

Government of Zimbabwe/UNFPA Zimbabwe 8th Country Programme Evaluation 2022-2026



Evaluation Report
November 2025





Map of Zimbabwe

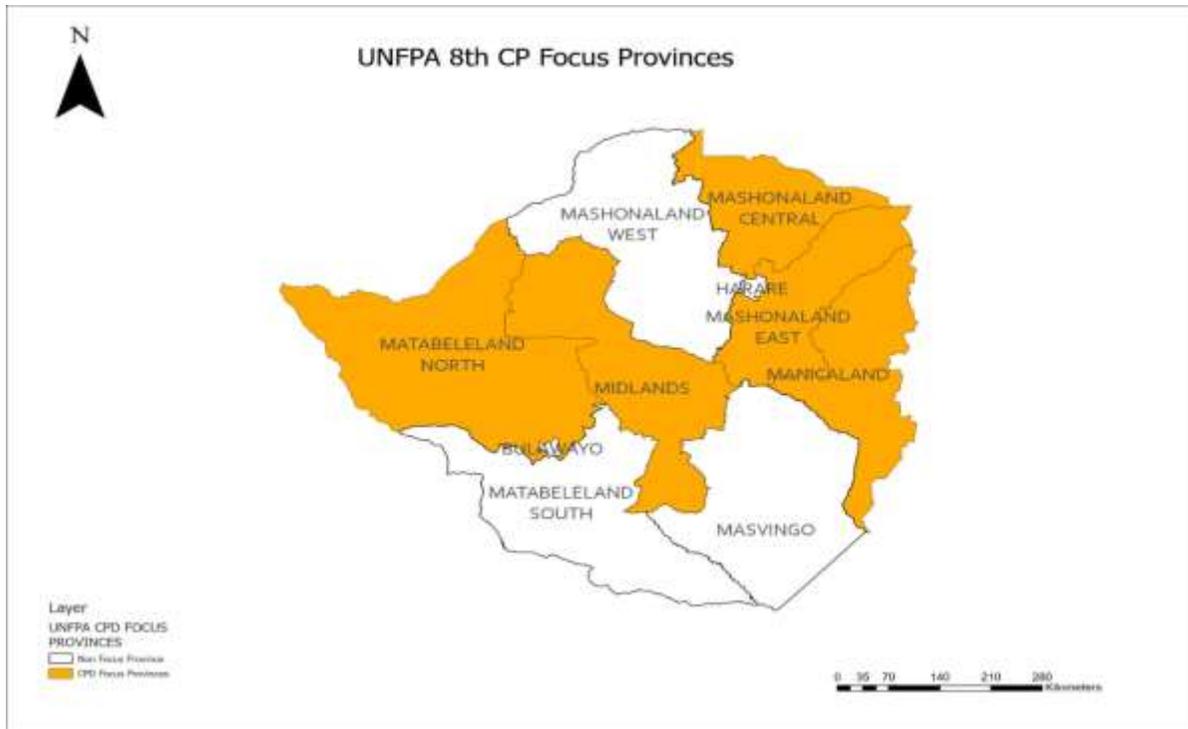


Figure 1: Map of Zimbabwe showing UNFPA 8th CP focus provinces

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Table of contents

Acknowledgements.....	iii
List of figures.....	vi
List of tables.....	vi
Abbreviations	vii
Executive summary.....	1
CHAPTER 1: INTRODUCTION	8
1.0 Purpose and objectives of CPE	8
1.2 Scope of the evaluation	8
1.3 Evaluation approach	12
1.3.1 Contribution analysis and theory of change	12
1.3.2 Methods of data collection and analysis.....	12
1.3.3 Stakeholders consulted and sites visited.....	15
1.3.4 Limitations and mitigation measures	17
1.3.5 Ethical considerations.....	18
1.3.6 Innovative practices.....	18
CHAPTER 2: COUNTRY CONTEXT	19
2.1 Development challenges and national strategies.....	19
2.1.1 General country context	19
2.1.2 Challenges and strategies for SRHR.....	21
2.1.3 Challenges and strategies for AY	22
2.1.4 Challenges and strategies for GBV	22
2.1.5 Challenges and strategies for PD.....	23
2.2 Role of external assistance.....	24
CHAPTER 3: UNFPA RESPONSE AND PROGRAMME STRATEGIES.....	25
3.1 United Nations and UNFPA strategic response	25
3.1.1 UN and UNFPA response	25
3.1.2 Link of CPD outputs with UNFPA SP outcomes.....	25
3.2 UNFPA response through the Country Programme.....	27
3.2.1 Description of UNFPA previous programme cycle, goals and achievements.....	27
3.2.2 The current 8 th CP (2022-2026) and an analysis of the ToC	28
3.2.3 Financial structure of the UNFPA CP	35
CHAPTER 4: FINDINGS.....	37
4.1 Answer to evaluation question 1 (Relevance).....	37
4.2 Answer to evaluation questions 2-4 (Coherence)	43
4.3 Answer to evaluation question 5 (Effectiveness)	48
4.3.1 Sexual and reproductive health and rights	48
4.3.2 Adolescents and young people	53
4.3.3 Gender equality and women’s empowerment	57
4.3.4 Population and development.....	61
4.4 Answer to evaluation question 6 (Efficiency)	64
4.5 Answer to evaluation question 7 (Sustainability).....	68
4.6 Lessons learnt and best practices	70
CHAPTER 5: CONCLUSIONS	72
5.1 Strategic level	72
5.2 Programmatic level	73
CHAPTER 6: RECOMMENDATIONS.....	75



Country Programme Evaluation of GoZ /UNFPA 8th CP 2022-2026



6.1 Strategic level	75
6.2 Programmatic level	77
ANNEXES	81
Annex 1: Evaluation matrix	82
Annex 2: Bibliography	136
Annex 3: List of stakeholders consulted /interviewed	140
Annex 4: Data collection tools.....	150
Annex 5: Stakeholder map.....	162
Annex 6: List of site visits undertaken during field phase	167
Annex 7: The 8th CP performance by end of March 2025	168
Annex 8: Terms of reference	171



List of figures

Figure 1: Map of Zimbabwe showing UNFPA 8th CP focus provinces	i
Figure 2: Data collection methods	13
Figure 3: Stakeholder by category and gender	17
Figure 4: SDG dashboard and trends	19
Figure 5: Population pyramid showing the age structure of Zimbabwe.....	20
Figure 6: Trend in total net ODA to Zimbabwe 2013-2022	24
Figure 7: Reconstructed ToC.....	32
Figure 8: Overview of findings	37

List of tables

Table 1: Key facts table - Zimbabwe.....	ix
Table 2: Evaluation criteria, EQs and assumptions	9
Table 3: Partners of UNFPA Zimbabwe.....	11
Table 4: Categories of stakeholders selected for interviews and selection criteria	15
Table 5: Selected provinces and districts and criteria used	16
Table 6: Limitations, risks and mitigation measures	17
Table 7: UNFPA Transformative results, indicators and the achievement level in Zimbabwe	25
Table 8: Link between CPD 2020-2026 and UNFPA Strategic Plan 2022-2025.....	26
Table 9: Allocation of budget 2022-2025 (US\$ million).....	35
Table 10: Evolution of overall budget and expenditure (US\$) (Up to 31st March 2025)	35
Table 11: Total budget and expenditure by implementing partner	36
Table 13: SRH output indicators	50
Table 14: AYP output indicators	54
Table 15: GEWE output indicators.....	58
Table 16: PD output indicators.....	61



Abbreviations

AI	Artificial intelligence
ANC	Antenatal care
ASRH	Adolescent sexual and reproductive health
AYP	Adolescents and young people
AUC	Africa Union Commission
AWP	Annual work plan
BEmONC	Basic emergency obstetric and neonatal care
CCA	Common country analysis
CEmONC	Comprehensive emergency obstetric and neonatal care
CeSHHAR	Centre for Sexual Health and HIV/AIDS Rights
CO	Country office
COVID	Corona Virus Disease
CP	Country programme
CPD	Country programme document
CPE	Country programme evaluation
CSE	Comprehensive sexuality education
DAC	Development Assistance Committee
DD	Demographic dividend
DHIS	District health information system
DSA	Daily subsistence allowance
EmONC	Emergency obstetric and neonatal care
e-MPDNS	Electronic maternal and perinatal deaths notification system
EQA	Evaluation quality assessment
EQAA	Evaluation quality assurance and assessment
ERG	Evaluation reference group
ESARO	East and Southern Africa Regional Office
ET	Evaluation team
EQ	Evaluation question
FP	Family planning
GALZ	Gays and Lesbians of Zimbabwe
GBV	Gender-based violence
GDP	Gross domestic product
GEWE	Gender equality and women empowerment
GoZ	Government of Zimbabwe
HDI	Human Development Index
HLPC	High Level Political Compact
HMIS	Health management information system
HP	Harmful practices
ICPD	International Conference on Population and Development
LGBTQI+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex and Others
LNOB	Leaving no one behind
M&E	Monitoring and evaluation
MMR	Maternal mortality ratio
MICS	Multiple indicator cluster survey
MISP	Minimum Initial Services Package
MoFEDIP	Ministry of Finance, Economic Development and Investment Promotion
MoHCC	Ministry of Health and Child Care



Country Programme Evaluation of GoZ /UNFPA 8th CP 2022-2026

MoJLPA	Ministry of Justice, Legal and Parliamentary Affairs
MoLGPWNH	Ministry of Local Government, Public Works and National Housing
MoPSE	Ministry of Primary and Secondary Education
MoPSLSW	Ministry of Public Service Labour and Social Welfare
MOU	Memorandum of understanding
MWACSMED	Ministry of Women Affairs, Community, Small and Medium Enterprises Development
NDS1	National Development Strategy 1
NDS2	National Development Strategy 2
NHS	National Health Strategy
NSS	National statistical system
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
ODA	Official development assistance
OECD	Organization for Economic Co-operation and Development
OSC	One stop centre
PD	Population and development
RMNACHN	Reproductive, maternal, neonatal, adolescent and child health and nutrition
SBA	Skilled birth attendance
SDG	Sustainable Development Goal
SMART	Specific, measurable, achievable, relevant and timebound
SYP	Safeguard young people
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
TA	Technical assistance
TOR	Terms of reference
TWG	Technical working group
UHC	Universal health coverage
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCT	United Nations Country Team
UNDP	United Nations Development Programme
UNECA	United Nations Commission for Africa
UNEG	United Nations Evaluation Group
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNPRPD	UN Partnership on the Rights of Persons with Disabilities
UNSDCF	United Nations Sustainable Development Cooperation Framework
US\$	United States Dollar
USAID	United States Agency for International Development
VFU	Victim friendly unit
WHO	World Health Organisation
YFHS	Youth friendly health services
ZDHS	Zimbabwe demographic and health survey
ZiG	Zimbabwe Gold
ZIMSTAT	Zimbabwe National Statistical Agency
ZNFPC	Zimbabwe National Family Planning Council
ZNAC	Zimbabwe National AIDS Council
ZUNSDCF	Zimbabwe United Nations Sustainable Development Cooperation Framework



Table 1: Key facts table - Zimbabwe

Indicators	Facts /Data value	Source /Year
Land		
Geographical location	Zimbabwe is a landlocked country located in Southern Africa, situated between the Zambezi and Limpopo Rivers. It borders South Africa to the south, Botswana to the southwest, Zambia to the north, and Mozambique to the east. Zimbabwe lies primarily between latitudes 15° and 23° South, and longitudes 25° and 34° East.	https://www.google.com/search?q=zimbabwe+geographical+location
Land area	390,757 square km	Zimbabwe National Statistical Agency (ZIMSTAT). Zimbabwe 2022 Population & Housing Census Report.
Demographics		
Total population size	15,178,957	ZIMSTAT. Zimbabwe 2022 Population & Housing Census Report.
Population size by sex composition	48% of the population are male and 52 % are female giving a sex ratio of 92 males per 100 females.	ZIMSTAT. Zimbabwe 2022 Population and Housing Census Report.
Population size by rural/urban	61.4% of the population live in the rural areas while 38.6% live in the urban areas.	ZIMSTAT. Zimbabwe 2022 Population and Housing Census Report.
Population growth rate	1.5%	ZIMSTAT. Zimbabwe 2022 Population & Housing Census Report.
Life expectancy at birth (disaggregated by sex)	64 years 68.2 years for females 61.3 years for males	ZIMSTAT. June 2024. 2022-2024 Zimbabwe Population Projections Report.
Under 5 mortality rate	69 deaths per 1,000 live births.	ZIMSTAT and ICF. Zimbabwe Demographic and Health Survey 2023–24: Key Indicators Report.
Human Development Index (HDI) index/rank	0.550 Ranked 146 th out 189 countries in world.	Zimbabwe UNDP Country Report 2024.
Gender Inequality Index (GII) index/rank	0.740 110 th out of 149.	UN Women 2022.
Young people		
Proportion of population aged 10-19 years	10-19 years: 23%. 10-24 years: 32%.	ZIMSTAT. Zimbabwe 2022 Population & Housing Census Report.



Country Programme Evaluation of GoZ /UNFPA 8th CP 2022-2026



Indicators	Facts /Data value	Source /Year
School attendance rate (disaggregated by sex; level of education e.g. primary, secondary)	Primary 90.5% (female: 91.5%; male: 89.6%). Secondary 44.5%. (female: 5%; male: 44%).	World Bank (2023) Zimbabwe Gender Assessment.
School completion rate (disaggregated by sex; level of education e.g. primary, secondary)	Primary - 91.4% (male: 90.0%; female: 92.9%) Lower secondary - 64.9% (male: 64.9%; female: 64.9%). Upper secondary – 10.6% (female: 11.0%; male: 10.2%). Tertiary education - 5.2%.	Government of Zimbabwe (2024). Report on the Education Performance Sector Review for 2023 and 2024. ECA (2024) Situation Analysis Report for Zimbabwe.
Teenage pregnancy rate (Proportion of women aged 15-19 years who have begun childbearing)	23%	Zimbabwe National Statistics Agency (ZIMSTAT) and ICF. Zimbabwe Demographic and Health Survey 2023–24: Key Indicators Report. Harare, Zimbabwe, and Rockville, Maryland, USA: ZIMSTAT and ICF.
Health and fertility		
Total fertility rate	3.9 children. 4.6 children among rural women. 3.1 children among urban women.	ZIMSTAT and ICF. Zimbabwe Demographic and Health Survey 2023–24: Key Indicators Report.
Adolescent birth rate	111 births per 1,000 women aged 15–19.	Zimbabwe Demographic and Health Survey Key Indicators Report 2023–24.
Contraceptive prevalence rate (modern methods)	70% 69% using a modern method 1% using a traditional method.	Zimbabwe Demographic and Health Survey Key Indicators Report 2023–24.
Unmet need for family planning (FP)	9%	Zimbabwe Demographic and Health Survey Key Indicators Report 2023–24.
Proportion of births attended by skilled health personnel	85%	Zimbabwe Demographic and Health Survey Key Indicators Report 2023–24.
Institutional deliveries	85%	Zimbabwe Demographic and Health Survey Key Indicators Report 2023–24.
Maternal mortality ratio	212 per 100,000 live births. 362 per 100,000 live births. 402 per 100,000 live births (rural). 298 per 100,000 live births - urban.	ZDHS Report 2023-24. ZIMSTAT. Zimbabwe 2022 Population and Housing Census Report.



Country Programme Evaluation of GoZ /UNFPA 8th CP 2022-2026



Indicators	Facts /Data value	Source /Year
HIV prevalence rate, 15-49 years (disaggregated by sex)	10.49% (9.74 – 11.22%) 13.0% among females. 7.9% among males.	AIDS and TB Programme Ministry of Health and Child Care 24 July 2024. Zimbabwe National HIV Estimates Report 2024.
HIV prevalence rate, 15-24 years (disaggregated by sex)	3.4% 2.76% (2.24 – 3.21%) among males. 3.99% (2.88 – 4.87%) among females.	AIDS and TB Programme Ministry of Health and Child Care 24 July 2024. Zimbabwe National HIV Estimates Report 2024.
Economic		
Gross National Income (GNI)	US\$29.08 billion.	World Bank Data 2023.
Gross domestic product (GDP) per capita	US\$62,501,252.	ZIMSTAT. September 25, 2024. Final Published GDP Tables 2019-2023 (2023 GDP at constant 2019 prices in US\$).
GDP growth rate	2.18%	ZIMSTAT Annual Growth Rate (Q3-2024). https://zimstat.co.zw/
Unemployment rate (by sex; rural/urban)	14.8% National strict unemployment rate. 45.0% Expanded unemployment rate. 11.8% among females. 19.3% among males. Rural/urban	ZIMSTAT. Zimbabwe 2022 Population and Housing Census Report.
Inflation rate	0.27%	ZIMSTAT March 2025. https://zimstat.co.zw/
Gini index	50.4	ZIMSTAT. Zimbabwe Poverty Update 2017-19
Major economic activity	Agriculture, fishing and forestry; mining and quarrying; Manufacturing; Wholesale and retail trade; and tourism.	ZIMSTAT. 27 December 2024. Presentation of Quarterly GDP at Constant Prices for Third Quarter, 2024.
Gender equality		
Proportion of women aged 20-24 years who were married or in a union before age 15 and before age 18 (child marriage)	34%	Zimbabwe MICS 2019.
Proportion of ever-partnered women and girls aged 15 - 49 who experienced physical violence by a current or former intimate partner in the previous 12	14%	ZIMSTAT, ZDHS 2023/24.



Indicators	Facts /Data value	Source /Year
months.		
Proportion of ever-partnered women (aged 15 - 49) who experienced sexual violence in the past 12 months.	5%	ZIMSTAT, ZDHS 2023/24.
Proportion of ever-partnered women (aged 15 -49) who experienced emotional violence by a current or former intimate partner in the past 12 months.	19%	ZIMSTAT, ZDHS 2023/24.

Executive summary

Overview of the context and intervention: In line with UNFPA Evaluation Policy 2024, the external evaluation of the Government of Zimbabwe/UNFPA 8th Country Programme 2022-2026 (8th CP) was conducted in 2025 (April to November) by a five-member independent evaluation team (ET), managed by the Country Office (CO) with close collaboration with the East and Southern Africa Regional Office (ESARO) Monitoring and Evaluation (M&E) Adviser. Zimbabwe is a lower middle-income country and as such the role of UNFPA is catalytic and to support the Government in the development programmes related to the UNFPA mandate. The Government of Zimbabwe (GoZ) drives the development agenda through policy formulation, strategy implementation, and the provision of essential services to its population. UNFPA, alongside other UN agencies, has adapted its approach to focus on technical support, capacity building, and policy advocacy. The 8th GoZ /UNFPA CP (2022-2026) was developed in collaboration with a wide range of stakeholders, including government departments at national and provincial levels, development partners, UN agencies, civil society organizations (CSOs), academia, and the private sector. The 8th CP supports the GoZ in addressing national priorities. The development of the 8th CP was informed by the Zimbabwe United Nations Sustainable Development Cooperation Framework (ZUNSDCF) (2022-2026), which aligns with the country's National Development Strategy 1 (NDS 1) 2020-2025. It also reflects lessons learned from previous programmes. The ZUNSDCF is a key framework outlining the support of the United Nations for Zimbabwe's development priorities. The 8th CP contributes to the UNFPA Global Strategic Plan (2020-2025) and supports the International Conference on Population Development Programme of Action (ICPD PoA).

Evaluation purpose, objectives and intended users: The purpose of the GoZ/UNFPA 8th Country Programme Evaluation (CPE) was to demonstrate accountability to stakeholders for the results achieved to; support evidence-based decision-making for programming; empower community, national and regional stakeholders; contribute important lessons learnt to the organization's knowledge base; and to provide independent inputs as well as actionable recommendations to the next UNFPA Zimbabwe CP cycle. The potential pathways for translating the key findings into actionable outcomes will include carrying out data-driven decision making; ensuring stakeholder engagement and participation; assessing institutional capacity and conducting capacity building plans; identifying potential partners and establishing partnership frameworks; developing innovative solutions; scaling up those solutions which are successful and establishing and implementing M&E frameworks. The audience and intended users of the CPE report includes key Government national and provincial departments in the five focus UNFPA supported provinces and others, development partners, including funders and UN agencies in the country as well as the UNFPA CO, ESARO, UNFPA headquarters, and the UNFPA Executive Board.

CPE scope and methodology: The scope of the CPE included national interventions and the geographical areas where the UNFPA Zimbabwe 8th CP was operational, namely the five focus provinces of Manicaland, Mashonaland Central, Mashonaland East, Matabeleland North and Midlands. The evaluation assessed key components such as integrated sexual and reproductive health and rights (SRHR) services, adolescents and youth (AY), gender equality and women's empowerment (GEWE), and population and development (PD). It also evaluated areas of coordination, M&E, innovation, resource mobilization, and strategic partnerships. The evaluation covered the period 2022 to April 2025 and aimed to assess both intended and unintended effects, draw some lessons as well as identify good practices. It was based on seven evaluation questions (EQs) premised upon the Organization for Economic Co-operation and Development-Development Assistance Committee (OECD-DAC) criteria, addressing relevance, coherence, effectiveness, efficiency, and sustainability. The CPE design was based on the 8th CP theory of change. It examined the casual linkages that drive programme results including assumptions), was gender-sensitive (recognized and responded to different needs of individuals based on their gender), was utilization-focused (prioritized the use of evaluation findings by stakeholders to inform decision-making) and was based on a contribution analysis (assessed the contribution of particular interventions to specific results). The evaluation followed seven evaluation questions based on five OECD criteria. The ET used purposive and convenience sampling within a mixed methods framework to select participants for the CPE based on the stakeholders' mapping provided by the CO. Data collection involved reviewing primary and secondary sources, including 8th CP-related publications, research, M&E reports, and financial and operational systems. Additional methods included structured and semi-structured interviews (in-person, phone, online), focus group discussions (FGDs), analysis of numerical data, field observations, and workshops. To mitigate biases, subjectivity, and limited representativeness in the sampling approach, the ET used data triangulation, participant validation, peer debriefing, and sample size expansion. Initially, the stakeholder map identified 85 key informant individuals, of whom 80



were approached for interviews representing a 95 percent response rate. However, the evaluation's field visits engaged a broader group, resulting in a total of 268 participants (59 percent women and 41 percent men), which was good to have more views and insights captured about the programme interventions. The ET had requested implementing partners (IPs) to include in FGDs community beneficiaries from vulnerable groups, such as people with disabilities (PWDs) and those identified as Lesbian, Gay, Bisexual, Transgender, Queer, Intersex and Others (LGBTQI+) individuals. The PWDs attended and participated actively in FGDs as well as key informant interviews (KIIs). The evaluation adopted an inclusive, participatory approach, engaging diverse partners and ensuring gender balance. Interviewed stakeholders included national and provincial government departments and agencies (49 per cent), programme beneficiaries (19 per cent), UNFPA staff at the CO and ESARO (12 per cent), civil society organizations and academia (ten per cent), and UN agencies and development partners (eight per cent). Two per cent of the respondents were PWDs. The ET followed the UN Norms and Standards for Evaluation, ensuring compliance with international standards. The team sought respondent consent, maintained confidentiality, safeguarded sensitive information, avoided bias, and was sensitive to discrimination issues. It prioritized inclusion, involving marginalized groups such as PWDs and those identified as LGBTQI+, upheld dignity and diversity, and was committed to avoiding harm throughout the evaluation process.

Summary of the most significant findings

Relevance: The UNFPA has successfully positioned itself within Zimbabwe's national development and policy space by proactively aligning its 8th CP with key national frameworks and adapting its strategies to address the needs of vulnerable populations, including emerging issues. All government stakeholders consulted (72 percent women, 28 percent men) at national and provincial levels unanimously affirmed the high relevance of UNFPA's 8th CP to Zimbabwe's policies, including the NDS 1 2020-2025, ZUNSDCF, UNFPA's mandate, and international commitments. Through document review, the 8th CP was deemed to be contributing directly to Sustainable Development Goal (SDG) 1 (No poverty), 3 (Good health and well-being), 5 (Gender equality), 10 (Reduce inequalities), 16 (Peace, justice and strong institutions) and 17 (Partnership for the goals). The interventions aligned with ICPD priorities, the 2030 SDG Agenda, and UNFPA's Strategic Plan 2022-2025 for the three transformative results of ending unmet need for family planning (FP), ending preventable maternal deaths, ending gender-based violence (GBV), and the UNFPA ESARO fourth transformative result of ending sexual transmission of HIV. UNFPA pro-actively positioned itself to bring value within the national development/policy space and adapted to changes that have taken place. It employed novel ways and advanced its influence through strategic partnerships, visibility, and thought leadership. It built strong networks with UN agencies, civil society, and government stakeholders, enhancing trust and credibility. UNFPA operates in a competitive policy environment with many actors supporting the GoZ but maintains influence through mutual respect, dialogue, and collaboration with all stakeholders involved. At the upstream level, UNFPA Zimbabwe positioned itself strategically in the national policy space through sustained engagement with the Ministry of Health and Child Care (MoHCC), Ministry of Finance, Economic Development and Investment Promotion (MoFEDIP), Ministry of Women Affairs, Community, Small and Medium Enterprises Development (MWACSMED), Ministry of Primary and Secondary Education (MoPSE), and collaboration with UN agencies. It provided technical support in developing and operationalizing key policies and strategies aligned with the NDS1. UNFPA's downstream interventions advanced national priorities, the SDGs, and human rights through inclusive SRH services, youth engagement, and GBV response. The PD component strengthened statistical systems via training, technology, and coordination. Nonetheless, the next CP should align with the upcoming UNFPA Strategic Plan (2026–2030) and NDS 2 (2025–2030). Outdated policies like the National Population Policy, and the Census Act require review. Due to LGBTQI+ restrictions in the country, UNFPA support to key populations (KPs) was hindered. Partners also sought clearer guidance on disability, emerging issues like climate change, mental health, and adolescent challenges.

Coherence: With respect to coherence, the 8th CP demonstrated strong coherence by integrating SRHR and GBV into the adolescents and young people (AYP) interventions, fostering synergy in service delivery and data use for decision-making. UNFPA Zimbabwe has to a large extent strategically cultivated a wide range of partnerships at national, provincial and district levels, significantly enhancing the delivery and reach of its 8th CP, particularly among vulnerable and marginalized populations thereby leaving no one behind (LNOB). UNFPA promoted cross-programme collaboration, supported LGBTQI+ and youth-friendly services, and strengthened youth participation through CSOs and budget consultations. Coordination with the CO's PD and M&E units enhanced data use, programme performance, and evidence-based policymaking. The evidence-based programming by UNFPA used national data [Zimbabwe Demographic Health Survey (ZDHS), Multiple Indicator Cluster Survey (MICS) 2019, District Health Information System



(DHIS2)] to programme interventions. UNFPA Zimbabwe plays a key role in strengthening national data systems, chairing the UN Data for Development and Innovation Technical Working Group (TWG) and closely collaborating with the Zimbabwe National Statistical Agency (ZIMSTAT). While progress has been made, challenges persist in optimizing data use for AYP. Issues include siloed service delivery, gaps in DHIS2, legal constraints on LGBTQ+ outreach, rising adolescent pregnancies despite comprehensive sexuality education (CSE), limited youth data, and inconsistent disability inclusion, underscoring the need for better coordination and integrated approaches. UNFPA's leadership has fostered office team cohesion and external cooperation. However, coordination challenges at the implementation level and slow responses to emerging issues still require more agile, adaptive strategies. UNFPA CO played a vital role in strengthening UNCT coordination mechanisms by leveraging its comparative advantage and holding key leadership positions across committees, TWGs, and joint initiatives. Its leadership in advocacy and coordination was widely acknowledged. UNFPA is an active member of the Programme Management Team and a key implementer of the United Nations Sustainable Development and Cooperation Framework (UNSDCF).

Effectiveness: Under the SRHR component, UNFPA Zimbabwe strategy on SRHR has to a large extent achieved the intended outcomes for the different target groups ensuring that no one is left behind and particularly the increased access to and use of integrated sexual and reproductive health (SRH) services. While output-level indicators are expected to be fully achieved by the end of the programme cycle, outcome-level indicators remain only partially met, though FP data showed a positive trend. Nationally, 87 per cent of FP demand was met with modern methods, which is above the UNFPA transformative result target of 70 per cent. Notably, through UNFPA and partners' advocacy efforts to the GoZ, a matched funding arrangement was established for reproductive health (RH) commodities. This partnership marked a significant advancement in strengthening domestic financing and enhancing sustainability in the procurement of RH commodities across the country. UNFPA provided critical support that led to significant improvements in SRH in Zimbabwe. Health facility capacity to deliver emergency obstetric and newborn care (EmONC) increased, resulting in more skilled birth attendance (SBA) and fewer labour complications. Fistula treatment exceeded targets, reaching 110 per cent of planned beneficiaries. Facilities were equipped to offer modern FP services, with contraceptive availability enhanced through the rollout of the electronic Logistics Management Information System (eLMIS). Functional Maternal and Perinatal Death Surveillance and Response (MPDSR) systems were established nationally and sub-nationally, improving maternal and neonatal death reporting by midwives. Midwifery training in 22 schools strengthened capacities for integrated SRH services. However, persistent human resource challenges, including high staff attrition and limited MoHCC capacity, delayed implementation of SRHR interventions.

Regarding the Adolescent and young people (AYP) component, the UNFPA Zimbabwe strategy for AYP has largely achieved its goals, effectively reaching diverse target groups. It has promoted inclusivity and empowered the youth to access SRHR, ensuring no one is left behind in exercising these fundamental rights. The programme fully met both output indicators, scoring over 100 per cent, though these focused on reach rather than behaviour change, an area for improvement in the next CP. The programme significantly boosted youth participation, expanded access to CSE, and improved adolescent SRH services. It reached millions via schools, media, universities, and health fairs, with 90 per cent of supported facilities certified youth-friendly. Key innovations included the "Not in My Village" campaign and youth desks in Government ministries. Targeted support for vulnerable groups promoted equity, but challenges remain around community norms, youth economic empowerment, and an unintended consequence of GoZ raising the age of consent to 18 years, which complicates health workers' ability to serve adolescents under that age with SRHR services.

