC) programme in 20 districts 5.8 Support youth empowerment and access to ASRH information and services in 3 innovation hubs (Hopely, Mbire and Bulilima), Phase II intervention	6.5 Support health sector response to GBV 6.6 Support a national GBV Information Management System 6.7 Maintain and innovate the GBV online knowledge portal 6.8 Support and innovate the GBV hotline 6.9 Improved Response to GBV in humanitarian settings 6.10 Support implementation of GBV ethical reporting guidelines	

4. Evaluation Purpose, Objectives and Scope

4.1. Purpose

The CPE will serve the following three main purposes outlined in the 2019 UNFPA Evaluation Policy: (i) demonstrate accountability to stakeholders on performance in achieving development results and on invested resources; (ii) support evidence-based decision-making; and (iii) contribute key lessons learned to the existing knowledge base on how to accelerate the implementation of the Programme of Action of the 1994 ICPD.

4.2. Objectives

The **purpose** of this CPE is:

i. to provide the UNFPA CO in Zimbabwe, national stakeholders, the UNFPA ESARO, UNFPA Headquarters as well as a wider audience with an independent assessment of the UNFPA Zimbabwe 7th CP (2016 – 2020).
ii. to broaden the evidence base for the design of the next programme cycle.

The **objectives** of this CPE are:

i. Provide an independent assessment of the relevance, effectiveness, efficiency and sustainability of UNFPA support and progress towards the expected outputs and outcomes set forth in the results framework of the country programme.
ii. Provide an assessment of the role played by the UNFPA country office in the coordination mechanisms of the UNCT with a view to enhancing the United Nations collective contribution to national development results.
iii. Draw key lessons from past and current cooperation and provide a set of clear and forward-looking options leading to strategic and actionable recommendations for the next programme cycle.

4.3. Scope

Geographical Scope

The evaluation will cover all the 10 provinces and 63 districts where UNFPA is implementing interventions In annex D a list is provided with the provinces and districts showing the interventions supported. The 7th CP adopted 20 districts where all the interventions are implemented. However, other interventions e.g. Family planning and maternal health are implemented countrywide. There are other interventions e.g. one stop centres, shelters and humanitarian response interventions that are implemented in specific provinces and districts.

Thematic Scope

The evaluation will cover the following thematic areas of the 7th CP: SRHR (Family Planning, Maternal Health, Cervical Cancer Screening and Treatment, HIV Prevention); Adolescent Sexual and Reproductive Health; Gender equality and the empowerment of women and girls; and Population and Development. In addition, the evaluation will cover cross-cutting issues such as human rights and gender equality, disability and humanitarian emergency/crisis, and transversal aspects of coordination; monitoring and evaluation (M&E); innovation; and strategic partnerships.

Temporal Scope

The evaluation will cover interventions planned and/or implemented within the time period of the current CP: 2016 – 2020.

5. Evaluation Criteria and Preliminary Evaluation Questions

5.1. Evaluation Criteria

In accordance with the methodology for CPEs outlined in the UNFPA Evaluation Handbook (see section 3.2, pp. 51-61), the evaluation will examine the following four OECD/DAC evaluation criteria: relevance, effectiveness, efficiency and sustainability. It will also use the evaluation criterion of coordination to assess cooperation and partnerships of UNFPA within the UNCT and whether UNFPA interventions promote synergy and avoid gaps and duplication. As the UNFPA country office has been operating in humanitarian settings (such as drought, cyclone), the evaluation will also use the humanitarian-specific evaluation criteria of coverage and connectedness to investigate to what extent UNFPA has been able to reach affected populations with life-saving services and work across the humanitarian-peace-development nexus and contribute to building resilience.

Relevance	The extent to which the objectives of the UNFPA country programme correspond to population needs at country level (in particular, those of vulnerable groups), and were aligned throughout the programme period with government priorities and with strategies of UNFPA.
Effectiveness	The extent to which country programme outputs have been achieved and the extent to which these outputs have contributed to the achievement of the country programme outcomes.
Efficiency	The extent to which country programme outputs and outcomes have been achieved with the appropriate amount of resources (funds, expertise, time, administrative costs, etc.).
Sustainability	The continuation of benefits from a UNFPA-financed intervention after its termination, linked, in particular, to their continued resilience to risks.
Coordination	The extent to which UNFPA has been an active member of, and contributor to existing coordination mechanisms of the UNCT
Coverage	The extent to which major population groups facing life-threatening suffering were reached by humanitarian action.
Connectedness	The extent to which activities of a short-term emergency nature are carried out in a context that takes longer-term and interconnected problems into account.

5.2. Preliminary Evaluation Questions

The country programme evaluation is expected to provide answers to a number of evaluation questions which are derived from the above criteria. The evaluation questions will delineate the thematic scope of the CPE and are meant to formulate key areas of inquiry that are of interest to various stakeholders, thereby optimizing the focus and utility of the CPE.

The evaluation questions presented below are indicative and the evaluators are expected to develop a final set of evaluation questions based on these preliminary questions, in consultation with the Evaluation Manager at the UNFPA Zimbabwe CO and the Evaluation Reference Group (ERG).

Relevance

1. To what extent is the country programme adapted to: i) the needs of diverse populations, including the needs of marginalized and vulnerable groups; ii) national development strategies and policies;

iii) the strategic direction and objectives of UNFPA; and iv) priorities articulated in the ICPD Programme of Action and SDGs, v) the New Way of Working and the Grand Bargain.

Effectiveness

2. To what extent have the interventions supported by UNFPA contributed to the achievement of the expected results (outputs and outcomes) of the country programme? In particular: i) increased access and use of integrated sexual and reproductive health services; ii) empowerment of adolescents and youth to access sexual and reproductive health services and exercise their sexual and reproductive rights; iii) advancement of gender equality and the empowerment of all women and girls; and iv) increased use of population data in the development of evidence-based national development plans, policies and programmes.
3. To what extent has UNFPA successfully integrated gender and human rights perspectives in the design, implementation and monitoring of the country programme?

Efficiency

4. To what extent did the intervention mechanisms (financing instruments, administrative regulatory framework, staff, timing and procedures) foster or hinder the achievement of the programme outputs?

Sustainability

5. To what extent has UNFPA been able to support implementing partners and beneficiaries (women and adolescents and youth) in developing capacities and establishing mechanisms to ensure ownership and the benefits continue beyond program termination?
6. To what extent has the UNFPA been able to support its partners and the beneficiaries in developing capacities that ensure the durability of outputs, and eventually outcomes?

Coordination

7. To what extent is the UNFPA CO coordinating with other UN agencies in the country and how is it aligned to the UNDAF?

Coverage

8. To what extent has the CO been able to respond to changes in national needs and priorities during the humanitarian emergencies and crisis e.g. drought, floods and cyclone? What was the quality of the response?
9. To what extent has the country office been able to respond to the humanitarian emergencies and changes in national needs and priorities, including those of vulnerable or marginalized communities? What was the quality of the response?

The final evaluation questions and the evaluation matrix will be presented in the design report.

6. Methodology and Approach

6.1. Evaluation Approach

Theory-based approach

The CPE will adopt a theory-based approach that relies on an explicit theory of change, which depicts how the interventions supported by the UNFPA CO in Zimbabwe are expected to contribute to a series of results (outputs and outcomes) that lead to the overall goal of UNFPA. The theory of change also identifies the

causal mechanisms, risks and contextual factors that support or hinder the achievement of desired changes. A theory-based approach is fundamental for generating insights about what works, what does not and why, as it focuses on the analysis of causal links (assumptions) between changes at different levels of the results chain described by the theory of change, and explores how these assumptions and contextual factors affected the achievement of intended results.

The theory of change will play a central role throughout the evaluation process, from the design and data collection to the analysis and identification of findings, as well as the articulation of conclusions and recommendations. The evaluation team will be required to verify the theory of change underpinning the UNFPA Zimbabwe 7th CP (2016 - 2020) (see Annex A) and use this theory of change to determine whether changes at output and outcome levels occurred (or not) and whether assumptions about change hold true. The analysis of the theory of change will serve as the basis for the evaluators to assess how relevant, effective, efficient and sustainable the support provided by the UNFPA Zimbabwe was during the period of the 7th CP.

As part of the theory-based approach, the evaluators shall use a contribution analysis to explore whether evidence to support key assumptions exists, examine if evidence on observed results confirms the chain of expected results in the theory of change, and seek out evidence on the influence that other factors may have had in achieving desired results. This will enable the evaluation team to make a reasonable case about the difference that the UNFPA Zimbabwe 7th CP (2016 - 2020) made.

Participatory approach

The CPE will be based on an inclusive, transparent and participatory approach, involving a broad range of partners and stakeholders at national and sub-national levels. The UNFPA Zimbabwe CO has developed a stakeholders map (Annex B) to identify stakeholders who have been involved in the preparation and implementation of the CP, and those partners who do not work directly with UNFPA and yet play a key role in a relevant outcome or thematic area in the national context. These stakeholders include representatives from government, civil society organizations, implementing partners, the private sector, academia, other United Nations organizations, donors and, most importantly, beneficiaries (women and adolescents and youth). They can provide insights and information, as well as referrals to data sources that the evaluators should use to assess the contribution of UNFPA support to changes in each thematic area of programming of the CP. Particular attention will be paid to ensuring participation of women, adolescent girls and young people, especially those from vulnerable and marginalized communities.

The Evaluation Manager in the UNFPA Zimbabwe CO has established an ERG comprised of key stakeholders of the CP including: governmental and non-governmental counterparts including CSOs, at national level, the academia, the UNFPA ESARO M&E Adviser. The ERG will provide inputs at different stages in the evaluation process.

Mixed-method approach

The evaluation will primarily use qualitative methods for data collection, including document review, interviews, group discussions and observations through field visits where possible, as appropriate. The qualitative data will be complemented with quantitative data to minimize bias. Quantitative data will be compiled through desk review of documents, websites and online databases to obtain relevant financial data and data on key indicators that measure change at output and outcome levels.

These complementary approaches described above will be used to ensure that the evaluation: (i) responds to the information needs of users and the intended use of the evaluation results; (ii) upholds gender and human rights principles throughout the evaluation process, including, to the extent possible, participation

and consultation of key stakeholders (rights holders and duty-bearers); and (iii) provides credible information about the benefits for recipients and beneficiaries (women and adolescents and youth) of UNFPA support through triangulation of collected data.

6.2. Methodology

The evaluation team shall develop the evaluation methodology in line with the evaluation approach and guidance provided in the UNFPA Evaluation Handbook. The handbook will help the evaluators develop a methodology that meets good quality standards for evaluation at UNFPA and the professional evaluation standards of UNEG. It is expected that, once contracted by the UNFPA Zimbabwe CO, the evaluators acquire a solid knowledge of the handbook.

The CPE will be conducted in accordance with the UNEG *Norms and Standards for Evaluation*[97], *Ethical Guidelines for Evaluation*[98], *Code of Conduct for Evaluation in the UN System*[99], *and Guidance on Integrating Human Rights and Gender Equality in Evaluations*[100]. When contracted by the UNFPA CO Zimbabwe, the evaluators will be requested to sign the UNEG *Code of Conduct* prior to starting their work.

The methodology that the evaluation team will develop builds the foundation for providing valid and evidence-based answers to the evaluation questions and for offering a robust and credible assessment of UNFPA support in Zimbabwe. The methodological design of the evaluation shall include in particular: (i) a theory of change; (ii) a strategy for collecting and analyzing data; (iii) specifically designed tools for data collection and analysis; (iv) an evaluation matrix; and (v) a detailed work plan.

The evaluation team is strongly encouraged to refer to the Handbook at all times and use the provided tools and templates at all stages of the evaluation process.

The evaluation matrix

The evaluation matrix is centerpiece to the methodological design of the evaluation (see Handbook, section 1.3.1, pp. 30-31 and Tool 1: The Evaluation Matrix, pp. 138-160 and the evaluation matrix template in Annex C). It contains the core elements of the evaluation: (i) what will be evaluated (evaluation questions for all evaluation criteria and key assumptions to be examined as part of the evaluation questions), and (ii) how it will be evaluated (data collection methods, sources of information and analysis methods for each evaluation question and associated key assumptions). By linking each evaluation question (and associated assumptions) with the specific data sources and data collection methods required to answer the question, the evaluation matrix plays a crucial role before, during and after data collection.

In the design phase, the matrix helps evaluators to develop a detailed agenda for data collection and analysis and to prepare the structure of interviews, group discussions and direct observation at sites visited. Where field visits will be possible, the evaluation matrix serves as a reference document to ensure that data is systematically collected for all evaluation questions and that data is documented in a structured and organized way. At the end of the field phase, the matrix is useful to verify whether sufficient evidence has been collected to answer all evaluation questions and identify data gaps that require additional data collection. In the reporting phase, the evaluation matrix facilitates the drafting of findings per evaluation

[97] http://www.unevaluation.org/document/detail/1914
[98] http://www.unevaluation.org/document/detail/102
[99] http://www.unevaluation.org/document/detail/100
[100] http://www.unevaluation.org/document/detail/980

question and the identification and articulation of conclusions and recommendations that cut across different evaluation questions.

As the evaluation matrix plays a crucial role at all stages of the evaluation process, it will require particular attention from both the evaluation team and the Evaluation Manager. The evaluation matrix will be drafted in the design phase and must be included in the design report. The evaluation matrix will also be included in the annexes to the final evaluation report, to enable users to access the supporting evidence for the answers to the evaluation questions.

Finalization of the evaluation questions and assumptions

Based on the preliminary evaluation questions presented in the present terms of reference (see section 5.2), the evaluators are required to finalize the set of questions that will guide the evaluation. The final set of evaluation questions will need to clearly reflect the evaluation criteria and key areas of inquiry (highlighted in the preliminary evaluation questions). The evaluation questions should also draw from the theory of change underlying the CP. The final evaluation questions will structure the evaluation matrix (see Annex C) and shall be presented in the design report.

The evaluation questions must be complemented by a set of critical assumptions that capture key aspects of how and why change is expected to occur based on the theory of change of the CP. This will allow evaluators to assess whether the preconditions for contribution to results at output and, in particular, outcome levels are met. The data collection for each of the evaluation questions and assumptions will be guided by clearly formulated quantitative and qualitative indicators, which need to be specified in the evaluation matrix.

Sampling strategy

The UNFPA Zimbabwe CO will provide an initial overview of the interventions supported by UNFPA, the locations where these interventions have taken place, and the stakeholders involved in these interventions. As part of this process, the UNFPA Zimbabwe CO has produced a stakeholder mapping to identify the whole range of stakeholders that are directly or indirectly involved in the implementation, or affected by the implementation of the CP (see Annex B)

Based on information gathered through desk review and discussions with the CO staff, the evaluators will refine the initial stakeholders map and develop a comprehensive stakeholders map. From this stakeholders map, the evaluation team will select a sample of stakeholders at national and sub-national levels who will be consulted through interviews and/or group discussions during the data collection phase. These stakeholders must be selected through clearly defined criteria and the sampling approach outlined in the design report (for guidance on how to select a sample of stakeholders see Handbook, pp. 62-63). In the design report, the evaluators should also make explicit what groups of stakeholders were not included and why. The evaluators should aim to select a sample of stakeholders that is as representative as possible, recognizing that it will not be possible to obtain a statistically representative sample.

The evaluation team shall also select a sample of sites that will be visited for data collection, and provide the rationale for the selection of the sites in the design report. The UNFPA Zimbabwe CO will provide the evaluators with information on the accessibility of different locations, including logistical requirements and security risks and concerns. The sample of sites selected for visits should reflect the variety of interventions supported by UNFPA in terms of thematic focus of programming and context.

The final sample of stakeholders to be consulted and sites to be visited will be determined in consultation with the Evaluation Manager based on the review of the design report.

Data collection
The evaluation will consider primary and secondary sources of information. For detailed guidance on the different data collection methods typically employed in CPEs, see Handbook, section 3.4.2, pp. 65-73.

Primary data will be collected through semi-structured interviews with key informants at national and sub-national levels (government officials, representatives of implementing partners, civil society organizations, other United Nations organizations, donors, and other stakeholders), as well as group discussions with service providers and beneficiaries (women and adolescents and youth) and direct observation during visits to programme sites.

Secondary data will be collected through desk review**,** primarily focusing on annual and mid-year reviews of the CP, progress reports and monitoring data, evaluations and research studies (incl. previous CPEs, assessments of the CP, evaluations by the UNFPA Evaluation Office, research by international NGOs and other United Nations organizations etc.), housing census and population data, and records and data repositories of the UNFPA Zimbabwe CO and its implementing partners, such as health clinics/centres. Particular attention will be paid to compiling data on key performance indicators of the UNFPA Zimbabwe CO during the period of the 7th CP (2016 - 2020).

The evaluation team will ensure that data collected is disaggregated by sex, age, location and other relevant dimensions (e.g., disability status) to the extent possible.

The evaluation team is expected to plan for data collection which will be mostly through virtual means with minimal field visits where possible. The data collection tools that the evaluation team will develop, which may include protocols for semi-structured interviews and group discussions, a checklist for direct observation at sites visited or a protocol for document review, shall be presented in the design report.