With regards the GEWE component, the UNFPA Zimbabwe strategy on GBV has largely contributed to the advancement of gender equality and the empowerment of all women and girls making sure that no one is left behind. The 8th CP significantly strengthened GBV prevention, response, and capacity-building systems in Zimbabwe. The contribution of the output to the outcome is deemed optimal since two indicators (50 per cent) have been achieved, and one indicator (25 per cent) is most likely to be achieved before the end of the CP. The output indicator target for survivors of GBV who received at least one essential service (social services, health, police or justice) was overachieved (108 per cent). Similarly, the target for women, men, girls and boys reached with community programmes to promote gender-equitable norms, attitudes and behaviours, including concerning women's and girls' sexuality and reproduction was also overachieved (101 per cent). Through strategic partnerships with Government ministries, humanitarian actors, academia, and civil society, the 8th CP expanded survivor access to timely, comprehensive, and rights-based GBV services. Humanitarian responses demonstrated adaptability and coordination, ensuring service continuity despite significant disruptions. Overall, the outputs delivered to-date demonstrate a strong contribution to



GEWE outcomes, particularly in improving access to survivor-centred services, promoting positive gender norms, and laying the groundwork for sustainable system-wide change.

Under the PD component, the UNFPA Zimbabwe strategy on PD has largely met its objectives across various target groups, promoting inclusivity and ensuring no one is left behind. It has notably enhanced the use of population data in formulating evidence-based national development plans, policies, and programmes. The contribution of the output to the outcome was deemed optimal since two indicators (50 per cent) out of four had been fully achieved (score of 100 per cent) and one indicator was most likely to be achieved by the end of the programme cycle. Under the 8th CP, UNFPA supported key data initiatives, including the 2022 Population and Housing Census (PHC), the 2023/24 Zimbabwe Demographic Health Survey (ZDHS) and preparations for the MICS. By 2024, 15 out of the targeted 26 in-depth analytical reports (58 per cent) had been completed using data from various surveys. An interactive data platform was launched, featuring indicators on transformative results, the SDGs, and NDS1. As a result, the proportion of SDG indicators with current data increased from 65 per cent in 2020 to 85.5 per cent by 2025. Upholding the “LNOB” principle, UNFPA and ZIMSTAT included the Washington Group disability questions in the 2022 Census and 2023/24 ZDHS, ensuring representation of PWDs.

Efficiency: By the end of March 2025, a total of US\$39.92 million had been mobilized across all outputs and of which US\$28.54 million was spent, which represented a utilization rate of 71 per cent. The UNFPA administrative and financial systems for the 8th CP were largely adequate and functional. The evaluation confirmed that UNFPA’s resource management systems were efficiently implemented and aligned with established procedures, supporting timely programme delivery. UNFPA demonstrated strong financial and administrative systems, with fast-tracked processes enabling effective humanitarian response. Regular work plan reviews, partner reporting, and routine audits of IPs ensured quality, accountability, and transparency. However, all IPs and provincial stakeholders reported fund transfer delays of three to six months, which hindered timely activity implementation. Systemic inefficiencies also arose from high staff attrition among nurses and midwives at provincial and district health facilities, leading to service disruptions and repeated training. Despite these issues, the professionalism and technical expertise of UNFPA staff were highly praised across all programme outcome areas. Capacity-building efforts and a functional M&E system further strengthened implementation of the interventions. UNFPA’s adaptation of its reporting to the UNFPA Strategic Plan enabled better alignment of thematic outputs with transformative results, fostering a more integrated, cross-cutting programme approach.

Sustainability: With respect to sustainability, the evaluation found satisfactory ownership of UNFPA-supported interventions and those of the respective national and provincial governments. The GoZ used the existing institutional structures at national and sub-national level to promote sustainability. However, some interventions such as fistula repair and support to fistula survivors, which require heavy funding were deemed not sustainable without continued external financial support. The One Stop Centre (OSC) model combines government support, donor funding, and civil society partnerships. However, uneven infrastructure, staffing, and coordination of OSCs often led to inconsistent service quality, which was largely attributed to inadequate funding from the Government. The evaluation revealed that there are no documented sustainability plans between UNFPA and the various Government ministries, which constrain long-term sustainability. However, it was noted that there was ongoing work related to OSCs to be completed by the end of 2025.

Main conclusions

Strategic level:

Conclusion 1: The UNFPA 8th CP was highly relevant to Zimbabwe’s national development priorities, sectoral needs, and aligned to government policy as well as UNFPA and the international development agenda.

Conclusion 2: UNFPA 8th CP addressed the needs of stakeholders and beneficiaries including vulnerable and marginalized populations considering the issue of disability, human rights and gender. The programme adapted to emerging issues like COVID-19, humanitarian needs, substance abuse, and teenage pregnancies. However, UNFPA recognized limited support for KPs amid LGBTQI+ restrictions and noted the need for stronger guidance to IPs on structured disability inclusion.

Conclusion 3: The strategic relationships between UNFPA and with government ministries (such as MoPSE, MWACSMED, and MoHCC), UN agencies (including UNICEF, WHO, and UNESCO), CSOs [such as SAYWHAT,



Young People's Network for Health and Wellbeing (YPNHW), and Population Services Zimbabwe (PSZ)], and other development partners facilitated co-created policies, joint planning, and coordinated programme implementation. However, some coordination gaps remain which constrain timely responsiveness to emerging issues.

Conclusion 4: UNFPA and its partners' advocacy to the GoZ for a matched funding arrangement marked significant progress in strengthening domestic financing and sustainability for RH commodities. However, the continued reliance on donor support for RH/FP commodity procurement limits the long-term sustainability of GoZ's funding efforts, underscoring the need for increased domestic investment.

Conclusion 5: UNFPA possesses a strong financial management and tracking system that supports programmatic and financial accountability. The introduction of the UNFPA global Quantum system in 2024 (a financial management system) was a move in the right direction. However, persistent delays between fund requisitions by IPs and UNFPA disbursements, coupled with IPs' limited absorptive capacity, hinder timely and high-quality implementation of interventions.

Conclusion 6: The UNFPA investment in its human resources and technical assistance (TA) is a major driver of programme success and efficiency. The well-staffed UNFPA CO delivered strong technical support, but systemic challenges like high attrition of IPs' key personnel such as nurses, midwives and GBV case managers hindered impact and sustainability of services, requiring repeated training.

Programmatic level

Conclusion 7: UNFPA's integrated approach at tertiary academic institutions combined mobile health services with CSE, addressing SRH, HIV, and GBV. Evidence-based targeting and youth participation ensured interventions were data-driven, relevant, and aligned with young people's needs and priorities. Limited economic empowerment integration, barriers to reaching LGBTQI+ populations, and inconsistent inclusion of youth with disabilities were key challenges.

Conclusion 8 (SRH): UNFPA support to MoHCC for health facilities to provide EmONC is critical in reducing maternal and newborn deaths. Though SBA improved, low-quality obstetric care in some facilities led to complications and deaths. Inadequate equipment and supplies limited full implementation of EmONC signal functions in some health facilities.

Conclusion 9 (SRH): The current approach for addressing obstetric fistula through treatment camps has achieved results but it is not sustainable due to the substantial financial resources required. In addition, limited attention has been given to the re-integration of fistula survivors. Obstetric fistula treatment camps reduced the backlog, but few survivors were reintegrated, highlighting the need for support to restore their dignity in society.

Conclusion 10 (AYP): UNFPA Zimbabwe's AYP strategies significantly empowered adolescents and young people by strengthening their voices, enhancing access to CSE and youth-friendly SRH services, and fostering policy engagement through institutionalized youth-led initiatives and government partnerships.

Conclusion 11 (AYP): UNFPA embraced technology to extend the reach of CSE among adolescents and young people. However, the operating landscape has a significant number of mobile applications offering inconsistent CSE which poses a risk for misinformation.

Conclusion 12 (GEWE): The 8th CP improved access to survivor-centred GBV care by establishing OSCs, mobile units, and safe spaces, overcoming geographic and social barriers. It ensured inclusivity by targeting vulnerable groups, including women and girls with disabilities, aligning with "LNOB" principle. However, sustaining these services over time, particularly in under-resourced provinces, remains a significant challenge.

Conclusion 13 (GEWE): Economic empowerment and livelihood support interventions under the 8th CP significantly enhanced the resilience and autonomy of GBV survivors. Combining economic and social support strengthened survivor agency and well-being, although sustaining these gains and ensuring equitable access across all communities remains a challenge.

Conclusion 14 (GEWE): Under the 8th CP, UNFPA, in collaboration with the Council of Social Workers and academic institutions, supported the development of a GBV case management curriculum, marking a significant step toward



institutionalizing GBV interventions. Once approved and implemented, this curriculum has the potential to build a skilled and consistent workforce, standardize GBV service delivery, and strengthen the evidence base for programming. .

Conclusion 15 (PD): UNFPA 8th CP strengthened the capacity of the national statistical system (NSS) to produce, analyze and use disaggregated population data to inform policy decision-making and development programming, including in humanitarian situations. Capacity development is a continuous process and ZIMSTAT's strengthening will persist through future censuses, ZDHS, MICS, and other surveys. With the revised Census and Statistics Act empowering ZIMSTAT to coordinate administrative data collection, ongoing support is essential to enhance the NSS's capacity and ensure effective data management.

Conclusion 16 (PD): Data disaggregation has improved over the years. UNFPA and ZIMSTAT increased efforts to provide disaggregated data. The disaggregation of census data by sex, age, disability (the Washington questions on disability incorporated in census), and geographic location right up to the lowest administrative level facilitates the realization of government's policy thrust of "leaving no one and no place behind". While data disaggregation by disability has improved in the census and ZDHS, significant gaps remain, particularly within MoHCC tools such as DHIS2, which are not yet configured to capture data on PWDs. This limits the availability of disability-related data. Key indicators like maternal mortality in ZDHS lack district-level disaggregation, limiting localized analysis, as sampling was adequate at provincial level, with only the census covering districts.

Conclusion 17 (PD): The promotion and support by UNFPA for the use of new technologies in data collection, analysis and dissemination was effective. Key digital innovations included: (i) Computer Assisted Personal Interviewing (CAPI) for ZDHS and census; (ii) GBV Information Management System (IMS); (iii) electronic Logistics Management Information System (eLMIS), supporting MoHCC's commodity and drug distribution; (iv) the WHO-supported Digital Adaptation System for collecting non-DHIS 2 indicators; and (v) the 'Impilo' app, designed to work alongside the Impilo Platform. However, the evaluation highlighted that the MoHCC system remains largely paper-based and does not capture all necessary indicators. The evaluation revealed that some hospital staff were yet to receive training on electronic health records. Additionally, misalignment between M&E tools and reporting frameworks, due to asynchronous review timelines, has caused data inconsistencies, particularly in areas such as ante-natal care (ANC) and the Mother/Baby Pair registers. While CAPI improved timeliness, census and ZDHS data were sent directly to the national server, preventing Field Supervisors and Provincial Managers from reviewing and ensuring data quality beforehand.

Key recommendations

The ET prioritized strategic and programme recommendations and indicated their priority (High/medium/low). The prioritization framework used: (i) High: Demands prompt attention to address a significant issue or opportunity; (ii) Medium: Requires attention within a moderate timeframe to address a notable issue or opportunity; (iii) Low: Can be addressed at a later time, as the consequences of delay are minimal. The recommendations were developed having in mind the needs and roles of the different stakeholders such as government, UN agencies, UNFPA and funders. For each recommendation, the responsible parties and operational implications have been indicated in the main report.

Strategic level

Recommendation 1: In close collaboration with relevant local and community actors, UNFPA should reinforce its strategy that focuses more on the most in-need and vulnerable populations. (**Priority: High**)

Recommendation 2: UNFPA should strengthen and streamline strategic partnerships with government ministries, UN agencies, CSOs, academic institutions, and development partners to improve coordination, responsiveness, and collective impact of GEWE, SRHR, GBV, and AYP interventions. A more structured and adaptive partnership framework is needed to address coordination gaps and ensure timely responses to emerging issues. (**Priority: High**)

Recommendation 3: UNFPA and partners should continue to advocate to the government at the national levels to make adequate annual budgetary allocations for SRH/FP and GBV services. The documented sustainability plans should show increasing annual government amounts matched with decreasing UNFPA/donor funds. (**Priority: High**)



Recommendation 4: UNFPA should continue to strengthen the technical capacity of implementing partners (IPs) particularly in financial reporting and accountability in order to improve timely reporting and fund absorption. **(Priority: High)**

Recommendation 5: To mitigate high staff turnover in key sectors, UNFPA should integrate sustainable capacity-building and retention strategies into partnership agreements. This includes scaling up "train-the-trainer" programmes, investing in digital learning platforms, integration in and enhancement of GBV and SRHR related modules in pre-service curriculum for midwives, nurses, social workers, police, judiciary et cetera and promoting non-monetary incentives and professional development. Strengthening institutional capacity in the health, social, and legal sectors ensures knowledge continuity, enhances partner resilience, and maximizes the long-term impact of TA from UNFPA. **(Priority: High)**

Programmatic level

Recommendation 6: UNFPA should enhance coordination mechanisms among IPs to promote "one-stop shop" models for young people that strengthen linkages with economic empowerment. Greater effort is needed to ensure LNOB is fully integrated in the UNFPA strategy and programmes. This will ensure AYP programmes are comprehensive and responsive to intersecting vulnerabilities. **(Priority: Medium)**

Recommendation 7: UNFPA should actively engage MoHCC to set operational standards in all health facilities carrying out EmONC in order to ensure high quality of obstetric care. In addition, UNFPA should continue to advocate to MoHCC to provide and maintain essential equipment and sundries for EmONC in facilities. **(Priority: Medium)**

Recommendation 8: UNFPA should advocate to MoHCC for fistula repair to be integrated into other routine health services and more attention should be given to the scaling up of the re-integration of fistula survivors in the general community. **(Priority: Medium)**

Recommendation 9: UNFPA and partners should support the development and national adoption of a unified, well-integrated "super SRH app" that consolidates all CSE information and digital platforms for young people. This centralized platform would enhance access, improve user experience, and reduce confusion caused by fragmented digital platforms, leveraging digitalization as an accelerator for impact. **(Priority: Medium)**

Recommendation 10: At the strategic level, UNFPA should continue to support Government ministries in integrating gender-responsive GBV and GEWE priorities into national policies and budgets. They should further enhance the GBV Coordination Forum at national, provincial and district level. At the programmatic level, UNFPA should advocate and provide TA to strengthen institutional capacity at service delivery points, including OSCs, mobile OSCs, and community-based mechanisms, to ensure accessible, comprehensive, and survivor-focused GBV prevention and response services. **(Priority: Medium)**

Recommendation 11: UNFPA should continue to support GBV survivors through programmes like livestock rearing, sewing, small-scale farming cooperatives, and other livelihood initiatives, combined with ongoing social and psychosocial support. **(Priority: High)**

Recommendation 12: UNFPA should continue to formalize partnerships with academic institutions and CSOs to include GBV response into their curricula, research, and practice for long-term sustainability. **(Priority: High)**

Recommendation 13: UNFPA should enhance efforts to adequately define the legal and institutional framework that empowers ZIMSTAT to systematically collect, harmonize, and integrate administrative data into official statistics in Zimbabwe. **(Priority: High)**

Recommendation 14: UNFPA is encouraged to further strengthen data disaggregation by sex, age, disability, and geographical area in all data collection processes to demonstrate inclusivity. **(Priority: High)**

Recommendation 15: UNFPA should scale up existing technical support to ZIMSTAT for expanding integrated data systems, enhancing interoperability, and broadening the reach and functionality of dashboards and mobile apps to increase accessibility and use of data, particularly census and SRHR-related indicators. **(Priority: High)**



CHAPTER 1: INTRODUCTION

1.0 Purpose and objectives of CPE

In line with the 2024 UNFPA Evaluation Policy,¹ the UNFPA Zimbabwe CO commissioned the CPE of the 8th CP of Assistance to the GoZ to enhance UNFPA's accountability for results and analyze the relevance and performance of the 8th GoZ/UNFPA CP for Zimbabwe (2022-2026). The CPE served four main purposes namely: (i) oversight and demonstrate accountability to stakeholders on performance in achieving development results and on invested resources; (ii) support evidence-based decision-making to inform development, humanitarian response and peace-responsive programming; (iii) aggregating and sharing good practices and credible evaluative evidence to support organizational learning on how to achieve the best results; and (iv) empowering community, national and regional stakeholders.

The CPE was scheduled for 2025 to ensure that the UNFPA CO meets the Evaluation Policy requirement of conducting a CPE once every programme cycle.² The evaluation had a clear forward-looking approach. In terms of its recommendations, the CPE focused on the opportunities for informing the development of the next CP cycle, including its programmatic strategies and implementation approaches, in line with changing national and international contexts as well as any adaptations required in terms of management arrangements for enhanced programme implementation.

Objectives: The objectives of the CPE as contained in the terms of reference (TOR) were the following:³ (i) to provide the UNFPA Zimbabwe CO, national stakeholders and rights-holders, the UNFPA ESARO, UNFPA Headquarters as well as a wider audience with an independent assessment of the UNFPA Zimbabwe 8th CP (2022- 2026) (ii) to broaden the evidence base to inform the design of the next programme cycle. The specific objectives were:

- To provide an independent assessment of the relevance, coherence, efficiency, sustainability, and effectiveness of UNFPA support, clearly articulating the achievements versus targets of the 8th CP
- To provide an assessment of the geographic and demographic coverage of UNFPA humanitarian assistance and the ability of UNFPA to connect immediate, life-saving support with long-term development objectives
- To provide an assessment of the role played by the UNFPA Zimbabwe CO in the coordination mechanisms of the United Nations Country Team (UNCT), with a view to enhancing the United Nations collective contribution to national development results
- To draw key conclusions from past and current cooperation and provide a set of clear, forward-looking and actionable recommendations for the next programme cycle.

Audience: The main audience and primary intended users of the evaluation are the following: (i) The UNFPA Zimbabwe CO; (ii) the GoZ; (iii) IPs of the UNFPA Zimbabwe CO; (iv) rights-holders involved in UNFPA interventions and the organizations that represent them (in particular women, adolescents and youth); (v) the UNCT; (vi) UNFPA ESARO; and (vii) donors. The evaluation results will also be of interest to a wider group of stakeholders, including (i) UNFPA headquarters divisions, branches and offices; (ii) the UNFPA Executive Board; (iii) academia; and (iv) local civil society organizations (CSOs) and international NGOs (INGOs).

1.2 Scope of the evaluation

1.2.1 Thematic scope [evaluation questions (EQs) with assumptions for verification]

The evaluation systematically used five OECD-DAC evaluation criteria namely:⁴ relevance, coherence, effectiveness, efficiency and sustainability.⁵ The ET reviewed and adopted the set of seven key EQs. The ET formulated assumptions

¹ UNFPA, UNFPA Evaluation Policy, Driving evidence-based actions, Delivering rights and choices for all, New York, 2024.

² UNFPA, UNFPA Evaluation Policy, Driving evidence-based actions, Delivering rights and choices for all, New York, 2024 (page 41).

³ Zimbabwe Terms of Reference for CPE final.

⁴ UNFPA Evaluation Office. (2024). Evaluation Handbook. How to Conduct a Country Programme Evaluation at UNFPA. Available at: www.unfpa.org/EvaluationHandbook

⁵ The DAC Principles for the Evaluation of Development Assistance. OECD (2000).



presented below for verification for each EQ that constitutes the hypothesis tested through data collection and analysis to answer the EQs as shown in Table 2. The EQs were unpacked and linked to corresponding assumptions, indicators, data sources and data collection methods and tools, which are indicated in the evaluation matrix (Annex 1).

Table 2: Evaluation criteria, evaluation questions and assumptions

EQ	Assumptions from the evaluation matrix
Relevance	
EQ 1: To what extent has UNFPA positioned itself within the national development/policy space and adapted to changes that have taken place, and strategies that it has taken to assist efforts on addressing the needs of vulnerable and marginalized populations taking into account the issue of disability, human rights and gender including emerging issues such as new diseases, drug abuses and challenges brought about by climate change?	<p>Assumption 1.1: The UNFPA Zimbabwe positioned itself within the national development/policy space and adapted to changes that took place.</p> <p>Assumption 1.2: The UNFPA Zimbabwe had strategies to assist efforts on addressing the needs of vulnerable and marginalized populations taking into account the issue of disability, human rights and gender.</p> <p>Assumption 1.3: The UNFPA Zimbabwe had strategies to assist efforts on addressing the needs of vulnerable and marginalized populations taking into account emerging issues such as new diseases, drug abuses and challenges brought about by climate change.</p>
Coherence	
EQ 2: To what extent have the different components of 8 th CP SRHR, GBV, adolescent and young people (AYP)] been integrated to ensure synergies in addressing SRHR issues, adolescents and youth, GBV and use of data for decision making?	Assumption 2.1: The different components of 8 th CP (SRHR, GBV, AYP) were effectively integrated to ensure synergies in addressing SRHR issues, adolescents and youth, GBV and use of data for decision making.
EQ 3: To what extent has UNFPA worked with stakeholders and leveraged strategic partnerships at all levels (national, provincial and district) and development partners and ensured that no one is left behind?	Assumption 3.1: The UNFPA Zimbabwe effectively worked with stakeholders and leveraged strategic partnerships at all levels (national, provincial and district) and development partners and ensured that no one is left behind.
EQ 4: To what extent has UNFPA contributed to the functioning of various coordination mechanisms such as UNCT, GBV Sub Cluster, Youth Networks, SRH technical working group (TWG), M&E TWG, Data for Development and Innovation TWG and other coordination mechanisms in the country?	Assumption: 4.1 UNFPA Zimbabwe played a significant role in strengthening and supporting various coordination bodies within the country, including the UNCT, GBV Sub-Cluster, Youth Networks, SRH TWG, M&E TWG, Data for Development and Innovation TWG, and other related forums.
Effectiveness	
EQ 5: To what extent has UNFPA Zimbabwe strategies on SRHR, GBV, AYP and PD achieved the intended outcomes for the different target groups making sure that no one is left behind? In particular: (i) increased access to and use of integrated SRH services.	Assumption 5.1: UNFPA Zimbabwe strategies on SRHR, GBV, AYP and PD successfully achieved the intended outcomes (i.e. reducing unmet need for FP and reducing preventable maternal deaths; and reducing GBV and harmful practices) for the different target groups making sure that no one is left behind and in particular the increased access to and use of integrated SRH services.
EQ 5: To what extent has UNFPA Zimbabwe strategies on SRHR, GBV, AYP and PD achieved the intended outcomes for the different target groups making sure that no one is left behind? In particular: (ii) empowerment of adolescents and youth to access SRH services and exercise their SRHR? (iii) advancement of gender equality and the empowerment of all women and girls?	Assumption 5.2: UNFPA Zimbabwe ensured that comprehensive, gender-sensitive, high-quality rights-based Adolescent Sexual and Reproductive Health (ASRH) services are in place and accessible with a focus on AYP to exercise their SRHR.
(iv) increased use of population data in the	Assumption 5.3: UNFPA Zimbabwe strategies on GBV, successfully achieved the intended outcome (i.e. ending GBV and harmful practices) for the different target groups making sure that no one is left behind and in particular advancement of gender equality and the empowerment of all women and girls.



EQ	Assumptions from the evaluation matrix
development of evidence-based national development plans, policies and programmes?	Assumption 5.4: UNFPA Zimbabwe strategies on PD achieved the intended outcomes for the different target groups making sure that no one is left behind in particular the increased use of population data in the development of evidence-based national development plans, policies and programmes.
Efficiency	
EQ 6: To what extent has UNFPA Zimbabwe used resources at its disposal efficiently to achieve the planned results following laid down policies and procedures of UNFPA and the GoZ?	<p>Assumption 6.1: The IPs received UNFPA financial and technical support as planned and in a timely manner, and UNFPA was able to mobilize appropriate resources in a timely manner to support the implementation of the 8th CP.</p> <p>Assumption 6.2: UNFPA Zimbabwe followed the laid down policies and procedures (administrative, procurement and financial) of UNFPA and the GoZ, which led to the efficient achievement of programme outputs and outcomes.</p>
Sustainability	
EQ 7: To what extent has UNFPA supported the establishment of local accountability and oversight systems to ensure sustainability and continuation of programmes that it is implementing?	Assumption 7.1: UNFPA supported the establishment of effective local accountability and oversight systems to ensure sustainability and continuation of programmes that it was implementing.

As part of several of the EQs, issues of vulnerability, inequality and the SDG principle of ‘LNOB/reaching the furthest behind’ were included. These focused on women, adolescent girls, young people, PWDs, people living with HIV and AIDS, KPs such as LGBTQI+ and sex workers as well as combinations of vulnerabilities. The application of a human rights-based and gender transformative approach was part of the evaluation. Besides the assessment of the intended effects of the programme, the CPE analyzed unintended effects of the programme, including positive changes as well as eventual negative and unwanted effects of interventions.

CP thematic areas: The thematic areas of the 8th CP covered by the CPE were the following: (i) SRHR; (ii) AYP; (iii) GBV and HP; (iv) PD. In addition, the evaluation covered cross-cutting issues, such as adherence to human rights; gender equality; disability inclusion, and transversal functions, such as coordination; M&E; innovation; resource mobilization and strategic partnerships. The specific EQs are listed at the beginning of each section under the findings and the assumptions for assessment are documented in the evaluation matrix in Annex 1.

Geographic coverage: The 8th CP was operational in five focus provinces namely Manicaland, Mashonaland Central, Mashonaland East, Matabeleland North and Midlands.

8th CP budget: The CPE covered assistance funded both from UNFPA’s core resources as well as non-core resources and UNFPA’s use of resources jointly mobilized with other United Nations agencies. By the end of March 2025, UNFPA had committed US\$39.92 million to support the GoZ under its 2022-2026 assistance programme. Details on the allocation of these funds for the initial four years are outlined in Section 3.2.3 of the report.

Main partners: According to the stakeholder map,⁶ the main partners of UNFPA Zimbabwe include (a) government ministries namely MoFEDIP; MoHCC; MWACSMED; MoPSE; Ministry of Public Service Labour and Social Welfare (MoPSLSW); Ministry of Justice, Legal and Parliamentary Affairs (MoJLPA); and Ministry of Local Government, Public Works and National Housing (MoLGPWNH); (b) government development agencies such as Judicial Services Commission, ZIMSTAT, Zimbabwe Youth Council (ZYC), and Zimbabwe National AIDS Council (ZNAC); (c) Non-governmental organizations (NGOs) such as Plan international, World Vision, Population Services Zimbabwe (PSZ), SAYWHAT, Musasa, Zimbabwe Cricket Association and Council of Social Workers; (d) academic institutions such as universities (University of Zimbabwe, Manicaland State University of Science, Great Zimbabwe University, Midlands State University and National University of Science and Technology) and teachers’ colleges (Mutare Teachers’ College,

⁶ Annex 5: Stakeholder map.



Hillside Teachers' College and Harare Institute of Technology) among others; (e) other UN partners such as UNICEF, UN Women, WHO, UNDP, UNHCR, UNESCO, FAO and OCHA; (f) development partners such as FCDO, EU, Irish AID, SIDA, World Bank, Government of Japan and Government of Sweden, and (g) rights holders (e.g., women, girls, PWDs). The partners' interests and needs, power and influence, and potential impact are indicated below in Table 3. Interviews with CO staff and partners revealed that UNFPA made a proactive approach to recognize partners' interests and needs, their power and influence, and the potential impact on the CP and themselves so that any negative impact on both sides is minimized.

Table 3: Partners of UNFPA Zimbabwe

Category of partners	Interests and needs	Power and influence (1-5 rating, 1=low, 5=high)	Potential impact
GoZ ministries, departments and agencies	Policy implementation, service delivery, economic development; effective programme execution and capacity building.	Policy influence, regulatory authority and funding allocation. (5)	High impact on policy implementation, service delivery, and economic development.
NGOs	Social impact, empowering communities, advocacy and policy change; capacity building, funding, networking and partnerships.	Influence and credibility, community connections, expertise and knowledge of specific issues. (5)	NGOs can significantly impact project success and have a strong interest in its outcome.
UN agencies and development partners	Financial support, capacity building, sustainable impact; regular updates, transparency and accountability.	Funding authority, strategic direction, accountability. (5)	These players can have a significant impact on project success and have a strong interest in its outcome.
Academic institutions	Research and knowledge generation, capacity building, collaboration and partnerships; access to data and information, funding, collaboration.	Expertise and specialist knowledge, research and analysis, influence on policy and practice. (4)	Academia can have a good impact on programmes when they are allowed to explore specific research issues.
Programme beneficiaries (rights holders)	Improved quality of life, sustainable benefits, ownership; basic services, economic opportunities, inclusion, safety and security.	Local knowledge, community support and participation. (5)	Impact by beneficiaries can be high if there are inclusive needs assessment and participation as well as culturally sensitive approaches.
Traditional, cultural and religious leaders	Community well-being, social cohesion, cultural preservation; respect and recognition, involvement in decision-making.	Authority and influence, communities obey them, community mobilization, cultural heritage. (5)	Local leaders can have a significant impact if they are given respect and recognition and involved in local decisions.

1.2.2 Geographic scope: The evaluation covered sampled districts from the following provinces: Manicaland, Mashonaland Central and Matabeleland North which were part of the five focus provinces, and Harare and Bulawayo which were non-focus provinces of the 8th CP.

1.2.3 Temporal scope: The evaluation covered interventions planned and/or implemented within the three-year and a quarter period of the current CP: 2022 - April 2025.⁷

1.2.4 Reason for the scope: The evaluation scope was determined by the TOR and the ET followed this to the book. There were no issues related to lack of access to particular geographic areas for political, humanitarian or safety reasons at the time of the evaluation.

1.2.5 Evaluation management and work plan

As stipulated in the UNFPA Evaluation Handbook 2024, the CPE had five phases namely:⁸

⁷ Given the timing of the CPE, with fieldwork conducted in June/July 2025, in addition to the three-year period 2022-2024, the evaluation included any major programmatic or organizational issues emerging in the first quarter of 2025, for which in addition to the primary data, quarterly reporting was available.