Data analysis
The evaluation matrix will be the major framework for analyzing data. Once all data will have been entered into the evaluation matrix for each evaluation question, the evaluators should identify common themes, patterns and relationships in the data, as well as areas that should be further explored to answer the evaluation questions (see Handbook, sections 5.1 and 5.2, pp. 115-117).

Validation mechanisms
All findings of the evaluation need to be firmly grounded in evidence. The evaluation team will use a variety of mechanisms to ensure the validity of collected data, including (for more detailed guidance see Handbook, section 3.4.3, pp. 74-77):

- Systematic triangulation of data sources and data collection methods (see Handbook, section 4.2., pp. 94-95);
- Regular exchange with the Evaluation Manager at the CO;
- Internal evaluation team meetings to share and discuss hypotheses, preliminary findings and conclusions and their supporting evidence (an important internal validation mechanism will take place when the evaluation team gets together to prepare the debriefing with the CO and the ERG); and
- The debriefing meeting with the CO and the ERG at the end of the field phase where the evaluation team present the preliminary findings and emerging conclusions.

Additional validation mechanisms may be established, as appropriate. Data validation is a continuous process throughout the different evaluation phases. The evaluators should check the validity of data and verify the robustness of findings at each stage in the evaluation, so they can determine whether they should further pursue specific hypotheses or disregard them when there are indications that these are weak (contradictory findings or lack of evidence).

The validation mechanisms will be presented in the design report.

7. Evaluation Process

The CPE process can be broken down into five different phases that include different stages and lead to different deliverables: preparatory phase; design phase; field phase where possible; reporting phase; and facilitation of use and dissemination phase. Quality assurance must be performed by the Evaluation Manager and the evaluation team leader throughout all phases to ensure the production of a credible, useful and timely evaluation.

7.1. Preparatory Phase *(Handbook, pp.35-40)*

The Evaluation Manager at the UNFPA Zimbabwe CO will lead the preparatory phase of the CPE, which includes:

- Establishment of the ERG.
- Drafting the terms of reference (ToR) for the CPE with support from the ESARO M&E Adviser and in consultation with the ERG, and approval of the draft ToR by the Evaluation Office.
- Selection of consultants by the CO, pre-qualification of the consultants selected by the Evaluation Office, and recruitment of the consultants by the CO to constitute the evaluation team.
- Compilation of background information and documents on the country context and CP for desk review by the evaluation team.
- Preparation of a first stakeholders map (Annex B) and list of Atlas projects (Annex D).
- Development of a communication plan by the Evaluation Manager in consultation with the communications officer at the UNFPA Zimbabwe CO to support dissemination and facilitate the use of evaluation results. This plan should be updated as the evaluation process evolves, so it is ready for immediate implementation when the final evaluation report is issued.

7.2. Design Phase *(Handbook, pp.43-83)*

The evaluation team will conduct the design phase in consultation with the Evaluation Manager and the ERG. This phase includes:

- Desk review of initial background information and documents on the country context and CP, as well as other relevant documentation.
- Formulation of a final set of evaluation questions based on the preliminary evaluation questions provided in the ToR.
- Development of a comprehensive stakeholders map and sampling strategy to select sites to be visited and stakeholders to be consulted in Zimbabwe through interviews and group discussions.
- Development of a data collection and analysis strategy, as well as a concrete work plan for the field and reporting phases (see Handbook, section 3.5.3, p. 80).
- Development of data collection methods and tools, assessment of limitations to data collection and development of mitigation measures.
- Development of the evaluation matrix (evaluation criteria, evaluation questions, assumptions, indicators, data collection methods and sources of information).

At the end of the design phase, the evaluation team will develop a **design report** that includes the results of the above-listed steps and tasks. The design report will be developed in consultation with the Evaluation Manager, the ERG and the ESARO M&E Adviser. The template for the design report is provided in Annex E.

7.3. Field Phase where possible*(Handbook, pp. 87 -111)*

The evaluation team will undertake a desk review and analysis of provided documents to collect the data required to answer the evaluation questions. The evaluation team will also conduct a preliminary analysis of the data to identify emerging findings and conclusions to be validated with the CO and the ERG. The evaluators will be expected to apply innovative approaches to allow sufficient time to collect valid and reliable data to cover the thematic scope of the CPE. Aa period of three weeks is recommended, however, the Evaluation Manager will determine the optimal duration of the field mission in consultation with the evaluation team during the design phase be determined by the methodology. The field phase includes:

- Online Meeting with the UNFPA Zimbabwe CO staff to launch the data collection.
- Online Meeting of evaluation team members with relevant programme officers at the UNFPA Zimbabwe CO.
- Data collection at national and sub-national levels to be done virtually as much as possible.

At the end of the field phase, the evaluation team will hold a **debriefing meeting with the CO and the ERG** to present the preliminary findings and emerging conclusions from the data collection. The meeting will serve as an important validation mechanism and will enable the evaluation team to develop credible and relevant findings, conclusions and recommendations.

7.4. Reporting Phase *(Handbook, pp.115 -121)*

In the reporting phase, the evaluation team will continue the analytical work (initiated during the field phase) and prepare a **draft evaluation report**, taking into account the comments and feedback provided by the CO and the ERG at the debriefing meeting at the end of the field phase.

This draft evaluation report will be submitted to the Evaluation Manager for quality assurance purposes. Prior to the submission of the draft report, the evaluation team must ensure that it underwent an internal quality control against the criteria outlined in the Evaluation Quality Assessment (EQA) grid (Annex F). The Evaluation Manager and the ESARO M&E Adviser will subsequently prepare an EQA of the draft evaluation report, using the EQA grid. If the quality of the report is satisfactory (form and substance), the draft report will be circulated to the ERG for comments and feedback. In the event that the quality of the draft report is unsatisfactory, the evaluation team will be required to revise the report and produce a new version.

The Evaluation Manager will collect and consolidate the written comments and feedback provided by the members of the ERG. On the basis of the comments, the evaluation team should make appropriate amendments, prepare the **final evaluation report** and submit it to the Evaluation Manager. The final report should clearly account for the strength of evidence on which findings rest to support the reliability and validity of the evaluation. Conclusions and recommendations need to clearly build on the findings of the evaluation. Conclusions need to clearly reference the specific evaluation questions from which they have been derived, while recommendations need to reference the conclusions from which they stem.

The evaluation report is considered final once it is formally approved by the Evaluation Manager at the UNFPA Zimbabwe CO.

7.5. Facilitation of Use and Dissemination Phase *(Handbook, pp.131 -133)*

In the facilitation of use and dissemination phase, the evaluation team will develop a **PowerPoint presentation for the dissemination of the evaluation results** that conveys the findings, conclusions and recommendations of the evaluation in an easily understandable and user-friendly way.

The Evaluation Manager, together with the CO communications officer, will implement the communication plan to share the evaluation results with the CO, ESARO, ERG, implementing partners and other stakeholders. The Evaluation Manager will also ensure that the final evaluation report is circulated to relevant business units in the CO, invite them to submit a management response, and consolidate all responses in a final management response document (see Annex G). The UNFPA Zimbabwe CO will subsequently submit the management response to the UNFPA Policy and Strategy Division in HQ.

It is also highly recommended that the Evaluation Manager, in collaboration with the communications officer at the UNFPA Zimbabwe CO, develop an evaluation brief that makes the results of the CPE more accessible to a larger audience (see sections 8 and 10 below).

The final evaluation report, along with the management response and the independent EQA of the final report will be published on the UNFPA evaluation database by the Evaluation Office. The final evaluation report will also be made available to the UNFPA Executive Board and will be published on the UNFPA Zimbabwe CO website.

8. Expected Deliverables

The evaluation team is expected to produce the following deliverables:

- **Design report.** The design report should translate the requirements of the ToR into a practical and feasible evaluation approach, methodology and work plan. It should include (at a minimum): (i) a stakeholders map; (ii) an evaluation matrix (incl. the final set of evaluation questions, indicators, data sources and data collection methods); (iii) the evaluation approach and methodology, with a detailed description of the agenda for the field phase; (iv) data collection tools and techniques (incl. interview and group discussion protocols). For guidance on the outline of the design report, see Annex E.
- **PowerPoint presentation of the design report.** The presentation will be delivered at an ERG meeting to present the contents of the design report and the agenda for the field phase. Based on the comments and feedback of the ERG, the Evaluation Manager and the Regional M&E Adviser, the evaluation team will develop the final version of the design report.
- **PowerPoint presentation for debriefing meeting with the CO and ERG.** The presentation provides an overview of key preliminary findings and emerging conclusions of the evaluation. It will be delivered at the end of the field phase to present and discuss the preliminary evaluation results with UNFPA Zimbabwe CO staff (incl. senior management) and the members of the ERG.
- **Draft and final evaluation reports.** The final evaluation report *(maximum 70 pages plus annexes)* will include evidence-based findings and conclusions, as well as a full set of practical and actionable recommendations to inform the next programme cycle, A draft report precedes the final evaluation report and provide the basis for the review of the CO, ERG members, the Evaluation Manager and the Regional M&E Adviser. The final evaluation report will address the comments and feedback provided by the UNFPA Zimbabwe CO, the ERG, the Evaluation Manager and the ESARO M&E Adviser. For guidance on the outline of the final evaluation report (see Annex H).
- **PowerPoint presentation of the evaluation results.** The presentation will provide an overview of the findings, conclusions and recommendations to be used for dissemination purposes.

Based on these deliverables, the Evaluation Manager, in collaboration with the communications officer at the UNFPA CO in Zimbabwe will develop an:

- **Evaluation brief.** The evaluation brief will be a short and concise document that provides an overview of the key evaluation results in an easily understandable manner, to promote use among decision-makers and other audiences. The structure, content and layout of the evaluation brief should be similar to the briefs that the UNFPA Evaluation produces for centralized (EO) evaluations.

All the deliverables will be developed in English language.

9. Quality Assurance and Assessment

The UNFPA Evaluation Quality Assurance and Assessment (EQAA) system aims to monitor the quality of centralized and decentralized evaluations at UNFPA through two processes: quality assurance and quality assessment. While quality assurance occurs throughout the evaluation process and covers all deliverables, quality assessment takes place following the completion of the evaluation process and is limited to the final evaluation report only.

The EQAA of this CPE will be undertaken in accordance with the guidance and tools that the UNFPA Evaluation Office developed as part of the EQAA system of the evaluation function at UNFPA (see https://www.unfpa.org/admin-resource/evaluation-quality-assurance-and-assessment-tools-and-guidance). An essential component of the EQAA system is the EQA grid (see Handbook, pp. 268-276 and Annex F) which defines a set of criteria against which draft and final evaluation reports are assessed to ensure the independence, impartiality, credibility and utility of evaluations. The EQA criteria will be systematically applied to this CPE.

The Evaluation Manager is primarily responsible for quality assurance of the key deliverables of the evaluation. However, the evaluation team leader also plays an important role in undertaking quality assurance. The evaluation team leader must ensure that all members of the evaluation team provide high-quality contributions and that the deliverables submitted to UNFPA comply with the quality assessment criteria outlined in the EQA grid.[101] The evaluation quality assessment checklist (see below), which is based on the EQA grid, is used as an element of the proposed quality assurance system for the draft and final versions of the evaluation report.

1. Structure and Clarity of the Report To ensure report is user-friendly, comprehensive, logically structured and drafted in accordance with international standards and following the editorial guidelines of the UNFPA Evaluation Office (Annex I).
2. Executive Summary To provide an overview of the evaluation, written as a stand-alone section including key elements of the evaluation, such as objectives, methodology and conclusions and recommendations.
3. Design and Methodology To provide a clear explanation of the methods and tools used, including the rationale for the methodological approach. To ensure constraints and limitations are made explicit (including limitations applying to interpretations and extrapolations; robustness of data sources, etc.)
4. Reliability of Data

[101] The evaluators are invited to look at good quality CPE reports that can be found in the UNFPA evaluation database, which is available at: https://web2.unfpa.org/public/about/oversight/evaluations/. These reports must be read in conjunction with their EQAs (also available in the database) in order to gain a clear idea of the quality standards that UNFPA expects the evaluation team to meet.

To ensure sources of data are clearly stated for both primary and secondary data. To provide explanation on the credibility of primary (e.g. interviews and group discussions) and secondary (e.g. reports) data established and limitations made explicit.
5. Findings and Analysis To ensure sound analysis and credible evidence-based findings. To ensure interpretations are based on carefully described assumptions; contextual factors are identified; cause and effect links between an intervention and its end results (including unintended results) are explained.
6. Validity of Conclusions To ensure conclusions are based on credible findings and convey evaluators' unbiased judgment of the intervention. Ensure conclusions are prioritized and clustered and include: summary, origin (which evaluation question(s) the conclusion is based on), and detailed conclusions.
7. Usefulness and Clarity of Recommendations To ensure recommendations flow logically from conclusions, are targeted, realistic and operationally feasible, and are presented in order of priority. Recommendations include: summary, priority level (very high/high/medium), target (administrative unit(s) to which the recommendation is addressed), origin (which conclusion(s) the recommendation is based on), and operational implications.
8. SWAP - Gender To ensure the evaluation approach is aligned with SWAP (guidance on the SWAP Evaluation Performance Indicator and its application to evaluation can be found at http://www.unevaluation.org/document/detail/1452 - UNEG guidance on integrating gender and human rights more broadly can be found here: http://www.uneval.org/document/detail/980).

The EQAA process for this CPE will be multi-layered and will involve: (i) the Evaluation Manager at the UNFPA Zimbabwe CO, (ii) the ESARO M&E Adviser, and (iii) the UNFPA Evaluation Office.

Evaluation Manager

- Undertakes quality assurance of the draft design report, with a particular focus on the final evaluation questions, the theory of change, the sample of stakeholders to be consulted and sites to be visited, the evaluation matrix, and the methods, tools and plans for data collection.
- Prepares an EQA of the draft evaluation report in collaboration with the ESARO M&E Adviser, in line with the EQA grid and its explanatory note.
- Performs final review of the final evaluation report to ensure that comments and feedback of the ERG are adequately incorporated.

Regional M&E Adviser

- Performs quality assurance of the draft ToR (including annexes) in accordance with the ready-to-use ToR produced by the Evaluation Office and the UNFPA Evaluation Handbook.
- Supports the Evaluation Manager in the identification of potential candidates for the evaluation team.
- Liaises with the Evaluation Office on ToR and the selection of the evaluation team.
- Supports the Evaluation Manager in undertaking quality assurance of the draft inception report, with a particular focus on the final evaluation questions, the theory of change, the sample of stakeholders to be consulted and sites to be visited, the evaluation matrix, and the methods, tools and plans for data collection.
- Supports the Evaluation Manager in preparing an EQA of the draft evaluation report in line with the EQA grid and the explanatory note.
- Supports the Evaluation Manager in the final review of the final evaluation report.

Evaluation Office

- Reviews and approves the draft ToR.
- Pre-qualifies consultants for the evaluation team.
- Performs the quality assessment of the final evaluation report and makes it publicly available on the UNFPA evaluation database along with the final evaluation report.

10. Indicative Timeframe and Work Plan

The table below indicates the specific activities and deliverables and their timelines (dates) at all stages of the evaluation. It also indicates where guidance and relevant tools and templates can be found in the UNFPA Evaluation Handbook.

Nota Bene: Column "Deliverables": Deliverables in *italic* are the responsibility of the CO/Evaluation Manager, while the deliverables in **bold** are the responsibility of the Evaluation team.