⁸ Zimbabwe Terms of Reference for CPE final (3).



- (i) **Preparatory phase:** This phase, led primarily by the CO, involved launching the CPE, informing stakeholders, establishing the Evaluation Reference Group (ERG), drafting the TOR, recruiting consultants, creating a document repository, and developing the CP stakeholder map.
- (ii) **Design phase (15th April to mid-June 2025):** The design phase involved an online kick-off meeting between the CO and consultants, a desk review of key documents, initial interviews, preparation of an evaluation approach, preparation for fieldwork, and drafting and presentation of the design report to the ERG members for review.
- (iii) **Field phase (mid-June to 18th July):** This included data collection, an analysis workshop, a preliminary analysis of findings and a debriefing meeting with the CO. The ET visited the provinces of Manicaland, Mashonaland Central, Matabeleland North, Bulawayo and Harare.
- (iv) **Reporting phase (23rd July to 15th October 2025):** This phase involved consolidation of the evaluation matrix, developing findings, establishing conclusions, co-creating the recommendations and drafting the CPE report.

1.3 Evaluation approach

1.3.1 Contribution analysis and theory of change

As part of the theory-based approach, the evaluators used a contribution analysis to explore whether the evidence to support key assumptions exists, examine if evidence on observed results confirmed the chain of expected results in the theory of change (ToC), and sought out evidence on the influence that other factors may have had in achieving desired results. This enabled the ET to make a reasonable case about the difference that the 8th CP made. The evaluation made use of a theory-based approach, providing a structured framework for understanding how and why the programme was expected to work. This was based on a reconstructed ToC, outlining the programme's activities, outputs, outcomes, and impacts in a logical sequence to clarify the causal pathways through which the programme was expected to achieve its desired outcomes. The reconstructed ToC guided the evaluation design, data collection and analysis and reporting. A contribution analysis was used to assess whether and how the programme contributed to observed outcomes. This entailed the following steps: (i) analyzing the existing three thematic ToCs, verifying that the assumptions behind why the programme is expected to work are sound; (ii) developing a reconstructed ToC; (iii) gathering the existing evidence on the ToC, including verifying that activities of the programme were implemented and the logic chain of expected results occurred.

The ET identified some gaps in the existing three thematic ToCs, which were addressed in the reconstructed /revised ToC:

- The reconstructed ToC captures the contribution of the 8th CP to the UNSDCF, UNFPA Strategic plan and NDS 1
- The reconstructed ToC includes risks and assumptions influencing the results
- The reconstructed ToC makes explicit the modes of engagement and interventions under each mode, the UNFPA accelerators under the 8th CP. It also indicates the various inputs required in the implementation of the 8th CP.

The reconstructed ToC, which is illustrated in Figure 7 shows the anticipated sequence of changes in the intervention logic of the 8th CP. The analysis of the ToC involved identifying the mechanisms of change while considering risks, critical assumptions, and the broader implementation context that underpinned the programme's logic. This process guided the ET in understanding how the programme contributed to observed results and in gathering evidence to validate conclusions about its performance during implementation. Additionally, the analysis assessed the validity and adequacy of the programme's outputs in achieving expected results, despite constraints within the implementation context. In the reporting phase, the ET conducted a reassessment of the ToC validity and confirmed its continued relevance, noting that the assumptions and risks largely remained accurate.

1.3.2 Methods of data collection and analysis

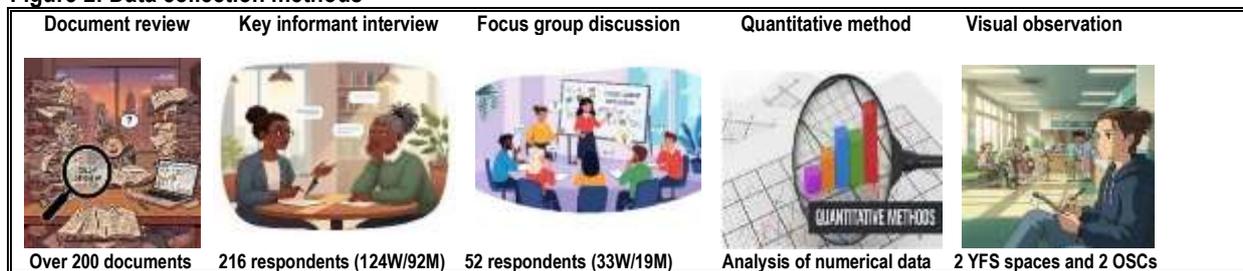
Overall approach: The CPE adopted a theory-based approach, anchored in a clearly articulated ToC that outlines how interventions supported by the UNFPA Zimbabwe CO are expected to contribute to outputs and outcomes aligned with UNFPA's strategic goals. The ToC outlined causal linkages and key assumptions across the results chain. The evaluation built on this to assess pathways, test assumptions, and analyze context, offering insights to strengthen future programming. The ToC guided all evaluation phases of design, data collection, analysis, and recommendations. The ET



validated the 8th CP ToC (2022-2026) using theory-based and contribution analysis, testing assumptions, causal pathways, and external factors. A participatory, gender-responsive and transparent approach ensured inclusive stakeholder engagement at national and sub-national levels, supporting evidence-based conclusions. Throughout the data gathering process, aspects of vulnerability and attention to groups and people left behind were included, attempting as much as possible to obtain disaggregated data that enabled the identification of inequalities. Criteria for disaggregation of data included sex, age and disability as well as geographical location and other relevant vulnerability criteria in local contexts, with attention to aspects of inclusivity of different programme beneficiaries and intersectionality, i.e. the combination of vulnerable aspects in specific groups and people.

Mixed methods approach: Data collection was methodologically aligned with the ToC, utilizing a mixed-methods approach to systematically collect and triangulate evidence across the results chain. The evaluation used qualitative and quantitative methods, including desk-based review of relevant documents, KIIs, FGDs, analysis of numerical data, and observations of youth friendly service (YFS) spaces and OSCs for GBV survivors as illustrated in Figure 2. Under subsection 1.3.3.3, there is a differentiation of stakeholders interviewed.

Figure 2: Data collection methods



Qualitative findings were triangulated with quantitative data from secondary sources like programme reports, official websites, and databases. The CO arranged appointments with key participants using a detailed list of stakeholders to be interviewed to guide the CPE from the design to reporting phases. The specific data sources were provided in the evaluation matrix (refer to Annex 1).

Document review: The document review method was chosen due to the advantages of being less expensive and being able to provide information /data more quickly than the primary methods. The ET continuously reviewed core and supplementary documents, aligning with the 2024 UNFPA Evaluation Handbook. This informed the design, supported data triangulation, and enabled assessment of CPD Results Framework performance using documentary evidence from reports provided by the CO. This documentation played a crucial role in the CPE, helping to address limitations in primary data access.

Key informant interviews: The KII method was selected for its flexibility and adaptability in obtaining in-depth insights across diverse settings, such as offices and homes, while accommodating stakeholders' schedules and needs. It targeted stakeholders with substantial knowledge of the programme. Stakeholders were purposively selected through refined mapping during the design phase, considering their roles, rights, interests, and influence. Key informants included UNFPA staff, government officials, donors, and NGOs across all levels. Semi-structured KIIs, conducted virtually and in person, explored performance, gaps, and disaggregated impacts. The ET explored gender issues and intersectional factors during interviews to ensure diverse gender perspectives were fully reflected in the feedback collected. The related KII guides are contained in Annex 4.

Focus group discussions: The FGD approach was chosen for its ability to encourage discussion and interaction among stakeholders, producing rich qualitative data while efficiently gathering insights from multiple programme rights-holders in a short time. The FGDs, held separately for men and women, included 8-12 participants plus facilitators (for translation) to ensure safe, open, and inclusive discussions. Diverse participants, including vulnerable groups, were purposively selected.



Facilitator bias was minimized through briefings of facilitators (about their roles and need for confidentiality) and cross-verification in multiple languages during FGDs. The ET explored gender issues and intersectional factors during interviews to ensure diverse gender perspectives were fully reflected in the feedback collected. The related FGD guides are contained in Annex 4.

Analysis of numerical data: This method was chosen given its advantages of being able to offer objectivity and reducing the influence of personal biases; precise measurement allowing for accurate conclusions; comparability across different groups, time periods or geographic locations. In addition, the method allows replicability by allowing other researchers or evaluators to verify findings. The ET analyzed data from the UNFPA results and resources framework, country office annual reports (COARs), and research studies by UNFPA and other partners.

Observations: As part of the data collection strategy, the ET conducted non-intrusive observational visits at selected sites involved in the UNFPA programme. Using a structured checklist, the observations focused on service environments, provider-client interactions, and OSCs (evaluating cleanliness, privacy, and accessibility) while also examining rights, gender equality, youth needs, participation, staffing, client flow, and overall service coordination and effectiveness. To uphold ethical standards and privacy, no individual consultations (especially for GBV, HIV, or SRH), were directly observed. The related observation checklist is contained in Annex 4.



Methods of data analysis

Both quantitative and qualitative methods of data analysis were utilized for the analysis of secondary and primary data collected during the evaluation process. Data collected and collated from the review of the documents provided both contextual information and quantitative data that, in combination with primary data from fieldwork, permitted the evaluators to provide detailed and credible answers to all the EQs. Triangulation enhanced reliability, and descriptive, content, and contribution analyses synthesized findings. Results were disaggregated by age, gender, and disability. Preliminary findings were validated and refined with CO and ERG input. Debriefings and a final stakeholder workshop were held, with feedback from the ERG and Regional Office integrated into the final report.

Qualitative data analysis: Qualitative data gathered through KIIs, FGDs and observations was transcribed in preparation for analysis. Content analysis made use of categorization and coding in order to break down large amounts of qualitative data into manageable portions in relation to assumptions and indicators identified in the evaluation matrix. Context analysis was used in order to assess the contextual enablers and constraints in programme implementation. Policy analysis was used to assess and analyze policy engagement initiatives and their results, including the policy cycle and type of policy engagement. Powerful beneficiary quotes supported the findings, and emerging themes informed recommendations for the next CP development.



Quantitative data analysis: Quantitative data analysis was largely descriptive statistical analysis of secondary data from country surveys such as the census, the ZDHS and the MICS, SDG’s progress reports, and 8th CP annual reports. As much as possible, the descriptive data on the indicators for each of the programmatic components was disaggregated by geographical location, gender, disability, and age to show any differentials and comparisons.

Artificial intelligence: No use was made of Artificial Intelligence in terms of data gathering and analysis. However, it was used in word-processing to improve grammar and coherence.

1.3.3 Stakeholders consulted and sites visited

1.3.3.1 Sampling of stakeholders

The UNFPA Evaluation Handbook (2024) guided comprehensive stakeholder selection. The ET employed non-probability sampling, meaning participants with greater involvement and expertise in programme implementation had a higher chance of selection than others due to their relevance. Purposive and convenience sampling were utilized.

1. **Purposive Sampling:** This method was used to select knowledgeable individuals and enabled CPE to group provinces by the 8th CP components, ensuring diverse perspectives from those involved in programme implementation and evaluation.

2. **Convenience Sampling:** The ET also used convenience sampling, selecting readily accessible participants. This approach was especially valuable for interviewing GBV survivors, requiring prior planning due to the sensitive nature of the information.

The ET selected stakeholders based on the intervention type, funding, geographic coverage, and diversity. Following the Handbook’s illustrative sampling approach, participants were chosen across national, provincial, and district levels to ensure broad representation. The sample of stakeholders selected for interviews was 80, which is 94 per cent of the total number (85) of stakeholders in the stakeholder map contained in Annex 5. The categories of the selected stakeholders are shown in Table 4.

Table 4: Categories of stakeholders selected for interviews and selection criteria

Categories of stakeholders	Name of stakeholder	UNFPA thematic area	Criteria for selection
National Government	Ministry of Health and Child Care	SRH, AY, GEWE, PD	Implementer
	Ministry of Primary and Secondary Education	AY	Implementer
	Ministry of Women Affairs, Community and Small Enterprise Development	GEWE	Implementer
	Ministry of Public Service Labour and Social Welfare (Dept. of Disability Affairs)	GEWE	Partner on GEWE
	Ministry of Local Government (Dept. of Civil Protection)	GEWE	Partner on GEWE
	Ministry of Finance, Economic Development and Investment	PD	Partner on population
	Ministry of Public Service Labour and Social Welfare (Dept. of Disability Affairs)	PD	Partner on population
	Zimbabwe National Family Planning Commission	SRH	Implementer
	Zimbabwe National Statistical Agency (ZIMSTAT)	PD	Implementer
	Zimbabwe Youth Council	AY	Implementer
	National AIDS Commission	AY	Implementer
International NGOs	Judicial Services Commission	GEWE	Implementer
	Plan International	AY	Implementer
	Population Services Zimbabwe	AY	Implementer
Local NGOs	World Vision	GEWE	Implementer
	Musasa	GEWE	Implementer
	SAYWHAT	AY	Strategic partner
	Zim Cricket Association	GEWE	Strategic partner
	Council of Social Workers	GEWE	Implementer
UN System	Family Support Trust	GEWE	Implementer
	UNFPA	Not applicable	UN Partner
	UNDP, UNICEF, WHO, UN Women, UNESCO	Not applicable	UN Partners /Joint Programme
	UNICEF, WHO, UNAIDS, OCHA	Not applicable	UN Partners on SRH
	UNESCO, UNICEF, UNAIDS, WHO	Not applicable	UN Partners on GEWE
UNESCO, UNOPS, UNDP, UNHCR, OCHA, WHO, FAO	Not applicable	UN Partners on GEWE	



Country Programme Evaluation of GoZ /UNFPA 8th CP 2022-2026



Categories of stakeholders	Name of stakeholder	UNFPA thematic area	Criteria for selection
Development Partners	UNICEF, UN WOMEN, UNRCO	Not applicable	UN Partners on population
	Health Resilience Fund (HRF), Health Development Fund (HDF), UBRAF, CERF, UNFPA Supplies Partnership	Not applicable	Donors/ Dev. Partners (SRH)
	HRF, HDF, Safeguard Young People, 2gether4SRHR	Not applicable	Donors/ Dev. Partners (AY)
	Takeda, HRF, CERF, Spotlight EU, Irish AID, Japan, Sweden SIDA, UNPRPD, MPTF, World Bank	Not applicable	Donors/ Dev. Partners (GEWE))
Academia	Mutare Teachers College	AY	Partner on youth
	Manicaland State University of Science	AY	Partner on youth
	Harare Institute of Technology	AY	Partner on youth
	Bindura University of Science Education	AY	Partner on youth
	Hillside Teachers College (Bulawayo)	AY	Other partner on youth
	University of Zimbabwe, Department of Demography, Settlement and Development	PD	Partner of P&D
Rights Holders	Women, girls	GEWE	Beneficiaries under gender
	PWDs	GEWE	Partners on gender
	Programme beneficiaries	SRH, AYP, GEWE	Beneficiaries
Other	Zimbabwe Gender Commission	GEWE	Partner on gender
	Deaf women	GEWE	Partners on gender

1.3.3.2 CPE sites visited

UNFPA Zimbabwe has five programme focus provinces namely Manicaland, Mashonaland Central, Mashonaland East, Matabeleland North and Midlands. There are five non-focus provinces namely: Mashonaland West, Masvingo, Matabeleland South, Harare and Bulawayo. The ET proposed to include both the focus and non-focus provinces and districts in order to have a reliable and credible evaluation. The evaluation was conducted in the three focus provinces (Manicaland, Mashonaland Central and Matabeleland North) and two non-focus provinces of Harare and Bulawayo. The selection criteria included the following: presence of interventions covering the thematic areas of SRH, AYP, GBV and HP; geographic location (rural /urban location), contextual issues such as remote and hard-to-reach places, farming, poor access to health care in artisanal mining areas and previous exposure to humanitarian crises (e.g. cyclones, flooding, drought and cholera). The ET also followed the UNFPA guidance on integrating the principles of LNOB.⁹

Sample: The sample included all five UNFPA focus provinces. The ET carried out in-depth assessment and field visits to 3 UNFPA focus provinces and six focus districts namely: (i) six focus districts of Chimanimani and Mutare (provincial capital) in Manicaland province; Tsholotsho and Bubi in Matabeleland North; Shamva and Bindura (provincial capital) in Mashonaland Central. In addition, the ET selected three non-focus districts namely Epworth and Hopley in Harare city and Bulawayo city. The details of the selected districts for field visits and the criteria used are shown in Table 5.

Table 5: Selected provinces and districts and criteria used

Province	District	Focus or non-focus	Thematic areas/ Initiatives	Emergencies / Humanitarian crisis	Rural / Urban location
Manicaland	Chimanimani	Focus	All thematic areas	Cyclones, drought	Rural and remote
	Mutare (Capital)	Focus	All thematic areas		Urban
Matabeleland North	Tsholotsho	Focus	SRHR; GBV; maternal health		Rural and remote
	Bubi	Focus	All thematic areas		
Mashonaland Central	Shamva	Focus	All thematic areas; Spotlight Initiative		Rural (resettlements; farming community; mining areas)
	Bindura (Capital)	Focus	All thematic areas; UNPRDP project focusing on PWDs	Cholera outbreak	Urban (poor access to health care in artisanal mining areas)
Harare	Epworth	Non focus	GBV (Spotlight);	Cholera outbreak	Urban

⁹ Guidance on integrating the principles of leaving no one behind and reaching the furthest behind in UNFPA evaluations. July 2021.



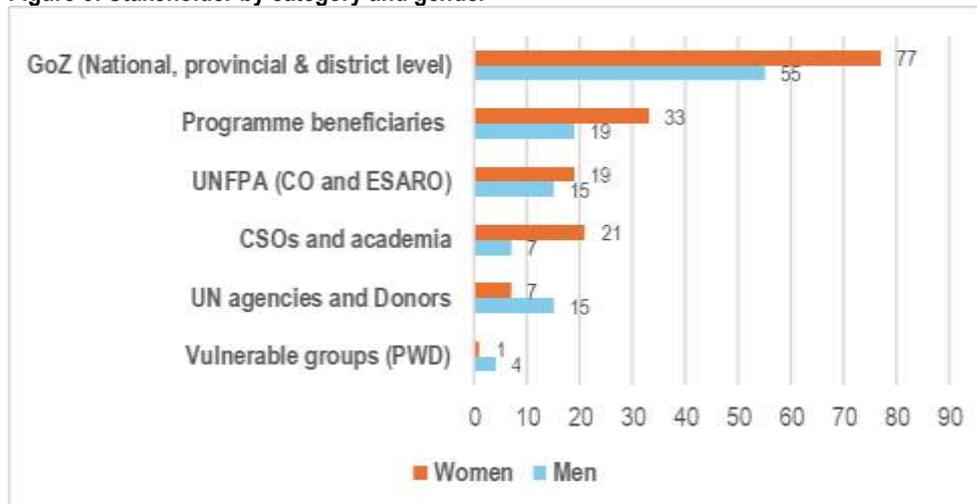
Province	District	Focus or non-focus	Thematic areas/ Initiatives	Emergencies / Humanitarian crisis	Rural / Urban location
	Hopley	Non focus	All thematic areas		Urban
Bulawayo	Bulawayo city	Non focus	HIV/AIDS maternal health		Urban

The details of the actual site visits in districts and provinces and the specific activities undertaken in each site are shown in Annex 7.

1.3.3.3 Differentiation of respondents

On the selection of different age groups, gender and vulnerable categories of people, the ET was guided by the UN Sustainable Development Group programming principle of 'LNOB'¹⁰ and the different target beneficiaries of the 8th CP. Initially, the stakeholder map identified 85 key informant individuals, of whom 80 were approached for interviews representing a response rate of 94 per cent). However, the evaluation's field visits engaged a broader group, resulting in a total of 268 participants (59 per cent women; 41 per cent men), which was good to have more views and insights captured about the programme interventions. Of these people, five (two per cent) were PWDs (four men; one woman), 52 were programme beneficiaries (63 per cent women; 37 per cent men) who were interviewed during FGD sessions. The analysis of categories of stakeholders (by gender and number) is shown diagrammatically in Figure 3.

Figure 3: Stakeholder by category and gender



1.3.4 Limitations and mitigation measures

The ET is aware that mixed-methods evaluation studies require the use of qualitative methods, such as KIIs and FGDs which heavily rely on face-to-face interactions for data collection. To address potential mobility restrictions in certain districts if they were caused by disease outbreaks or insecurity, the ET had prepared to use virtual platforms like Zoom or Microsoft Teams for data collection. Microsoft Teams was used for some national level stakeholders who preferred virtual meetings. Immediate peer debriefings and in-depth internal discussions helped mitigate challenges linked to virtual interviews. A summary of potential limitations, risks and mitigation measures are in Table 6.

Table 6: Limitations, risks and mitigation measures

Limitations	Risks	Mitigation measures
Challenges related to scheduling of interviews due to sparsely located sites and long distance covered.	This had the potential of prolonging the data collection phase beyond the planned itinerary.	The ET (especially national consultants) obtained the actual locations of sites plus the distances and planned the travel schedule accordingly.
Evaluation is largely qualitative with a quantitative element, but the results will not be statistically representative of large population.	This has the potential of introducing bias.	Consultants triangulated data from multiple sources with secondary quantitative information, using national surveys, censuses, and evaluations by development partners to reduce

¹⁰<https://unsdg.un.org/resources/leaving-no-one-behind-unsdg-operational-guide-un-country-teams-interim-draft> [Accessed 30 May 2025].



Limitations	Risks	Mitigation measures
		bias and strengthen the reliability of evaluation findings.
Challenges in scheduling appointments with key stakeholders (absence from office due to other tasks).	This had the potential of having a sample bias with regard to coverage of stakeholders.	The ET shared the interview agenda with stakeholders in advance and scheduled appointments early, following up by phone.
Potential bias from stakeholder interviewees.	In qualitative data-collection interviews, there was an inherent risk that stakeholders could filter information	The evaluation organized, facilitated, and engaged in conducting interviews with strategies to put interviewees at ease.
Potential analytical bias from the ET.	As with all qualitative interview exercises, humans have the tendency to be easily influenced by the factors surrounding some information	Interviewers from the ET shall make detailed notes, which will be validated with the rest of the ET.

The consultants concluded that the limitations outlined in this section were adequately resolved and did not significantly affect the validity or credibility of the evaluation findings.

1.3.5 Ethical considerations

The ET members committed themselves to adhering to the internationally accepted ethical standards in research¹¹ and the United Nations Evaluation Group (UNEG) Norms and Standards for evaluation.¹² The ET followed ethical guidelines by obtaining informed consent, ensuring respondent anonymity and data confidentiality, allowing non-response to sensitive questions, avoiding bias or misinformation, and respecting dignity, diversity, and anti-discrimination principles. Interviews were conducted privately without recording names, prioritizing ethical standards and sensitivity throughout the data collection process. For interviews with survivors of GBV, World Health Organization (WHO) guidelines were followed. The ET applied do-no-harm strategies, including safeguarding measures to prevent abuse and harm, particularly for vulnerable groups like PWDs, ensuring their protection and ethical engagement throughout.

1.3.6 Innovative practices

The innovation practices, which the ET used to improve the quality of the evaluation process included the following:

- *Textual and visual analysis:* During field visits to health facilities and OSCs, the ET conducted both textual and visual analyses of the content and imagery displayed on posters located on walls and noticeboards to assess messaging and communication effectiveness
- *Immediate sharing of draft recommendations with the stakeholders interviewed:* Stakeholders provided recommendations to improve CP interventions during interviews. These suggestions were shared with them within 24 hours to ensure data triangulation and foster a sense of ownership over the evaluation results, enhancing their engagement and validation.

¹¹ <https://www.who.int/activities/ensuring-ethical-standards-and-procedures-for-research-with-human-beings>

¹² UNEG, United Nations Evaluation Group, Norms and Standards for Evaluation, 2016, 2017; UNEG, Ethical Guidelines for Evaluation, March 2008; UNEG, UNEG Code of Conduct for Evaluation in the UN System, March 2008.



CHAPTER 2: COUNTRY CONTEXT

2.1 Development challenges and national strategies

2.1.1 General country context

Zimbabwe is a landlocked country located in the Southern Africa region, situated between the Zambezi and Limpopo Rivers. It borders South Africa to the south, Botswana to the southwest, Zambia to the north, and Mozambique to the east. The country has a total surface area of 390,757 square kilometres.

Sustainable Development Goals: UNFPA globally contributes directly to the 2030 Agenda for Sustainable Development, in line with the Decade of Action to achieve the SDGs.¹³ In addition to the three UNFPA transformative results, the UNFPA East and Southern Africa region has a fourth transformative result to End sexual transmission of HIV. These three plus one transformative results contribute to the achievement of all the 17 SDGs, but directly contribute to the following six goals:¹⁴ (a) ensure healthy lives and promote well-being for all at ages (Goal 3); (b) achieve gender equality and empower all women and girls (Goal 5); (c) reduce inequality within and among countries (Goal 10); take urgent action to combat climate change and its impacts (Goal 13); promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels (Goal 16); and strengthen the means of implementation and revitalize the Global Partnership for Sustainable Development (Goal 17). Zimbabwe carried out periodic reviews to assess the performance of the SDGs (Quarterly Reviews, Voluntary National Reviews and Voluntary Local Reviews Biannual). When assessing the overall status of the SDGs in the country,¹⁵ it was observed that the SDGs which were moderately improving but with challenges remaining include Goal 3 (good health and well-being) and Goal 5 (gender equality). Only two goals were achieved (on track or maintaining achievement) namely Goal 12 on responsible consumption and production and Goal 13 on climate action. The status for all SGD goals is shown in Figure 4.

Figure 4: SDG dashboard and trends



Population: According to the Zimbabwe PHC 2022,¹⁶ Zimbabwe had a population of 15,178,957 (48 per cent women; 52 per cent men) and is projected to increase to 21.2 million by 2042. An annual growth rate of 1.5 per cent has been reported between 2012 and 2022. The population is relatively young with 54 per cent of the population in the economical

¹³ UNFPA Strategic Plan 2022-2025

¹⁴ UNFPA Zimbabwe approved CPD 2022-2026.

¹⁵ 2024 Zimbabwe Annual SDGs Review Report; Sustainable Development Report 2025.

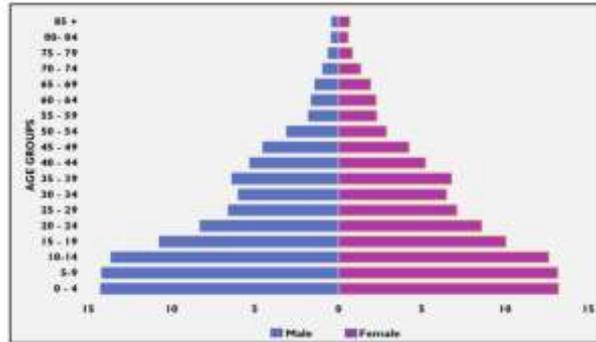
<https://s3.amazonaws.com/sustainabledevelopment.report/2025/sustainable-development-report-2025.pdf>.

¹⁶ ZIMSTAT. Zimbabwe 2022 Population and Housing Census Report.



age group of 15 to 64 years, 32 per cent aged 10 to 24 years and 10 per cent aged 15 to 19 years. Harare, the capital of Zimbabwe remains the most populous province with 16 per cent of the total population residing in the city, followed by Manicaland (13.4 per cent) and Mashonaland West (12.5 per cent), while the least populous provinces are Bulawayo (four point four per cent), Matabeleland South (five per cent) and Matabeleland North (five point five per cent).¹⁷ The population pyramid is shown in Figure 5.

Figure 5: Population pyramid showing the age structure of Zimbabwe



Source: ZIMSTAT. Zimbabwe 2022 Population and Housing Census Report.

Poverty: Between 2011 and 2017, extreme poverty, calculated using the national food poverty line, rose from 23 to 30 per cent of the population. It increased further to 38 per cent in April-May 2019.^{18,19} By 2019, the poverty rate had risen further, with almost two-fifths (40 per cent) of the population found to be in extreme poverty.²⁰ A further increase in the extreme poverty rate was noted after the COVID-19 pandemic, reaching 49 per cent at its peak in mid-2020 and decreasing to 43 per cent in 2021 due to the gradual opening of the economy and a good maize harvest in the 2020/2021 season. Extreme poverty is much higher in rural areas than in urban areas.

Economics: Zimbabwe has a multi-currency monetary system, with the Zimbabwe dollar known as the Zimbabwe Gold (ZiG) and the US dollar (US\$) as the dominant currencies. The ZiG exchange rate is market determined and backed by the US\$ and mineral reserves. On its introduction on April 5, 2024, the exchange rate stood at ZiG13.55/\$1 but fell to ZiG25/\$1 in September 2024 and ZiG30/\$1 in November 2024. The monthly inflation rate stood at 0.27 per cent in March 2025.²¹ Real GDP of Zimbabwe in 2023 was US\$62,501,252 at constant 2019 prices.²²

Human Development Index: In 2024, Zimbabwe's Human Development Index (HDI) was 0.550, placing it in the medium human development category according to UNDP.²³ This score represents a marginal increase from 0.549 in 2021. Zimbabwe's HDI score places it 22nd in Africa and 146th out of 189 countries in the world.

Political context: Zimbabwe functions as a presidential republic, where the President serves as both head of state and government, as well as commander-in-chief of the armed forces. Elected directly by the people, the President operates within a constitutional democracy that divides power among the Executive, Judiciary, and Legislature, each authority derived from the national Constitution.²⁴ The major political events during the period being evaluated were the Presidential and Parliamentary elections, which were held in 2023; and the introduction of the Zimbabwe Gold (ZiG) currency.²⁵ The UNFPA CO flexibly adapted to the new government ministries.²⁶

¹⁷ ZIMSTAT. Zimbabwe 2022 Population and Housing Census Report.

¹⁸ World Bank. *Zimbabwe Poverty and Equity Brief: October 2024 (English)*. Poverty and Equity Brief Washington, D.C.: World Bank Group. <http://documents.worldbank.org/curated/en/099750501132516918>

¹⁹ World Bank Group. 2024. Zimbabwe: Country Climate and Development Report: Zimbabwe.