Evaluation Phases and Activities	Deliverables	Dates	Handbook
Preparatory Phase			
Preparation of **letter for government and other key stakeholders** to inform them about the upcoming CPE	*Letter from the UNFPA Country Representative*	20 January 2020	
Establishment of the **Evaluation Reference Group (ERG)**		31 January 2020	Template 14: Letter of Invitation to Participate in a Reference Group, p. 277
Compilation of **background information and documentation** for desk review by the evaluation team	*Creation of a Google Drive folder containing all relevant documents on country context and CP* *List of Atlas projects*	20 January 2020	Tool 8: Checklist for the Documents to be Provided by the Evaluation Manager to the Evaluation Team, pp. 179-183 Template 3: List of Atlas Projects by Country Programme Output and Strategic Plan Outcome, pp. 253-254 Tool 3: List of UNFPA Interventions by Country Programme Output and Strategic Plan Outcome, pp. 164-165
Development of a first **stakeholders map**	*Stakeholders map*	20 January 2020	Tool 4: The Stakeholders Mapping Table, p. 166-167 Template 4: The Stakeholders Map, p. 255
Drafting the **terms of reference (ToR)** based on ready-to-use ToR produced by the Evaluation Office (in consultation with the Regional M&E Adviser and with input from the ERG)	*Draft ToR*	20 January2019	Evaluation Office Ready-to-Use ToR (and Template 1: The Terms of Reference for CPE, p.245)
Review and approval of the **ToR** by the Evaluation Office	*Final ToR*	31 January 2020	
Selection of **consultants** by the CO	*Summary assessment table*	14 February 2020	Template 2: Assessment of Consultant CVs, pp. 249-252
Pre-qualification of **consultants** by the Evaluation Office		28 February 2020	
Recruitment of the **evaluation team** by the CO		31 March 2020	
Development of a **communication plan** by the Evaluation Manager (in consultation with the communications officer at the CO)	*Communication plan*	31 March 2020	Template 16: Communication Plan for Sharing Evaluation Results, p. 279
Design Phase			

Desk review of initial background information and documents on country context and the CP (incl. bibliography and resources in the ToR)		13 – 24 April 2020	
Drafting of the design report (incl. articulation of evaluation methodology, finalization of evaluation questions, development of evaluation matrix, methods and tools and indicators, development of comprehensive stakeholders map and sampling strategy, and drafting the agenda for the field phase)	**Draft design report**	27 April – 1 May 2020	Template 8: The Design Report for CPE, pp. 259-261 Tool 5: The Evaluation Questions Selection Matrix, pp. 168-169 Tool 1: The Evaluation Matrix, pp. 138-160 Template 5: The Evaluation Matrix, pp. 256 Template 15: Work Plan, p. 278 Tool 10: Guiding Principles to Develop Interview Guides, pp. 185-187 Tool 11: Checklist for Sequencing Interviews, p. 188 Template 7: Interview Logbook, p. 258 Tool 9: Checklist of Issues to be Considered When Drafting the Agenda for Interviews, pp. 183-187 Template 6: The CPE Agenda, p. 257 Tool 6: The CPE Agenda, pp. 170-176
Presentation of the draft design report to the ERG for comments and feedback	**PowerPoint presentation of the design report**	4 May 2020	
Review of the draft design report by the Evaluation Manager, ERG and the Regional M&E Adviser	*Consolidated feedback provided by Evaluation Manager to evaluation team leader*	4 - 8 May 2020	
Revision of the draft design report and submission to the Evaluation Manager for **approval**	**Final draft design report**	11 - 13 May 2020	
Field Phase			
Meeting of the evaluation team with CO staff to launch data collection	***Meeting between evaluation team/CO staff***	14 May 2020	Tool 7: Field Phase Preparatory Tasks Checklist, pp. 177-183
Individual meetings with relevant programme officers at the CO	***Meeting of evaluators/CO programme officers***	14 - 15 May 2020	
Data collection (incl. interviews with key informants, site visits, direct observation, group discussions, desk review etc.)	**Entering data/information into the evaluation matrix**	11 – 22 May 2020	Tool 12: How to Conduct Interviews: Interview Logbook and Practical Tips, pp. 189-202 Tool 13: How to Conduct a Focus Group: Practical Tips, pp. 203-205 Template 9: Note of the Results of the Focus Group, p. 262

Debriefing meeting with CO staff and the ERG to present preliminary findings and emerging conclusions from data collection	**PowerPoint presentation for debriefing with the CO and the ERG**	26 May 2020	Example of PowerPoint presentation (for a centralized evaluation undertaken by the Evaluation Office): https://www.unfpa.org/sites/default/files/admin-resource/FINAL_MTE_Supplies_PPT_Long_version.pdf
Reporting Phase			
Drafting of the evaluation report and submission to the Evaluation Manager	**Draft evaluation report**	27 May – 5 June 2020	Template 10: The Structure of the Final Report, pp. 253-264 Template 11: Abstract of the Evaluation Report, p. 265 Template 18: Basic Graphs and Tables in Excel, p. 288
Review of the draft evaluation report by the Evaluation Manager, the ERG and the Regional M&E Adviser Joint development of the **EQA** of the draft evaluation report by the Evaluation Manager and the Regional M&E Adviser	*EQA of the draft evaluation report*	8 - 12 June 2020	Template 13: Evaluation Quality Assessment Grid and Explanatory Note, pp. 269-276 Tool 14: Summary Checklist for a Human Rights and Gender Equality Evaluation Process, pp. 206-207 Tool 15: United Nations SWAP Individual Evaluation Performance Indicator Scorecard, pp. 208-209
Drafting of the final evaluation report (including annexes) and submission of the final evaluation report to the Evaluation Manager	**Final evaluation report (including annexes)**	15 - 25 June 2020	
Preparation of the **management response** by CO	*Management response*	26 June – 10 July 2020	Template 12: Management Response, pp. 266-267
Submission of the final evaluation report to the Evaluation Office **and the management response** to the Policy and Strategy Division		13 July 2020	
Preparation of the independent **EQA of the final evaluation report** by the Evaluation Office	*Final EQA of the evaluation report*	13 - 24 July 2020	
Dissemination and Facilitation of Use			
Development of the **presentation** for the dissemination of the evaluation results by evaluation team	**PowerPoint presentation of the evaluation results**	25 July 2020	
Development of the **evaluation brief** by the Evaluation Manager, with support from the communications officer at CO	*Evaluation brief*	20 – 27 July 2020	Example of evaluation brief (for a centralized evaluation undertaken by the Evaluation Office): https://www.unfpa.org/sites/default/files/admin-resource/UNFPA_MTE_Supplies_Brief_FINAL.pdf
Publication of the final evaluation report, the EQA and the management response on the UNFPA evaluation database		August 2020	
Dissemination of the evaluation report and the evaluation brief to stakeholders	*Including (but not limited to): Communication via email; stakeholders meeting; workshops with implementing partners etc.*	20 July 2020	

Once the evaluation team leader has been recruited, she/he will develop a detailed work plan (see Annex J) in close consultation with the Evaluation Manager.

11. Management of the Evaluation

The **Evaluation Manager** at the UNFPA Zimbabwe CO will be responsible for the management of the evaluation and supervision of the evaluation team in line with the UNFPA Evaluation Handbook. The Evaluation Manager will oversee the entire process of the evaluation, from the preparation to the dissemination and facilitation of the use of the evaluation results. She/he will also coordinate the exchanges between the evaluation team and the ERG. The major task of the Evaluation Manager is to ensure the quality, independence and impartiality of the evaluation in line with the UNEG norms and standards and ethical guidelines for evaluation. The Evaluation Manager has the following roles and responsibilities:

- Compile a preliminary list of background information and documentation on both the country context and the UNFPA CP and file them in a Google drive to be shared with the evaluation team upon recruitment.
- Prepare a first stakeholders map and a list of Atlas projects and share them with the evaluation team.
- Prepare the ToR for the evaluation in line with the ready-to-use ToR from the Evaluation Office, with support from the Regional M&E Adviser, and submit the ToR to the Evaluation Office for approval.
- Establish the ERG.
- Chair the ERG, convene meetings with the evaluation team and manage the interaction between the evaluation team and the ERG.
- Launch and lead the selection process for the team of evaluators in consultation with the Regional M&E Adviser.
- Identify potential candidates to conduct the evaluation, complete the consultant assessment matrix to assess their qualifications, and propose a final selection of evaluators with support from the Regional M&E Adviser, to be submitted to the Evaluation Office for pre-qualification.
- Provide evaluators with logistical support in making arrangements for data collection (site visits, interviews, group discussions etc.).
- Prevent any attempts to compromise the independence of the evaluation team throughout the evaluation process.
- Perform the quality assurance of the deliverables submitted by the evaluators throughout the evaluation process (notably the design report and draft and final evaluation reports) and approve final versions.
- Coordinate feedback and comments on the deliverables produced by the evaluation team throughout the evaluation process.
- Conduct an EQA (and complete the EQA grid) of the draft evaluation report.
- Develop a communication plan (in coordination with the CO communication officer) to guide the dissemination of the evaluation results, and update the plan as the evaluation process evolves.
- Lead and participate in the preparation of the management response.
- Submit the final evaluation report, EQA and management response to the Regional M&E Adviser and the Evaluation Office.

At all stages of the evaluation process, the Evaluation Manager will require support from staff of the UNFPA Zimbabwe CO. Specifically, the roles and responsibilities of the **Country Office staff** are:

- Contribute to the preparation of the ToR, the stakeholder mapping and the compilation of initial background information and documentation, and provide input to the evaluation questions.
- Be available for meetings with/interviews by the evaluation team.
- Provide support to the Evaluation Manager in making logistical arrangements for site visits and setting up interviews and group discussions with stakeholders at national and sub-national levels.
- Provide input to the management response.
- Contribute to the dissemination of the evaluation results.

The progress of the evaluation will be followed closely by the **Evaluation Reference Group (ERG)** which is composed of relevant UNFPA staff from the Zimbabwe CO, ESARO, representatives of the national Government of Zimbabwe, non-governmental implementing partners, as well as other relevant key stakeholders (see Handbook, section 2.3., p.37). The ERG will serve as an entity to ensure the relevance, quality and credibility of the evaluation. It will provide inputs on key milestones in the evaluation process, facilitate the evaluation team's access to sources of information and undertake quality assurance from a technical perspective. The ERG has the following roles and responsibilities:

- Provide input to the drafting of the ToR, including the selection of preliminary evaluation questions.
- Provide feedback and comments on the design report.
- Provide comments and substantive feedback from a technical perspective on the draft and final evaluation reports.
- Act as the interface between the evaluators and key stakeholders of the evaluation, and facilitate access to key informants and documentation.
- Assist in identifying key stakeholders to be consulted during the evaluation process.
- Participate in review meetings with the evaluation team as required.
- Contribute to learning, knowledge sharing and dissemination of evaluation results, as well as the completion and follow-up on the management response.

The **Regional M&E Adviser** at UNFPA ESARO will provide guidance and backstopping support to the Evaluation Manager at all stages of the evaluation process. The roles and responsibilities of the ESARO M&E Adviser are:

- Provide feedback and comments on the draft ToR and submit the final draft version to the Evaluation Office for approval.
- Support the Evaluation Manager in identifying potential candidates and assessing the qualifications of consultants, review the completed consultant assessment matrix and proposed final selection of evaluators and submit it to the Evaluation Office for pre-qualification.
- Review the design report and provide comments to the Evaluation Manager.
- Prepare jointly with the Evaluation Manager an EQA of the draft final evaluation report.
- Ensure the CO complies with the request for a management response.
- Support the CO in the dissemination and use of the evaluation results.

The UNFPA **Evaluation Office** will play a crucial role in the EQAA of the evaluation. The roles and responsibilities of the Evaluation Office are as follows:

- Review and approve the final draft ToR
- Review and pre-qualification of the consultants who will constitute the evaluation team.
- Update and maintain the UNFPA consultant roster with pre-qualified consultants for the evaluation.
- Commission the independent, external EQA of the final evaluation report.
- Publish final evaluation report, EQA and management response in the evaluation database.

12. Composition of the Evaluation Team

The evaluation will be conducted by a team of independent, external evaluators, consisting of: (i) an evaluation team leader (international) with overall responsibility for carrying out the evaluation exercise, and (ii) 3 team members (local) who will provide technical expertise in thematic areas relevant to the UNFPA mandate (SRHR, adolescents and youth, gender equality, and population and development). The team leader shall also perform the role of technical expert for one of the thematic areas of programming under the 7th UNFPA CP in Zimbabwe.

The evaluation team leader will be recruited internationally (incl. in the sub-region), while the evaluation team members will be locally recruited to promote national evaluation capacity development and to ensure adequate knowledge of the country context. The evaluation team leader must have solid knowledge and experience in conducting evaluations of development interventions and humanitarian action. In addition, the evaluation team should have the requisite level of knowledge to conduct human rights- and gender-responsive evaluations and be able to work in a multidisciplinary team in a multicultural environment.

12.1. Roles and Responsibilities of the Evaluation Team

Evaluation team leader

The evaluation team leader will hold the overall responsibility for the design and implementation of the evaluation. She/he will be responsible for the production and timely submission of all expected deliverables in line with the ToR. She/he will lead and coordinate the work of the evaluation team and ensure the quality of all deliverables at all stages of the evaluation process. The Evaluation Manager will provide methodological guidance to the evaluation team in developing the design report, in particular, but not limited to, the evaluation approach, methodology, work plan and agenda for the field phase, the draft and final evaluation reports, and the PowerPoint presentation of the evaluation results. She/he will lead the presentation of the design report and the debriefing meeting with the CO and ERG at the end of the field phase. The Team leader will also be responsible for liaising with the Evaluation Manager. Beyond her/his responsibilities as team leader, the evaluation team leader will serve as technical expert for one of the thematic areas of programming of the CP. The Evaluation team leader will also need to have the profile of at least one of the thematic expertise areas listed below.

Evaluation team member: SRHR expert

The SRHR expert will provide expertise on integrated SRH services, HIV and other sexually transmitted infections, maternal health, obstetric fistula, family planning and cervical cancer screening and treatment. She/he will contribute to the methodological design of the evaluation and take part in the data collection and analysis work, with overall responsibility of contributions to the expected deliverables in her/his thematic area of expertise. She/he will provide substantive inputs throughout the evaluation process by contributing to the development of the evaluation methodology, evaluation work plan and agenda for the field phase, participating in meetings with the Evaluation Manager, UNFPA Zimbabwe CO staff and the ERG. She/he will hold interviews and group discussions with stakeholders, and undertake desk review, as advised by the evaluation team leader. In the evaluation team, either the SRHR or GE expert need to have experience in humanitarian response.

Evaluation team member: Adolescents and youth expert

The adolescent and youth expert will provide expertise on youth-friendly SRHR services, comprehensive sexuality education, adolescent pregnancy, SRHR of young women and adolescent girls, access to

contraceptives for young women and adolescent girls and youth leadership and participation. She/he will contribute to the methodological design of the evaluation and take part in the data collection and analysis work, with overall responsibility of contributions to the expected deliverables in her/his thematic area of expertise. She/he will provide substantive inputs throughout the evaluation process by contributing to the development of the evaluation methodology, evaluation work plan and agenda for the field phase, participating in meetings with the Evaluation Manager, UNFPA Zimbabwe CO staff and the ERG. She/he will hold interviews and group discussions with stakeholders, and undertake desk review, as advised by the evaluation team leader.

Evaluation team member: Gender equality expert

The gender equality expert will provide expertise on the human rights of women and girls, especially sexual and reproductive rights, the empowerment of women and girls, engagement of men and boys, as well as gender-based violence and harmful practices, such as child, early and forced marriage. She/he will contribute to the methodological design of the evaluation and take part in the data collection and analysis work, with overall responsibility of contributions to the expected deliverables in her/his thematic area of expertise. She/he will provide substantive inputs throughout the evaluation process by contributing to the development of the evaluation methodology, evaluation work plan and agenda for the field phase, participating in meetings with the Evaluation Manager, UNFPA Zimbabwe CO staff and the ERG. She/he will hold interviews and group discussions with stakeholders, and undertake desk review, as advised by the evaluation team leader. In the evaluation team, either the SRHR or GE expert need to have experience in humanitarian response.

Evaluation team member: Population and development expert

The population and development expert will provide expertise on population and development issues, such as census, ageing, migration, population dynamics, the demographic dividend, and national statistical systems. She/he will contribute to the methodological design of the evaluation and take part in the data collection and analysis work, with overall responsibility of contributions to the expected deliverables in her/his thematic area of expertise. She/he will provide substantive inputs throughout the evaluation process by contributing to the development of the evaluation methodology, evaluation work plan and agenda for the field phase, participating in meetings with the Evaluation Manager, UNFPA Zimbabwe CO staff and the ERG. She/he will hold interviews and group discussions with stakeholders, and undertake desk review, as advised by the evaluation team leader.

The modality and participation of the evaluation team members in the evaluation process, including data collection analysis, provision of technical inputs to the drafting of the design and draft and final evaluation reports will be agreed with the evaluation team leader and these tasks performed under her/his supervision and guidance.

12.2. Qualifications and Experience of the Evaluation Team

Team leader

The competencies, skills and experience of the evaluation team leader should include:

- Master’s degree in Public Health, Social Sciences, Demography or Population Studies, Statistics, Development Studies or a related field.
- 10 years of experience in conducting or managing evaluations in the field of international development.
- Extensive experience in leading complex evaluations commissioned by United Nations organizations and/or other international organizations and NGOs.

- **Demonstrated expertise in one of the thematic areas of programming covered by the evaluation (see profiles below).**
- In-depth knowledge of theory-based evaluation approaches and ability to apply both qualitative and quantitative data collection methods and to uphold standards for quality evaluation as defined by UNFPA and UNEG.
- Preferred: knowledge of humanitarian strategies, policies, frameworks and international humanitarian law, and principles as well as the international humanitarian architecture and coordination mechanisms.
- Ability to ensure ethics and integrity of the evaluation process, including confidentiality and prevention of harm to evaluation subjects.
- Ability to consistently integrate human rights and gender perspectives in all phases of the evaluation process.
- Excellent management and leadership skills to coordinate and supervise the work of the evaluation team.
- Experience working with a multidisciplinary team of experts.
- Excellent analytical skills and demonstrated ability to formulate evidence-based conclusions and realistic and actionable recommendations.
- Excellent communication (written and spoken), facilitation and knowledge-sharing skills.
- Good knowledge of the national development context of Zimbabwe.
- Fluent in written and spoken English.

SRHR expert

The competencies, skills and experience of the SRH expert should include:

- Master's degree in Public Health, Medicine, Health Economics and Financing, Epidemiology, Biostatistics or a related field.
- 5-7 years of experience in conducting evaluations, reviews, assessments, research studies or M&E work in the field of international development.
- Substantive knowledge of sexual and reproductive health and rights.
- Preferred: Good knowledge of humanitarian strategies, policies, frameworks and international humanitarian law, and principles as well as the international humanitarian architecture and coordination mechanisms.
- Ability to ensure ethics and integrity of the evaluation process, including confidentiality and prevention of harm to evaluation subjects.
- Ability to consistently integrate human rights and gender perspectives in all phases of the evaluation process.
- Solid knowledge of evaluation approaches and methodology and demonstrated ability to apply both quantitative and qualitative data collection methods.
- Excellent analytical and problem-solving skills.
- Experience working with a multidisciplinary team of experts.
- Excellent communication (written and spoken), facilitation and knowledge-sharing skills.
- Good knowledge of the national development context of Zimbabwe.
- Familiarity with UNFPA or other United Nations organizations' mandates and operations will be an advantage.
- Fluent in written and spoken English.

Adolescent and youth expert

The competencies, skills and experience of the evaluation team leader should include:

- Master's degree in Public Health, Medicine, Health Economics and Financing, Epidemiology, Biostatistics, Social Sciences or a related field.

- 5-7 years of experience in conducting evaluations, reviews, assessments, research studies or M&E work in the field of international development.
- Substantive knowledge of adolescent and youth issues, in particular sexual and reproductive health and rights of adolescents and youth.
- Ability to ensure ethics and integrity of the evaluation process, including confidentiality and prevention of harm to evaluation subjects.
- Ability to consistently integrate human rights and gender perspectives in all phases of the evaluation process.
- Solid knowledge of evaluation approaches and methodology and demonstrated ability to apply both quantitative and qualitative data collection methods.
- Excellent analytical and problem-solving skills.
- Experience working with a multidisciplinary team of experts.
- Excellent communication (written and spoken), facilitation and knowledge-sharing skills.
- Good knowledge of the national development context of Zimbabwe.
- Familiarity with UNFPA or other United Nations organizations' mandates and operations will be an advantage.
- Fluent in written and spoken English.

Gender equality expert

The competencies, skills and experience of the gender equality expert should include:

- Master's degree in Women/Gender Studies, Human Rights Law, Social Sciences, Development Studies or a related field.
- 5-7 years of experience in conducting evaluations, reviews, assessments, research studies or M&E work in the field of international development.
- Substantive knowledge on gender equality and the empowerment of women and girls, gender-based violence and other harmful practices, such as female genital mutilation, early, child and forced marriage, and issues surrounding masculinity, gender relationships and sexuality.
- Preferred: Good knowledge of humanitarian strategies, policies, frameworks and international humanitarian law, and principles as well as the international humanitarian architecture and coordination mechanisms.
- Ability to ensure ethics and integrity of the evaluation process, including confidentiality and prevention of harm to evaluation subjects.
- Ability to consistently integrate human rights and gender perspectives in all phases of the evaluation process.
- Solid knowledge of evaluation approaches and methodology and demonstrated ability to apply both quantitative and qualitative data collection methods.
- Excellent analytical and problem-solving skills.
- Experience working with a multidisciplinary team of experts.
- Excellent communication (written and spoken), facilitation and knowledge-sharing skills.
- Good knowledge of the national development context of Zimbabwe.
- Familiarity with UNFPA or other United Nations organizations' mandates and operations will be an advantage.
- Fluent in written and spoken English.

Population and development expert

The competencies, skills and experience of the population and development expert should include:

- Master's degree in Demography or Population Studies, Statistics, Social Sciences, Development Studies or a related field.

- 5-7 years of experience in conducting evaluations, reviews, assessments, research studies or M&E work in the field of international development.
- Substantive knowledge on the generation, analysis, dissemination and use of housing census and population data for development, population dynamics, migration and national statistics systems.
- Ability to ensure ethics and integrity of the evaluation process, including confidentiality and prevention of harm to evaluation subjects.
- Ability to consistently integrate human rights and gender perspectives in all phases of the evaluation process.
- Solid knowledge of evaluation approaches and methodology and demonstrated ability to apply both quantitative and qualitative data collection methods.
- Excellent analytical and problem-solving skills.
- Experience working with a multidisciplinary team of experts.
- Excellent communication (written and spoken), facilitation and knowledge-sharing skills.
- Good knowledge of the national development context of Zimbabwe.
- Familiarity with UNFPA or other United Nations organizations' mandates and operations will be an advantage.
- Fluent in written and spoken English.

13. Budget and Payment Modalities

The evaluators will receive a daily fee according to the UNFPA consultancy scale based on qualifications and experience.

The payment of fees will be based on the submission of deliverables, as follows:

Upon approval of the design report	20%
Upon satisfactory completion of the draft final evaluation report	40%
Upon approval of the final evaluation report and PowerPoint for dissemination of evaluation results	40%

In addition to the daily fees, the evaluators will receive a daily subsistence allowance (DSA) in accordance with the UNFPA Duty Travel Policy, using applicable United Nations DSA rates for the place of mission. Travel costs will be settled separately from the consultancy fees.

The provisional allocation of workdays among the evaluation team will be the following:

	Team Leader	**Team Members (Thematic Experts)**
Design phase	*15*	*10*
Field/virtual data collection phase	*8*	*8*
Reporting phase	*15*	*14*
Dissemination and facilitation of use phase	*1*	*1*

TOTAL (days)	*39*	*33*

The exact number of workdays and distribution of the workload will be proposed by the evaluation team in the design report, subject to approval by UNFPA Evaluation Manager.

14. Bibliography and Resources

The following documents will be made available to the evaluation team upon recruitment:

Global UNFPA documents

1. UNFPA Strategic Plan (2014-2017) (incl. annexes) https://www.unfpa.org/resources/strategic-plan-2014-2017
2. UNFPA Strategic Plan (2018-2021) (incl. annexes) https://www.unfpa.org/strategic-plan-2018-2021
3. UNFPA Evaluation Policy (2019) https://www.unfpa.org/admin-resource/unfpa-evaluation-policy-2019
4. Evaluation Handbook: How to Design and Conduct a Country Programme Evaluation at UNFPA (2019) https://www.unfpa.org/EvaluationHandbook
5. Relevant centralized evaluations conducted by the UNFPA Evaluation Office – available at: https://www.unfpa.org/evaluation

Zimbabwe national strategies, policies and action plans

6. Interim Poverty Reduction Strategy Paper (I-PRSP) 2016 – 2018
7. Transitional Stabilisation Programme
8. United Nations Development Assistance Framework (UNDAF)
9. Relevant national strategies and policies for each thematic area of programming

UNFPA CO programming documents

10. GoZ/UNFPA 7th Country Programme Document 2016 - 2020
11. United Nations Common Country Analysis/Assessment (CCA)
12. GoZ/UNFPA 7th Country Programme 2016 – 2020 needs assessment
13. CO annual work plans
14. Joint programme documents
15. Mid-term reviews of interventions/programmes in different thematic areas of programming
16. Reports on core and non-core resources
17. CO resource mobilization strategy

UNFPA CO M&E documents

18. GoZ/UNFPA 7th Country Programme M&E Plan 2016- 2020
19. CO annual results plans and reports
20. CO quarterly monitoring reports
21. Previous CPE of GoZ/UNFPA 6th Country Programme Document 2012 - 2015 available at: https://web2.unfpa.org/public/about/oversight/evaluations/

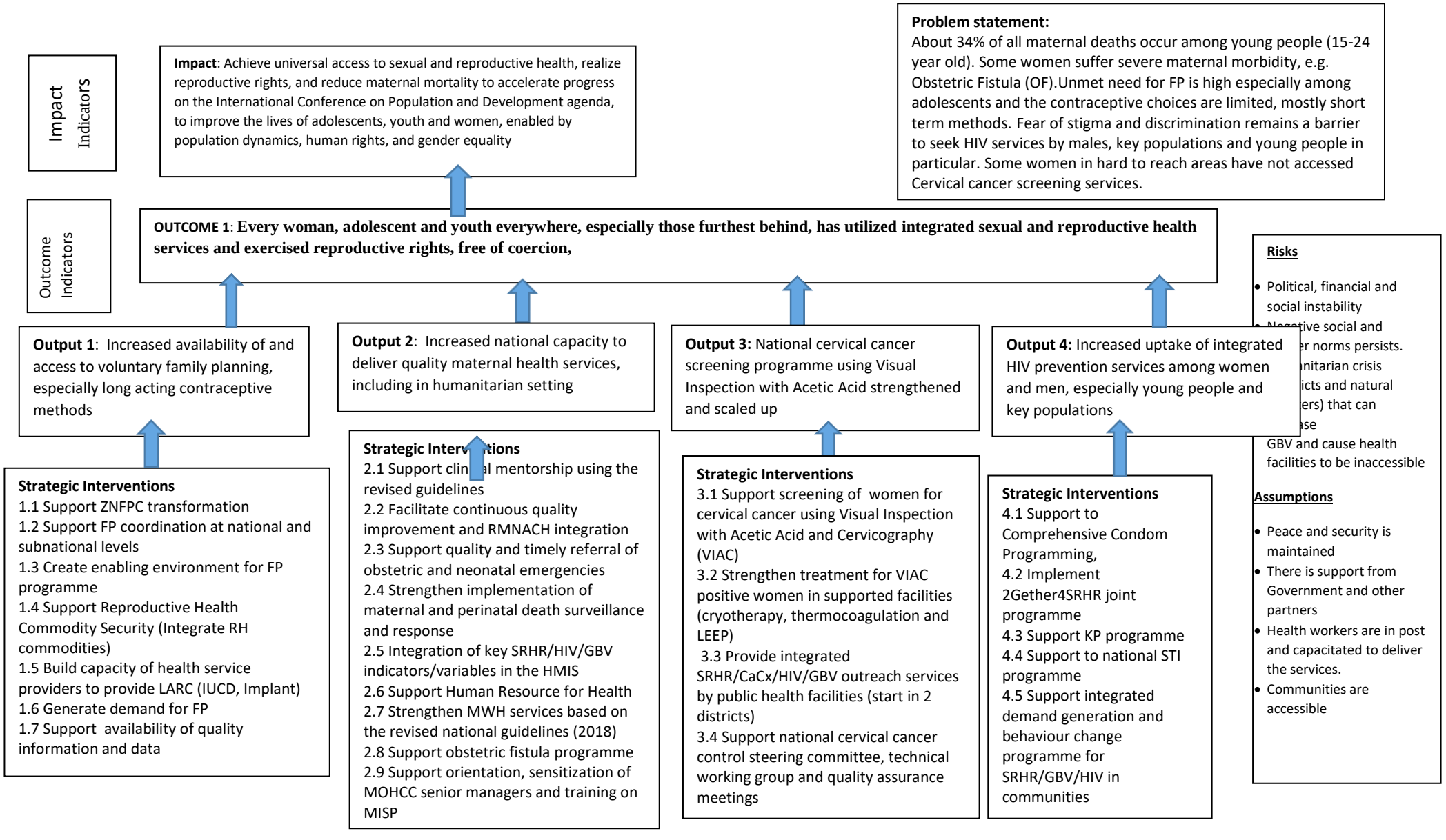
Other documents

1. Implementing partner work plans and progress reports
2. Implementing partner assessments
3. Audit reports and spot check reports
4. Meeting agendas and minutes of joint United Nations working groups
5. Donor reports

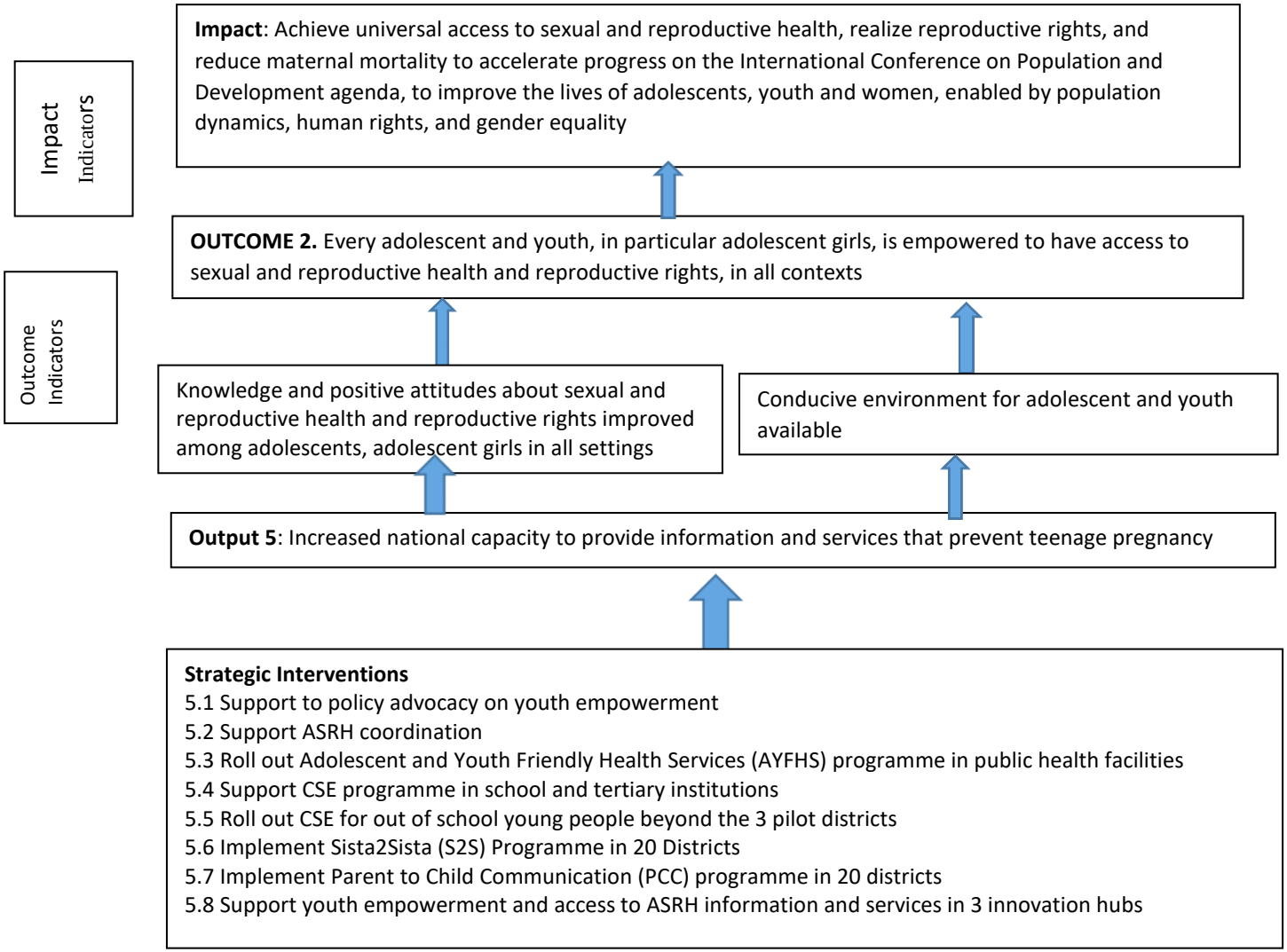
15. Annexes

Annex A: Theory of Change

Outcome 1 Theory of Change



Outcome 2 Theory of Change



Problem Statement:
Adolescents girls are at risk of teenage pregnancies due to lack of knowledge, socio-cultural norms, high school drop-outs, limited access to contraception, household poverty, and lack of Comprehensive Sexuality Education (CSE) both in schools and communities, and low coverage of youth-friendly services at public health facilities.