²⁰ World Bank Group. 2024. Zimbabwe: Country Climate and Development Report: Zimbabwe.

²¹ ZIMSTAT. <https://zimstat.co.zw/>

²² ZIMSTAT. September 25, 2024. Final Published GDP Tables 2019-2023.

²³ Zimbabwe UNDP Country Report 2024.

²⁴ <https://www.google.com/search?q=zimbabwe+type+of+government+2024>

²⁵ https://www.google.com/search?q=Zimbabwe+NGO+Act&rlz=1C1GCEU_enZW1161&oq=Zimbabwe+NGO+Act

²⁶ Klls with UNFPA CO staff; GoZ ministry officials.



Human rights: According to Zimbabwe's NDS 1 2020-2025, the country is committed to upholding international human rights standards, having both ratified and domesticated key human rights treaties. These include among others the Convention on the Elimination of All Forms of Discrimination against Women; the Convention on the Rights of the Child; and the Convention on the Rights of Persons with Disabilities. Zimbabwe has also participated in the United Nations Human Rights Council's Universal Periodic Review, during which it accepted to implement numerous recommendations across a broad spectrum of rights, including civil, political, economic, social, cultural, and environmental rights.²⁷ Document review and interviews with national level government stakeholders revealed that the GoZ introduced specific indicators and measurable targets to monitor human rights progress.²⁸ These include among others the Human Freedom Index and the Universal Human Rights Index (which tracks implementation of the Universal Periodic Review recommendations).

LNOB/reaching the furthest behind: The GoZ espouses the principle of "leaving no-one and no place behind", which is indicated in the NDS 1 (2021-2025), and this is aligned to the SDG principle of "LNOB /reaching the furthest behind". In order to put the latter principle in practice, the Office of the President and Cabinet mandated the MoPSLSW to coordinate the implementation, monitoring, evaluation and reporting of the 2030 Agenda for Sustainable Development and SDGs as well as the Agenda 2063.²⁹ The GoZ's "leaving no-one and no place behind" principle is further reflected in the sectoral strategies. For example,

- The national GBV response ensures inclusive participation and outreach by engaging marginalized groups, including those in remote areas, PWDs, conflict-affected communities, all age groups, and others, through accessible, relevant, and appropriate communication formats³⁰
- Under the MoPSE, the GoZ has adapted educational infrastructure and materials for students with disabilities, ensuring all newly constructed schools include disability-friendly access features in line with the principle of LNOB.³¹

Humanitarian and security situation: Over the years, Zimbabwe has grappled with the effects of the climate crisis, and numerous health crises. Since the 2023/24 agricultural season, the country has faced an El Niño induced drought leaving at least seven point six million people in urgent need of humanitarian aid across Zimbabwe in April 2024.³² By the end of 2024, six million people were expected to be food insecure in Zimbabwe during the 2024-2025 lean season.³³ In response to the ongoing drought, the GoZ provided social assistance to around four million vulnerable people. The cholera outbreak that started in February 2023 and declared an emergency in August 2024, included peri-urban and rural hotspots of Hwedza, Mt Darwin, and Uzumba Maramba Pfungwe (UMP) districts. UNFPA and other UN agencies provided technical and financial support to respond to the outbreak. In terms of security, Zimbabwe was peaceful during the period of the 8th CP even with the presidential and parliamentary elections in June 2023 which was in contrast to previous ones normally associated with politically motivated violence.

2.1.2 Challenges and strategies for SRHR

Maternal health: Maternal mortality ratio (MMR) declined from 651 per 100,000 live births in 2015 ZDHS to 462 per 100,000 live births in 2019 MICS and 362 per 100,000 live births in 2022 (2022 Census) and 212 in 2024 (ZDHS Report 2023-2024). Despite a commendable decline, institutional maternal mortality remains unacceptably high, rising from 107 to 114 per 100,000 between 2022 and 2024, which is far above the SDG target of less than 70 per 100,000 live births.³⁴ This increase occurs despite reported high values of healthcare access indicators, including 95 per cent ANC coverage and 85 per cent of births attended by skilled health professionals. As for the MMR by province,³⁵ Midlands had the highest MMR of 424 followed by Mashonaland East (401), Manicaland (391), Masvingo (377), Mashonaland West (377), Matabeleland South (375), Matabeleland North (365) and Harare (303). Bulawayo had the lowest MMR (248) followed

²⁷ National Development Strategy 1 (2020-2025).

²⁸ Review of NDS 1 (2020-2025); KIs with GoZ ministry officials.

²⁹ 2024 National Voluntary Review III Report (page 2).

³⁰ Zimbabwe National Strategy to Prevent and address Gender Based Violence 2023-2030 (page 27).

³¹ 2024 National Voluntary Review III (page 46).

³² OCHA (2025) Zimbabwe: Flash Appeal Response Monitoring (May 2024 - June 2025) (as of December 2024). <https://reliefweb.int/report/zimbabwe/zimbabwe-flash-appeal-response-monitoring-may-2024-june-2025-december-2024>

³³ <https://reliefweb.int/disaster/dr-2024-000066-zwe>

³⁴ ZDHS 2024; KIs with staff at MoHCC and UNFPA CO.

³⁵ Population and Housing Census Report 2022 (page 67).



by Mashonaland Central (292). The proportion of budget allocated to the MoHCC from the national budget dropped from 11.2 per cent in 2023 to 10.8 per cent in 2024 and 10.2 per cent in 2025, remaining below the Abuja Declaration's 15 per cent target for health sector budget allocations.

Contraception (FP): Seventy per cent of currently married women were using a contraceptive method, with 69 per cent using a modern method³⁶ and 1 per cent using a traditional method.³⁷ Thirty per cent of currently married women were not using any contraceptive method. On trends, the use of contraceptives among currently married women increased from 48 per cent in 1994 to 70 per cent in 2023-2024.³⁸ Over the same period, the use of modern contraception increased from 42 per cent to 69 per cent.

National strategies for SRHR

From document review and interviews, it was noted that the GoZ established key policies and strategies to improve access to SRH services, including the National Health Strategy (NHS) 2021-2025, the Zimbabwe National HIV and AIDS Strategic Plan 2021-2025 and the National Family Planning Strategy 2022-2026 among others. The National HIV and AIDS Strategic Plan marked a shift from a generalized, centrally planned HIV response to a more targeted approach, focusing on specific populations and geographic areas to better reach vulnerable and key groups.

2.1.3 Challenges and strategies for AY

In Zimbabwe, AYP (10-24 years) constitute 32 per cent of the total population, and adolescents (10-19 years) account for 23 per cent of the population in the country.³⁹ A healthy adolescent and youth population is key to unlocking Zimbabwe's demographic dividend (DD) for sustainable growth. However, many adolescents face serious health challenges such as early sexual activity, teenage pregnancy, child marriage, low contraceptive use, HIV/STIs, substance abuse, GBV, and poor mental health. The 2019 MICS showed that four point six per cent of women and three point eight per cent of men had sex before the age of 15 years, and 23 per cent of girls aged 15-19 years had ever been pregnant. Nearly ten per cent of adolescent girls gave birth annually (half unintentionally) due to limited access to youth-friendly SRHR services. Rural areas were most affected.

National strategies for adolescents and youth

Over the years, the government and its partners have invested in improving accessibility of SRH services by AYP. Zimbabwe has improved adolescent SRH by establishing youth-friendly corners in health facilities, integrating CSE into the school curricula and teacher training, and strengthening SRH services in tertiary institutions. An annual certification using WHO standards ensures quality care. National policies like the ASRH Strategy and AHIP guide efforts, supported by partners through peer education, mobile clinics, and community-based SRH programmes have enhanced SRH services. Despite investments in adolescent-friendly SRH services, progress is hindered by high health worker turnover due to low pay, poor conditions, and emigration. Legal inconsistencies restrict access for those under 16 years, while CSE remains weak in rural areas due to limited teacher capacity, resources, and supportive services.

2.1.4 Challenges and strategies for GBV

Despite the existence of multiple legislative frameworks to address GBV, women's experiences with physical violence have changed little over the past two decades, despite some fluctuations. The proportion of women aged 15-49 years who reported ever experiencing physical violence since the age of 15 years was 36 per cent in the 2005-2006 ZDHS, 30 per cent in 2010-2011, and 35 per cent in 2015, before declining to 27 per cent in the ZDHS 2023-2024 survey.⁴⁰ Although recent data shows a slight decline, GBV remains a serious challenge. Nine percent of women had experienced sexual violence at least once in their lifetime, with five percent reported it within the past year. These statistics reveal persistent gaps in Zimbabwe, despite laws, empowerment programmes, and ongoing efforts by government, NGOs and UN partners to combat GBV.

³⁶ Modern methods include male and female sterilization, injectables, intrauterine contraceptive devices (IUCDs), contraceptive pills, implants, female and male condoms, emergency contraception, and the lactational amenorrhoea method (2024 ZDHS, page 11).

³⁷ Zimbabwe Demographic Health Survey (ZDHS) 2024: Key Indicator Report (page 12).

³⁸ Zimbabwe Demographic Health Survey (ZDHS) 2024: Key Indicator Report (page 12).

³⁹ Census 2022.

⁴⁰ *ibid*



According to the MWACSMED, and UNFPA, although the legal framework on GBV is quite robust and progressive, a challenge that constrains the system is the weak enforcement of laws and policies, which allows many perpetrators of GBV to evade accountability.⁴¹ The majority of GBV incidents occur within domestic settings, placing ever-partnered women at heightened risk. Among ever-partnered women aged 15-49 years who ever experienced sexual violence, 68 per cent reported that the perpetrator was their current husband/intimate partner and 20 per cent their former husband/intimate partner⁴². Most vulnerable women are those with limited education (15 per cent had experiences of sexual violence), in rural areas (38 per cent in rural areas, 27 per cent in urban areas from current or most recent partner) and those belonging to the lowest wealth quintiles (three percent experienced violence in their lifetime)⁴³. In addition to these challenges is the issue of child marriage which is highly prevalent (33.7 per cent) and a significant contributor of GBV in Zimbabwe. Though various common groups have been identified, there are other at-risk groups to be considered which include PWDs, sex workers, LGBTQI+ individuals, orphans, and girls living on the streets, all of whom face heightened exposure to GBV.⁴⁴

National strategies for GBV

Zimbabwe has implemented several strategies to tackle GBV and HP, guided by a strong legal and policy framework. These include among others the National Constitution (2013); The Domestic Violence Act of 2007; the Sexual Offences Act (2002); the Marriages Act No.1 of 2022; High Level Political Compact (HLPC) on Ending Gender Based Violence and Harmful Practices (2021-2030) in Zimbabwe; the new National Gender Policy (2023); the NDS (2021- 2025); and the National Strategy for the Elimination of Sexual Harassment and Gender Based Violence in the Workplace in Zimbabwe (2021-2025).⁴⁵ The country's National Strategy on Ending GBV (2023-2030) provides a coordinated roadmap emphasizing multi-sectoral response, community engagement, and accountability.⁴⁶

2.1.5 Challenges and strategies for PD

The Zimbabwe population of 15,178,979 (48 per cent women; 52 per cent men) is relatively young with 54 per cent of the population in the economical age group of 15 to 64 years, 32 per cent aged 10 to 24 years and 10 per cent aged 15 to 19 years.⁴⁷ With its large and youthful population, Zimbabwe could benefit from its DD, which began around 2004 and is projected to last until 2060. Zimbabwe has been consistent in generating demographic data through population censuses and demographic surveys. Since 1982, the country has religiously carried out national population censuses every ten years, with the last PHC conducted in 2022. In between the censuses, Inter-Censual and Demographic Surveys are carried out with the next one planned for 2027. Since 1988, Zimbabwe carries out the ZDHS every five years, with the last survey carried out in 2023/24. Another survey implemented consistently since 2009, is the MICS carried out in between the ZDHS, with the last one being undertaken in 2019.

The national statistical system in Zimbabwe is fairly developed and built around strong routine information systems and a comprehensive national household survey capability programme.⁴⁸ The national statistics system is coordinated by the ZIMSTAT through implementing activities in the National Strategies for the Development of Statistics II 2016-2020.⁴⁹ Zimbabwe's data system relies primarily on routine information systems (at varying stages of development) and national household surveys such as the ZDHS, MICS, and labour force surveys. However, significant data gaps remain, including limited geographical coverage, outdated information, restricted accessibility, and insufficient disaggregation by age, disability, and socioeconomic status across social, economic, environmental, and humanitarian sectors. Overall, UNFPA⁵⁰ in supporting the GoZ focuses on enhancing the availability and use of timely, disaggregated data to inform national policies, improve programme planning, and enable evidence-based advocacy for inclusive development.

National Strategies for PD

⁴¹ Ministry of Women Affairs, Community, Small and Medium Enterprises Development and UNFPA, 2023. *Zimbabwe National GBV Strategy 2023–2030*. Harare: Government of Zimbabwe and UNFPA (page11).

⁴² ZDHS 2023-2024.

⁴³ Ibid

⁴⁴ GBVoR UNFPA. <https://gbvaor.net/global-gbv/country/529#:~:text=Access%20to%20GBV%20risk%20mitigation,the%20services%20as%20being%20unsatisfactory>.

⁴⁵ Government of Zimbabwe. *National Strategy on Ending Gender-Based Violence 2023–2030*.

⁴⁶ Ibid

⁴⁷ ZIMSTAT. Zimbabwe 2022 Population and Housing Census Report.

⁴⁸ Preliminary interviews with key ZIMSTAT stakeholders.

⁴⁹ ZIMSTAT. Development of Statistics II 2016-2020.

⁵⁰ UNFPA. 2021. Country Programme Document for Zimbabwe.

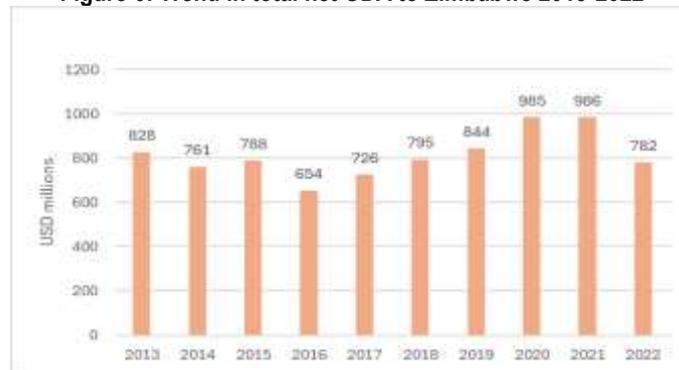


Zimbabwe has various policies and strategies for the development and implementation of PD interventions in the country. These include the National Population Policy (1998),⁵¹ Vision 2030,⁵² the NDS1 (2021-2025),⁵³ the Census and Statistics Act [Chapter 10:29] 2007,⁵⁴ the Zimbabwe National Strategy for the Development of Statistics (NSDS III) 2021-2025,⁵⁵ and the NHS 2021-2025.⁵⁶ The adoption of 17 SDGs at the United Nations in 2015,^{57, 58} paved the way for the historic adoption of the Political Declaration on Universal Health Coverage in September 2019. The SDGs provided broad parameters by which Zimbabwe developed its health system with the objective of achieving universal health coverage (UHC) by 2030. The ZUNSDCF 2022-2026⁵⁹ articulates the strategic engagement of the UNCT in Zimbabwe to support the country to achieve the SDGs.

2.2 Role of external assistance

According to the World Bank, net Official Development Assistance (ODA) and official aid received (current US\$) in Zimbabwe was reported at US\$ 782,289,978 in 2022.⁶⁰ ODA has been fluctuating over the past decade with a clear decline from US\$ 828m in 2013 to US\$ 654m in 2016, then an increase from US\$ 726m in 2017 to US\$ 986m in 2020 and further declining to US\$ 782m in 2022. Some of the largest bilateral development partners are the United States, United Kingdom, Sweden and Germany while the European Union (EU), the Global Fund to Fight AIDS, TB and Malaria, and UN agencies are among the largest multilateral partners. The trend in net ODA is shown in Figure 6.

Figure 6: Trend in total net ODA to Zimbabwe 2013-2022



Source: World Bank /OECD data, 2025

In the first nine months of 2024, the country received US\$529.86 million in ODA (US\$417 million from bilateral partners and US\$113 million from multilateral partners) supporting diverse sectors such as health, agriculture, education, emergency response, governance, and others.⁶¹

⁵¹ Government of Zimbabwe. 1998. The Zimbabwe National Population Policy.

⁵² Republic of Zimbabwe VISION 2030 "Towards a Prosperous & Empowered Upper Middle-Income Society by 2030" September 2018.

⁵³ Republic of Zimbabwe. "Towards a Prosperous & Empowered Upper Middle-Income Society by 2030" National Development Strategy 1 January 2021 – December 2025.

⁵⁴ Government of Zimbabwe. Census and Statistics Act [Chapter 10:29] 20th July, 2007.

⁵⁵ Government of Zimbabwe. 2021. The Zimbabwe National Strategy for the Development of Statistics (NSDS III) 2021-2025.

⁵⁶ Ministry of Health & Child Care Republic of Zimbabwe. National Health Strategy 2021-2025.

⁵⁷ United Nations. Department of Economic and Social Affairs Sustainable Development Goals. <https://sdgs.un.org/goals>

⁵⁸ Ministry of Health & Child Care Republic of Zimbabwe. National Health Strategy 2021-2025.

⁵⁹ Government of Zimbabwe. Zimbabwe United Nations Sustainable Development Cooperation Framework (ZUNSDCF) 2022-2026.

⁶⁰World Bank/OECD. 2025. <https://tradingeconomics.com/zimbabwe/net-official-development-assistance-received-us-dollar-wb-data.html>

⁶¹ 2024 Zimbabwe Annual SDGs Review Report (page 140).



CHAPTER 3: UNFPA RESPONSE AND PROGRAMME STRATEGIES

3.1 United Nations and UNFPA strategic response

3.1.1 UN and UNFPA response

UNFPA contributes directly to the 2030 Agenda for Sustainable Development, in line with the Decade of Action to achieve the SDGs. In pursuit of this goal, UNFPA works towards three transformative and people-centered results namely: (i) *ending preventable maternal deaths*; (ii) *ending unmet need for FP*; and (iii) *ending GBV and all harmful practices, including female genital mutilation and child, early and forced marriage*.⁶² UNFPA's latest business model classified the 119 global programme countries in three tiers namely: Tier one consisting of countries in which all three of the transformative results have not yet been achieved; Tier two including countries where two of these results have not yet been achieved and Tier three where only one of the results is yet to be achieved. At the beginning of the 8th CP, Zimbabwe was in Tier one. However, based on the assessed achievement level by the end of December 2024 (refer to Table 7), the country is now part of Tier two with one of the three transformative results achieved.

Table 7: UNFPA Transformative results, indicators and the achievement level in Zimbabwe

Transformative result	Indicator	Threshold by 2030	Achievement	Source of data
Ending the unmet need for FP	Need for FP satisfied with modern methods	>= 70%	87%	Zimbabwe Demographic and Health Survey Key Indicators Report 2023-2024
Ending preventable maternal deaths	Maternal mortality ratio	<= 70 per 100,000 livebirths	212 (Overall) 362 (Overall) 402 (Rural) 298 (Urban)	ZDHS report 2023/24 Zimbabwe 2022 PHC Report
Ending gender-based violence and harmful practices, including female genital mutilation and child, early and forced marriage	Gender inequality index	<= 0.3 (with 1.0 being unequal and 0.0 being equal)	0.740	UN Women 2022

Key: Green colour means that an indicator for a transformative result is achieved; red colour means the indicator is not yet achieved.

The UNCT⁶³ collaborates closely with the Government to support the achievement of national development priorities and outcomes. This partnership is directed by the UNSDCF for Zimbabwe, which was developed by the GoZ and aligned with UNDG programming principles, international standards, and a human rights-based approach. The framework also emphasizes the 2030 Agenda for Sustainable Development, ensuring a focus on UNFPA transformative and sustainable results.

3.1.2 Link of CPD outputs with UNFPA SP outcomes

The UNFPA Strategic Plan (SP) 2022-2025 provides an overarching framework for UNFPA programming globally. In Zimbabwe, interventions are guided by national priorities and local needs. The CP serves as the primary mechanism for implementing the five-year strategic plan, aligning with SDGs. It is closely aligned with the outcomes and outputs of the UNFPA Strategic Plan and implemented in an integrated manner, while also supporting the objectives of the UNSDCF 2022-2026. The linkage between the UNFPA Zimbabwe 8th CP 2022-2026, UNFPA Strategic Plan 2022-2025 and UNSDCF^{64,65,66} is shown in Table 8.

⁶² UNFPA Strategic Plan 2022-2025.

⁶³ UNCT comprises of resident and non-resident UN agencies.

⁶⁴ UNFPA Zimbabwe Country Programme Document (2022-2026).

⁶⁵ United Nations Population Fund Strategic Plan (2022-2025).

⁶⁶ United Nations Sustainable Development Framework (UNSDF) / Zimbabwe Vision 2030.



Table 8: Link between CPD 2020-2026 and UNFPA Strategic Plan 2022-2025

GoZ /UNFPA 8 th CPD outputs 2020-2026	UNFPA Strategic Plan outputs 2022-2025	UNSDCF outcomes 2022-2026
<p>Output 1: Sexual and reproductive health: Strengthened institutional capacity to deliver quality integrated SRHR and HIV services and information, including for adolescents, young people and other vulnerable groups, at national, provincial, district, and community levels including in humanitarian situations.</p>	<p>Policy and Accountability Output: By 2025, improved integration of sexual and reproductive health and reproductive rights, as well as the prevention of and response to GBV and harmful practices, into universal health coverage-related policies and plans, and other relevant laws, policies, plans and accountability framework.</p> <p>Quality of care and services output: By 2025, strengthened capacity of systems, institutions and communities to provide high-quality, comprehensive sexual and reproductive health information and services, including supplies, as well as essential services, to address GBV and harmful practice.</p>	<p>(People Centred, Equitable, Human development and wellbeing) By 2026, all women, youth and men in Zimbabwe, especially women and girls in most vulnerable, marginalized communities realize their rights to equitable and quality social services and protection.</p>
<p>Output 2: Adolescent and young people: AYP, including vulnerable and disadvantaged groups, are equipped with knowledge and skills to participate in decision making and make informed decisions on SRHR.</p>	<p>Policy and accountability Output: By 2025, improved integration of sexual and reproductive health and reproductive rights, as well as the prevention of and response to GBV and harmful practices, into universal health coverage-related policies and plans, and other relevant laws, policies, plans and accountability framework.</p> <p>Quality of care and services output: By 2025, strengthened capacity of systems, institutions and communities to provide high-quality, comprehensive sexual and reproductive health information and services, including supplies, as well as essential services, to address GBV and harmful practice.</p>	<p>(People Centred, Equitable, Human development and wellbeing) By 2026, all women, youth and men in Zimbabwe, especially women and girls in most vulnerable, marginalized communities realize their rights to equitable and quality social services and protection.</p>
<p>Output 3: GBV and harmful practices: Gender equality, the empowerment of all women and girls, and reproductive rights are advanced in development and humanitarian settings.</p>	<p>Policy and accountability Output: By 2025, improved integration of sexual and reproductive health and reproductive rights, as well as the prevention of and response to GBV and harmful practices, into universal health coverage-related policies and plans, and other relevant laws, policies, plans and accountability framework.</p> <p>Quality of care and services output: By 2025, strengthened capacity of systems, institutions and communities to provide high-quality, comprehensive sexual and reproductive health information and services, including supplies, as well as essential services, to address GBV and harmful practice.</p> <p>Gender and social norms output: By 2025, strengthened mechanisms and capacities of actors and institutions to address discriminatory gender and social norms to advance gender equality and women's decision-making.</p>	<p>(People Centred, Equitable, Human development and wellbeing) By 2026, all women, youth and men in Zimbabwe, especially women and girls in most vulnerable, marginalized communities realize their rights to equitable and quality social services and protection.</p>
<p>Output 4: Population and development: Strengthened capacity of the national statistical system to produce, analyze and use disaggregated population data to inform policy decision-making and development programming, including in humanitarian situations.</p>	<p>Population change and data output: By 2025, strengthened data systems and evidence that take into account population changes and other megatrends (including ageing and climate change), in development policies and programmes, especially those related to sexual and reproductive health and reproductive rights.</p>	<p>(Transformative, Accountable, Equitable and Inclusive Governance) By 2026, all people in Zimbabwe, especially the most vulnerable and marginalized, benefit from more accountable institutions.</p>



3.2 UNFPA response through the Country Programme

3.2.1 Description of UNFPA previous programme cycle, goals and achievements

The UNFPA 7th CP covered the period from 2016 to 2020. The 7th CP was guided by the Zimbabwe UN Development Assistance Framework (ZUNDAF) 2016-2020 which supported the country to achieve its development objectives set out in the Transitional Stabilization Plan (2018-2020). The 7th CP aimed to ensure universal access to SRH, uphold reproductive rights, and reduce maternal mortality in line with the ICPD agenda. It delivered results across four outcome areas and six outputs through partnerships with government, UN agencies, parliamentarians, faith-based organizations, academia, and youth and women's networks.

The achievements per outcome area were as follows:

- **Outcome 1 (SRHR):** The CP strengthened voluntary FP, enhanced national capacity to provide quality maternal health services including in humanitarian contexts and increased uptake of HIV-prevention services among women, men, and KPs
- **Outcome 2 (Adolescents and Youth):** The 7th CP contributed to increased national capacity to provide information and services that prevent teenage pregnancy as well as increased availability of CSE
- **Outcome 3 (GEWE):** The 7th CP contributed to improvements in increased national capacity to prevent GBV and the delivery of multi-sectoral services as well as promotion of women's equality and empowerment
- **Outcome 4 (Population Dynamics):** The 7th CP contributed to the improvement in national capacity for production and the use of disaggregated data on population, SRH and GBV for the formulation and monitoring of evidence-based policies, plans and programmes, including in humanitarian settings.

Lessons learnt from the previous 7th CP: The following lessons can be drawn from the implementation of the 7th CP providing SRH and GBV services in emergency and humanitarian settings:⁶⁷

Relevance

- UNFPA's COVID-19 response revealed key lessons for maintaining service delivery during pandemics, many of which can be integrated into the CP to enhance overall efficiency and effectiveness.

Coherence

- Since 2018, UNFPA's collaboration with UNAIDS, UNICEF, and WHO has strengthened MoHCC's integration of SRH, HIV, and GBV services, while boosting UNFPA's high-level advocacy impact
- UNFPA's leadership of the Protection Cluster and GBV sub-cluster within the UNCT ensured GBV and HIV services were prioritized in emergencies.

Effectiveness

- During COVID-19 and Cyclone Idai, radio and online programmes boosted awareness and service demand. Key lessons included leveraging virtual platforms for training, setting up hotlines and mobile GBV services, and providing personal protective equipment ensuring continuity of essential health services during crises.

Efficiency

- The joint programming approach was critical in leveraging the resources and expertise of other UN agencies to achieve the CP results in SRH and HIV prevention.

Sustainability

- Government leadership in the identification of priorities and implementation of interventions supported by the CP promoted ownership of the CP and contributed to the sustainability of the benefits of the programme.

⁶⁷ UNFPA COARs 2022, 2023, 2024.



3.2.2 The current 8th CP (2022-2026) and an analysis of the ToC

The GoZ and UNFPA jointly developed the CPD (2022-2026) through a participatory process involving national and district stakeholders, including civil society, the private sector, young people, UN organizations and development partners.⁶⁸ The CP is aligned to the Zimbabwe Vision 2030, the UNSDCF 2022-2026, the ICPD, the 2030 Agenda for Sustainable Development, and FP 2030. UNFPA 8th CP 2022-2026 for Zimbabwe has four major outcome areas of SRH, adolescents and youth, gender equality and the empowerment of women (GEWE), and population development.⁶⁹ Under the outcomes are four outputs. UNFPA's CP operates nationally and sub-nationally, aligning with GoZ priorities and contextual realities, with programme areas driven by government requests and, occasionally, donor interests. As a UNCT member, UNFPA works with UN agencies to monitor UNSDCF (2022–2026) outcomes.⁷⁰ In humanitarian settings, inter-agency responsibilities are coordinated through mechanisms like the Common Humanitarian Action Plan, Consolidated Appeal Process, and Flash Appeal processes.

3.2.2.1 Sexual and reproductive health and rights

The SRHR outcome area supports GoZ priorities in maternal and child health, FP, and reproductive health.

Output 1 specifically focuses on strengthening institutional capacity to deliver high-quality, integrated SRHR services and information, including for adolescents and vulnerable groups, at national, provincial, district and community levels, including in humanitarian situations.

The intervention logic for Output 1 builds on the following programme interventions namely:

(a) Enhancing selected health facilities' readiness with infrastructure, staff, equipment, and supplies for comprehensive EmONC, cervical cancer prevention, and youth-friendly SRH, HIV, and GBV services; (b) Providing TA to improve high-quality SRHR service delivery, including the use of maternal and perinatal death surveillance and response as a quality-improvement tool; (c) Strengthening government capacity to manage SRH commodities and reduce stock-outs; (d) Ensuring SRHR service continuity during emergencies and integrating minimum initial service packages; (e) Enhancing training institutions' capacity to deliver competency-based education and strengthen health management and clinical skills for quality, integrated SRHR service provision; (f) Carrying out advocacy to invigorate and better integrate comprehensive condom programming, including for KPs; (g) Fostering partnerships with government, private sector, UN, and academia to drive innovation, and promote research, documentation, and knowledge sharing; and (h) Strengthening advocacy with the Government to increase domestic funding for FP and SRH, and expand human resources for health management, including bringing innovation to the issue of staff retention.

Output 1 and the SRHR outcome area contributed to the UNFPA SP Outputs of Quality of services and care, and Policy and accountability as well as to the Health pillar of the ICPD Framework of Action.⁷¹

3.2.2.2 Adolescents and youth

The United Nations Youth Strategy emphasizes the importance of engaging and empowering young people to advocate for their rights and actively participate in development, recognizing this as essential to achieving results across peace and security, human rights, and sustainable development. UNFPA fully supports this vision, acknowledging youth engagement as vital to advancing the SDGs in Zimbabwe. As result, UNFPA Zimbabwe is committed to support the GoZ in addressing factors influencing adolescent and youth reproductive health.