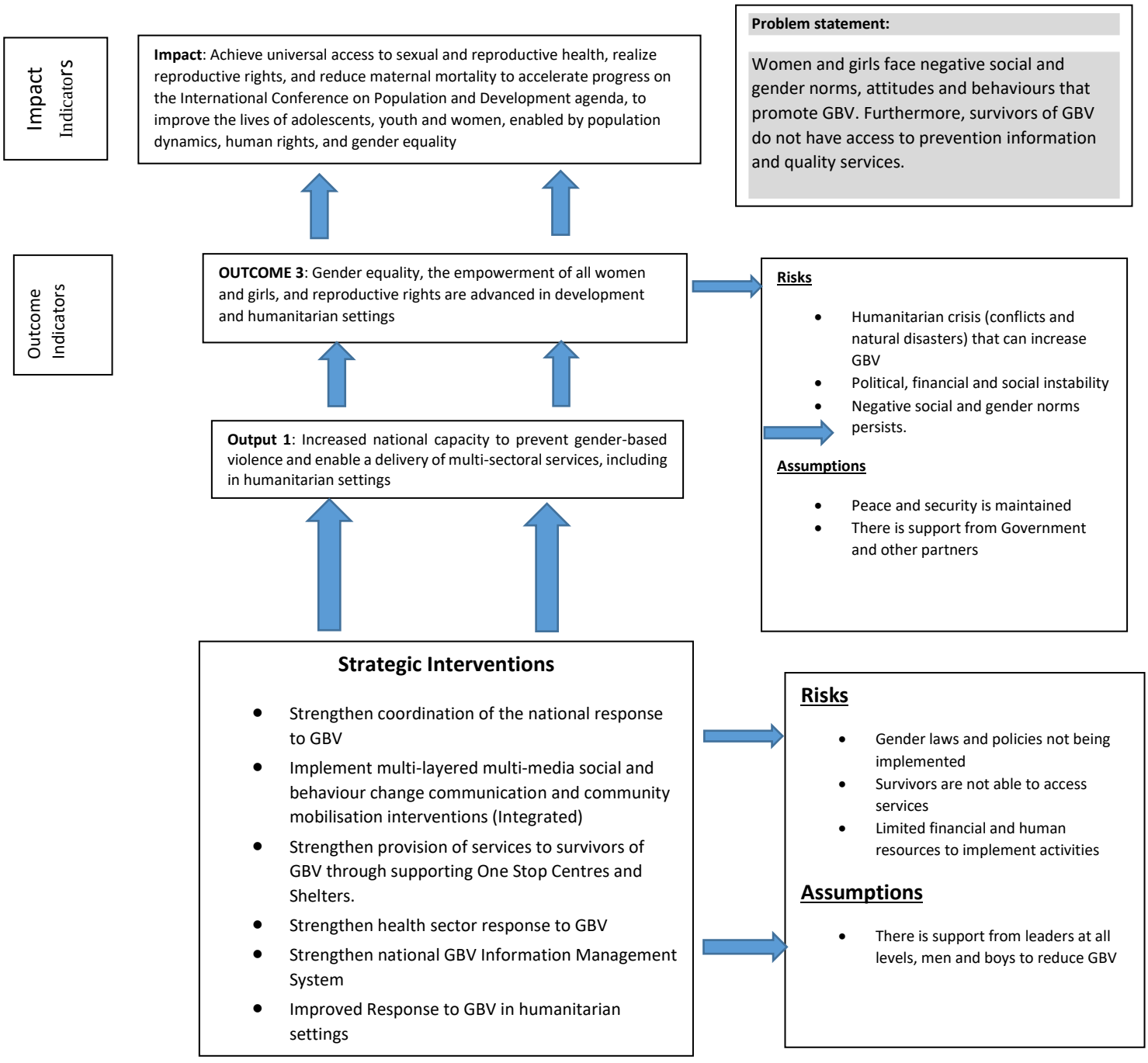
Risks

- Limited financial resources to carry out activities
- Programme delivery in communities can be hampered by political instability
- Negative socio-cultural practices

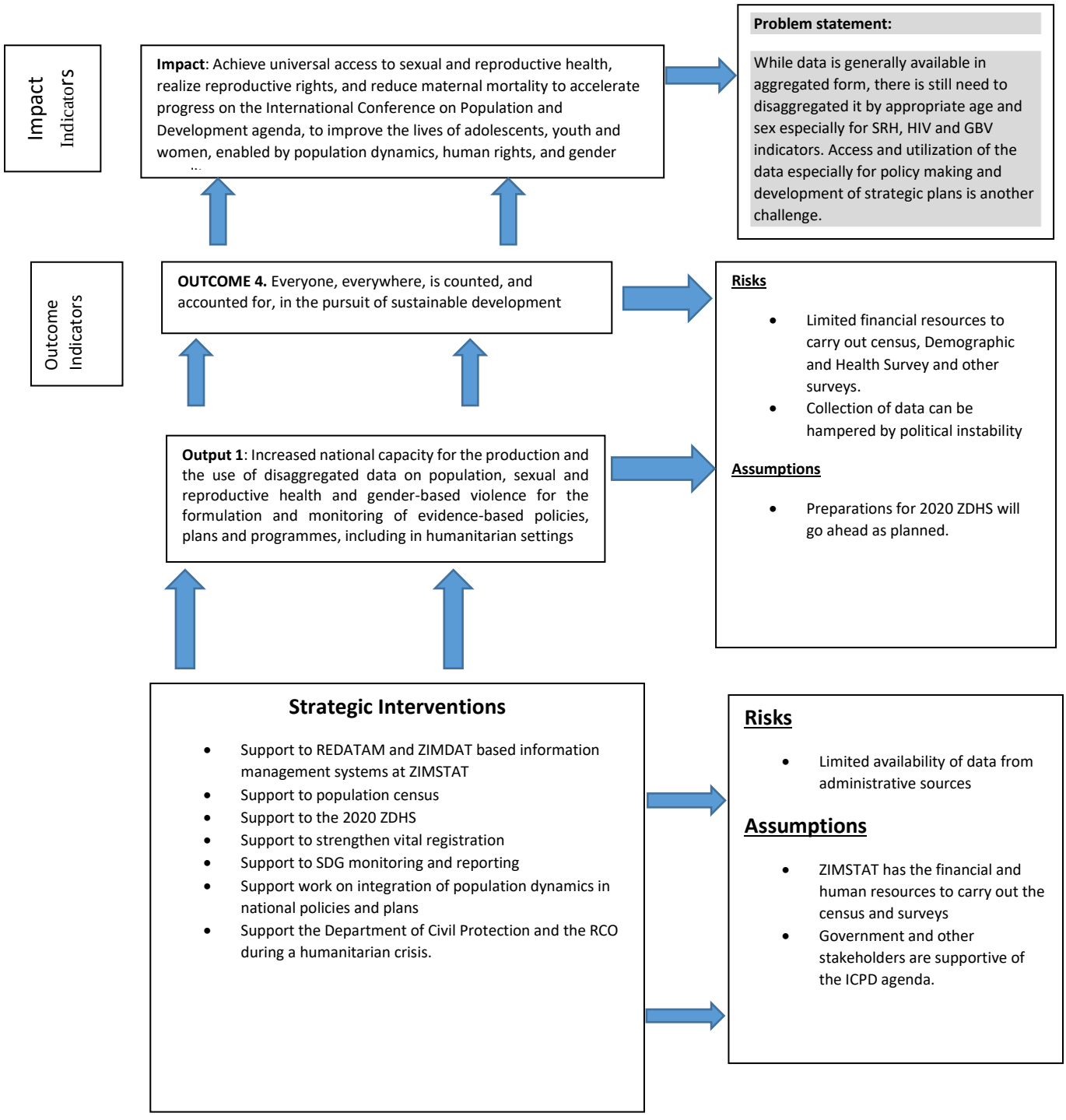
Assumptions

- Stable economic and political environment
- ASRH strategy is implemented as planned
- Health workers in post and capacitated to provide services
- Communities are accessible
- Commodities are available

Outcome 3 Theory of Change



Outcome 4 Theory of Change



Annex B

Stakeholders map

Donor	Implementing agency							Other partners							Rights holders	Other
	Gov	Local NGO	Int NGO	WRO	Other UN	Academia	Other	Gov	Local NGO	Int NGO	WRO	Other UN	Academia	Other		
OUTCOME 1: SRHR																
Strategic Plan (2018-2021) Outcome 1: *Every woman, adolescent and youth everywhere, especially those furthest behind, has utilized integrated sexual and reproductive health services and exercised reproductive rights, free of coercion, discrimination and violence*.																
CPAP Output1: Increased availability of and access to voluntary family planning, especially long acting contraceptive methods (Atlas Project: ZWE07101, FPRHCZWE)																
HDF	MOHCC, ZNFPC		Crown Agents, Jhpiego, FHI360						PSZ	PSI			UZ			
CPAP Output 2: Increased national capacity to deliver quality maternal health services, including in humanitarian setting (Atlas Projects: ZWE07102, UZJ10ZWE, UZJ14ZWE, HRF01ZWE, UZJ27ZWE, UQA64ZWE)																
HDF	MOHCC									WRA**, CORDAID		UNICEF, WHO	UZ			
CPAP Output 3: Increased national capacity to provide quality cervical cancer screening and treatment services for precancerous lesions (Atlas Project: ZWE07103)																
HDF	MOHCC									OPHID, I-TECH		WHO				
CPAP Output 4: Increased uptake of HIV prevention services among women and men, especially young people and key populations (Atlas Project: ZWE07104, UBRAFZWE)																
HDF, UBRAF	MOHCC, NAC	ZICHIRE,	World Vision									UNAIDS, WHO,	UZ			

		ZAPSO, SAYWHAT, FACT, CeSHHAR Zimbabwe, Sexual Rights Centre, Gays and Lesbians Zimbabwe										UNICEF				
● UNFPA Strategic Plan outcome 2: *Every adolescent and youth, in particular adolescent girls, is empowered to have access to sexual and reproductive health and reproductive rights, in all contexts.*																
CPAP Output 5: **Increased national capacity to provide information and services that prevent teenage pregnancy** (Atlas Project: **ZWE07205, CHA20ZWE CHA28ZWE)**																
HDF, SYP	MOPSE, MOHCC, ZNFPC, NAC, ZYC	SAYWHAT, ZICHIRE, ZAPSO, FACT, Stimulus Africa	World Vision									WHO, UNESCO, UNICEF	UZ			

UNFPA Strategic Plan outcome *3: Gender equality, the empowerment of all women and girls, and reproductive rights are advanced in development and humanitarian settings (ATLAS Project: ZWE07306)*																
CPAP Output 6: Increased national capacity to prevent gender-based violence and enable the delivery of multi-sectoral services, including in humanitarian settings *(ZWE07306, HRF01ZWE)*																
HDF, Spotlight	MWACSMED, MOHCC, Judicial Services Commission,	MUSASA, Adult Rape Clinic, Family Support Trust, SAYWHAT, ZICHIRE, FACT, ZAPSO	World Vision; Leonard Cheshire									UNICEF, UNWomen	UZ			
Output 7: Increased national capacity for the production and use of disaggregated data on population, sexual reproductive health and gender-based violence for the formulation and monitoring of evidence-based policies, plans and programmes including in humanitarian settings (Atlas Project: ZWE07407)																
EU, DFID, Sweden	MOF, ZIMSTAT											UNICEF	UZ			

*WRO= Women's Rights Organization

**WRA= White Ribbon Alliance

Annex C UNFPA Interventions in Supported Provinces and Districts

Province	District	Gender			RH		HIV	ASRH		Community Mobilisation (Demand generation)
		One Stop Centre (MWAGCD)	Spotlight initiative	Shelter (Musasa)	Maternity Waiting Homes	Obstetric Fistula [102]	Sex Work	Sista 2sista	2gether4SHRH project.	
Bulawayo Metropolitan	Bulawayo						X			
Harare	Epworth		X							
Harare	Harare	X - Musasa		X				X		X
Harare	Hopley		X						X	
Harare	Mabvuku							X		
Manicaland	Buhera				X		X		X	
Manicaland	Chimanimani		X		X					
Manicaland	Chipinge		X		X		X			
Manicaland	Makoni	X			X		X		X	
Manicaland	Marange			X						
Manicaland	Mutare						X	X		X
Manicaland	Mutasa		X		X			X		X
Manicaland	Nyanga				X			X		X
Mashonaland Central	Bindura						X	X		X
Mashonaland Central	Centenary				X					

[102] Obstetric Fistula repair camps are being conducted in Chinhoyi Hospital. Other facilities conduct repairs but very few cases e.g. United Bulawayo Hospital.

Mashonaland Central	**Guruve**				**X**			**X**		**X**
Mashonaland Central	**Mazowe**				**X**					
Mashonaland Central	**Mbire**		**X**		**X**			**X**	**X**	**X**
Mashonaland Central	**Mt Darwin**		**X**		**X**			**X**		**X**
Mashonaland Central	**Muzarabani**		**X**					**X**		**X**
Mashonaland Central	**Rushinga**		**X**		**X**					
Mashonaland Central	**Shamva**		**X**					**X**	**X**	**X**
Mashonaland East	**Chikomba**			**X**	**X**		**X**	**X**		**X**
Mashonaland East	**Goromonzi**				**X**		**X**			
Mashonaland East	**Hwedza**				**X**			**X**		**X**
Mashonaland East	**Marondera**						**X**	**X**		**X**
Mashonaland East	**Mudzi**				**X**		**X**	**X**	**X**	**X**
Mashonaland East	**Murehwa**				**X**		**X**	**X**		**X**
Mashonaland East	**Uzumba Maramba Pfungwe**				**X**			**X**	**X**	**X**

Mashonaland East	**Mutoko**				**X**		**X**			
Mashonaland West	**Chegutu**				**X**			**X**	**X**	**X**
Mashonaland West	**Hurungwe**		**X**		**X**		**X**	**X**	**X**	**X**
Mashonaland West	**Kadoma**						**X**	**X**		**X**
Mashonaland West	**Kariba**				**X**		**X**	**X**		**X**
Mashonaland West	**Makonde**		**X**		**X**	**X**	**X**	**X**		**X**
Mashonaland West	**Mhondoro Ngezi**				**X**					
Mashonaland West	**Sanyati**				**X**					
Mashonaland West	**Zvimba**				**X**					
Masvingo	**Bikita**				**X**			**X**		**X**
Masvingo	**Chiredzi**				**X**		**X**			
Masvingo	**Chirumhanzu**				**X**		**X**	**X**		**X**
Masvingo	**Chivi**				**X**					
Masvingo	**Gutu**			**X**	**X**		**X**	**X**		**X**
Masvingo	**Masvingo**				**X**		**X**			
Masvingo	**Mwenezi**				**X**		**X**			
Masvingo	**Zaka**				**X**			**X**		**X**

Matebelelan d North	**Binga**				**X**					
Matebelelan d North	**Bubi**			**X**	**X**			**X**		**X**
Matebelelan d North	**Hwange**				**X**		**X**	**X**	**X**	**X**
Matebelelan d North	**Insiza**				**X**					
Matebelelan d North	**Lupane**				**X**		**X**	**X**	**X**	**X**
Matebelelan d North	**Nkayi**				**X**			**X**		**X**
Matebelelan d North	**Tsholotsho**				**X**			**X**		**X**
Matebelelan d North	**Umguza**				**X**					
Matebelelan d South	**Beitbridge**				**X**		**X**	**X**		**X**
Matebelelan d South	**Bulilima**				**X**			**X**	**X**	**X**
Matebelelan d South	**Gwanda**	**X**			**X**		**X**	**X**		**X**
Matebelelan d South	**Mangwe**		**X**		**X**			**X**	**X**	**X**
Matebelelan d South	**Maphosa**				**X**					
Matebelelan d South	**Matobo**				**X**			**X**		**X**

Matebeleland South	**Umzingwani**		**X**							
Midlands	**Churumhanzu**				**X**					
Midlands	**Gokwe South**				**X**		**X**			
Midlands	**Gokwe North**				**X**					
Midlands	**Gweru**	**X**		**X**	**X**		**X**	**X**		**X**
Midlands	**Kwekwe**				**X**		**X**			
Midlands	**Mberengwa**				**X**			**X**		**X**
Midlands	**Shurugwi**				**X**			**X**		**X**
Midlands	**Zvishavane**				**X**		**X**			
Obstetric Fistula is being conducted at Chinhoyi Provincial Hospital										

Annex D

Evaluation Matrix Template

Evaluators must fill in the boxes below with all relevant data and information gathered during the field phase in relation to the elements listed in the "assumptions to be assessed" column and their corresponding indicators. The information placed here can stem from: documentary review, interviews, focus group discussions, etc. Since the filled matrix will become the main annex of the final evaluation report, the evaluation team leader and evaluation manager must ensure that all of the information displayed:

• Is directly related to the indicators listed
• Is drafted in a readable and understandable manner
• Makes visible the triangulation of data
• Has source(s) that are referenced in footnotes

Evaluation Question 1: To what extent...			
Assumptions to be assessed	**Indicators**	**Sources of Information**	**Methods and tools for data collection**
Assumption 1 ***(See example in the UNFPA Evaluation Handbook Tool 1, handbook section 7.1.1, pp. 138-160)***			
Evaluators must fill in this box with all relevant data and information gathered during the field phase in relation to the elements listed in the "assumptions to be assessed" column and their corresponding indicators. The information placed here can stem from: documentary review, interviews, focus group discussions, etc. Since the filled matrix will become the main annex of the final evaluation report, the evaluation team leader and evaluation manager must ensure that all of the information displayed: ***• Is directly related to the indicators listed above*** ***• Is drafted in a readable and understandable manner***			

• *Makes visible the triangulation of data* • *Has source(s) that are referenced in footnotes*			
Assumption 2 ***(See example in Tool 1)***			
Assumption 3 ***(See example in Tool 1)***			
Evaluation Question 2: To what extent...			
Assumptions to be assessed	**Indicators**	**Sources of Information**	**Methods and tools for data collection**
Assumption 1 ***(See example in Tool 1)***			
Assumption 2 ***(See example in Tool 1)***			
Assumption 3 ***(See example in Tool 1)***			
Evaluation Question 3: To what extent...			
Assumptions to be assessed	**Indicators**	**Sources of Information**	**Methods and tools for data collection**
Assumption 1 ***(See example in Tool 1)***			

Annex E

List of Atlas Projects for the period under evaluation

Year […]								
	Fund type	**IA Group**	**Implementing agency**	**Activity description**	**Geographic location**	**Atlas budget**	**Expense**	**Implementation rate**
Regional projects								
Activity 1								
…								
Activity 2								
…								
Activity 3								
…								
GENDER EQUALITY								
Strategic plan Outcome:								
Country Programme Output:								
Annual work plan *(code and name):*								
Activity 1								
…								
Activity 2								
…								
Activity 3								
…								
POPULATION DYNAMICS								
Strategic plan Outcome:								
Country Programme Output:								
Annual work plan *(code and name):*								
Activity 1								
…								
Activity 2								
…								
Activity 3								
…								

REPRODUCTIVE HEALTH								
Strategic plan Outcome:								
Country Programme Output:								
Annual work plan *(code and name):*								
Activity 1								
…								
Activity 2								
…								
Activity 3								
…								
OTHER PROGRAMMATIC AREA								
Strategic plan Outcome:								
Country Programme Output:								
Annual work plan *(code and name):*								
Activity 1								
…								
Activity 2								
…								
Activity 3								
…								
ADMINISTRATION								
…								
…								
…								

Annex F

Outline of design report

TEMPLATE: DESIGN REPORT FOR UNFPA COUNTRY PROGRAMME EVALUATIONS

After an initial review of relevant documentation, the evaluation team will prepare the Design Report. The Design Report provides the conceptual and analytical framework of the evaluation, establishes the key evaluation questions and refines the methodology, including providing specific information on data collection tools, data sources, and analysis methods. The Design Report is also a means to ensure a mutual understanding of the conduct of the evaluation between the evaluation manager and the evaluation team.