Output 2 focuses on AYP, including vulnerable groups, being equipped with the knowledge and skills to participate in decision-making and make informed decisions on SRHR.

The intervention logic for Output 2 builds on the following programme interventions:

⁶⁸ KIs with stakeholders at national and provincial levels.

⁶⁹ UNFPA. 2021. Country Programme Document for Zimbabwe.

⁷⁰ Document review of UNSDCF 2022-2026; KIs with UN agencies and GoZ counter-parts.

⁷¹ United Nations, Framework of actions for the follow-up to the Programme of Action of the International Conference of Population and Development Beyond 2014, Report of the Secretary-General.



(a) Supporting advocacy to promote inclusive policies, laws, and accountability to uphold young people's rights, including menstrual health management for adolescents, KPs, and youth with disabilities; (b) Enhancing capacities of educational institutions, faith groups, and youth networks to deliver innovative CSE and SBC interventions for in-school, tertiary and out-of-school youth; (c) Supporting access to CSE, SRHR, GBV and HIV information and services by young people and strengthening their agency to make informed decisions; (d) Providing technical support to improve adolescent girls' access to menstrual health information and services, including eco-friendly, reusable sanitary pad innovations; (e) Strengthening national and subnational platforms to generate, share, and disseminate strategic information and best practices on AYP to inform policies and programmes; and (f) Developing strategic partnerships and enhancing collaboration with the GoZ, UN agencies, and academia to advance innovation and operational research in adolescent SRHR.

Output 2 and the AYP outcome area contributed to the UNFPA SP Outputs of Quality of services and care, and Policy and accountability as well as to the Dignity and human rights pillar of the ICPD Framework of Action.

3.2.2.3 Gender equality and women empowerment

UNFPA at the corporate level has a Gender Equality Strategy that includes five strategic priority areas as well as three tools to support application within the organization. The GEWE outcome area of the 8th CP focuses on strengthening capacities to prevent and respond to GBV and HP, including in humanitarian contexts. It aims to promote gender equality, empower women and girls, and advance reproductive rights, particularly for those most at risk of being left behind.

Output 3 focuses on strengthening national, provincial, district and community capacity to prevent and respond to GBV and HP, including in humanitarian settings.

The intervention logic for Output 3 builds on the following programme interventions:

(a) Carrying out advocacy for the development and implementation of gender-responsive legislation, policy guidelines and strategies, and improved funding for reducing GBV; (b) Enhancing women and girls' knowledge of life skills, gender-equitable norms, and confidence, while strengthening their ability to access GBV services; (c) Enhancing the capacity of national and subnational partners on GBV in emergencies preparedness; (d) Enhancing men's and boys' engagement on positive masculinities for their active involvement; (e) Enhancing the communities' capacity to ensure gender equality and increase the agency of women and girls; (f) strengthening the integrated essential services package on GBV within the health, judicial and other sectors; (g) scaling up mobile and remote GBV service provision models in remote and hard-to-reach areas; and (h) scaling up partnership with the GoZ, UN agencies and other key stakeholders for joint programming.

Output 3 and the GEWE outcome area contributed to the UNFPA SP Outputs of Quality of services and care, Gender and social norms, and Policy and accountability as well as to the Dignity and human rights pillar of the ICPD Framework of Action.

3.2.2.4 Population and development

The focus of **Output 4** was Strengthened capacity of the NSS to produce, analyze and use disaggregated population data to inform policy decision-making and development programming, including in humanitarian situations.

The intervention logic for Output 4 builds on the following programme interventions:

(a) Advocating and supporting the use of new technologies and sustainable funding for the NSS; (b) Generating knowledge around the DD based on the latest population data; (c) Strengthening sector information management systems (health, education, GBV) and their inter-linkages; (d) Building capacity on data analysis and utilization for producers and users of data at all levels; (e) Strengthening partnerships with international financial institutions and research bodies on the coordination of national statistics, partnerships in data generation and use during humanitarian response; and (f) Coordinating and collaborating with other UN agencies, especially for data generation and analysis in humanitarian settings.

Output 4 and the PD outcome area contributed to the UNFPA SP Outputs of Population change and data as well as to the Governance and accountability pillar of the ICPD Framework of Action.



Modes of engagement:

The modes of engagement, which UNFPA undertook during the CP cycle included the following: (a) Advocacy and policy dialogue; (b) Capacity development; (c) Coordination and partnership; (d) Knowledge management; and (e) Service delivery.

Implementation status of 8th CP

By the time of the evaluation field phase in June 2025, the 8th CP was in its fourth year of implementation having started on 1st January 2022. The evaluation assessed the implementation progress up to the end of April 2025 and the achievements are contained in Chapter 4.

Analysis of the UNFPA 8th CP Theory of change

The TOR indicated that the ET would perform an in-depth analysis of the 8th CP ToC and its intervention logic at the design stage. The ToC describes how and why the set of activities planned under the CP are expected to contribute to a sequence of results that culminate in the strategic goal of UNFPA. The CP ToC explains how the activities undertaken contribute to a chain of results that lead to the intended or observed outcomes.

The elements of the intervention logic are inputs (human and financial resources, administrative arrangements, systems, agreements, and contracts with IPs and consultants); intervention activities (different modes of engagement); outputs (the immediate or short-term improvements generated once the activities have been completed); and outcomes (short- and medium-term changes in conditions or effect) corresponding to tangible improvements compared to the baseline situation of target beneficiaries.⁷² This theory simply assumes that when the inputs are implemented as intervention activities, there would be a change in the quality of life of the beneficiaries of the CP. The ToC⁷³ Concept Note 2016 notes that a good ToC should be clear, plausible, logical, based on evidence and consulted. Based on this assessment criteria, the presentation of the three ToCs is clear and can be easily understood. The problems, the assumptions and the risks are clearly articulated. The output and outcome indicators are specific, measurable, achievable, relevant and timebound with a clear cause-effect pathway from outputs to the outcomes.

Currently, the 8th CP has three separate ToCs for the thematic areas of SRH, GEWE and PD. The CO clarified that AYP output was encompassed within the SRHR ToC. The 8th CP ToCs were built on the previous CP ToC and recommendations of the previous CPE; hence it was informed by evidence. Indications from the CPD are that the ToCs were developed at the design stage in a consultative manner with the government, stakeholders and partners, UN agents, CSOs and NGOs. The ToCs were reviewed and critiqued by the ET.

Analysis of the ToC

The analysis of the three ToCs shows the following:

- For each thematic ToC, the UNFPA Zimbabwe CP outcomes are well linked to the higher level namely the national priorities and the ZUNSDCF outcomes.
- There are measurable indicators at the outcome and output levels with specific baseline and target figures. The targets are deemed realistic.
- The achievement of the output indicator targets would result in the fulfillment of the outcomes. However, under the AYP component, the indicator targets were activity numbers rather than the changes expected. One example of the output indicator used was - *number of young people reached with life skills programmes that build their health, social and economic assets in schools, universities and communities in supported provinces*.
- The strategic interventions under each thematic ToC are grouped under the 5 UNFPA modes of engagements namely i) advocacy and dialogue; ii) knowledge generation and sharing; iii) capacity building; iv) service delivery; and v) partnership and coordination. The implementation of these interventions is likely to result in the achievement of the outputs.
- Within the ToC framework, the specific risks and assumptions are clearly stated. For each thematic component, the ToC indicates the complementarity of the other outcomes to support the implementation of strategic interventions. The major problems(s) under each thematic component have been indicated

⁷² OECD-DAC.

⁷³ This document has been prepared jointly by the Peer Support Group (PSG) and the UNDG LAC Secretariat to provide support to RCs/UNCTs in the application of the Theory of Change as included in the new Interim UNDAF guidance.



- The risks have also been indicated. However, there is no mention of a linkage to a risk mitigation plan.

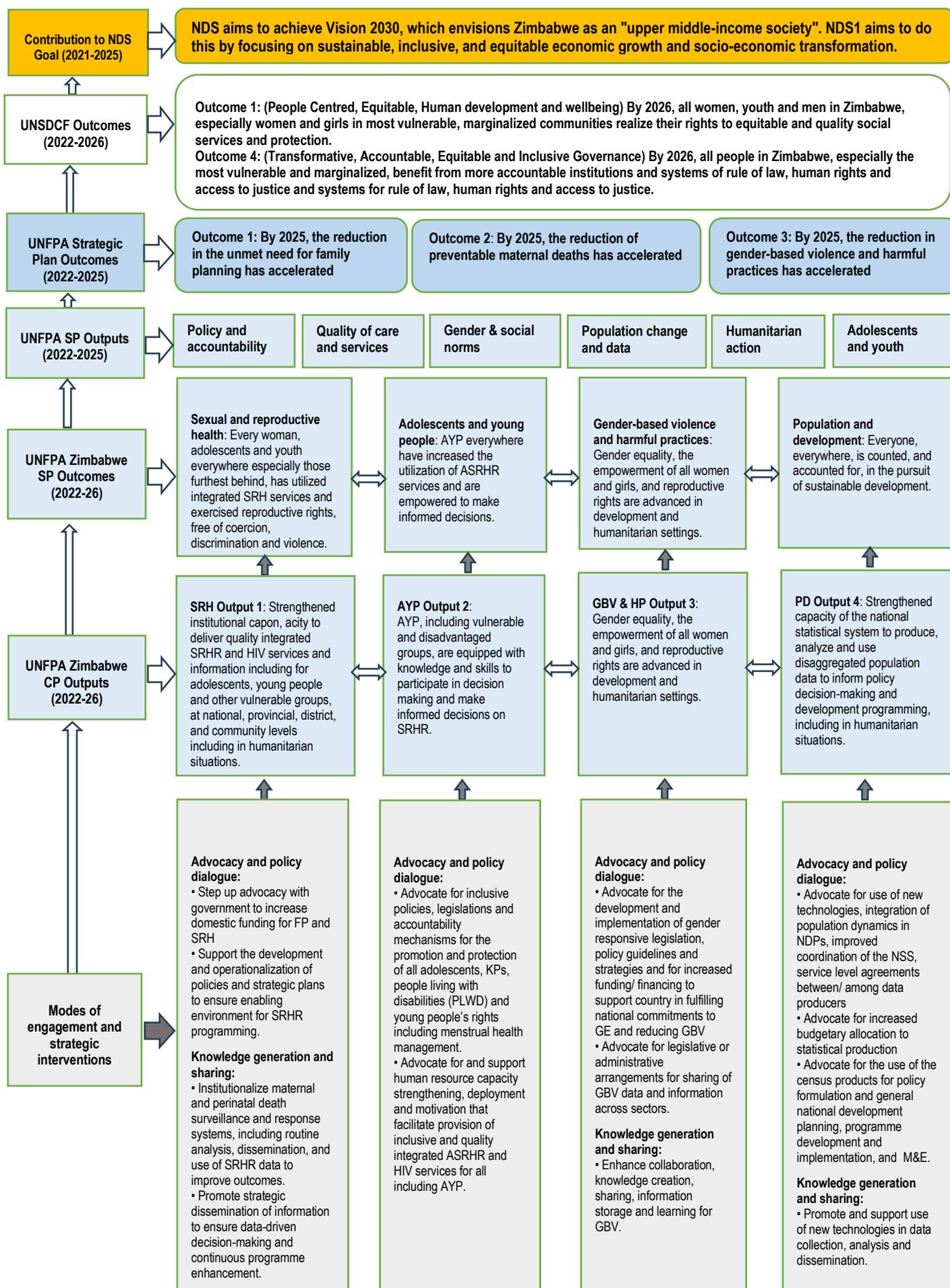
Critique

The ToC for AYP was integrated in the broader SRH outcome. This limits the exploration of the causal pathways of the AYP component and undermines the assessment of UNFPA's contribution to outcomes. To improve evaluability of the AYP interventions, the ET developed a separate AYP ToC. Given the fact that there are three separate ToCs, the overall strategic overview and oversight of CP ToC is limited. It was recommended that a central ToC be constructed, which will be used by high level management. The ET has presented a reconstructed ToC on the next page. The ET further recommends that the separate thematic ToCs continue to be used by the thematic sectors.

Description of the reconstructed ToC

The ToC for the 8th CP was reconstructed during the design phase to illustrate the changes across the logic chain (refer to Figure 7). The reconstruction aimed to assess how results were achieved through the 8th CP interventions. It evaluated the adequacy of the three thematic ToCs to ensure a logical and coherent results chain. Causal links across result pathways clarified expected outcomes and how interventions and outputs interacted. The reconstructed ToC guided both the fieldwork and reporting phases, while factoring in assumptions and risks. It was aligned with the UNFPA Strategic Plan 2022-2025, integrating the result accelerators and the UNFPA modes of engagement, including capacity development, knowledge management and policy level engagement to achieve its objectives making use of partnerships with the Government, civil society and academic stakeholders in the various parts of the programme. The results contributed to the UNFPA Strategic Plan, UNSDCF, and NDS 1, with reporting to UNFPA and the Government.

Figure 7: Reconstructed ToC





Modes of engagement and strategic interventions



Knowledge generation and sharing:

- Institutionalize maternal and perinatal death surveillance and response systems, including routine analysis, dissemination, and use of SRHR data to improve outcomes
- Support HMIS review for generating, sharing, and utilizing age- and gender-disaggregated SRHR data, especially for AYP, to inform policies and programmes

Capacity building:

- Build capacities of the training schools (midwifery, medical) and health workforce in health management and clinical skills for delivering high-quality and integrated SRH services provision, including for AYP and PWDs
- Expand innovative capacity building approaches such as blended/e-learning to mitigate against other emergencies.

Partnerships and coordination:

- Develop strategic partnerships and cooperation with Gov't, private sector including tech companies, UN, CSOs and academia to improve innovations, operational research to explore emerging issues in SRHR to enhance service delivery and humanitarian response.

Service delivery:

- Support continuous quality improvement in SRHR service delivery (including AYFS, OF, CCP, MHPSS, KPs, the referral system) including promoting alternative ways of service delivery to strengthen the health system resilience.

Service delivery:

- Support capacity to effectively forecast, procure, distribute and track the delivery of SRH commodities
- Support the readiness of the health facilities to offer comprehensive and integrated SRH, HIV and GBV services

Advocacy & policy dialogue:

- Support the development and operationalization of policies and strategic plans to ensure an enabling environment for ASRHR programming

Knowledge generation and sharing:

- Enhance collaboration, knowledge creation, sharing, information storage and learning for AYP.

Capacity building:

- Support implementation of Youth Friendly Service Provision standards
- Support the readiness (basic infrastructure, staff, equipment, RH kits, supplies and sundries) of the health facilities to offer comprehensive and integrated SRH, HIV and GBV services that are youth friendly, including during emergencies
- Build the capacity of health staff to provide effective integrated SRH/HIV services for men who have sex with men.

Partnerships and coordination:

- Develop strategic partnerships & cooperation with Gov't, private sector including tech companies, UN, CSOs and academia to improve innovations, operational research to explore emerging issues in ASRH to enhance service delivery and humanitarian response.
- Ensure Youth Networks coordination in its core functions, and participation to the relevant TWG, in partnership with Gov't counterparts and UN agencies.

Capacity building:

- Improve knowledge of women and girls on life skills, gender equitable norms attitudes and behaviours including sexuality and reproduction, self-confidence and self-esteem, and capacity to adequately access GBV services.
- Enhance National and sub-national GBV partners' capacity on GBVIE preparedness
- Build capacity of Health sector personnel on clinical management of SGBV
- Support the Victim Friendly Justice system to provide survivor centred support
- Support capacity of national and sector data management information systems to ensure quality data collection, analysis including during slow and rapid onset humanitarian crises.

Partnerships and coordination:

- Scale-up partnership and coordination and cooperation with government, UN agencies, and other key stakeholders for joint programming, and improved coordination to address GBV & early marriage.
- Ensure GBV sub-cluster coordination in its core functions, & participation to the Health Cluster/SRH working group, in partnership with Gov't counterparts, OCHA and the Inter-cluster team.

Service delivery:

- Strengthen integrated essential service package on GBV within the health sector and across sectors.
- Establish, operationalize and run OSCs, integrating multi-sectoral SGBV services into MNCH, RH, HIV & FP services & support SGBV clinics
- Support operation of community shelters, scale up Faith Based Shelter models and strengthen psycho- social/ mental health support to GBV survivors.

Knowledge generation and sharing:

- Generate evidence on the demographic dividend
- Support data analysis and publication of census, DHS and other data products for wider utilization
- Support training courses on population studies at the Centre of Population Studies and knowledge exchange with the regional demographic institutions
- Support the roll out of standardized vulnerability assessment that includes SRHR issues.

Capacity building:

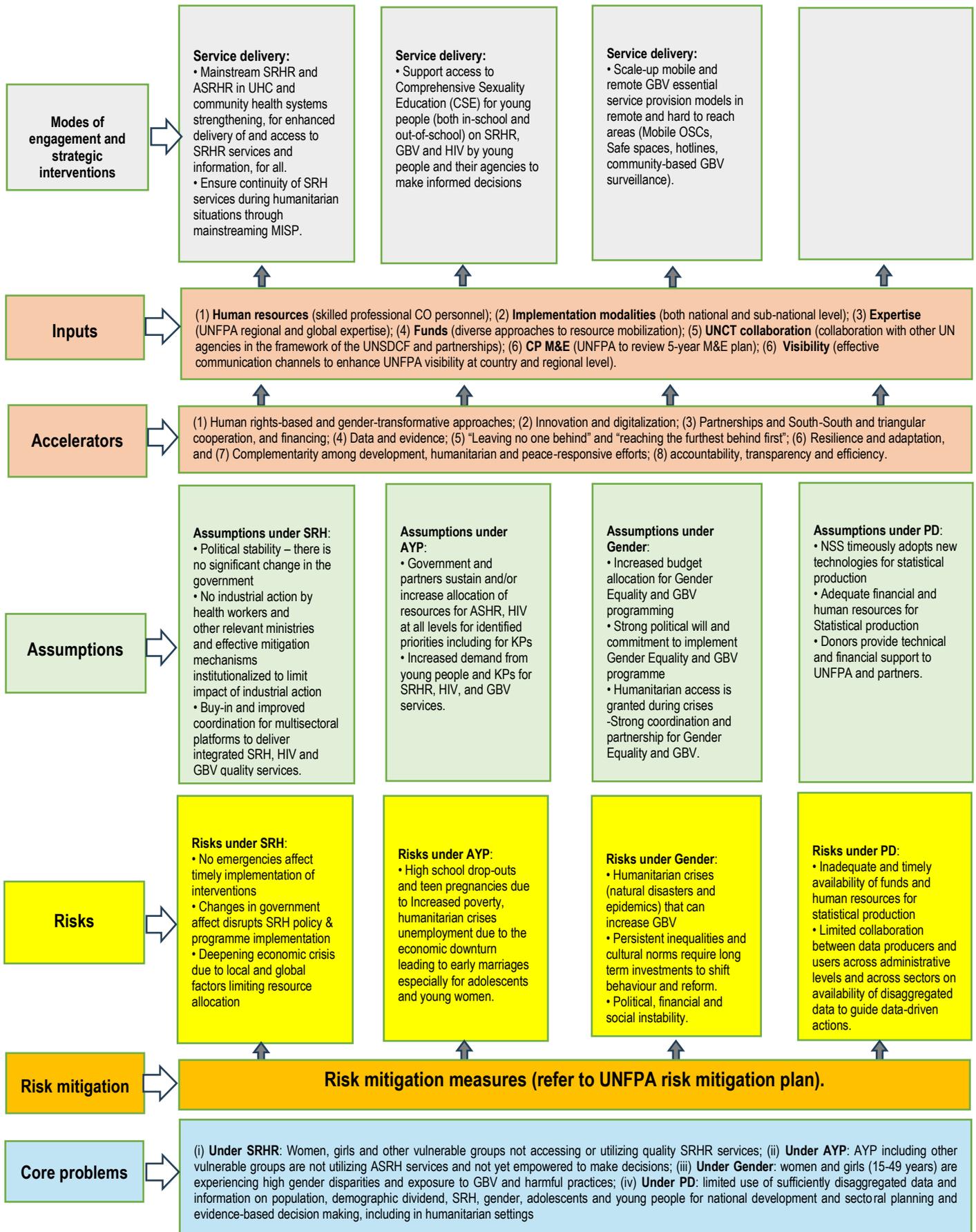
- Support training, mentorship and technical assistance on demographic analysis, use of new tech., sampling, etc. in line ministries, ZIMSTAT)
- Support use of population data for policy making through seminars, policy dialogues
- Support generation, analysis, dissemination and use of population-based census and survey data; and the use of facility-based assessment data
- Support establishment and/or maintenance of routine/ administrative information management systems (health, education, GBV, AYPs) and analysis and use of data thereof
- Support the CRVS system
- Maintain and improve functionality of national statistical database systems (ZIMDAT, REDATAM) for SDG monitoring and reporting.

Partnerships and coordination:

- Expand partnerships with IFIs (WB, AfDB), UNECA AUC, Centre for Population Studies, universities and research and training institutions)
- Strengthen collaboration with UN agencies and other partners on generation and analysis of data for humanitarian response.



Country Programme Evaluation of GoZ /UNFPA 8th CP 2022-2026



3.2.3 Financial structure of the UNFPA CP

Allocation of budget, 2022-2025

As of the end of March 2025, UNFPA had initially committed US \$ 39.92 million over the four years of the programme of assistance to the GoZ (2022-2026). The financial resources for the four years were distributed as shown in Table 9.⁷⁴

Table 9: Allocation of budget 2022-2025 (US\$ million)

Output	Description	Project budget	% of total budget
Output 1	Sexual and reproductive health	27.73	69%
Output 2	Adolescents and youth	4.75	12%
Output 3	Gender equality and women's empowerment	6.77	17%
Output 4	Population dynamics	0.67	2%
Total		39.92	100%

The SRH component accounted for the highest allocation (69 per cent) of the total budget. The GEWE component accounted for 17 per cent of the budget followed by the AY component with 12 per cent of the budget allocation and the PD component at two per cent of the budget.

Cash available/allocated versus expended resources, 2022-2025

UNFPA develops annual Resource Mobilization Plans with an indicative budget needed to deliver on each of the four strategic output areas as stipulated in the 8th CP. By the end of March 2025, a total of US\$39.92 million had been mobilized across all outputs and of which US\$28.54 million (71 per cent) had been utilized to implement programme interventions. The implementation rate for SRHR interventions was at 73 percent, reflecting steady resource absorption across the years. However, the implementation rate for AYP interventions was below average (51 percent), indicating low utilization of available resources in this area. The implementation rates for GEWE and PD outputs were 79 percent and 75 percent respectively, both above the overall average.

Evolution of overall budget and expenditure, 2022-2025

Budget utilization was highest in 2022 (93 per cent), and thereafter it declined to 60 per cent in 2023 and 72 per cent in 2024 before falling further to 59 per cent in 2025. The percentage in 2025 is low because only one quarter of January - March 2025 is included by the time the design report was prepared. Overall, the budget utilization across the four years averaged 71 per cent (as shown in the Table 10), with a total expenditure of US\$28,537,998.00 against a total budget of US\$39,921,713.31. Note that the budget and expenditure during 2025 is up to 31st March 2025.

Table 10: Evolution of overall budget and expenditure (US\$) (Up to 31st March 2025)

	2022	2023	2024	2025	Total
Budget	9,466,161.87	13,133,260.18	12,465,866.66	4,856,424.60	39,921,713.31
Expenditure	8,791,289.68	7,881,478.42	8,985,145.89	2,880,084.01	28,537,998.00
Budget utilization rate	93%	60%	72%	59%	71%

Budget and expenditure by origin of funds and by year

The total budgeted / cash available was higher for non-core sources (other resources) than the core sources (regular resources) in each of the years from 2022 up to 2025. This reflects the effective and successful resource mobilization efforts by the CO.

Total budget and expenditure by implementing partner

Among the IPs who had a utilization rate above 95 percent were UNICEF (100 percent), SRC (98 percent), ZNFPC, Musasa, and GALZ (95 percent) as shown in Table 11. The IPs who had less than 50 percent were NAC (28 percent) and MoPSE.

⁷⁴ Analysis of UNFPA CO Cognos financial data.



Country Programme Evaluation of GoZ /UNFPA 8th CP 2022-2026



Table 11: Total budget and expenditure by implementing partner

Implementing partners (IPs)	Interagency	Main intervention areas	Project Budget	Utilization	Utilization rate per partner
UNICEF	PU0081	Support costs to Vital Medicines Availability and Health Services Survey (VMAHSS); Electronic Last Mile Information System (ELMIS) roll out.	111,309.98	111,309.98	100%
SRC	PN6867	KPs (mobilization and service provision)	576,337.85	562,423.80	98%
ZNFPC	PGZW01	FP strategies development; FP service delivery; FP demand creation; FP research.	471,227.66	446,032.51	95%
MUSASA	PN4230	GBV prevention & response - GBVie OSCs; Disability inclusion; Spotlight OSCs.	1,807,222.44	1,719,839.73	95%
GALZ	PN6868	UBRAF HIV Zimbabwe - KP services provision; Integrated SRHR services - KP services provision, capacity development;	948,513.22	902,353.60	95%
World Vision	PN4634	GBV prevention and response-GBVie – TA, comm. mobilization, Sista2Sista, safe spaces; Spotlight - SBCC Strategy, GBV Surveillance;	667,080.41	612,209.03	92%
CeSHHAR	PN5877	GBV prevention and response-Spotlight - KP mobilization; Spotlight – OSCs; Spotlight – YWSS	44,608.34	41,060.78	92.%
ZIMSTAT	PGZW04	2022 Census; 2023 ZDHS	347,075.00	316,096.13	91%
SAYWHAT	PN5876	BV prevention and response-Spotlight PSEA; Spotlight - GBV IMS; Spotlight – Male engagement; Availability and access to SRH; AYP advocacy; Condom programming; CSE in tertiary institutions	423,643.58	384,464.07	91%
FACT	PN4639	GBV prevention and response - GBVie Safe spaces; Spotlight - HR Support, comm. mobilization, GBV Surveillance; Sista2Sista;	1,165,115.95	996,740.02	86%
MoWACSMED	PGZW03	GEWE - GBV capacity building; Spotlight - Survivor-cent. system, new OSCs, Mobile OSC campaign;	344,482.22	256,769.68	75%
UNFPA	PU0074	GBV prevention and response-Programme planning, monitoring; Implementation of Global Programme - Sustainable FP Financing, FP Communication and Advocacy; Safeguard Young People (SYP) - capacity building; ASRH strategies, coordination; UBRAF HIV; Strengthened SRHR/HIV and SGBV-2Gether4SRHR Advocacy; Spotlight – CSE, Integrated SRHR services; Clinical midwifery (CM) gap analysis,	24,746,681.35	17,711,282.16	72%
Plan International	PN5603	Youth economic empowerment; AYP advocacy, AYP networks strengthening; Menstrual health management; SYP; Self-care model	566,250.40	396,127.48	70%
ZYC	PGZW07	ASRH advocacy; AYP networks strengthening	106,786.55	72,001.15	67%
PSZ	PN4281	Community mobilization; Project planning, monitoring and evaluation; Self-care model; Post-abortion care	239,907.33	145,243.78	61%
MoHCC	PGZW02	FP strategies development, FP demand generation; SYP - ASRH strategies development; Implementation of Global Programme; Maternal health - Midwifery in-service learning; RMNCAH research; Community MPDSR; Integrated SRHR services - contraceptives procurement; SC management; Obstetric fistula repair.	6,097,732.76	3,607,439.73	59%
NAC	PGZW06	UBRAF HIV Zimbabwe - KAP coordination; ASRH advocacy; In-school CSE; AYP networks strengthening; Not in My Village Campaign; YFS	899,768.27	254,884.23	28%
MoPSE	PGZW10	In-school CSE; CSE in tertiary institutions	357,970.00	1,680.14	0.005%
	Grand Total		39,921,713.31	28,537,998.00	71%

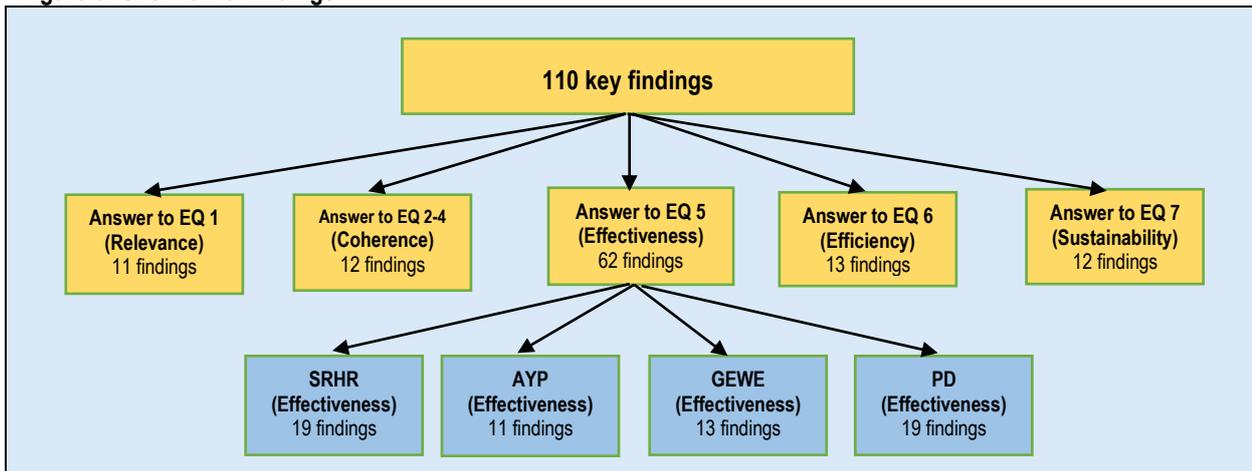


CHAPTER 4: FINDINGS

Overview of findings

This section presents the key findings from the evaluation. As illustrated in Figure 8, the findings section is structured into five areas namely: answer to EQ 1 (relevance); answer to EQ 2-4 (coherence); answer to EQ 5 (effectiveness); answer to EQ 6 (efficiency); and answer to EQ 7 (sustainability).

Figure 8: Overview of findings



4.1 Answer to evaluation question 1 (Relevance)

EQ 1: To what extent has UNFPA positioned itself within the national development/policy space and adapted to changes that have taken place, and strategies that it has taken to assist efforts on addressing the needs of vulnerable and marginalized populations taking into account the issue of disability, human rights and gender including emerging issues such as new diseases, drug abuses and challenges brought about by climate change?

Summary of findings

The UNFPA has successfully positioned itself within Zimbabwe's national development and policy space by proactively aligning its 8th CP with key national frameworks and adapting its strategies to address the needs of vulnerable populations, including emerging issues.

The 8th CP was highly relevant, aligning with Zimbabwe's Vision 2030, NDS1 (2021-2025), the UNSDCF (2022-2026), and key national strategies, ensuring responsiveness to development priorities, sectoral needs, and policies. UNFPA pro-actively positioned itself to bring value within the national development/policy space and adapted to changes that have taken place. It employed novel ways and advanced its influence through strategic partnerships, visibility, and thought leadership. It built strong networks with UN agencies, civil society, and government stakeholders, enhancing trust and credibility. UNFPA increased its visibility via policy briefings, media engagement, and participation in national and global events. It provided TA and capacity building to partners, reinforcing its expertise. Through research, policy analysis, and active involvement in platforms like UNCT and UNSDCF results groups, UNFPA demonstrated thought leadership, shaping policy discussions and promoting evidence-based decision-making across various sectors and levels of government and society. UNFPA operates in a competitive policy environment with many actors supporting the GoZ but maintains influence through mutual respect, dialogue, and collaboration with all stakeholders involved. At the upstream level, UNFPA Zimbabwe positioned itself strategically in the national policy space through sustained engagement with Government ministries such as MoHCC, MoFEDIP, MWACSMED, MoPSE, and collaboration with UN agencies. It provided technical support in developing and operationalizing key policies and strategies aligned with the NDS1 and NHS 2021-2025, review of the Marriages Act and the Sexual Offences Act, the National Gender Policy (2023), the development and 2022 launch of the High-Level Political Compact on Ending GBV (2021-2030), and the formulation of the National Strategy for Preventing and Addressing GBV (2023-2030). At the downstream level,



UNFPA's interventions aligned with national priorities, SDGs, human rights commitments, and beneficiary needs, focusing on comprehensive SRH service provision, youth-friendly services. It also addressed GBV, youth vulnerabilities, and engaged the youth in design, effectively tackling health, education, gender, rights, disability, drug abuse, and teenage pregnancy. The PD component of the 8th CP aligned with national priorities and stakeholder needs, while UNFPA strengthened the National Statistical System through staff training, technology upgrades, and coordination mechanisms. Nonetheless, NDS2 (2025-2030) needs to be considered in 9th CP. The National Population Policy and the Census and Statistics Act are outdated and are due for review. Additionally, UNFPA acknowledged that more could have been done for KPs, partly due to the challenging operational environment where LGBTQI+ rights are restricted. Though partners embraced disability inclusion in various ways, they noted that UNFPA could have offered stronger guidance to IPs on structured disability inclusion. Emerging issues highlighted included climate change, increase in adolescent pregnancies, drug and substance abuse, and mental health.

For details of the evidence supporting findings in section 4.1, see the evaluation matrix: Assumptions 1.1-1.3 in Annex 1.

Overview

The 8th CP was relevant to Zimbabwe's national development priorities, sectoral needs, and policy environment. The programme was aligned to Zimbabwe's Vision 2030, the NDS1 (2021-2025), the UNSDCF (2022-2026) and other national strategies.⁷⁵

4.1.1 Positioning within the national development and policy space

Finding 1: UNFPA pro-actively positioned itself to bring value within the national development/policy space and adapted to changes that have taken place. It employed the following ways among others:^{76, 77, 78}

- (a) **Strategic positioning and visibility:** UNFPA produced regular data briefs and reports that provided timely and relevant analyses. Examples of the data briefs produced and shared with MoHCC and other stakeholders are the 2023-24 ZDHS HIV factsheet, the ZDHS factsheet-family planning; and the Fertility factsheet. The briefs raised awareness about the current topics, promoting a deeper understanding of issues; they also provided evidence-based information that enabled decisionmakers to understand complex issues and make informed choices.⁷⁹ UNFPA participated in high-profile in-country and global events to amplify its visibility (e.g., Government launch of the final 2024 ZDHS report; World Population Day on 11th July; International Women's Day on 8th March; International Midwives Day on 5th May; International Day for the Elimination of Violence against Women on 25th November; International AIDS Day on 1st December among others), conferences [International Conference on AIDS and STIs in Africa (ICASA) in December 2023 among others], or summits to showcase UNFPA's expertise and influence. Additionally, UNFPA built relationships with media outlets and journalists to secure coverage and shape public discourse.
- (b) **Capacity building and TA:** UNFPA provided TA to government agencies and other organizations (mentioned above), demonstrating UNFPA's expertise and building trust. Examples include the TA provided for the preparation and implementation of the 2024 ZDHS; and drafting of the FP cost recovery framework for enhanced domestic financing. UNFPA also offered training and capacity building programmes for policymakers, civil society organizations, or other stakeholders. Examples include the (i) capacity building of health workers in integrated SRH/ASRH, HIV and GBV service provision as well as on-job training for the implementation of innovations such as the rolling out of Sayana press for self-care; and (ii) capacity building of MWACSMED staff and partners like Musasa on GBV prevention and survivor support.
- (c) **Thought leadership and expertise:** UNFPA offered expert advice, commentary on policy issues (e.g. through UNCT meetings, UNSDCF, TWGs), demonstrating UNFPA's knowledge and authority. Further, UNFPA facilitated the production of high-quality research, analysis, and data briefs that provided valuable insights and recommendations.

⁷⁵ Review of UNFPA Programme document, KIs with UNFPA Staff.

⁷⁶ Review of strategic documents (8th CPD, UNSCDF 2022-2026); UNFPA COARs).

⁷⁷ KIs with GoZ ministries and agencies; UNFPA CO staff.

⁷⁸ KIs with in-country UN agencies; development partners (donors).

⁷⁹ KIs with government stakeholders at national and provincial levels; KIs with CO staff.



Finding 2: At the upstream level, UNFPA Zimbabwe positioned itself within the national development/policy space through active and regular engagement with MoHCC. Interviews and review of documents revealed that UNFPA in liaison with other UN agencies provided technical support to the MoHCC in the development and the operationalization of the following policies, strategies and initiatives during the current programme cycle:^{80,81} (i) NHS 2021-2025: The strategy focuses on reproductive, maternal, neonatal, child, and adolescent health, as well as GBV and harmful traditional practices; (ii) Health Resilience Fund (HRF) 2022-2025: Launched in 2023, this fund is aligned with Zimbabwe's NDS1 and the NHS 2021-2025. It focuses on three health pillars namely: (a) Ending preventable maternal, newborn, child, and adolescent deaths; (b) Global health security; (c) Health systems strengthening; (iii) National Community Health Strategy (2021-2025); (iv) Investment Case for the NHS (2019-2020): This initiative calls for efficiencies in utilizing available health resources, ensuring better healthcare outcomes; (v) SMART advocacy for increased domestic financing for FP; (vi) Community Health Supply System for contraceptives; (vii) Human Resources for Health (HRH) Strategy and Compact (2024-2026); (viii) National Family Planning Strategy 2022-2026; (ix) National HIV and AIDS Strategic Plan 2021-2025 and (x) National EmONC guidelines (2024): With TA from UNFPA, EmONC guidelines were updated to standardize the provision of quality maternal health services in line with emerging innovations in obstetric care such as E-MOTIVE; (xi) Sayana Self-Care Implementation Plan (March 2024); (xii) Comprehensive Abortion Care guidelines; (xiii) Minimum Initial Services Package (MISP) guidelines (November 2024) and (xiv) Revitalization of the Electronic Maternal and Perinatal Deaths Notification System (e-MPDNS) (2024). The above policies, strategies and guidelines are aligned to the national priorities on health contained in NDS1 and Vision 2030, which are to drive sustainable development meant to achieve the GoZ's principle of 'LNOB and no place behind'.

UNFPA provided critical technical support in government-led policy development processes, notably the review of the National Gender Policy (2023).⁸² This support ensured that revised policies were evidence-informed, rights-based, and aligned with international norms and standards. Its cross-sectoral engagement involved close collaboration with MWACSMED, other government ministries, UN agencies, civil society organizations, and NGOs. UNFPA also played a catalytic role in developing and launching the High-Level Political Compact on Ending GBV (2021-2030) in 2022, providing both technical expertise and financial support to strengthen political commitment and accountability. Similarly, UNFPA contributed significantly to the formulation of the National Strategy for Preventing and Addressing GBV (2023-2030), ensuring alignment with CPD priorities through extensive consultations and technical support.

Interviews revealed that throughout the programme cycle, UNFPA maintained a strong partnership with MWACSMED and other relevant ministries. Government ownership and endorsement at both design and implementation stages reinforced UNFPA's role as a trusted development partner.⁸³ UNFPA also contributed significantly to the National Strategy for Preventing and Addressing GBV (2023-2030) through technical assistance, stakeholder consultations, and alignment with the CPD.⁸⁴ These contributions reflect UNFPA's strong positioning within Zimbabwe's national development and GBV response framework.

A detailed review of literature and primary data from CPE respondents indicated that the PD component of the UNFPA 8th CP is aligned to national policies and strategies, government priorities, and to the needs of stakeholders and beneficiaries. Firstly, it is aligned to the Zimbabwe National Population Policy (NPP) developed in 1998,⁸⁵ which is used as the basis in the development and implementation of PD policies and strategies in the country. In 2019, the GoZ made a commitment under the ICPD@25 (Nairobi Summit) to update the policy. The UNFPA annual work plans (AWPs) indicated that the policy was to be reviewed under the current programme, with funds set aside to support the process.⁸⁶ However, due to competing priorities this process was delayed.⁸⁷

Secondly, the Census and Statistics Act [Chapter 10:29] 2007⁸⁸ establishes ZIMSTAT for collecting and processing statistics, repealing the Census and Statistics Act [Chapter 10:05], and related matters. However, the review found it

⁸⁰ Document review of Annual Work Plans (AWPs) and Country Office Annual Reports (COARs) (2022 – 2025).

⁸¹ KII with staff of MoHCC Directorates.

⁸² Interviews with MWACSMED and UNFPA staff.

⁸³ KII with ministry staff.

⁸⁴ KII with ministry staff.

⁸⁵ Government of Zimbabwe. 1998. The Zimbabwe National Population Policy.

⁸⁶ Annual Workplans 2022 to 2025; ICPD POA, and GoZ/UNFPA 7th CPE Report.

⁸⁷ KIIs with UNFPA CO staff, MoFEDIP; ZIMSTAT.

⁸⁸ Government of Zimbabwe. Census and Statistics Act [Chapter 10:29] 20th July, 2007.



outdated, lacking coverage of the broader NSS and failing to assign a coordination role to ZIMSTAT. At the time of the CPE fieldwork, the Southern Africa Development Cooperation (SADC) Secretariat had called for an individual consultant to review and update the Act.⁸⁹

Thirdly, Vision 2030,⁹⁰ is GoZ's overarching planning framework with the goal to achieve a prosperous upper middle-income economy by 2030. The UNFPA PD component is aligned to 3 of the 5 pillars of Vision 2030: the Governance Pillar addresses human rights, devolution, and decentralization of essential services like birth and death registration and passport issuance. The Infrastructure Development Pillar integrates ICT as a development enabler and promotes housing as a human right. The Social Development Pillar emphasizes "LNOB," ensuring vulnerable groups and people with disabilities receive support for participation in policy-making and development opportunities.

Fourthly, The NDS1 aims to transform the economy to upper middle-income status by 2030 while aligning with the SDGs. Data and statistics fall under the Governance Pillar. As NDS1 ends in December 2025, the GoZ, with support from UNFPA and other partners has approved priorities for the second five-year plan, NDS2 (2026-2030).⁹¹

Lastly, the national statistics system is coordinated by ZIMSTAT, implementing activities under the Zimbabwe National Strategy for the Development of Statistics (NSDS III) 2021-2025⁹² a framework aimed at improving the production and use of statistics to support national development planning and decision-making. UNFPA supported the GoZ population data priorities through joint workplans and interventions with ZIMSTAT, guided by the NSDS III (2021–2025). Both UNFPA and ZIMSTAT co-chair the national Data for Development and Innovation TWG.^{93, 94}

Finding 3: At the downstream level, the interviews and review of documents showed that the CP interventions under SRH were aligned to national priorities and adapted to the needs of beneficiaries⁹⁵ in the following areas: (i) support for the readiness (e.g. basic infrastructure, staff, equipment and supplies) of selected health facilities to offer SRH comprehensive obstetric and neonatal care (CEmONC); cervical cancer prevention and youth friendly integrated SRH/HIV/GBV services; (ii) quality improvement and assurance for SRH (maternal health, ASRH and GBV); (iii) MPDSR; (iv) strengthening the management of post-partum haemorrhage (PPH); (v) obstetric fistula repair and re-integration of fistula clients into their communities; (vi) capacity building of health workers in the following (a) integrated SRH/ASRH, HIV and GBV service provision; (b) job training for the implementation of innovations such as, rolling out e-learning, rolling out of Sayana press for self-care and the eLMIS. The UNFPA's interventions for AYP were highly relevant, developed with substantial government support, leadership and participation. The programme aligned with national ASRH policies and priorities. It scaled up training, quality assessments, and certification of youth-friendly health facilities under government guidelines.⁹⁶ UNFPA supported major frameworks including the National Youth Policy (2020–2025), Life Skills Empowerment Strategy (2018–2025), and Zimbabwe Adolescent Health and Well-Being Implementation Plan (2025–2030), providing technical leadership and financing.⁹⁷

4.1.2 Adaptation to policy, developmental changes and emergencies

Finding 4: UNFPA support during humanitarian situations was critical and appreciated by beneficiaries. In 2024, UNFPA's assessment of cholera in pregnancy identified a critical gap: the absence of specific care guidelines for pregnant women. In response and utilizing complementary resources from the Emergency Response Fund (managed by UNFPA Headquarters), UNFPA provided support to 12 districts and two health facilities in Harare City. This included distributing 516 dignity and hygiene kits, 520 maternity kits, 150 cholera beds, and 30 tents to strengthen health facility preparedness and response.⁹⁸ Thirty spaces for cholera management and safe birth of pregnant women with cholera

⁸⁹ SADC Secretariat. 22 April 2025. TORs Request for Expression of Interest Individual Consultancy to Review the Current Statistics Act of Zimbabwe and Develop a New Statistics Act in Line With Latest Developments.

⁹⁰ Republic of Zimbabwe VISION 2030 "Towards a Prosperous & Empowered Upper Middle-Income Society by 2030" September 2018.

⁹¹ KII with UNFPA CO staff, MoFEDIP, ZIMSTAT.

⁹² Government of Zimbabwe. 2021. The Zimbabwe National Strategy for the Development of Statistics (NSDS III) 2021-2025.

⁹³ UNFPA CO Annual Reports from 2022 to 2024.

⁹⁴ KII various stakeholders at national level.

⁹⁵ Document review of Annual WPs and COARs (2022 – 2025); KII with staff of MoHCC Directorates and UNFPA CO.

⁹⁶ KII UNFPA staff, KII with MoPSE and MoHCC; Review of Annual Reports (2022, and 2023).

⁹⁷ KII with ZYC, MoPSE, and UNFPA staff.

⁹⁸ Document review of COARs, KII with staff in provincial and district hospitals; KII with UNFPA Co staff.



were also set up. In addition, 48 Provincial Health Executives were capacitated in a national trainer of trainers on the provision of MISP on SRH services during emergencies.

UNFPA support during the COVID-19 pandemic was applauded by IPs and beneficiaries since lives were saved.⁹⁹ UNFPA played a key role in enhancing emergency obstetric and neonatal care (EmONC) in areas heavily affected by COVID-19, collaborating through national TWGs, including the National COVID-19 Case Management TWG. Support focused on the Case Management and Infection Prevention and Control Pillars, with equipment procured for isolation areas for pregnant women and infection prevention supplies distributed to maternity waiting homes and hospitals across the country. This intervention was funded through the Health Development Fund and contributions from the Governments of China and Japan.

The 8th CP adapted its GBV strategies to address rising violence during COVID-19, youth substance abuse, and GBV risks worsened by climate and economic hardships. In crises like Cyclone Idai, UNFPA partnered with Musasa, Family AIDS Caring Trust, and the police Victim Friendly Unit (VFU), providing technical and financial support to run mobile OSCs, delivering health, psychosocial, legal, and protection services to survivors in remote areas. UNFPA coordinates over 50 humanitarian actors, including UN agencies, NGOs, CSOs, the Red Cross/International Federation of the Red Cross, and donor partners, to facilitate strategic planning, resource mobilization, capacity building, and service delivery for GBV in emergencies.

UNFPA played a critical role in humanitarian response by supplying dignity kits, which were described as “impactful and well received”.¹⁰⁰ These kits contained sanitary towels, underwear, toothbrushes, toothpaste, wrapping cloth, and torches. This programme implemented mobile OSCs to address cyclone-related livelihood vulnerabilities in partnership with World Vision and Family AIDS Caring Trust in Chipinge and Chimanimani. Anticipatory action during the El Niño-induced drought in Chipinge and Buhera included women’s empowerment initiatives such as Village Savings and Loan Associations, poultry rearing, and sewing to build economic resilience and reduce GBV risks. Through the USAID Bureau for Humanitarian Assistance funded project, UNFPA supported shuttle services in Hwange, Mt Darwin, Rushinga, and Zvishavane to improve survivor access to emergency care including GBV case management, psychosocial support and health services including post-exposure prophylaxis and emergency contraception.

Finding 5: In line with the aspirations of the NDS1 (2021-2025) to increase youth participation in decision making and development processes, UNFPA supported meaningful youth engagement in policy reform processes, including the review of the Marriages Act and Sexual Offences Act. The Young People’s Network for Health and Wellbeing (YPNHW) led consultations, providing valuable insights into adolescents’ needs and aspirations. Through the UN Youth Group, UNFPA supported CSO advocacy, by providing data and technical support, for the review of the Marriages Act and the Sexual offences Act, which raised the age of marriage and consent to sex to 18 years from 16 years.¹⁰¹ However, stakeholders highlighted that this created dilemmas for health workers, who were hesitant to provide services to adolescents below 18 years for fear of legal repercussions. This hesitation is not only prevalent at the frontline but finds itself among health managers as noted by one UN stakeholder:

“We had challenges in agreeing on the terminology for the provision of services to adolescents as the official from MoHCC was of the opinion that this could go against the position of government of sex after 18 years”.

Some health officials noted UNFPA could have done more to alert relevant stakeholders of the risks of increasing the age of consent to sex to 18 years on adolescents’ access to SRH services.¹⁰²

The programme addressed new challenges including the emergence of adolescent pregnancies, drug and substance abuse, and mental health. The post-COVID rise in adolescent pregnancies inspired the “Not in My Village” campaign.¹⁰³ UNFPA also supported YPNHW in co-creating the “Not in My Village” campaign, which mobilized traditional and religious leaders to combat child marriage and adolescent pregnancies.^{104,105} Chiefs introduced local bylaws, and the

⁹⁹ KII with IPs at provincial level; FGDs with beneficiaries.

¹⁰⁰ FGDs with multisectoral stakeholders and beneficiaries.

¹⁰¹ KII with UNFPA staff and UN staff.

¹⁰² KII with UN and NGO staff.

¹⁰³ KII with UNFPA staff and FGD with YPNHW members.



campaign won a UNFPA global innovation award. Its success spurred MoPSE to consider a “Not in My School” campaign tackling teenage pregnancy, drug abuse, and related risks.¹⁰⁶ Partners also raised drug abuse, climate change, and mental health as new priorities and included them in their interventions.¹⁰⁷ UNFPA’s advocacy efforts contributed to the government’s recognition of drug abuse as a national crisis in 2024. This led to the integration of drug abuse issues into national frameworks such as the Prevention and Management of Adolescent Pregnancies and the Zimbabwe Adolescent Health and Well-Being Implementation Plan (ZAYHIP) 2025-2030 which UNFPA supported.¹⁰⁸

Finding 6: Detailed review of literature and stakeholder consultative engagements (e.g. with MoHCC, ZNFPC, ZNAC, ZIMSTAT and other stakeholders) were undertaken to identify the UNFPA areas of interventions in the 8th CP. Geographical targeting for programme implementation was informed by national and sub-national data analysis from the census, ZDHS, MICS, and DHIS2, ensuring interventions addressed the needs of rights holders. The PD outcome aligns with the UNSDCF goal that, by 2026, all Zimbabweans, especially the vulnerable and marginalized, benefit from more accountable, rights-based institutions and systems for rule of law, human rights and access to justice.¹⁰⁹

Finding 7: UNFPA 8th CP strengthened the capacity of the national statistical system to produce, analyze and use disaggregated population data to inform policy decision-making and development programming, including in humanitarian situations. UNFPA supported the generation and use of timely, disaggregated data to inform national policies, enhance programme planning and targeting, and drive evidence-based advocacy aligned with the ‘LNOB’ agenda. ZIMSTAT and MoHCC staff participated in national and regional trainings, with ZIMSTAT receiving additional capacity-building on the SDG portal and the Geographic Information System.

4.1.3 Human rights, gender, and disability considerations

Finding 8: To ensure cultural appropriateness, gender and social inclusion, UNFPA engaged in co-creation with community members, religious leaders, and traditional authorities, involving them in programme design and implementation. The current CP was shaped through extensive consultations with key stakeholders, including government bodies, civil society, NGOs like Musasa and World Vision, and disability umbrella organizations such as the Federation of Organizations of Disabled People in Zimbabwe and the National Association of Societies for the Care of the Handicapped, ensuring relevance to local needs and practical application. OSCs were equipped with ramps and, in some cases, accessible toilet facilities to support PWDs. However, gaps remain in accommodating individuals with visual impairments, as most of the reading materials are not available in braille.

Consultations were conducted at both national and sub-national levels, involving NGOs currently partnering with UNFPA. These engagements built upon a long-standing collaboration during the development of the CP. For disability inclusion, the needs of PWDs were taken care of in terms of having user-friendly access¹¹⁰ (a) ramps at health facility buildings and (b) appropriate toilet facilities. Partners embraced disability inclusion in various ways. MoPSE adapted CSE manuals to enhance disability focus, and NGO partners included disability data in planning interventions and service delivery as well as ensuring inclusion of PWDs in various activities. Much of this work was through partners’ own aspirations and in the case of MoPSE, UNFPA encouragement. Partners noted UNFPA could have offered stronger guidance on structured disability and gender integration.¹¹¹ Integration of boys’ specific information platforms e.g. the Mugota platform, a social media engagement platform to discuss boys’ issues, helped to differentiate messaging and ensure that support is gender specific.¹¹²

Partners embraced disability inclusion in various ways. MoPSE adapted CSE manuals to enhance disability focus, and NGO partners included disability data in planning interventions and service delivery as well as ensuring inclusion of people with disabilities (PWDs) in various activities. The ZYC reserved ten per cent of Junior Parliament seats for young

¹⁰⁴ KIIs with MWACSMED (Bindura and Shamva), and UNFPA.

¹⁰⁵ FGD with YPHNW members in Shamva.

¹⁰⁶ KII with MoPSE staff.

¹⁰⁷ KIIs with government, NGO partners.

¹⁰⁸ KIIs with UNFPA staff, and Review of the Zimbabwe Adolescent Health and Well-Being Implementation Plan (ZAYHIP) 2025-2030.

¹⁰⁹ UNFPA ZIMBABWE CO, 8th COUNTRY PROGRAMME 2022-2026 MONITORING AND EVALUATION PLAN, January 2022.

¹¹⁰ KIIs with DMOs, hospital staff (Mpilo, UBH, Inyathil, Bindura hospitals among others).

¹¹¹ KIIs with NGO partner, government staff.

¹¹² FGD with peer educators Mutare Teachers College; KII with SAYWHAT.



PWDs and facilitated their contributions during consultations and engagements on policy processes.¹¹³ Support for CSE was based on teacher consultations, learner feedback, and platforms such as the junior parliament.¹¹⁴ A formal collaboration with MoPSE enabled joint planning, implementation, and monitoring. An MoPSE official emphasized:

“We have a joint work plan signed by the Permanent Secretary and UNFPA Country Representative. We plan, implement, and monitor together.”

Finding 9: The programme integrated analysis of gendered vulnerabilities and worked with KPs. Through the Global Fund, it supported men who have sex with men (MSM) service centres with Gays and Lesbians of Zimbabwe (GALZ) and Sexual Rights Centre (SRC), trained health workers, and engaged religious leaders and families on provision of SRH services to KPs.¹¹⁵ However, UNFPA acknowledges that more could have been done for KPs, partly due to the challenging operational environment where LGBTQ+ rights are restricted.

4.1.4 Innovations and partnerships developed

Finding 10: The MoPSE with UNFPA support created a WhatsApp chatbot to enhance provision of accurate SRH/HIV/GBV information to learners.¹¹⁶ At the time of the evaluation, the development of the chatbot was completed with content still to be developed. SAYWHAT had a mobile application to support CSE access by students in tertiary colleges.¹¹⁷ However, the availability of multiple mobile platforms offering inconsistent SRHR content to AYP poses a risk of misinformation.

Finding 11: The 8th CP has built strong, strategic partnerships that enhance Zimbabwe’s efforts in quality GBV services, response, and capacity building, notably through collaboration with local universities to develop and implement a standardized GBV case management module. Following substantial groundwork, universities are now positioned to integrate GBV Case Management system into their curricula, enabling sustainable pre-service training for social workers and other practitioners. As part of this effort, the Council of Social Work was contracted under the *Women at the Centre* project in July 2024, funded by Takeda through UNFPA to support the development of the curriculum in line with international guidelines and regulate social work education, including curriculum and competency standards.¹¹⁸

4.2 Answer to evaluation questions 2-4 (Coherence)

EQ2: *To what extent have the different components of 8th CP (SRHR, GBV, AYP) been integrated to ensure synergies in addressing SRHR issues, adolescents and youth, GBV and use of data for decision making?*

Summary of findings

The different components of the 8th CP (SRHR, GBV, and AYP) have been integrated to a strong extent, creating synergies in service delivery and data use for decision-making.

Services in tertiary training institutions and CSE curricula linked SRH, HIV, GBV, and life skills. UNFPA promoted cross-programme collaboration, supported LGBTQ+ and youth-friendly services, and strengthened youth participation through CSOs and budget consultations. Coordination with the CO’s P&D and M&E units enhanced data use, programme performance, and evidence-based policymaking. The evidence-based programming by UNFPA used national data (ZDHS, MICS 2019, DHIS2) to guide adolescent and youth interventions. It supported partners like YPNHW in co-creating targeted campaigns using fertility data. Data and ongoing assessments also informed the programme’s adaptability to emerging challenges with IPs reporting that issues such as drug abuse, climate change, and mental health emerged during implementation. This led them to advocate for the prioritization of issues by the government, leveraging data to guide programming. UNFPA Zimbabwe leads in strengthening national data systems, chairing the UN Data for Development and Innovation TWG and coordinating with ZIMSTAT. It spearheads GBV data efforts through supporting the development of the GBV Information Management System (GBV IMS), supporting harmonized data

¹¹³ KIIs with government ministry staff.

¹¹⁴ KIIs with MoPSE and UNFPA staff.

¹¹⁵ Global Fund ZWE-H-UNDP 985 HIV Grant Quarterly reports January 2023 to December 2024; UNFPA annual reports 2022 and 2023.

¹¹⁶ KIIs with MoPSE and UNFPA staff.

¹¹⁷ KIIs with SAYWAHT and FGDs with young people in MSU and MTC.

¹¹⁸ KIIs with IPs, UNFPA staff.



collection for prevention and response. Under the new Spotlight programme, UNFPA will pilot GBV IMS with government and key partners. Despite the progress, challenges remain in optimizing data use and integration for AYP. These include siloed service delivery, DHIS2 data issues, legal barriers for LGBTQ+ outreach, rising teen pregnancies despite CSE, limited data on youth issues, and inconsistent disability inclusion, which highlighted the need for better coordination, guidance, and holistic approaches.

For details of the evidence supporting findings in section 4.2, see the evaluation matrix: Assumption 2.1 in Annex 1.

4.2.1 Integration of 8th CP components

Finding 12: The coherence of the 8th CP is evident in the integration of SRHR and GBV within interventions targeting AYP, fostering a synergistic, holistic approach. Tertiary institutions (e.g. national, provincial health facilities) offered integrated mobile SRH, HIV, and GBV services, while secondary and tertiary CSE was holistically designed to link life skills, HIV/AIDS, and GBV. UNFPA fostered cross-programme collaboration, including LGBTQI+ inclusion and youth-friendly SRH services under the HRF. Programme convergence emphasized youth participation, with UNFPA supporting CSOs such as SAYWHAT and YPNHW by providing data and fostering engagement between Parliament and CSOs for youth-responsive budget consultations. The evaluation highlighted strong collaboration between the PD Unit and other UNFPA programmes, including support for adolescent fertility data analysis, GBV IMS initiation, and continuous engagement with the M&E unit to assess programme performance.

Finding 13: The new leadership officials of UNFPA was especially credited by UNFPA staff for facilitating collaborations across the programmes through their focus on results and cross-partnerships of programmes which were limited prior to their arrival as noted by one staff:

“UNFPA has had good leadership, they are hands-on. Everything has to be discussed. There are no bureaucracies, Country Representative and Deputy Country Representative are pushing things and demand results and excellence. This has helped us to break down silos and we are now working as a team. As team leaders we managed to break the silos and work collaboratively”.