The Design Report is prepared and drafted by the evaluation team after their preliminary review of relevant documentation.

The Design/Inception Report of the evaluation should follow the below structure:

1. Introduction
2. Country Context
3. UNFPA Response and Country Programme
4. Methodological Approach
5. Evaluation phases, work plan, deliverables, management structure and quality assurance
6. Annexes

Note that this template is grounded in and expands upon the 2013 "Handbook: How to Design and Conduct a Country Programme Evaluation at UNFPA." Kindly refer to the Handbook for additional guidance and specific examples, as needed. The Handbook can be found here: https://www.unfpa.org/EvaluationHandbook

1. INTRODUCTION: PURPOSE, OBJECTIVES AND SCOPE OF THE EVALUATION

This section should describe and further elaborate on the purpose, objectives and scope of the evaluation presented in the terms of reference.

This section should describe the purpose of country programme evaluations (CPE) generally and provide a concise overview of the specific objectives of the CPE within the country context.

The scope of the evaluation should be included in this section, consisting in a short and straightforward description of the area of work being evaluated as well as the geographical scope and timeframe of the evaluation.

Finally, this section should note that the evaluation was commissioned by the country office, and state the aim of the design report as well as its role in the design phase.

2. COUNTRY CONTEXT

This section should detail the wider country context, including relevant social, political and economic data, language and cultural traits, demography, geographic location, etc. The country's situation and development challenges vis a vis UNFPA programmatic areas should be included as should national strategies to respond to these challenges.

This section should also include the country's progress towards the achievement of relevant internationally agreed development goals (including the MDGs, SDGs and the ICPD benchmarks).

Finally, information on official development assistance (ODA) and the role of external assistance (currently and over time) should be discussed. The main donors / ODA providers should be included.

3. UNFPA STRATEGIC RESPONSE AND COUNTRY PROGRAMME

This section should situate the country programme within the broader UN System's framework and UNFPA's corporate strategic/normative framework.

UNFPA's response through the particular country programme should be detailed, including the main elements of the country programme as set forth in programming documents as well as the underlying intervention logic (i.e. the links among activities, outputs and outcomes). The geographical coverage of the programme, as well as the evolution of the programme over time, should also be explained.

A detailed financial analysis of the programme budget by output and outcome should be included, clearly distinguishing between resource targets set out in the country programme document (CPD) and the actual resources mobilized during the programme cycle. Implementation rates should also be included.

4. METHODOLOGICAL APPROACH

This section should provide a clear and detailed description of the evaluation's approach and methodology (i.e. a theory based approach, outlining the intervention logic leading to a reconstructed theory of change of UNFPA support). How the methodology is gender and human rights responsive should also be laid out (as should any limitations toward implementing a gender and human rights responsive evaluation).

This section should include the evaluation questions and the evaluation criteria to which they respond, noting that an evaluation question may correspond to multiple criteria. OECD-DAC evaluation criteria (relevance, effectiveness, efficiency, and sustainability) should be used and, as relevant, two additional criteria: added value and coordination with the UNCT. An explanation as to why each question was selected should be included.

Consider referring to Annex I of "Integrating Human Rights and Gender Equality in Evaluation: Towards UNEG Guidance" for guidance on criteria and questions that are gender and human rights responsive.

An evaluation matrix (the primary analytical tool of the evaluation) should be presented, linking the evaluation questions to the evaluation criteria. Evaluation questions should be broken down into assumptions (aspects to focus upon) and attendant indicators. Evaluation questions should be linked to data sources and data collection methods.

Data collection and analysis methods and the stakeholder map (including the methodological approach for stakeholder selection) should be included. A description of how gender and human rights were considered vis a vis data collection and analysis methods, as well as stakeholder selection should be included. Consider referring to Table 3.2 (Tailoring common methods to address human rights and gender equality) on page 40 of "Integrating Human Rights and Gender Equality in Evaluation: Towards UNEG Guidance" for guidance tailoring data collection methods appropriately. The document can be found here: http://www.uneval.org/document/detail/980

Finally, any limitations and risks to the evaluation should be discussed. This section should explain data gaps and any issues affecting data quantity and quality. Factors that may restrict access to key sources of information should also be listed. Relevant limitations to implementing a gender and human rights responsive evaluation should be included, as well.

Mitigation measures to address limitations should be detailed and, in cases where limitations are unable to be addressed, a brief explanation on the extent to which the validity and credibility of the evaluation results could be affected should be provided.

5. EVALUATION PHASES, WORK PLAN, DELIVERABLES, MANAGEMENT, AND QUALITY ASSURANCE

This section should detail the overall evaluation process and its stages. It should present a detailed work plan for each phase/stage of the evaluation, including expected deliverables per stage set against appropriate and realistic timelines.

It should also detail the team composition and establish clear roles and responsibilities for the evaluation manager, the team leader and the team itself. As appropriate, details on field work, including specifications on logistic and administrative support, should be included, as should the budget required.

This section should, additionally, outline the management and governance arrangements of the evaluation and clearly describe the approach to quality assurance.

6. ANNEXES

Annexes may differ, but could include:

-Terms of Reference
-Evaluation Matrix
-Templates or outlines of data collection methods (i.e. interview protocols/guides, logbooks (or equivalent), survey questionnaire)
-List of Atlas interventions and financial data
-Stakeholder map and list of persons consulted
-Bibliography/documents consulted
-CPE agenda

Annex G: Zimbabwe/UNFPA 7th Country Programme (2016 - 2020**) Results Framework**

	Indicator	Baseline (2018)	Cumulative Target unless specified	
			2019	2020
Goal: Achieved universal access to sexual and reproductive health, realized reproductive rights, and reduced maternal mortality to accelerate progress on the International Conference on Population and Development agenda, to improve the lives of adolescents, youth and women, enabled by population dynamics, human rights, and gender equality				
1.	Maternal mortality ratio (maternal deaths per 100 000 live births)	**651 (2015)**		**600**
2.	Adolescent birth rate (aged 15-19 years births per 1,000 women in that age group)	**110 (2015)**		**100**
3.	Proportion of women aged 20-24 years who were married or in a union before age 18	**33.5 % (2015, MICS)**		**28%**
4.	Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations			
	4 (a) Age group 15-24	**4 per 1,000 (2015)**		**2 per 1,000**
	4 (b) Age group 15-49	**6 per 1000 (2015)**		**3 per 1000**
5.	Number of maternal deaths averted (Non cumulative)	**1,900**	**2,000**	**2,000**
6.	Number of unintended pregnancies averted (Non Cumulative)[103]	**621,000**	**642,000**	**674,000**
7.	Number of unsafe abortions averted (Non Cumulative)[104]	**139,000**	**190,000**	**200,000**
Outcome 1: Every woman, adolescent and youth everywhere, especially those furthest behind, has utilized integrated sexual and reproductive health services and exercised reproductive rights, free of coercion, discrimination and violence				
1.1	Proportion of deliveries attended by a skilled birth attendant	**78% (2015)**		**85%**
1.2	Contraceptive Prevalence Rate	**67% (2015)**		**68%**
1.3	Unmet need for family planning	**10% (2015)**		**6.5%**
Output 1: Increased availability of and access to voluntary family planning, especially long acting contraceptive methods				
1.1.1	Percent of health facilities providing LARC (by method and by level of facility)			
	1.1.1 (a) % of hospitals providing IUCD	**70%**	**80%**	**85%**
	1.1.1.(b) % facilities (clinics and hospitals) providing Implants	**83%**	**83%**	**85%**
1.1.2	Number of IUCD insertions among women aged 16 to 49 years	**35,640**	**49,640**	**63,640**
1.1.3	Number of implant insertions among women aged 16 to 49 years	**311,427**	**388,400**	**465,400**
1.1.4	Percent of health facilities eligible to provide family planning services with no stock out of contraceptives in the past 3 months (by method and by level of facility)			
	1.1.4 (a) Combined pills	**89**	**90**	**90**
	1.1.4 (b) Progestogen only pills	**95**	**95**	**95**
	1.1.4 (c) Injectables	**95**	**95**	**95**
	1.1.4 (d) IUCD (facilities with trained staff)	**93**	**93**	**93**
	1.1.4 (e) Implants (facilities with trained staff)	**98**	**98**	**98**

[103] ZNFPC CIP targets

[104] ZNFPC CIP targets

	Indicator	Baseline (2018)	Cumulative Target unless specified	
			2019	2020
Output 2: Increased national capacity to deliver quality maternal health services, including in humanitarian setting				
2.1.1	Percent of PHC facilities providing the 6 selected signal functions of basic emergency obstetric and new-born services[105]	**9.53%**	**11%**	**13%**
2.1.2	Number of women and girls living with obstetric fistula receiving treatment with support of UNFPA	**560**	**800**	**1,040**
Output 3: National cervical cancer screening programme using Visual Inspection with Acetic Acid strengthened and scaled up				
3.1.1	Number of women screened for cervical cancer	**484,739**	**584,739**	**684,739**
3.1.2	Percent of public health facilities (hospitals) supported to provide Visual Inspection with Acetic Acid and Cervicography (VIAC) services[106]	**58%**	**58%**	**58%**
3.1.3	Percent of VIAC positive women with lesions eligible for cryotherapy treated	**60%**	**65%**	**70%**
Output 4: Increased uptake of integrated HIV prevention services among women and men, especially young people and key populations				
4.1.1	Percent of facilities in supported districts trained to implement SRH and HIV integration guidelines[107]	**90%**	**92%**	**95%**
4.1.2	Percent of households reached by innovative and integrated social behavioural change communication and demand generation strategies in supported districts[108]	**48%**	**56% (Up to June 2019)**	**-**
Outcome 2: Every adolescent and youth, in particular adolescent girls, is empowered to have access to sexual and reproductive health and reproductive rights, in all contexts				
2.1	Percentage of population age 15-24 years with comprehensive correct knowledge of HIV/AIDS			
	2.1 (a) Women	**46.3% (2015)**		**50%**
	2.1 (b) Men	**46.6% (2015)**		**50%**
Output 5: Increased national capacity to provide information and services that prevent teenage pregnancy				
5.1.1.	Percent of health facilities in 20 districts providing youth friendly services that meet established national standards	**85%**	**100%**	**100%**
5.1.2	Percent of secondary schools with teachers trained in evidence-based life skills, sexuality, and HIV and AIDS in 20 supported districts	**92%**	**96%**	**100%**
5.1.3	Availability of institutional mechanism for the participation of young people in policy dialogue and programming, including in peace building processes	**Yes**	**Yes**	**Yes**

[105] Parenteral treatment of infection (antibiotics), Parenteral treatment of severe pre-eclampsia/eclampsia (Provision of MgSO4); Treatment of post-partum haemorrhage (Provision of Uterotonics); Manual vacuum aspiration of retained products of conception; Assisted vaginal delivery (e.g. vacuum extraction); Manual removal of placenta; Neonatal resuscitation (Using bag and mask)

[106] The number of hospitals supported will remain the same and the focus is on improving quality of service.

[107] This refers to health facilities with at least two health workers trained in 13 supported districts.

[108] The target is up to June 2019 because there will be a new Community strategy which will determine the approach the program will be using and the targets beyond June 2019.

	Indicator	Baseline (2018)	Cumulative Target unless specified	
			2019	2020
Outcome 3: Gender equality, the empowerment of all women and girls, and reproductive rights are advanced in development and humanitarian settings				
3.1	Percent of ever-married women aged 15-49 who have experienced any form of emotional and/or physical and/or sexual violence committed by their husbands/partners.			
	3.1 (a) Ever experienced violence	**45% (2015)**		**43%**
	3.1 (b) In the past 12 months	**30% (2015)**		**28%**
Output 6: Increased national capacity to prevent gender-based violence and enable a delivery of multi-sectoral services, including in humanitarian settings				
6.1.1	Percent of health facilities with at least two health care providers with knowledge and skills to provide clinical management of SGBV cases and refer SGBV survivors (disaggregated by level)	**58%**	**80%**	**100%**
6.1.2	Availability of budgeted emergency preparedness and response and disaster risk reduction plan which integrate sexual and reproductive health	**No**	**No**	**Yes**
6.1.3	Number of women, girls, boys and men subjected to violence that have accessed the essential services package (disaggregated by sex, age and disability status).			
	6.1 4(a) Number of survivors who accessed One stop centres	**49,691**	**59,700**	**69,700**
	6.1.4(b) Number of survivors who access shelters	**11,299**	**14,499**	**17,699**
	6.1.4(c) Number of SGBV clients accessing health services within 72 hours in supported 20 districts.	**6,351**	**8,377**	**10,603**
Outcome 4: Everyone, everywhere, is counted, and accounted for, in the pursuit of sustainable development				
4.1	Availability of the census report (conducted in the last 10 years)	**Yes**	**Yes**	**Yes**
4.2	Availability of a vital registration report	**No**	**No**	**Yes**
Output 7: Increased national capacity for the production and the use of disaggregated data on population, sexual and reproductive health and gender-based violence for the formulation and monitoring of evidence-based policies, plans and programmes, including in humanitarian settings				
7.1.1	Number of in-depth Census and Demographic and Health survey thematic reports produced and disseminated	**3**	**4**	**7**
7.1.2	Number of civil service training centres and university institutions offering population and development curricula	**0**	**1**	**2**
7.1.3	Number of web-enabled database systems operationalized	**2**	**2**	**2**
7.1.4	Availability of a national system to collect and disseminate disaggregated data on the incidence and prevalence of gender-based violence	**No**	**No**	**Yes**

Annex H

Evaluation Quality Assessment Grid

Organizational unit:		**Year of report:**	
Title of evaluation report:			
Overall quality of report:	**Very Good**	**Date of assessment:**	
Overall comments:			

Assessment Levels	**Very Good**	strong, above average, best practice	**Good**	satisfactory, respectable	**Fair**	with some weaknesses, still acceptable	**Unsatisfactory**	weak, does not meet minimal quality standards

Quality Assessment Criteria	*Insert assessment level followed by main comments.* (use 'shading' function to give cells corresponding colour)		
1. Structure and Clarity of Reporting	Yes No Partial	Assessment Level:	**Very good**
To ensure the report is comprehensive and user-friendly			
1. Is the report easy to read and understand (i.e. written in an accessible language appropriate for the intended audience) with minimal grammatical, spelling or punctuation errors?	Yes		
2. Is the report of a reasonable length? (maximum pages for the main report, excluding annexes: 60 for institutional evaluations; 70 for CPEs; 80 for thematic evaluations)	Yes		
3. Is the report structured in a logical way? Is there a clear distinction made between analysis/findings, conclusions, recommendations and lessons learned (where applicable)?	Yes		
4. Do the annexes contain – at a minimum – the ToRs; a bibliography; a list of interviewees; the evaluation matrix; methodological tools used (e.g. interview guides; focus group notes, outline of surveys) as well as information on the stakeholder consultation process?	Yes		
Executive summary			
5. Is an executive summary included in the report, written as a stand-alone section and presenting the main results of the evaluation?	Yes		

6. Is there a clear structure of the executive summary, (i.e. i) Purpose, including intended audience(s); ii) Objectives and brief description of intervention; iii) Methodology; iv) Main conclusions; v) Recommendations)?	Yes		
7. Is the executive summary reasonably concise (e.g. with a maximum length of 5 pages)?	Yes		
2. Design and Methodology	Yes No Partial	Assessment Level:	**Very good**
To ensure that the evaluation is put within its context			
1. Does the evaluation describe the target audience for the evaluation?	Yes		
2. Is the development and institutional context of the evaluation clearly described and constraints explained?	Yes		
3. Does the evaluation report describe the reconstruction of the intervention logic and/or theory of change, and assess the adequacy of these?	Yes		
To ensure a rigorous design and methodology			
4. Is the evaluation framework clearly described in the text and in the evaluation matrix? Does the evaluation matrix establish the evaluation questions, assumptions, indicators, data sources and methods for data collection?	Yes		
5. Are the tools for data collection described and their choice justified?	Yes		