Finding 14: UNFPA implemented a data-driven programme by strengthening national data systems to guide interventions. Adolescent and youth initiatives were informed by national and sub-national evidence (including ZDHS, MICS 2019, and DHIS2) developed in partnership with government stakeholders. This evidence-based approach extended to partners, with UNFPA supporting YPNHW to use adolescent fertility data and youth consultations to co-create the “Not In My Village” campaign with one key informant emphasizing that,

“The data we had on the teenage pregnancies gave birth to the not in my village”. Key informant evidence from PSZ, explicitly stated their approach: “Our design was data driven, looking at the ZDHS data, MICS survey data in terms of teenage pregnancy prevalence, fertility rates, early marriages, early sexual debut, child marriages, GBV, HIV, STIs, daily subsistence allowance (DSA) issues. These challenges informed the project concept at subnational level”.

Finding 15: UNFPA Zimbabwe played a lead role in strengthening national data systems to support evidence-based decision-making. It chairs the UN Data for Development and Innovation and at national level UN co-chairs the national DFDI with ZIMSTAT, positioning itself as the lead agency for information management within the UN Country Team. UNFPA is leading the development of the GBV IMS to improve the collection and analysis of administrative data. Piloted in collaboration with MWACSMED and ZIMSTAT, the GBV IMS will enable harmonized, reliable data to inform GBV prevention and response efforts. Additionally, UNFPA supported Zimbabwe’s reporting on the global and continental commitments, including the ICPD@30, Addis Ababa Report, and Nairobi Commitments in 2022 and 2023.

Challenges in integration

Finding 16: Despite the above significant efforts, some challenges persist in fully optimizing integration and data use namely:

- The operating environment where LGBTQ+ activities being illegal presents difficulties for more extensive work with KPs, despite UNFPA’s efforts to establish drop-in centres and expand services for MSM communities



- While the evaluation noted evidence of disability inclusion in the various interventions, the extent of inclusion varied across supported interventions, with ZYC noting that UNFPA "did not provide much direct guidance on integrating gender, human rights, and disability, as they rely on government policies for programming". This suggests a need for more explicit and comprehensive guidance for portfolio-wide structured integration of disability for AYP.

EQ3: *To what extent has UNFPA worked with stakeholders and leveraged strategic partnerships at all levels (national, provincial and district) and development partners and ensured that no one is left behind?*

Summary of findings

UNFPA Zimbabwe has to a large extent strategically cultivated a wide range of partnerships at national, provincial and district levels, significantly enhancing the delivery and reach of its 8th CP, particularly among vulnerable and marginalized populations thereby LNOB. Collaborations have included government ministries, CSOs, UN agencies, and development partners. UNFPA's proactive, hands-on leadership has strengthened internal team integration and external collaboration, helping to break down operational 'silos' and promote coordinated action. While partnerships remain a core strength, challenges persist in coordination at the implementation level and in responding swiftly to emerging issues requiring agile approaches. UNFPA demonstrated strong leadership in areas aligned with its mandate, serving as the lead UN agency for information management in-country. The UNFPA Country Representative and ZIMSTAT Director co-chaired the Data for Development and Innovation TWG. UNFPA also collaborated with UN agencies, government, and stakeholders on GBV data management and expanded partnerships with International Financial Institutions, United Nations Economic Council for Africa (UNECA), and the Africa Union Commission (AUC). Establishing the GBV IMS remains a key priority for effective programme data management.

For details of the evidence supporting findings in section 4.2, see the evaluation matrix: Assumption 3.1 in Annex 1.

In the context of this evaluation, a strategic partnership is defined as a collaborative agreement between two or more organizations to achieve mutually beneficial goals and objectives. Key characteristics include shared vision, complementary strengths, long-term commitment, risk and reward sharing, flexibility and adaptability.

4.2.2 Partnerships at national level

Finding 17: UNFPA succeeded in leveraging strategic and functional partnerships with government ministries, UN agencies, CSOs and the private sector. The examples of these partnerships include the following:¹¹⁹

- The three UN agencies UNICEF, UNFPA and WHO are the first-tier IPs of the HRF. The UN agencies and the Funding Partners' Technical Advisors and Programme managers met to facilitate technical discussions and ensure excellent and efficient collaboration in the implementation of the HRF
- UNFPA collaborated well with the Higher Life Foundation (HLF), and GFF/WB in working together with the Family Health Directorate at MoHCC and responding to Maternal and Neonatal health problems in the country
- UNFPA collaborated with WFP to support maternity waiting homes with food for pregnant women in 38 districts.

UNFPA built strong partnerships with key government ministries, particularly the MoPSE, MWACSMED, MoHCC and MoFEDIP enabling joint policy development, technical support, and annual intervention planning. These collaborations were informed by ongoing monitoring and feedback and bolstered by active UNFPA leadership engagement, which helped resolve bottlenecks and reinforced UNFPA's commitment to supporting government priorities, as acknowledged by one MoPSE official:

"We find evidence, plan and implement together and monitor together".

UNFPA engaged MoHCC on health facility certification and nursing services, collaborating with UN agencies to share resources and build capacity across various organizations including:

- UNAIDS: UNFPA worked with UNAIDS on the Scorecard for SRHR, advocating for policy implementation and monitoring the UNSDCF together. UNAIDS views UNFPA as a core sponsor for HIV programmes, valuing UNFPA's expertise in young people, SRHR, condom programming, and KPs

¹¹⁹ Document review of UNSDCF 2022-2026; KIs with staff of in-country UN agencies.



Country Programme Evaluation of GoZ /UNFPA 8th CP 2022-2026



- UNICEF and WHO: UNFPA partnered with UNICEF and WHO as first-tier IPs of the Health Resilience Fund (HRF), holding regular meetings to ensure efficient and excellent collaboration
- UNESCO: UNFPA collaborated with UNESCO through platforms like the UN joint team on youth and the ASRH forum meetings.

One staff had this to say on UNFPA's complementary role in service provision:

"When we push CSE using the education lenses – UNFPA complements the work we are doing and therefore we are able to deliver a comprehensive package".

UNFPA played a leading role in partnerships aligned with its mandate, particularly through close collaboration with ZIMSTAT from joint workplan development to project implementation. ZIMSTAT reported progress to the MoFEDIP, which coordinates donor-supported interventions and participates in thematic working groups. With the support of UNFPA, MoFEDIP also led the development of NDS1, which underpins SDG indicator tracking via the national SDG platform.

UNFPA collaborated with UN agencies, government and stakeholders in the management of GBV data from ZRP, NPA, MWACSMED, MoHCC, ZIMSTAT, Musasa project and other IPs.^{120, 121} UNFPA and UN Women partnered to strengthen gender and GBV data management systems. The GBV IMS rollout faced delays due to weak inter-ministerial coordination and the lack of an M&E unit in MWACSMED, which has since been established. Under the Spotlight Sustaining the Gains programme (launched 1 June 2025), UNFPA plans to pilot the GBV IMS with MWACSMED and ZIMSTAT.

EQ4: *To what extent has UNFPA contributed to the functioning of various coordination mechanisms such as the UNCT, GBV Sub Cluster, Youth Networks, SRH TWG, M&E TWG, Data for development and Innovation TWG and other coordination mechanisms in the country?*

Summary of findings

UNFPA CO played a vital role in strengthening UNCT coordination mechanisms by leveraging its comparative advantage and holding key leadership positions across committees, TWGs, and joint initiatives. Its leadership in advocacy and coordination was widely acknowledged, with interview responses from UN agencies emphasizing its positive impact on national development and inter-agency collaboration. UNFPA is an active member of the Programme Management Team and a key implementer of the UNSDCF. As part of the UNSDCF People's Pillar alongside other UN agencies, UNFPA contributed to advancing UHC and protection services. This includes strengthening health systems, promoting gender equality, reducing violence against women and girls, and supporting comprehensive GBV and psychosocial services. UNFPA has shown technical leadership in adolescent and youth empowerment, particularly through the Youth TWG, and manages the Youth Scorecard. However, there is a need to broaden its mandate to expand more on youth economic empowerment. Within the UNCT, UNFPA coordinates the prevention of sexual exploitation and abuse activities. Furthermore, UNFPA co-chairs the GBV Sub Cluster in partnership with the MWACSMED, leading GBV in Emergencies and coordinating humanitarian response and provided technical and financial support to strengthen GBV coordination at the Provincial and District level. As a member of the Health Cluster led by WHO, UNFPA plays a key role in emergency programming, focusing on Reproductive, Maternal, Neonatal, Adolescent and Child Health and Nutrition (RMNACHN) in crisis situations and promoting human rights-based and gender equality approaches. In liaison with other UN agencies, UNFPA participated actively in joint programmes such as 2gether4SRH, Spotlight Initiative, UN Partnership on Rights of Persons with Disabilities (UNPRPD), and Prevention of adolescent pregnancies. In addition, UNFPA effectively led information management, with strong support from UN agencies like ILO, UNDP, UNICEF, WFP, and UNHCR in data collection and analysis. It also expanded partnerships with international finance institutions, UNECA, and the AUC.

For details of the evidence supporting findings in section 4.2, see the evaluation matrix: Assumption 4.1 in Annex 1.

¹²⁰ UNFPA COARS and AWP's 2022 to 2024.

¹²¹ KIIs with UNFPA CO staff, UN Women, MWACSMED, IPs, ZIMSTAT, and stakeholder FGDs.



4.2.3 Coordination within UNCT and UNSDCF

Finding 18: From the interviews and document review of selected minutes of UNCT meetings, the evaluation noted that the UNFPA CO contributed positively to the UNCT and applied its comparative advantage for the effective and efficient running of the UN coordination mechanisms.¹²² Both UN agencies and GoZ ministries/agencies have appreciated the important role UNFPA has played in bringing multi-disciplinary strategic partners together to increase the efficiency and effectiveness of the country's development agenda. The active contribution was evident from the role UNFPA played in participating as chair, co-chair, lead and member in TWGs, thematic groups and joint initiatives. All key UN agencies who responded to the interviews indicated the important role UNFPA plays in, contributing effectively to improving UNCT coordination mechanisms, particularly strengthening advocacy in several areas useful to other UN agency members.

Finding 19: Interviews and document review revealed that UNFPA is an active chair of the Programme Management Team (PMT) and is an implementer of the UNSDCF.¹²³ Alongside other UN agencies (UNICEF, WHO, UNDP, WFP, IOM, UNAIDS and UNHCR), UNFPA is a member of the *People's Pillar* of UNSDCF and participated effectively. For example, UNFPA with others contributed to the improvement of UHC (e.g. strengthening of healthcare systems; access to health services among others) and protection [e.g. (i) policy development to strengthen national protection systems and advance gender equality; (ii) reducing violence against women and girls; (iii) comprehensive protection services, including GBV support and psychosocial services].¹²⁴ Within the UNSDCF, UNFPA has been technically strong in its work on the empowerment of AYP through the Youth TWG.¹²⁵ UNFPA is responsible for the Youth Scorecard and has provided support to integrate human rights-based approaches and gender equality. UNFPA is an active member in the UNCT Health Cluster Group focusing on RMNACHN in emergencies as well as being very active in emergency programming.

Finding 20: UNFPA participated actively in joint programmes with other UN agencies. These include the following:¹²⁶

- 2gether4SRH (e.g. UNFPA, WHO, UNICEF), (Phase I: 2018-2023); Phase II 2024-2025)
- Spotlight Initiative (UNFPA, UNICEF, WHO, UN Women et cetera), January 2019 - September 2023
- UN Partnership on Rights of Persons with Disability (UNPRDP) Programme (UNFPA, UNESCO, UNDP et cetera) (February 2021 - August 2025)
- Prevention of adolescent pregnancies (UNFPA, UNDP and UNICEF).

Finding 21: UN agencies including the ILO, UNDP, UNICEF, WFP, UNHCR supported UNFPA data collection and analysis efforts through several activities inclusive of the ZDHS; Labour market information system development; census data analysis; Social development survey; evidence collection and analysis for education sector; capacity building for statistical systems; Livelihoods Assessment and Support; and Food Security assessment.¹²⁷

Finding 22: UNFPA broadened partnerships with the international finance institutions, UNECA, and AUC, partnering with the World Bank on GBV including the study on the Economic Cost of GBV and the GBV investment case and financing mechanism.¹²⁸ UNECA provided additional support for the 2022 PHC.¹²⁹ The expected partnership with the University of Zimbabwe's Department of Demography, Human Settlements and Development did not materialize. Key informants described the relationship as 'strange', noting UNFPA engaged individuals rather than the Department itself, with no formal Memorandum of Understanding (MOU) established. The Department indicated that they are collaborating better with the RCO than with UNFPA.

"Our staff are used by the regional office but not by the national office. Instead of perpetuating the status quo, the anomalies need to be corrected and establish institutional level engagement which works much better for sustainability," said a KII respondent at the Department of Demography, Human Settlements and Development.

¹²² KIIs with staff of in-country UN agencies; review of UNCT meeting minutes (Aug. 2023; Feb. 2024 and Jul. 2025).

¹²³ KIIs with staff of in-country UN agencies; KIIs with GoZ ministries; review of ZUNSDCF Mid-term Review Report.

¹²⁴ Document review of ZUNSDCF Mid-term Review Report.

¹²⁵ KIIs with staff of in-country UN agencies; KIIs with GoZ ministries.

¹²⁶ Document review of UNFPA COARs; KIIs with UN agencies and UNFPA CO staff.

¹²⁷ Review of UN Country Team. Zimbabwe 2023 Annual Report - Priorities for 2024.

¹²⁸ KIIs with staff at UNFPA CO and MWACSMED.

¹²⁹ 2022 UNFPA CO Annual Report – Zimbabwe Finalized - 30 Jan. 2023.



4.2.4 Coordination at national level

Finding 23: The MoFEDIP is the government institution responsible for coordination between GoZ and UNFPA. UNFPA, as the lead UN agency for coordinating data for development in-country, fulfilled its role effectively. In 2024, its co-leadership with ZIMSTAT of the restructured Data for Development and Innovation TWG improved coordination, stakeholder engagement and alignment with national work plans.¹³⁰ The revival of the TWG improved coordination within Zimbabwe's NSS through Joint Work Plans across six clusters, aligning data-driven decisions with NDS1 and SDGs. UNFPA collaborated with other UN agencies and development partners in carrying out surveys and studies. For instance, UNFPA collaborated with other UN agencies and development partners on key surveys and studies - partnering with UNICEF on MICS development, USAID on the 2023/2024 ZDHS, and with UNESCO and UNICEF (as lead) on a National Study on Adolescent Pregnancies in December 2023.¹³¹ The Framework to guide implementation of the findings of the study was being developed during the time of the 8th CP evaluation. UNICEF is the fund administrator for the HRF which is the funding basket for the UNFPA/ZIMSTAT programme.

4.3 Answer to evaluation question 5 (Effectiveness)

EQ5: *To what extent has UNFPA Zimbabwe strategies on SRHR, GBV, AYP and PD achieved the intended outcomes for the different target groups making sure that no one is left behind? In particular, (i) increased access to and use of integrated SRH services; (ii) empowerment of adolescents and youth to access SRH services and exercise their SRH 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?*

4.3.1 Sexual and reproductive health and rights

To what extent has UNFPA Zimbabwe strategies on SRHR, GBV, AYP and PD achieved the intended outcomes for the different target groups making sure that no one is left behind? In particular, (i) increased access to and use of integrated SRH services.

Summary of findings

The UNFPA Zimbabwe strategy on SRHR has to a large extent achieved the intended outcomes for the different target groups ensuring that no one is left behind and particularly increased access to and use of integrated SRH services. The outcome level indicators are both national level targets and the outputs are likely to contribute to the outcome level changes from a qualitative analysis point of view. While output-level indicators are expected to be fully achieved by the end of the programme cycle, outcome-level indicators remain only partially met, though FP data shows a positive trend. Nationally, 87 per cent of FP demand is being met with modern methods. Notably, through UNFPA and partners' advocacy efforts to the GoZ, a matched funding arrangement was established for reproductive health (RH) commodities. This partnership marks a significant advancement in strengthening domestic financing and enhancing sustainability in the procurement of RH commodities across the country. UNFPA provided significant support, leading to several key achievements in SRH. Firstly, the capacity of health facilities to deliver EmONC services was strengthened, contributing to increased SBA and reduced complications during labour and delivery. Secondly, treatment for young women and adolescent girls with fistula exceeded targets, reaching 110 per cent of the planned figure. Thirdly, facilities at various levels were equipped to provide modern FP methods. Fourthly, contraceptive visibility and last-mile distribution improved through the rollout of the electronic Logistics Management Information System (eLMIS). Fifthly, functional Maternal Perinatal Death Surveillance and Response (MPDSR) systems were established nationally and sub-nationally. Lastly, national and district capacities to deliver quality integrated SRH services were enhanced through midwifery training in 22 schools of midwifery. Implementation was delayed due to human resource challenges, particularly within the MoHCC, the main implementing partner. High staff attrition affected service quality, while inadequate and outdated equipment, along with limited availability of essential medicines and supplies, remained major barriers to delivering quality healthcare.

For details of the evidence supporting findings in section 4.3, see the evaluation matrix: Assumptions 5.1 in Annex 1.

¹³⁰ Review of UN Zimbabwe. Annual Report 2024; KIIs with staff at UNFPA CO, ZIMSTAT and UNICEF.

¹³¹ Review of 2023 Annual Report - Zimbabwe Finalized - 19 Jan., 2024 and KIIs with UNFPA CO staff, UNICEF and ZIMSTAT.



4.3.1.1 Assessment of results at outcome and output levels

Finding 24: Document review revealed that there was a positive trend for the outcome indicators namely MMR, unmet need for FP and FP demand being satisfied using modern methods.

Maternal mortality ratio

The combined efforts of UNFPA, government counterparts and other UN agencies on maternal health interventions in the country has contributed to the reduction of MMR from 364 to 362 per 100,000 live births (2022 Census) and 212 (ZDHS report 2023-2024). The MMR for rural areas is 402 and 298 per 100,000 live births for urban areas. Despite the reduction and an improved SBA rate, which increased from 65 per cent in the 2010-2011 ZDHS to 85 per cent in the 2023-24 ZDHS, the MMR is still far above the SDG target of less than 70 per 100,000 live births.

Unmet need for FP

Among currently married women, nine per cent have an unmet need for FP, while 87 per cent have their FP demand met through modern methods.¹³² In contrast, 14 per cent of sexually active unmarried women have an unmet FP need, with 83 per cent having their demand satisfied by modern contraceptive methods, indicating disparities in access. The percentage of married women with unmet need for modern methods of contraceptives declined from 14 per cent in 2012 to 11 per cent in 2023. The contraceptive prevalence rate among married women increased from 61 per cent in 2012 to 67 per cent in 2023.¹³³

Seventy per cent of currently married women were using a contraceptive method, with 69 per cent using a modern method¹³⁴ and one per cent using a traditional method.¹³⁵ Thirty per cent of currently married women were not using any contraceptive method. On trends, the use of contraceptives among currently married women increased from 48 per cent in 1994 to 70 per cent in 2023-2024.¹³⁶ For the UNFPA focus provinces, the unmet need for FP was highest in Manicaland (10.7 per cent) followed Midlands (nine point six per cent), both Mashonaland Central and Matabeleland North (seven per cent). It was lowest in Mashonaland East (six point six per cent). As for the FP demand being satisfied with modern methods, this was 87 per cent at the national level according to the 2024 ZDHS Report. UNFPA, GoZ counterparts and other UN agencies contributed to the achievement, which was higher than the UNFPA target of 70 per cent. The FP demand was highest in Mashonaland East (90.3 per cent) followed by Matabeleland North (89.8 per cent), Mashonaland Central (89.7 per cent) and it was lowest in Manicaland (81.8 per cent). The above provincial data has got some implications for programming which need to be thought through by UNFPA and partners.

Skilled birth attendance (SBA)

Finding 25: The percentage of live births that were assisted by a skilled provider increased from 65 per cent in the 2010-2011 ZDHS to 85 per cent in the 2023–24 ZDHS. The percentage of live births delivered by a skilled provider was higher in urban areas (94 per cent) than in rural areas (79 per cent). Births to mothers with more than secondary education were more likely to be attended by a skilled provider (98 per cent) than births to mothers with primary education (70 per cent).¹³⁷

Client satisfaction index

Finding 26: By the time of the evaluation, there was no data available for the indicator on *client satisfaction index* as the Vital Medicine Availability and Health Services (VMHAS) survey was not conducted due to lack of funding.¹³⁸ However, the CO planned to conduct it towards the end of 2025 and data for this indicator will be collected. Nevertheless, the lack of readily available data for the indicator means that the CO is limited in knowing the actual trend for the indicator in time and being able to carry out any remedial action.

Contribution to outcome level

¹³² Zimbabwe Demographic Health Survey 2024: Key Indicator Report.

¹³³ Zimbabwe Demographic Health Survey 2024: Key Indicator Report.

¹³⁴ Modern methods include male and female sterilization, injectables, intrauterine contraceptive devices (IUCDs), contraceptive pills, implants, female and male condoms, emergency contraception, and the lactational amenorrhoea method (LAM) (2024 ZDHS, page 11)

¹³⁵ Zimbabwe Demographic Health Survey (ZDHS) 2024: Key Indicator Report (page 12).

¹³⁶ Zimbabwe Demographic Health Survey (ZDHS) 2024: Key Indicator Report (page 12).

¹³⁷ ZDHS Report 2023-2024.

¹³⁸ KIIs with staff at MoHCC and UNFPA CO; Review of COARs 2023, 2024.



Finding 27: The outcome level indicators are both national level targets and the UNFPA outputs are most likely to contribute to the national outcome level changes from a qualitative analysis point of view.

4.3.1.2 Analysis of the output level indicators

Under the SRHR component, there was one output namely Output 1: *Strengthened institutional capacity to deliver high-quality, integrated SRHR services and information, including for adolescents and vulnerable groups, at national, provincial, district and community levels, including in humanitarian situations.* The indicator statements, targets and achievement level for output 1 are shown in Annex 7.

Finding 28: The evaluation assessed the performance of the four output indicators linked to the above output and the underlying interventions. three (75 per cent) out of the four indicators were most likely to achieve the target; one (25 per cent) had no achievement data.¹³⁹ The results are summarised in Table 13.

Table 12: SRH output indicators

Output	Total output indicators	Achieved $\geq 100\%$	Most likely to be achieved 70-99%	Likely to be achieved 25-69%	Unlikely to be achieved <25%	No data reported for achievement
SRH Output 1	4		3			1
Total	4		3			1
Per cent			75%			25%

Finding 29: By the time of the field phase of the evaluation, there was no data for the indicator - *Percentage of clients that received two or more SRHR, HIV and SGBV services in supported provinces* - as the Service Delivery Point (SDP) survey was not done due to funding constraints. According to interviews with CO staff, the CO plans to carry it out towards the end of 2025. Nevertheless, the lack of data at the time of evaluation meant that it was not possible to assess whether or not clients were receiving the expected SRHR, HIV and SGBV services.

Finding 30: Contribution to the outcome: The contribution of the outputs to the outcome was deemed sub-optimal since three (75 per cent) of four indicators were most likely to be achieved.

4.3.1.3 Assessment of the results for SRHR component

This information on achievement of planned results is drawn primarily out of secondary data available in the annual reports and the performance measurement framework¹⁴⁰ as well as key interviews.

Family planning

Finding 31: Zimbabwe is committed to FP2030, which bridges advocacy for harmonization between global commitments and national priorities, the National Family Planning Strategy 2022-2026 and the work programmes of the ministries and institutions that focus on population and FP, to accelerate the achievement of the FP programme in Zimbabwe. UNFPA supported development of the tracking sheet to monitor the progress of FP 2030 achievement. With the technical and financial support of UNFPA and partners, 94.8 per cent of health facilities had no stock out of FP commodities,¹⁴¹ which meant that women and girls were able to access the FP services readily. In addition, the demand for FP met with modern methods was 87 per cent,¹⁴² which was higher than the UNFPA transformative result target of 70 per cent.

Rights-based FP

Finding 32: UNFPA and its partnership with the Zimbabwe National Family Planning Council (ZNFPC) capacitated Provincial and District health executives on the human rights-based approach (HRB) to FP as part of improving the provision of quality services. A pool of 58 National trainers of trainers in FP was trained on HRB approach to FP and training has been cascaded across the country. The results of this training were as follows:¹⁴³ Healthcare providers were

¹³⁹ Evaluation team analysis of UNFPA CO Annual and quarterly reports (2022-2025).

¹⁴⁰ UNFPA CPD Indicator Database 2022-2026.

¹⁴¹ Review of Vital Medicines Availability and Health Services Survey report 2023; KIIs with CO staff.

¹⁴² ZDHS Key Indicators Report 2023-2024.

¹⁴³ KIIs with staff at health facilities visited and UNFPA CO.



able to prioritize clients' rights and needs; FP clients were empowered to make informed choices about their reproductive health allowing them to choose the FP methods that best suited their needs.

Finding 33: Due to the advocacy of UNFPA and partners to GoZ, UNFPA and GoZ established a matched funding arrangement for reproductive health (RH) commodities, and this demonstrated significant strides in efforts to improve domestic financing for reproductive health commodity procurement. Through the support from the HRF, UNFPA facilitated the procurement of FP commodities with US\$2.6 million, whilst the GoZ and UNFPA contributed US\$1.5 million and US\$2.5 million respectively during 2023.¹⁴⁴ During 2024, the GoZ contributed US\$1.5 million, and this unlocked US\$ 2 million from the UNFPA global supplies partnership. The HRF added USD 1.5 million, and the Global Financing Facility (GFF) contributed US\$ 1.4 million, complemented by PEPFAR support, ensuring sufficient FP supplies for 2024. Over three years, GoZ has contributed US\$ 4.7 million under this arrangement, demonstrating its ability to unlock government funding for commodities.

Finding 34: With the support from UNFPA and Global Fund, there was enhanced contraceptive visibility through tracking and distribution of FP commodities to the last mile using the eLMIS. UNFPA supported the roll-out of the e-LMIS to 150 health facilities by the end of 2023. By the end of 2024, MoHCC had e-LMIS rolled out to a cumulative total of 1,400 health facilities (out of approximately 1800, ~77.8 per cent) and this enabled real-time availability of logistics data.

Maternal Perinatal Death Surveillance and Response

Finding 35: UNFPA provided support for the establishment of functional MPDSR systems at national and sub-national levels. UNFPA has supported MoHCC in the implementation of MPDSR cycle at national and sub-national levels with emphasis of strengthening maternal death notification, quality reviews as part of the key indicators for improving service delivery in health facilities. UNFPA supported the revision of the eMPDNS whose electric module of the forms was configured in the MoHCC DHIS2, seventy-six participants underwent a TOT on using the eMPDNS and this increased the awareness among stakeholders on the use of MPDSR as a quality improvement tool for mitigating the occurrence of maternal deaths.¹⁴⁵

Emergency obstetric neonatal care (EmONC)

Basic EmONC (BEmONC) is critical to reducing maternal and newborn death.¹⁴⁶ This care, which can be provided with skilled staff in health centres, large or small, includes the capabilities for carrying out seven signal functions (SF) of EmONC. The CEmONC, typically delivered in hospitals, includes all the basic functions listed below, plus capabilities for two other functions namely performing Caesarean sections and safe blood transfusion. Signal functions for EmONC consist of life-saving treatments and procedures including administering parenteral antibiotics (SF1), administering uterotonic drugs (SF2), administering anticonvulsants (SF3), manual removal of placenta (SF4), removal of retained placenta products (SF5), assisted vaginal delivery (SF6), newborn resuscitation (SF7), cesarean sections/delivery (SF8) and blood transfusion (SF9).¹⁴⁷

Finding 36: UNFPA support contributed to improved capacity of health facilities to provide EmONC services and the improved SBA implies that the risk of mothers getting complications during labour and delivery was minimized. In order to strengthen the capacity of health centres to carry out BEmONC and hospitals perform CEmONC, UNFPA supported MoHCC with the following:¹⁴⁸ (i) provision of essential maternal/delivery equipment to health facilities; (ii) renovation of maternity and labour wards; and (iii) training of midwives. The quote below from a KI at the sub-national level exemplifies the services provided.

“The hospital is providing CEmONC, However, there is no continuous supply of blood for maternity cases. The ideal situation would be the availability of 20 units of blood per week,” said a KI participant at Mpilo hospital, Bulawayo city.

¹⁴⁴ Document review of UNFPA COARs; KIs with stakeholders at MoHCC and staff at CO.

¹⁴⁵ KIs with staff at MoHCC at national, provincial and district levels.

¹⁴⁶ Setting standards for Emergency Obstetric and Newborn Care, UNFPA 2014.

¹⁴⁷ Monitoring Obstetric Care: Handbook (WHO, UNFPA, UNICFF, AMDD), 2009.

¹⁴⁸ KIs with staff at national (MoHCC, UNFPA CO staff) and sub-national level (health staff at provincial and district hospitals in Mutare, Bindura, Bubi, Tsholotsho).



Finding 37: UNFPA supported the MoHCC and ZNAC to implement programmes targeted at reducing maternal deaths, unmet need for FP and GBV. By the end of 2024, the majority of health facilities (95 per cent) offered BEmONC services and 89.5 per cent of the primary health care facilities offering delivery services provided five signal functions. The proportion of secondary level facilities which offered CEmONC was 81.7 per cent and 84.8 per cent of the hospitals had the capacity to perform Caesarean sections. The proportion of hospitals providing CEmONC was lower than the target of 92 per cent partly due to staff attrition of doctors, challenges with lack of equipment (including anaesthetic machines) and the limited availability of blood and blood transfusion services.¹⁴⁹ To mitigate the shortage of equipment, UNFPA provided support to MoHCC for the procurement and distribution of anaesthetic machines, doppler foetal heart monitors, multi para monitors, ultrasound scan and blood pressure machines. In addition, health workers were capacitated in EmONC with the use of anti-shock garments for the management of obstetric haemorrhage as one of the strategic interventions to reduce maternal deaths. Though the staff were able to apply the skills in EmONC, document review and interviews with frontline health staff and provincial medical officials¹⁵⁰ revealed that the disparity between improved SBA and high institutional maternal deaths is linked to several factors. These include among others: inadequate equipment like caesarean sets, staff shortages in operating theatres, migration of EmONC-trained midwives, unreliable electricity in some maternity wards, and a weak ambulance referral system for obstetric emergencies, all of which compromise timely and quality maternal healthcare delivery.