6. Is there a comprehensive stakeholder map? Is the stakeholder consultation process clearly described (in particular, does it include the consultation of key stakeholders on draft recommendations)?	Yes		
7. Are the methods for analysis clearly described for all types of data?	Yes		
8. Are methodological limitations acknowledged and their effect on the evaluation described? (Does the report discuss how any bias has been overcome?)	Yes		
9. Is the sampling strategy described?	Yes		
10. Does the methodology enable the collection and analysis of disaggregated data?	Yes		
11. Is the design and methodology appropriate for assessing the cross-cutting issues (equity and vulnerability, gender equality and human rights)?	Yes		
3. Reliability of Data	Yes No Partial	Assessment Level:	**Very good**
To ensure quality of data and robust data collection processes			
1. Did the evaluation triangulate data collected as appropriate?	Yes		
2. Did the evaluation clearly identify and make use of reliable qualitative and quantitative data sources?	Yes		

3. Did the evaluation make explicit any possible limitations (bias, data gaps etc.) in primary and secondary data sources and if relevant, explained what was done to minimize such issues?	Yes		
4. Is there evidence that data has been collected with a sensitivity to issues of discrimination and other ethical considerations?	Yes		
4. Analysis and Findings	Yes No Partial	Assessment Level:	**Very good**
To ensure sound analysis and credible findings			
1. Are the findings substantiated by evidence?	Yes		
2. Is the basis for interpretations carefully described?	Yes		
3. Is the analysis presented against the evaluation questions?	Yes		
4. Is the analysis transparent about the sources and quality of data?	Yes		
5. Are cause and effect links between an intervention and its end results explained and any unintended outcomes highlighted?	Yes		
6. Does the analysis show different outcomes for different target groups, as relevant?	Yes		
7. Is the analysis presented against contextual factors?	Yes		

8. Does the analysis elaborate on cross-cutting issues such as equity and vulnerability, gender equality and human rights?	Yes		
5. Conclusions	Yes No Partial	Assessment Level:	**Very good**
To assess the validity of conclusions			
1. Do the conclusions flow clearly from the findings?	Yes		
2. Do the conclusions go beyond the findings and provide a thorough understanding of the underlying issues of the programme/initiative/system being evaluated?	Yes		
3. Do the conclusions appear to convey the evaluators' unbiased judgement?	Yes		
6. Recommendations	Yes No Partial	Assessment Level:	**Very good**
To ensure the usefulness and clarity of recommendations			
1. Do recommendations flow logically from conclusions?	Yes		

2. Are the recommendations clearly written, targeted at the intended users and action-oriented (with information on their human, financial and technical implications)?	Yes		
3. Do recommendations appear balanced and impartial?	Yes		
4. Is a timeframe for implementation proposed?	Yes		
5. Are the recommendations prioritized and clearly presented to facilitate appropriate management response and follow up on each specific recommendation?	Yes		
7. Gender	0 1 2 3 (**)	Assessment Level:	**Very good**
To assess the integration of Gender Equality and Empowerment of Women (GEEW) (*)			
1. Is GEEW integrated in the evaluation scope of analysis and indicators designed in a way that ensures GEEW-related data to be collected?	3		
2. Is a gender-responsive methodology used, including gender-responsive methods and tools, and data analysis techniques?	3		

3. Do the evaluation findings, conclusions and recommendations reflect a gender analysis?	3	

(*) This assessment criteria is fully based on the UN-SWAP Scoring Tool. Each sub-criteria shall be equally weighted (in correlation with the calculation in the tool and totalling the scores 11-12 = very good, 8-10 = good, 4-7 = Fair, 0-3=unsatisfactory).

(**) Scoring uses a four point scale (0-3).
0 = Not at all integrated. Applies when none of the elements under a criterion are met.
1 = Partially integrated. Applies when some minimal elements are met but further progress is needed and remedial action to meet the standard is required.
2 = Satisfactorily integrated. Applies when a satisfactory level has been reached and many of the elements are met but still improvement could be done.
3 = Fully integrated. Applies when all of the elements under a criterion are met, used and fully integrated in the evaluation and no remedial action is required.

Overall Evaluation Quality Assessment

	Assessment Levels (*)			
Quality assessment criteria (scoring points*)	**Very good**	**Good**	**Fair**	**Unsatisfactory**
1. Structure and clarity of reporting, including executive summary (7)	**7**			
2. Design and methodology (13)	**13**			
3. Reliability of data (11)	**11**			
4. Analysis and findings (40)	**40**			
5. Conclusions (11)	**11**			

6. Recommendations (11)	**11**			
7. Integration of gender (7)	**7**			
Total scoring points	**100**			
Overall assessment level of evaluation report	**Very Good**			
	Very good very confident to use	**Good** confident to use	**Fair** use with caution	**Unsatisfactory** not confident to use

(*) (a) Insert scoring points associated with criteria in corresponding column (e.g. - if 'Analysis and findings' has been assessed as 'Good', enter 40 into 'Good' column.
(b) Assessment level with highest 'total scoring points' determines 'Overall assessment level of evaluation report'. Write corresponding assessment level in cell (e.g. 'Fair').
(c) Use 'shading' function to give cells corresponding colour.

If the overall assessment is 'Fair', please explain

• How it can be used?

• What aspects to be cautious about?

Where relevant, please explain the overall assessment Very good, Good or Unsatisfactory

Consideration of significant constraints

The quality of this evaluation report has been hampered by exceptionally difficult circumstances:	☐ Yes	☐ No

If yes, please explain:

Annex I

Management Response template

	Evaluation report title	Year	Responsible Office	Eval. report type	Region	Period covered	Recommendation title	Recommendation text	Recommendation status (accepted, partially accepted or rejected)	Priority (high, medium or low)	Action point title	Action point text	Reporting focal point email (one for entire MR, usually M&E staff)	Action point due date (MM/DD/YYYY)	Head of Office Email	ContributorEmail (Regional M&E Advisor)
EXAMPLE	Ukraine Country Programme Evaluation (2012-2017)	2017	Ukraine CO	Country Programme Evaluation (CPE)	EECA	2013-2017	1. Programme focus	1. The next UNFPA National programme for Ukraine should consider to narrow the number	Accepted	High	1.1 CPD dev-t consultations	1.1 Organize consultation with key stakeholders/conduct	Zamostian@unfpa.org	6/30/2020	peek@unfpa.org	malam@unfpa.org

Annex J

Outline of final evaluation report

Cover page

UNFPA CPE: NAME OF THE COUNTRY

Period covered by the evaluation

FINAL EVALUATION REPORT

Date

Second page
Country map (half-page)
Table (half-page)

Evaluation Team	
Titles/position in the team	Names

Third page
Acknowledgement

Fourth page
Table of contents

Fifth page
Abbreviation and acronyms
List of tables
List of figures

Sixth page
Key facts table

Section	Title	Suggested length
EXECUTIVE SUMMARY		5 pages max
CHAPTER 1: Introduction		
1.1	Purpose and objectives or the CPE	5-7 pages max
1.2	Scope of the evaluation	
1.3	Methodology and process	
CHAPTER 2: Country Context		
2.1	Development challenges and national strategies	5-6 pages max
2.2	The role of external assistance	
CHAPTER 3: United Nations/UNFPA response and programme strategies		
3.1	UNFPA strategic response	5-7 pages max
3.2	UNFPA response through the country programme	
3.2.1	Brief description of UNFPA previous cycle strategy, goals and achievements	
3.2.2	Current UNFPA country programme	
3.2.3	The financial structure of the programme	
CHAPTER 4: Findings: answers to the evaluation questions		
4.1	Answer to evaluation question 1	25-35 pages max
4.2	Answer to evaluation question 2	
4.3	Answer to evaluation question 3	
4.4	Answer to evaluation question X	
CHAPTER 5: Conclusions		
5.1	Strategic level	6 pages max
5.2	Programmatic level	
CHAPTER 6: Recommendations		
6.1	Recommendations	4-5 pages max
(total number of pages)		55-70 pages

ANNEXES
Annex 1 Terms of reference
Annex 2 List of persons/institutions met
Annex 3 List of documents consulted
Annex 4 The evaluation matrix

Annex K

UNFPA Evaluation Office Editorial Guidelines

Supplementary editorial guidelines for UNFPA Evaluation Office

UNFPA Evaluation Office documents, publications and other written material follow UN editorial guidelines, available here at http://dd.dgacm.org/editorialmanual/
Building on the UN editorial guidelines, the supplementary editorial guidelines cover some common editorial issues that are encountered in evaluation reports and related products.

1. SENTENCES IN GENERAL

- Avoid long, complicated sentences. Short, clear sentences convey meaning more effectively.
- When a sentence does need a series of sub clauses, who is doing what can become unclear. It's often better to put the shortest sub clause at the start of the sentence. For example:

"The principles emanate from decisions taken by the General Assembly, from the Executive Board, and from UNFPA executive management's commitment to nurture an evaluation culture." In this instance, it is unclear from whom the decisions emanate. (Is it both the General Assembly and the Executive Board or just the General Assembly?) However, if it is written *"The guiding principles emanate from the Executive Board, from decisions taken by the General Assembly, and from UNFPA executive management's commitment to nurture an evaluation culture."* (SHORTEST, MIDDLE LENGTH, LONGEST), this is clearer. If there is any lack of clarity in a running list, consider the use of a colon and semi colon structure. (in running text, there is no capital letter after the colon.)

- Do not put two words where one will do. For example:

  "… their *relevance* and *significance* to planning". The two words in italics have the same meaning, so just use one or the other. The meaning is clearer in **"… their relevance to planning ".** Using two words where only one is needed does not strengthen a sentence; it weakens it.

- Avoid using metaphors, if possible. They can be hard to translate and difficult concepts for non-native speakers to understand.

- Use the active voice over the passive voice whenever possible. For example, "The implementation and modification of the report is being undertaken by the Government."

(passive voice) Can be written more clearly: “The Government is modifying and implementing the report.” (active voice)

- It can be clearer to use verbs in sentences (“modifying” and “implementing”) rather than nouns (“the implementation” and “the modification”.) As we can see from the above example.

- Avoid using too many adjectives and adverbs. They can impede clarity, rather than add to it.

2. POSSESSIVES (‘S)

Do not use the possessive with:

- Inanimate objects. For example: **“the capacity of the trucks”**, not “the trucks’ capacity”.
- United Nations and other organization acronyms (like UNFPA, WFP, do not use WFP’s or UNFPA’s.)
- Names of countries (e.g. use Government of Brazil, and not Brazil’s Government)

3. ITALICS AND BOLD

Do not use italic or bold fonts in text for emphasis. The emphasis should be reflected in the wording.

Use ***italic*** only for publications, book titles and for words and expressions in languages other than English.

Use bold only for headings.

4. CAPITALIZATION

Use capitals sparingly.

Use initial capital letters to mark beginnings of the first word of a sentence, the first word of a subparagraph or an item on a list.

The official titles of persons, councils, commissions, committees, secretariat units, organizations, institutions, political parties, organized movements and plans etc are all written in caps, when they are introduced. Also capitalize them when they are used as a shortened title, for example, the ‘Conference’ (when referring to a specific Conference) or the ‘Committee’ (when referring to a particular Committee). However, do not capitalize when used as common nouns – e.g. ‘there were several regional conferences.’

Job titles: References in running text to job titles such as budget officer, project manager and accountant are not given as acronyms or capitalized. However, the following titles and officers ARE capitalised as a courtesy to their position: Secretary-General, Executive Director, Assistant Executive Director, Regional Director, Country Director, Evaluation Director, President, Vice-President, Treasurer, Chief, External Auditor, Chief Financial Officer and Evaluation Office. NOTE: job titles ARE given caps when used in conjunction with a person - for example: “John

Smith, Budget Officer, was present at the meeting..", or in a list of acknowledgements "John Smith - Budget Officer, Cameroon Country Office".

Used as adjectives or in plural: With persons, councils, commissions, committees, organizations, institutions, political parties organized movements and plans, groups, offices, divisions and others words of this ilk, including government, if the word is referring to something that is unique and specific, then it is written in caps (as noted above), but if the word is being used as an adjective, in a generic sense, or as a plural then it should be written in lower case. For example: we would refer to the country office, headquarters or regional offices, (nonspecific and non-unique) but if we would refer to the "South Sudan Country Office" or the "UNFPA East and Southern Africa Regional Office". However, note: it is UNFPA headquarters, not UNFPA Headquarters. Further, we would use Technical Division when referring to the actual division, but would say technical division reports - because in this instance "technical division" is being used as an adjective describing the reports.

There are a number of UNFPA strategic plans and only when the plan is given its full title, UNFPA Strategic Plan 2018-2021, would we write it out with caps.

We do not need to use capitals when using a phrase that is often written as an acronym. For example, gender-based violence is often written GBV. When we are writing "gender-based violence" in running text, we don't write "Gender-Based Violence", but, instead we write "gender-based violence". Another example would be "people living with HIV". If written out, we don't use capitals so we don't write "People Living with HIV" just because the acronym is "PLHIV"

Programmes, conferences, seminars, workshops*:* Once the full title is given, references to "the programme", "the conference", etc. are not capitalized.

Bodies proposed but not yet established*:* These are not capitalized. The same holds true for references to draft conventions and treaties that do not yet exist.

References to parts of documents*:* Do not capitalize the word "paragraph", e.g. "In paragraph 12, reference is made to …". However, the word "Annex" is capitalized, e.g. "See Annex IV". Annexes should be numbered in roman capital numerals I, II, III, etc.

Headings and sub-headings: Use capital initial letters in headings and sub-headings

Government names: Government is capitalized when it refers to a certain government but not when it is plural or used as an adjective:

- the Government will provide funding
- it is a government programme
- the governments of the Russian Federation and Mozambique were present
- the Government of Uganda responded.

Member States: We would write "the Member State(s) of… United Nations", when referring to the specific UN Member States, but member state(s)/country(ies) if it's another institution or undefined.

Exceptions: Some things are always referred to with caps, because they are unique and specific such as Sustainable Development Goals, Agenda 2030, Member States, United Nations Development Assistance Framework is always written in caps.

5. ABBREVIATION RULES AND ACRONYMS

Acronyms should be used sparingly. This is written in every editing manual, but a great many acronyms are still routinely used.

If an acronym appears in a document three times or less, it should be written out in full each time and it doesn't need to be included in the acronym list.

See the above point in "Capitalization" about the fact that when introducing an acronym, there is no need to capitalize the phrase. (for example, the acronym PLHIV can be introduced as "people living with HIV (PLHIV)…" we do not need to write "People Living with HIV (PLHIV)…")

If the acronym is less than three words long, consider writing it out in full every time unless it is very frequently used.

There are some exceptions to this rule:

- Phrases that hinder the meaning of a sentence, rather than clarify it, can be kept as acronyms. For example: ToR. –We understood this to be a specific document, but this is nevertheless a plural word. Therefore if we use the phrase "terms of reference" then what follows the phrase has to be plural, ("the terms of reference are..") which is confusing when ToR is actually referring to a singular document. It's also sufficiently well known as a term that it's instantly recognisable. So, it is fine to use ToR (but not TOR, as the rule is we don't capitalize prepositions, such as "of"). Another example of where it is fine to use a three letter acronym would be "IPC" – as the words "integrated food security phase classification" (which this acronym stands for) do not fit comfortably into the flow of a sentence.
- Abbreviations such as SDG and MDG, which are universally known in United Nations circles and would always be written with caps anyway, could be left as acronyms once they have been written out once. The same rule would apply to abbreviations like NGO and the names of other United Nations agencies, like UNDP etc.

Once the acronym has been introduced by brackets, it does not need to be introduced in brackets again later in the document.

"United Nations" should not be abbreviated in English. The form "ONU" is acceptable in French.

Do not use acronyms to refer to governments or ministries. The only countries referred to by an acronym are the Democratic People's Republic of Korea (DPRK) and the Democratic Republic of the Congo (DRC). With these countries, we would introduce the names in full when we first meet it. (Please note the second "the" in DRC). The "short names" from FAO Country Names terminology site can be used once the full name has been introduced initially (see 'Country Names', below). An example would be The Republic of South Sudan. The country can be introduced with its full name and referred to as South Sudan thereafter.

Abbreviations and acronyms should not be used in the possessive form for United Nations organizations: the Commander of UNMIL or the UNMIL Commander, not UNMIL's Commander. "The UNFPA document" or "the document of UNFPA", not UNFPA's document
Acronyms should be spelt out in full at their first occurrence in text. A list of acronyms must be attached to documents in which acronyms are used. Always check that the acronym used is in the list.
If an acronym is being used, make sure you are not repeating part of the acronym. For example: "The EECARO office". This reads "the Eastern Europe and Central Asia regional office office".
Acronyms and spelled out version of acronyms should be written as set out in the FAO TERM portal. The FAO term portal also advised on capitalization of acronyms.

Additional notes on acronym usage
Please note as far as acronym usage is concerned, consider the executive summary (situated in the report) as a separate product from the rest of the report. In other words, we expand an acronym the first time it appears in the executive summary and then use the acronym throughout the executive summary. The same rule applies to the report, we expand an acronym the first time it appears in the report and then use the acronym throughout the report.
Example: when we use "sexual and gender based violence" for the first time: (i) it should not be capitalized; (ii) it should be followed by (SGBV). This rule applies to the Executive Summary and then again to the report.

6. QUOTES

Direct quotations should reproduce the original text exactly and should be carefully checked for accuracy. Only typographical and other clearly unintentional errors may be corrected.

When the quote forms part of a sentence, the final quotation mark goes inside the full stop. This is because the punctuation is for the whole sentence, not for the quote. When the quote is a full sentence in its own right, then it has its own integral punctuation. For example:

- Mr Smith was said to be "resigned to his fate".
- Mr Smith was said to be "resigned to his fate in the restructuring. He did not expect miracles."

If the quote is more than three lines long it should be indented.

The quote does not need an introductory colon as long as the sentence flows smoothly into the quote.

If there is a clash in tenses between the quote and the running text, break the quote into phrases that can be accommodated by the running text.

7. NUMBERING PARAGRAPHS

Paragraphs are not numbered in summaries or other front matter.

Break up paragraphs to create space

Use paragraph numbering for evaluation reports (only)

8. SPELLING, (including S vs Z)

Use **z** (not s) in such words as reali**z**e, organi**z**ation and mobili**z**ation.

Use **s** in words such as analy**s**e, cataly**s**e and paraly**s**e.

The English UK spelling rules apply - for example, “centre”, not “center”. (unless you are reproducing the name of an organization that has this specific spelling)

Email (not e-mail) is now the accepted spelling. The United Nations editorial guidelines have a list of spelling, but it is not comprehensive. The Oxford English Dictionary is the recommended reference on spelling.

9. TABLES, FIGURES, BOXES

Each table should have a title that describes it accurately and briefly.

The title is set in bold type, flush left and stacked below the table number. Only the first word is capitalized (unless it’s supposed to be capitalised in running text).

10. BULLET/LIST

A bullet list should:

• Use an initial capital letter

• Always agree with the ‘platform’ sentence before the colon

• Not have semicolons at the end of each item

• Not have ‘and’ after the second last item

• Close with a full stop.

If each bullet list entry is a complete sentence in itself and the platform sentence for the bullet list is a full sentence too, then each bullet point should end with a full stop.

11. COUNTRY NAMES

UNFPA generally uses the "short names" from FAO Country Names terminology site
Use the full name – the Republic of South Sudan for example – the first time the country is named, and then switch to the short name after that.

12. OTHER POINTS TO REMEMBER

PERCENTAGES: In running text, write out the words “per cent”. The symbol % can be used in tables, figures and footnotes. Always use the number, not the word, for the percent, even if it’s number one to ten. (e.g say 3 per cent and not three per cent)

NUMBERS: The numbers one to ten are written out as words. However, there are exceptions:

- When the number is a percentage.
- When the number appears with a larger number and both numbers are referring to the same subject then the smaller number is written as a number. For example, it is correct to write – “There were six girls in the room.” but if there are girls and more boys for example, then it changes to: “There were 6 girls and 15 boys in the room.” This rule does not apply when the things being counted are disparate items, for example: “a total of 23 people were injured in four separate incidents.”
- When used for children’s ages or for units of measurements such as cm, etc – use the number, not the word.

When a number starts a sentence, it is always written as a word, never a number. If the number is an awkward or very long one, consider rephrasing the sentence slightly to avoid starting with the long number.

QUALIFIERS: Do not use vague qualifiers – "some", "more than", "over" etc.

TENSE**:** Make sure that the tense is consistent. There should not be a mix of past and present in one paragraph unless in exceptional circumstances.

Avoid the perfect tense (e.g."it has") unless the action is still ongoing in the present and use the simple past instead (e.g. it was).

A general caveat to consider: The report might have been written in the present, but, by the time it is presented, the information will be in the past. It would be wrong to say in a report that "the country is at war" (for example) because when the reader is reading the report, that information may no longer be accurate.

FOOTNOTES: When using footnotes, the punctuation comes before the superscript footnote number, this includes commas as well as full stops. For example: "The motion was not adopted owing to the negative votes of three permanent members.[3]"

OXFORD COMMA: The Oxford comma shouldn't be used unless it helps to clarify a sentence. In other words, it can be used, but should be done so sparingly. Here is the wording from the United Nations guidelines on the use of the Oxford comma:

The final comma before *and* is not normally used in United Nations documents. The practice is to write "organs, organizations and bodies", not "organs, organizations, and bodies"; and "disarmament, demobilization, rehabilitation and reintegration", not "disarmament, demobilization, rehabilitation, and reintegration".

However, the final comma may sometimes have to be included for the sake of clarity, for instance in sentence comprising lengthy or complex elements.

COMPOUND ADJECTIVES: The hyphen is used to form a compound adjective out of two linked words modifying a noun: "long term", "grass roots", "civil society", "private sector", when used as adjectives before the noun they qualify become "a long-term programme", "grass-roots support", "civil-society organizations", "private-sector involvement". When a hyphenated adjective is a title, both words are in caps, e.g.: Inter-Agency Standing Committee

THAT OR WHICH: "That" and "which" have different uses.

That (restrictive) is defining:

The northern regions that are prone to drought are the ones to target with aid. (There might be other northern regions, but it is only those that are susceptible to drought that are being targeted for aid.)

Which (non-restrictive) is not defining; it gives additional information that could be omitted and not affect the intended message of the sentence.

The northern regions, which are prone to drought, will each receive aid. (Being drought-prone is a characteristic of the northern regions.)

That, as a relative pronoun, is not preceded by a comma; ***which***, as a relative pronoun, normally is.

'N' DASH VS 'M' DASH: (e.g., "as said - for example - in this text" versus "as said—for example—in this text…") The use of N dash is preferred for evaluation reports.

"An em dash, or **long dash**, is used: in pairs, to mark off information or ideas that are not essential to an understanding of the rest of the sentence and to show other kinds of break in a sentence where a comma, semicolon, or colon would be traditionally used: *One thing's for sure—he doesn't want to face the truth.* Note that there is no space added on either side of an em dash. Em dashes are especially common in informal writing, such as personal emails or blogs, but it's best to use them sparingly when you are writing formally."

The Associated Press says this: "En dashes can be used to separate thoughts in a sentence or create emphasis; when using en dashes in this way, always put a space on either side of the dash. This style is used in technical writing."

MALE/FEMALE: Avoid the use of 'male' and 'female' as adjectives where possible and use 'man' or 'woman' instead."

13. BIBLIOGRAPHY

Author (last name first), Title of the book, City: Publisher, Date of publication.

Author (last name first), "Article title," Name of magazine (type of medium). Volume number, (Date): page numbers, date of issue.

URL (Uniform Resource Locator or WWW address). author (or item's name, if mentioned), date.

14. LIST OF PEOPLE CONSULTED

- should include the full name and title of people interviewed as well as the organization to which they belong
- should be organized in alphabetical order (English version) with last name first
- should be structured by type of organization

Before submitting draft country notes and evaluation reports, please check them for grammar, spelling, punctuation, and perform a thorough editing.

14. USE OF SENSITIVE WORDS

This guidance for use of specific sensitive terminology in Evaluation Office material is based on the following:

- **UNFPA website**: If a UNFPA document is published on the website, including any web story, that includes certain 'sensitive/political' words, then they are generally acceptable to use.
- **UNFPA Issue Briefs**: They also serve as a guide for acceptable terms to use.
- **Particularly related to HIV and AIDS,** there are two additional guides to follow:

a) UNAIDS terminology guidelines
b) WHO glossary of terms
Details are available in the attachment 'Guidance for Terminology'.

Annex L

Evaluation work plan

= Responsibility of evaluation manager, UNFPA CO staff, Regional M&E Adviser and/or eva
reference group
= Responsibility of evaluation team
= Responsibility of UNFPA Evaluation Office

Evaluation Phases and Tasks	Jan				Feb				March				April				May				June				July				Aug				Sept				Oct				Nov				Dec			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Preparatory phase																																															
Preparation of letter for Government and other key stakeholders																																														
Establishment of the ERG																																														
Compilation of initial background information and documentation																																														
Development of first stakeholders map																																														
Drafting ToR																																														
Review and approval of ToR																																														
Identification and pre-selection of consultants																																														
Pre-qualification of consultants																																														
Recruitment of the evaluation team																																														
Design phase																																														
Development of communication plan																																														

Desk review of initial background information and documentation	
Drafting design report	
Presentation of draft design report to the ERG	
Review of draft design report	
Revision of draft design report and approval of final design report	
Field phase	
Meeting of evaluation team with CO staff to launch data collection	
Individual meetings of evaluators with relevant programme officers at CO	
Data collection (desk review, site visits, interviews, group discussions etc.)	

Debriefing meeting with CO staff and ERG																																																
Reporting phase																																																
	Jan	2	3	4	Feb	2	3	4	Mar	2	3	4	Apr	2	3	4	May	2	3	4	Jun	2	3	4	Jul	2	3	4	Aug	2	3	4	Sep	2	3	4	Oct	2	3	4	Nov	2	3	4	Dec	2	3	4
Drafting evaluation report																																																
Review of draft evaluation report																																																
Development of EQA of draft report																																																
Drafting final evaluation report																																																
Preparation of management response																																																
Submission of final evaluation report to EO and of final management response to PSD																																																
Development of independent EQA of final evaluation report																																																
Dissemination and facilitation of use phase																																																
Development of PowerPoint presentation for dissemination of evaluation results																																																

Development of evaluation brief																																																
Publication of final evaluation report, independent EQA and management response on UNFPA evaluation database																																																
Dissemination of evaluation report and evaluation brief to stakeholders																																																

Annex 8 :TORs for Establishing an evaluation reference group for UNFPA Country Programme Evaluations

Background

The UNFPA Evaluation Policy, together with Executive Board Decision of 2018/11, and is

the result of extensive consultations with key stakeholders. The policy is informed by the General Assembly resolution 71/243 on the quadrennial comprehensive policy review and by the UNFPA Strategic Plan and is aligned to the 2016 norms and standards of the United Nations Evaluation Group. It outlines evaluation principles and procedures; sets out roles and responsibilities; describes contributions to system-wide evaluations and national evaluation capacity development; highlights human and financial resource requirements; and concludes with a note on the implementation, reporting and future review of the policy. Country Program Evaluations are part of the decentralized evaluations which are conducted by UNFPA units (country, regional, and headquarter divisions).

Management and Conduct of Evaluations

UNFPA is committed to excellence in evaluation and strives for rigor in the design, management and conduct of evaluations. Evaluations should be designed, conducted and managed in line with UNEG norms and standards, as well as those set out in the present policy. Staff responsible for designing, managing and conducting evaluations should conform to UNEG ethical standards and UNEG guidance on integrating human rights and gender equality in evaluation. The Evaluation Office will ensure that staff responsible for designing, managing and conducting evaluations have been trained in UNEG norms and standards and the ethics of the profession.

Purpose of Evaluation

First, evaluation is a means to demonstrate accountability to stakeholders on its performance in achieving development results and invested resources.

Second, evaluation supports evidence-based decision-making: utilization focused evaluations (which enhance the utility and use of evaluations) provide credible information to support decision-making by management on planning, budgeting, implementation and reporting, as well as improvements in policies and programmes.

Third, evaluation provides important lessons learned, expanding the existing knowledge base on how to accelerate implementation of the Programme of Action of the International Conference on Population and Development. In particular, evaluation provides important lessons on how best to advance sexual and reproductive health and reproductive rights, and on how UNFPA can effectively support the achievement of the Sustainable Development Goals.

The policy and the related Executive Board and Management decisions stipulate that:

- The 2019 UNFPA Evaluation Policy requires CPs to be evaluated at least once every two programme cycles.

- Country programme evaluations are carried out in a manner that enhances national evaluation capacity through the participation of governments and key stakeholders, through support for country-led evaluations, using national evaluation systems;
- UNFPA evaluations must be of high quality and carried out with the highest level of objectivity and impartiality;
- Programme evaluation must focus on achievement of results and support accountability and learning functions in UNFPA;
- Management responses must be prepared for every evaluation, and evaluation results should be used to inform decision-making at all levels;

Country programme evaluation procedures include four key phases: a) Planning for evaluation; b) Preparation for an evaluation; c) Desk review, field work and reporting; and d) using results of an evaluation.

Establishment of an Evaluation Reference Group

During the preparation phase, the country office should establish an **Evaluation Reference Group (ERG**) to guide and enhance the quality of the evaluation by peer reviewing and providing impartial and constructive feedback on the products of the evaluation, endorsing the reports, and increasing national participation and ownership. The group should include key stakeholders, especially Government as well as other civil society organizations familiar with the UNFPA mandate. The evaluation manager should be part of this group, together with additional evaluation expertise such as that from academicians. The table below shows specific roles and responsibilities of this group:

Evaluation Reference Group (ERG) Summary Roles and Responsibilities

- Provides input to the Evaluation Terms of Reference
- Contributes to the selection of evaluation questions
- Contributes to the selection of the evaluation team
- Provides comments on the design report
- Provides comments on the draft final evaluation report
- Ensures the final draft meets the UNFPA quality standards

Competencies of Evaluation Reference Group Members

- Knowledgeable in project management
- Significant knowledge and experience of UNFPA Country Programme and mandate
- Skills in monitoring and evaluation

UNFPA ZIMBABWE CO PROCESS FOR ESTABLISHING ERG

UNFPA Management wrote to the key stakeholders including Government, CSOs and academia to nominate ERG members. The TORs for establishing an ERG were shared with all organisations. The organisations considered the above criteria and the availability of the members to be able to participate in all the processes of the Evaluation.

The following members were nominated and these participated in the TOR development, attended the presentation meetings for the different stages of the evaluation. The ERG members also peer reviewed all the products from inception report, draft evaluation report and final evaluation report and comments. The ERG members also facilitated identifying key informants, setting up of interviews with key informants and sharing evaluation products within their organisations. The ERG members also played a key role in assisting with validating recommendations.

Members the Evaluation Reference Group

Organisation	Type of Organisation	Nominated Person
Ministry of Finance and Economic Development	Government and Coordinating Authority for the CP	Brighton Shayanewako and Innocent Madziva
Ministry of Health and Child Care	Government	Rugare Kangwende
Ministry of Primary and Secondary Education	Government	Pepukai Nyevero
Musasa	Government	Shylet Muserere
MWACSMED	Government	Mrs Chritisne Chideme
NAC	Government	Amon Mpofu
ZICHIRE	CSO	Mr Walter Chikanya
Zimstat	Government	
ZYC	Government	Mr Lungani Zwangobani
Centre for Population Studies	Academic Institution	Marvelous Mhloyi

Annex 9: Status of outcome indicators by 2020

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

Original Result Framework (2016)				
Outcome indicator	**Baseline (2015)**	**Target (2020)**	**Current status**	**Comment**
Percentage of women aged 15-49 using long-acting contraceptive methods	<1$	5%	No data	Next ZDHS will provide data on this indicator
Percentage of district hospitals providing comprehensive emergency obstetric and new-born care services	65.5%	80%	90%	Data source for current status is from VMAS report of 2020 Q3
Percentage of women aged 15-49 accessing cervical cancer screening services	7.2%	35%	21%	Data source for current status is from the NHSP midterm review conducted in 2019
Percentage of sexually active HIV-positive women who use a modern method of family planning	64%	68%	No data	Next ZDHS will provide data on this indicator
New indicators in revised result framework (2018)	**Baseline (2015)**	**Target (2020)**	**Current status**	**Comment**
Proportion of deliveries attended by a skilled birth attendant	78%	85%	85%	Current status data is from MICS 2019
Contraceptive Prevalence Rate	67%	68%	67%	
Unmet need for family planning	10%	6.5%	8.6%	Current status data is from the 2019 FP2020 report

Outcome 2: Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education

Outcome indicators for Zimbabwe CP	Baseline	Target (2020)	Current status
Adolescent fertility rate	124	115	108 MICS 2019
Unmet need for family planning among females aged 15-19 years	11	8.5	Next ZDHS will provide data on this indicator
% of facilities offering youth friendly services that meet national standards	6	25	22
New indicator for revised result framework in 2018			
% of population age 15-24 years with comprehensive correct knowledge of HIV/AIDS	Women: 46.3 Men: 46.6	50	Next ZDHS will provide data on this indicator

Outcome 3: Gender Equality, the empowerment of all women and girls and reproductive rights are advanced in development and humanitarian settings

Outcome indicator	Baseline (2016)	Target (2020)	Current status	Comments
Percentage of young women (15-24 years) who have ever experienced physical violence.	28.8	21	-	Data not available
Percentage of women and girls who report having used services after being abused.)	15 Police and Social welfare 2.2	20 and 10	-	Data not available

Outcome 4: Population dynamics Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality

Outcome indicator	Baseline 2015	Target 2018	Achieved result 2018	% Achieved
Number of national development plans and sector policies incorporating population dynamics	**0**	2	1	50%
Outcome 4: Everyone, everywhere, is counted, and accounted for, in the pursuit of sustainable development (2018-2021 UNFPA Strategic Plan)				
Results framework revised in 2018	**Baseline 2018**	**Target 2019**	**Achieved result 2019**	**% Achieved**
Availability of the census report (conducted in the last 10 years)	Yes	Yes	Yes	
Availability of a vital registration report	No	No	No	