Obstetric fistula prevention and treatment

Obstetric fistula¹⁵¹ is one of the most devastating medical conditions affecting women as a result of complications arising from a lack of timely and effective interventions for prolonged and obstructed labour. Though the extent of fistula problem is not well known, several women have been getting fistula. A module to assess the prevalence of obstetric fistula in Zimbabwe was added to the Zimbabwe Demographic Health Survey and results will assist in future planning and implementation of "the Campaign to End Obstetric Fistula" in Zimbabwe.

Finding 38: UNFPA and partners have supported the MoHCC to strengthen the national capacity for obstetric fistula management including social reintegration. UNFPA supported the procurement of fistula kits and 106 obstetric fistula repairs were conducted at mission and provincial hospitals during 2024. The cumulative total repairs done by the end of 2024 was 833 against a target of 802, which was a 104 per cent achievement. Through the advocacy efforts of UNFPA and partners, the GoZ agreed to offer free fistula repair services. UNFPA and partners have shown commitment to ending obstetric fistula by supporting MoHCC in "the Campaign to End Obstetric Fistula" in Zimbabwe as well marking the annual International Day to End Obstetric Fistula on 23rd May. However, despite the progress made in fistula repair, the social reintegration of fistula survivors back into the community did not move as fast as had been expected due funding constraints.¹⁵² This has an effect of reinforcing social stigma towards the women with fistula.

Midwifery training

Finding 39: UNFPA provided support to strengthen the capacities at national and district levels, to improve quality integrated SRH services through midwifery training. UNFPA supported MoHCC in midwifery training (Human resource for Health) and has established e-learning systems. This started off with six pilot schools namely - Chinhoyi, Mpilo, Sally Mugabe, St. Lukes, Karanda and Masvingo and eventually covered 22 schools of midwifery. The specific challenges faced at the schools are the erratic power supply, which makes the use of e-learning platform difficult as well as shortages of tutors due to brain drain.

4.3.1.5 Leaving no one behind /reaching the furthest behind

Finding 40: From the interviews with multiple stakeholders, UNFPA CO and IPs were committed to the approach of 'LNOB/reaching the furthest behind' which is one of the programming principles of the UN Sustainable Development Group (UNSDG).¹⁵³ UNFPA Zimbabwe is operating in provinces and districts where the developmental problems are highest and these include among others Tsholotsho and Chimanimani Districts in Matabeleland North and Manicaland

¹⁴⁹ Document review of UNFPA COARs; KIIs with stakeholders at MoHCC and staff at CO.

¹⁵⁰ KIIs with Provincial Medical Officers; health staff in the hospitals visited - Inyathi and Tsholotsho in Matabeleland North; Victoria Chitepo and Bindura in Mashonaland Central; Mpilo and United Bulawayo in Bulawayo Province.

¹⁵¹ Obstetric fistula is an abnormal opening between the vagina and bladder and/or rectum through which the urine and faeces continually leak. UNFPA ESARO discussion paper – Silent Struggles: Voices of women overcoming obstetric fistula and disability.

¹⁵² KIIs with stakeholders at national and provincial levels; KII with CO staff.

¹⁵³ <https://unsdg.un.org/resources/leaving-no-one-behind-unsdg-operational-guide-un-country-teams-interim-draft>



Provinces respectively. The CO made some attempts to provide services for the vulnerable /reaching the furthest behind groups using a number of approaches, namely Village Health Teams for FP uptake and peer education among others:

- **Village health workers for FP uptake:** With UNFPA support, the MoHCC has used the village health workers teams as a strategy to increase utilisation of FP services in the grassroots communities.¹⁵⁴ VHWs are not initiating FP but supplying what is initiated already. In 2024, MoHCC trained VHWs in five districts namely Mashonaland Central: Bindura, Mbire, Mt Darwin, Guruve and Mazowe and the training covered about 100 VHWs in each district. In 2025, the training covered Manicaland Province targeting Chipinge, Chimanimani and Makoni Districts and Matabeleland North targeting Bubi, Lupane and Tsholotsho Districts. The trained village health workers have increased the reach of FP messages and utilization of FP services¹⁵⁵
- **Peer education:** UNFPA has implemented programmes using peer education approaches for years. Research studies have revealed that peers are the primary source of SRH information for young people and that programmes with peer educators can positively influence young people’s attitudes and knowledge.¹⁵⁶

4.3.1.6 Challenges

Finding 41: The key challenges encountered were as follows:

1. Longer production and shipment lead times resulted in delayed shipments of contraceptives and medical equipment. This was because of the evolving geopolitical issues namely the wars in Ukraine and Gaza as well as the elections in Mozambique.¹⁵⁷
2. Human resources challenges faced by IPs, especially MoHCC affected timely implementation of some activities. The high staff attrition from the MoHCC, the main implementing partner, undermined the provision of quality services.¹⁵⁸ The capacity of implementation of activities and follow-up with supervision to lower facilities further contributes to the quality of services provided at the service delivery points.
3. Inadequate and obsolete equipment and availability of essential medicines and supplies continue to be a major setback in the provision of quality services.¹⁵⁹ The process of equipping facilities is ongoing and will improve the provision of quality comprehensive obstetric and neonatal care with better outcomes.

4.3.1.7 Unintended effects

Finding 42: There were no unintended effects reported or identified by the evaluation.

4.3.2 Adolescents and young people

To what extent has UNFPA Zimbabwe strategies on SRHR, GBV, AYP and PD achieved the intended outcomes for the different target groups making sure that no one is left behind? In particular, (ii) empowerment of adolescents and youth to access SRH services and exercise their sexual and reproductive rights.

Summary of findings

The UNFPA Zimbabwe strategy for AYP has largely achieved its goals, effectively reaching diverse target groups. It has promoted inclusivity and empowered the youth to access SRHR services, ensuring no one is left behind in exercising these fundamental rights.

At output level, the two AYP output indicators were fully achieved (a score above 100 per cent). However, the indicators measured mainly reach rather behaviour change, which is an issue to be addressed in the next CP. The AYP programme significantly enhanced youth participation, expanded access to CSE and improved the quality of adolescent SRH services. It reached millions through schools, radio, TV, universities, and health fairs, with 90 per cent of supported health facilities certified as youth friendly. Key innovations included the “Not in My Village” campaign and youth desks in Government ministries, showcasing strong youth leadership and institutional engagement. The programme promoted equity by targeting vulnerable groups (equipping MSM drop-in centres, launching sex work initiatives and developing disability-inclusive CSE materials). These efforts influenced national policy and addressed service access gaps.

¹⁵⁴ KIIs with officials at MoHCC and Provincial Medical Offices; UNFPA CO staff.

¹⁵⁵ KIIs with stakeholders at provincial and district levels in Manicaland and Matabeleland.

¹⁵⁶ <https://www.jhsph.edu/research/centers-and-institutes/research-to-prevention/publications/peereducation.pdf>

¹⁵⁷ Review of UNFPA quarterly reports and COARs (2024, 2025); KIIs with staff at CO and MoHCC.

¹⁵⁸ KIIs with staff at MoHCC and CO.

¹⁵⁹ KIIs with MoHCC stakeholders at national, provincial and district levels; staff at CO.



However, challenges persist in tackling community-level causes of adolescent pregnancies and supporting youth economic empowerment. An unintended consequence was the raising the age of consent to 18 years, complicating health workers' ability to provide ASRH services to adolescents under that age.

For details of the evidence supporting findings in section 4.3, see the evaluation matrix: Assumption 5.2 in Annex 1.

4.3.2.1 Assessment of the results at outcome and output levels

Finding 43: The AYP portfolio exceeded targets set for its output indicators. The AYP component had one output namely Output 2: AYP, including vulnerable groups, are equipped with the knowledge and skills to participate in decision-making and make informed decisions on SRHR.

The indicator statements for the two output indicators, targets and achievement are shown in Annex 7.

The assessment of the output indicators revealed that all the two were achieved (e.g., a score above 100 per cent) as shown in Table 14.

Table 13: AYP output indicators

Output	Total output indicators	Achieved $\geq 100\%$	Most likely to be achieved 70-99%	Likely to be achieved 25-69%	Unlikely to be achieved <25%	No data reported for achievement
AYP Output 2	2	2				
Total	2	2				
Per cent		100%				

Source: ET analysis

Finding 44: While the above figures show that UNFPA-supported programme have exceeded their cumulative targets in reaching young people with life skills programmes (153 per cent achievement) and engaging ministries/institutions in policy dialogue (128 per cent achievement), it is crucial to recognize the inherent limitations of these indicators as being output-level indicators. These metrics primarily demonstrate the volume of activities undertaken and the number of individuals/entities reached. For instance, the number of young people reached with life skills programmes indicates exposure, but not necessarily improved knowledge, attitude, or practices related to SRHR. Similarly, the indicator on the number of key ministries and institutions that effectively engage youth networks highlights collaboration, but not the impact of that engagement on policy, budgeting, or youth-friendly services. The true measure of empowerment lies in the sustained changes in behaviour, access, and decision-making, which these indicators did not fully capture.

These indicators emphasized activity rather than meaningful transformation. Counting young people reached shows programme reach but not whether SRHR knowledge, attitudes, or behaviours improved. Likewise, tracking institutional engagement reflects collaboration but not its effect on policies or services. Consequently, the measures overlooked genuine empowerment, which depends on sustained behavioural change, equitable access, and youth influence.

However, the contribution of the output to the outcome 'AYP everywhere have increased the utilization of ASRHR services and are empowered to make informed decisions' was deemed optimal. The evidence is contained in findings 46, 47 and 48 in the subsequent sections.

4.3.2.2 Assessment of the results for AYP component

Finding 45: UNFPA Zimbabwe's strategies significantly contributed to the empowerment of AYP in accessing SRHR services and exercising their reproductive rights. This contribution is evident across several key areas particularly in strengthening youth voices, enhancing access to CSE, improving SRH service provision, and fostering policy engagement.

The evaluation reviewed the performance of the AYP programme on two outcomes:

- Strengthening youth voices and policy influence (contributing to outcome 4: Increased policy and budgetary support for adolescent and youth SRHR from government and partners)
- Enhancing access to SRH services and knowledge (contributing to outcomes 1, 2 and 3: Increased use of contraceptives and condoms, Reduction in risky sexual practices, Reduction in child marriages).



Strengthening youth voices and policy influence

Finding 46: UNFPA demonstrated a strong commitment to empowering youth voices on SRHR, which has directly translated into enhanced youth participation in policy and programmatic decisions largely achieved through sustained support to key youth networks and parliamentary caucuses.¹⁶⁰ UNFPA continued to build the capacity of YPNHW which is now described as a “very powerful” and “informed” network.¹⁶¹ This capacity is demonstrated in their ability to lead the development and implementation of national and local initiatives that include the “Not in My Village Campaign” which brought government and traditional leaders to address adolescent pregnancies. In Shamva (Mashonaland Central Province), the YPNHW chapter was leading local fundraising for initiatives aimed at addressing adolescent SRHR including an annual concert for raising awareness and increasing access to services through mobile SRHR/GBV/HIV services in partnership with service providers.¹⁶² It was also a critical platform during the 8th CP development assisting in national consultations with young people¹⁶³ as exemplified by a quote:

“YPNHW has helped us to understand our dreams, their aspirations, the challenges that we are facing, and even some of the solutions that they think are viable”.

Finding 47: The 8th CP’s support enabled youth engagement in legislative processes with ZYC confirming UNFPA’s role in reviewing the national youth policy (2020-2025) and building capacity for the parliamentary youth caucus and ministry youth desks. This has led to increased youth participation in national dialogues, with the youth caucus developing a youth model parliament and actively participating in budget consultative processes where young people make submissions. UNFPA’s support to ZYC contributed to government’s adoption of youth desks in all ministries and has been instrumental in building capacities of staff in these desks to enhance youth participation and inclusion in decision-making processes. By 2023 about 1,325,911 youth members were reported to have received services from 18 youth desks.¹⁶⁴ A KII from ZYC noted:

“UNFPA’s partnership is based on enabling youth to engage government on youth friendly policies... we managed to engage government at the levels as we intended”.

Enhancing access to SRH services and knowledge

Finding 48: The CP interventions aimed to equip adolescents and youth with the knowledge and skills necessary to make informed SRHR decisions and to access services. UNFPA provided extensive support for CSE in schools. This included the development of interactive radio programmes, and the creation and distribution of “fit for life” books and the sponsorship of national schools’ quiz aired on TV. The Life Skills Empowerment Strategy (2018-2025), developed and regularly reviewed with UNFPA support, serves as a guiding framework for implementing guidance, counselling, and CSE. MoPSE also confirmed that in the development of CSE materials, MoPSE coordinated inputs from various ministries with UNFPA’s support, ensuring a multi-sectoral approach. Through support to SAYWHAT, UNFPA was able to deliver CSE and social behaviour change interventions to young people in tertiary institutions reaching about 725,328 students by the end of December 2023.¹⁶⁵ It also strengthened access to integrated quality SRH/HIV/GBV services in these institutions through “health fairs” and medical expense vouchers for referral services.¹⁶⁶ As a result of increased access to SRH/HIV/GBV services, there have been improvement in the FP and HIV/AIDS areas. Regarding the unmet need for FP, it was 14.6 for young people aged 15-19 years and 8.6 for those aged 20-24 years.¹⁶⁷ According to the national HIV estimates published by the MoHCC, HIV incidence and prevalence among adults aged 15 to 49 years was estimated at 0.15 and 10.49 per cent in 2023 while that in the age group 15 to 24 years was estimated at 0.14 and 3.4 per cent respectively. For the young people aged 15-24 years, half of the young women (50 per cent) and men (49 per cent) had knowledge about HIV Knowledge of HIV prevention was lowest among women in Matabeleland North (39 per cent).

¹⁶⁰ KIIs with staff of ZYC, UNFPA CO and NGO partners.

¹⁶¹ KIIs with UNFPA, MWACSMED (Mashonaland Central) staff, FGD with District Stakeholders Shamva.

¹⁶² FGD with YPNHW members.

¹⁶³ KIIs with UNFPA CO staff.

¹⁶⁴ UNFPA CO Annual report 2023.

¹⁶⁵ KIIs with SAYWHAT staff, UNFPA and Review of UNFPA CO Annual Report 2023.

¹⁶⁶ FGDs with young people in MSU and MTC.

¹⁶⁷ Zimbabwe Demographic Health Survey (ZDHS) 2024: Key Indicator Report



Finding 49: UNFPA directly supported the strengthening of youth friendly health services (YFHS) in health facilities. By the time of the evaluation, UNFPA had supported (through on-job training of health workers, supervision visits, and certification of facilities) 90 per cent of health facilities to be certified as youth friendly.¹⁶⁸ The MoHCC acknowledged the efforts of UNFPA in capacitating health officials to integrate AYP-friendly services into hospital experiences, leading to the establishment of dedicated AYP-friendly SRH clinics.¹⁶⁹

4.3.2.3 LNOB/reaching the furthest behind

Finding 50: The CP interventions were grounded in an understanding of gendered vulnerabilities and the exclusion of other vulnerable groups, such as MSM, sex workers and those staying in hard-to-reach places.

- **KP services:** Despite a challenging operating environment where LGBTQI+ individuals are largely criminalized by law, UNFPA was able to lead the establishment and equipping of drop-in sites for LGBTQI+ individuals enhancing their access to SRHR/HIV/GBV services.¹⁷⁰ UNAIDS recognized UNFPA as a core sponsor for HIV programmes, noting UNFPA's initiation of the national sex work programme, which later involved the Global Fund and local IPs like GALZ and Centre for Sexual Health and HIV/AIDS Rights (CeSHHAR). This demonstrated a leveraging of partnerships for comprehensive KP programming
- **Disability inclusion:** UNFPA was very deliberate in making CSE manuals disability-focused and disability inclusive and partners were conscious of disability inclusion in the activities
- **Reaching the furthest behind:** With the support from UNFPA, IPs delivered CSE in out-of-school settings reaching those furthest behind including young KPs, young people living with disabilities, young pregnant mothers and other young people who were not in school.¹⁷¹

4.3.2.4 Challenges

Finding 51: Despite notable achievements, challenges remain. A significant constraint identified is the limitation in the provision of youth economic empowerment,¹⁷² which is undermining efforts to reduce adolescent pregnancies.¹⁷³ This is seen as a missing intervention to support decision making among young people. A KII from an NGO noted as follows:

"Though CSE was implemented, teenage pregnancies increased which may not speak to the effectiveness of CSE. Economic empowerment has been a missing intervention to support decision making among young people".

UNFPA has actively led the UN Youth Group in supporting government efforts to develop a Youth Empowerment Policy and Strategy, emphasizing economic empowerment. Still under development during the time of the evaluation, these efforts are complemented by UNFPA's expanded partnerships, including funding a project with Plan International that explores the intersection of SRHR and economic empowerment. Further guidance in this area is expected through the UNFPA regional office that was in the process of developing a standard CSE manual for integration into economic empowerment activities.

Finding 52: The UNFPA's AYP portfolio was skewed towards institution-based interventions namely: improving YFHS delivery in health facilities; enabling access and utilization of SRHR services and behaviour change in tertiary academic institutions; improving delivery and effectiveness of CSE in primary and secondary schools and tertiary institutions; and supporting capacity of young people to engage in policy processes and decision making for SRHR.¹⁷⁴ This was a strategic shift by UNFPA premised on some of its models for social behaviour change, which had been taken up by partners and being scaled up. For example, Sista2Sista, PCC, Determined, Resilient, Empowered, AIDS-free, Mentored and Safe programme among others and therefore has been leveraging the presence of other players in this space to address socio-economic drivers. While these are commendable in addressing key SRHR challenges for AYP (adolescent pregnancies, child marriages, et cetera) by improving access and utilization of SRHR services, they fell short of addressing social and behavioural drivers for these problems. The "Not in My Village" campaign and its success

¹⁶⁸ KIIs with UNFPA CO staff, Review of UNFPA CO Annual report 2022-2024.

¹⁶⁹ KIIs with MoHCC staff.

¹⁷⁰ KIIs with stakeholders at national level.

¹⁷¹ Review of UNFPA COAR 2024; KIIs with stakeholders in Manicaland and Matabeleland Provinces.

¹⁷² This support is limited in the design and implementation of the AYP programme. Although some initiatives were implemented, these were sporadic and not integrated with other portfolio interventions (Ref. UNFPA Annual report 2023)

¹⁷³ KIIs with UNFPA, UN and NGO staff.

¹⁷⁴ Review of UNFPA CO Annual Reports 2022-2024.



demonstrate the importance of a community-based approach and the complementary effect such interventions can have in achieving the overall ToC of the AYP portfolio. One key stakeholder from a UN agency had this to say,

“In terms of reaching AYP – UNFPA used to be very strong in their community programming – you could see what they were doing in the community. Whether it’s a strategic shift to upstream work but there is a challenge. The organization initiated good programming which was dropped along the way. They no longer have that much input and presence at community level”.

4.3.2.5 Unintended effects

Finding 53: As indicated earlier, increasing the age of consent to sex to 18 years created dilemmas for health workers, who became hesitant to provide SRH/HIV/FP services to adolescents below the age of 18 years for fear of legal repercussions for “abating sexual abuse (rape)”. This further complicated the promotion of a HRB approach to SRH/FP service delivery which is supported by UNFPA.

4.3.3 Gender equality and women’s empowerment

To what extent has UNFPA Zimbabwe strategies on SRHR, GBV, AYP and PD achieved the intended outcomes for the different target groups making sure that no one is left behind? In particular; (iii) advancement of gender equality and the empowerment of all women and girls.

Summary of findings

The UNFPA Zimbabwe strategies have largely contributed to the advancement of gender equality and the empowerment of all women and girls making sure that no one is left behind. The contribution of the output to the outcome is deemed optimal since only two indicators (50 per cent) out of four have been achieved, and one indicator (25 per cent) is most likely to be achieved before the end of the CP. The output indicator target for survivors of GBV who received at least one essential service (social services, health, police or justice) was overachieved (108 per cent). Similarly, the target for women, men, girls and boys reached with community programmes to promote gender-equitable norms, attitudes and behaviours, including concerning women’s and girls’ sexuality and reproduction was also overachieved (101 per cent). The GBV interventions under the 8th CP have been largely effective in strengthening prevention, response, and capacity-building systems in Zimbabwe. Through strategic partnerships with Government ministries, humanitarian actors, academia, and civil society, the programme has expanded survivor access to timely, comprehensive, and rights-based GBV services. Humanitarian responses demonstrated adaptability and coordination, ensuring service continuity despite some disruptions. Overall, the outputs delivered to-date demonstrate a strong contribution to GEWE outcomes, particularly in improving access to survivor-centred services, promoting positive gender norms, and laying the groundwork for sustainable system-wide change. However, following the ending of the Spotlight Initiative programme, there were no sufficient funds for the continuity of OSCs. This was all due to overall funding for GBV programmes in Zimbabwe being significantly reduced by donors and the Government not allocating adequate funds for sustainability. As a result, some facilities were temporarily closed and this created gaps in service delivery. Despite the efforts of UNFPA’s programmes to empower women, there remains a need for more economic empowerment initiatives, as financial independence is a critical factor in reducing women’s vulnerability, particularly since many survivors of GBV lack sustainable livelihoods.

For details of the evidence supporting findings in section 4.3, see the evaluation matrix: Assumption 5.3 in Annex 1.

4.3.3.1 Assessment of results at outcome and output levels

The GEWE component had one output namely Output 3: *Strengthened national, provincial, district and community capacity to prevent and respond to GBV and harmful practices, including in humanitarian settings.* The indicator statements for the four output indicators, targets and achievement are shown in Annex 7.

Finding 54: The evaluation assessed the performance of the four output indicators linked to the above output and the underlying interventions. Two indicators (50 per cent) out of the four were achieved, one (25 per cent) was most likely to



achieve the target; and one indicator (25 per cent) was unlikely to be achieved.¹⁷⁵ The results are summarised in Table 15.

Table 14: GEWE output indicators

Output	Total output indicators	Achieved $\geq 100\%$	Most likely to be achieved 70-99%	Likely to be achieved 25-69%	Unlikely to be achieved <25%	No data reported for achievement
GBV Output 3	4	2	1		1	
Total	4	2	1		1	
Per cent		50%	25%			25%

4.3.3.2 Assessment of the results for GEWE component

Strengthened GBV response

Through service delivery expansion

Finding 55: The 8th CP successfully expanded the geographical reach of GBV services, ensuring that survivors in both rural and urban areas could access quality multi-sectoral support. The establishment and ongoing operation of OSCs and mobile OSCs at community and district levels significantly improved access to integrated services, including GBV case management, psychosocial support, legal aid, and health services such as cervical cancer screening (using visual inspection with acetic acid method), FP, and HIV testing. Under the Spotlight Initiative, services specifically targeted remote and underserved areas, an approach stakeholders hailed as a “breakthrough” in decentralizing GBV prevention and response for MWACSMED.¹⁷⁶

The needs of women and men were addressed through differentiated yet complementary interventions that recognized their distinct social roles, vulnerabilities, and capacities.¹⁷⁷ Women and girls primarily needed access to comprehensive SRH services, protection from GBV, and economic empowerment. Programmes addressed these through expanded FP and maternal health services, strengthened GBV prevention and response systems, and initiatives supporting women’s entrepreneurship. Men and boys were engaged as partners and change agents to challenge harmful gender norms, promote positive masculinities, and improve health-seeking behaviours through community dialogues, male engagement campaigns, and collaboration with traditional and religious leaders to transform inequitable attitudes and practices.

Through targeted initiatives for vulnerable groups and economic empowerment

Finding 56: UNFPA operated mobile OSCs, funded through the Government of Japan, that provided dignity kits to replace unsafe menstrual practices (e.g. use of cow dung) and conducted GBV sensitization. UNFPA-supported Musasa shelters, offered an emergency transport fund for survivors of GBV, enabling timely access to specialized services including urgent cases involving children. In collaboration with FACT, survivors received livelihood support, such as sewing machines, aiding recovery and resilience.¹⁷⁸ Additionally, a Central Emergency Response Fund supported project focused on drought-affected communities by enhancing access to GBV services alongside economic empowerment. The UNPRPD programme (Feb. 2021 - Aug. 2025), a joint UN initiative (UNFPA, UNESCO, UNDP et cetera), included Phase I where UNFPA supported the strengthening of legal and policy frameworks and Phase II, which piloted disability-friendly mobile OSCs serving primarily women and girls with disabilities. The pilot, implemented in Mt Darwin, Bindura, and Muzarabani, aimed to identify effective practices and lessons to inform future programming.¹⁷⁹

Through innovation

Finding 57: Initial steps have been taken towards the establishment of the national GBV IMS. Although the indicator remains unmet, with no functional GBV IMS in place by 2024, significant groundwork has been laid. UNFPA supported an assessment of GBV data collection tools and existing systems and facilitated the development and validation of a National Harmonized Framework for the GBV IMS.¹⁸⁰ Furthermore, funding commitments from the EU and SDC under

¹⁷⁵ Evaluation team analysis of UNFPA CO Annual and quarterly reports (2022-2025).

¹⁷⁶ KIIs with staff at MWACSMED and UNFPA CO.

¹⁷⁷ KIIs with staff at MWACSMED (national and provincial level) and UNFPA CO.

¹⁷⁸ KIIs with IPs and FGD with multi sectoral stakeholder.

¹⁷⁹ KIIs with UNFPA staff and IPs.

¹⁸⁰ UNFPA Annual report 2024.



the joint programme *Sustaining the Gains of the Spotlight Initiative in Zimbabwe* provide renewed momentum, with implementation expected to commence in 2025, including piloting of the system in one province.

Finding 58: The introduction of a safe and confidential shuttle service, implemented with NGOs such as Musasa, significantly improved GBV survivors' access to shelters, medical care, police services, and other support points.¹⁸¹ Survivors reported that the service significantly improved their safety, access to emergency care, and overall well-being; one described it as *"more than a vehicle as it saved my life from death."*¹⁸² Shuttle services were successful as data show that 6,479 survivors received psychosocial support through this intervention, surpassing the target of 6,000 survivors (108 per cent).¹⁸³ Additionally, fuel voucher schemes supported survivors and GBV service providers to access centralized services, including psychiatric evaluations in Harare and age estimations in town centres.¹⁸⁴

UNFPA community-based GBV prevention and support

Finding 59: Under the Women at the Centre programme, UNFPA supported the establishment of ten safe spaces in Bubi District (Matabeleland North Province) in partnership with World Vision and in collaboration with the MWACSMED. The safe spaces provide psychosocial support, GBV information, and referral services, while also functioning as platforms for livelihoods and economic strengthening. In 2024, World Vision and communities jointly identified cadres to manage the spaces, reaching 198 vulnerable women and girls.¹⁸⁵ while Musasa provided GBV response services through mobile OSCs in these communities.

Finding 60: UNFPA supported initiatives to raise awareness among survivors on the importance of timely reporting and accessing services to prevent further complications.¹⁸⁶ The proportion of survivors of GBV who report to health facilities within 72 hours in supported provinces in 2023 targeted 29 per cent, but only 28 per cent of survivors achieved this benchmark.¹⁸⁷ Out of 8,551 survivors who accessed health facilities across the five supported provinces, 2,359 sought care within 72 hours.¹⁸⁸ As such, UNFPA, in partnership with MWACSMED, Zimbabwe Cricket Association, and the Adult Rape Clinic, supported the #72Hours campaign to urge SGBV survivors to access critical medical, psychosocial, and legal services within 72 hours. Leveraging sports as a powerful platform, Zimbabwe Cricket Association players served as champions, delivering nationwide awareness and prevention messages through widely disseminated video campaigns nationwide.¹⁸⁹

UNFPA capacity strengthening

Finding 61: Through comprehensive training and resource provision, key frontline actors and community leaders have improved their survivor-centred referrals and data reporting skills, leading to better service outcomes. Frontline service providers were trained in clinical management of rape, disability-inclusive approaches, GBV risk mitigation, and response in emergencies.¹⁹⁰ Within the MWACSMED, targeted support has strengthened administrative and operational functions. For example, extension staff received bicycles for outreach capacity, while some OSCs have benefited from financial support for staff salaries and management resources.¹⁹¹ One participant narrated as follows:

"Senior counsellors were trained to improve case handling and equipped with self-care tools to manage burnout, ensuring sustained quality of support for survivors".¹⁹²

Finding 62: In 2024, with UNFPA support, MWACSMED conducted 22 training workshops on GBV in Emergencies and Protection from Sexual Exploitation and Abuse (PSEA) across 22 districts. These sessions engaged key stakeholders, including government officials, traditional and religious leaders, and CSOs, both GBV and non-GBV actors. Additionally, the ZNAC's Sister-to-Sister programme empowered adolescent girls and women with knowledge on SRHR, financial

¹⁸¹ Musasa Q4, 2024 report.

¹⁸² Musasa Q4 Report.

¹⁸³ Musasa Q4 Report.

¹⁸⁴ FGDs with multi-sectoral stakeholders.

¹⁸⁵ World Vision Q4, 2024 Annual Report.

¹⁸⁶ KIIs with IPs.

¹⁸⁷ UNFPA Annual Report 2024.

¹⁸⁸ UNFPA Annual Report 2024.

¹⁸⁹ KIIs with IPs.

¹⁹⁰ KIIs with IPs.

¹⁹¹ FGDs with multi-sectoral stakeholders.

¹⁹² KIIs with an implementing partner.



literacy, and GBV prevention, addressing the economic drivers of GBV.¹⁹³ Community-based structures were capacitated to identify and respond to GBV cases; Social and Behavioural Change Champions and Safe Space Peer Facilitators received training on GBV, psychological first aid, referral pathways, and survivor-centred approaches.¹⁹⁴ Implementing partner narrated as follows:

“Survivor Support and Empowerment Facilitators identified survivors within communities, while Social and Behavioural Change Champions mobilized awareness and referred cases through village heads to police authorities.”¹⁹⁵

4.3.3.3 LNOB/reaching the furthest behind

Finding 63: The programme’s design and implementation reflected a strong commitment to the principle of “LNOB/reaching the furthest behind.” It included targeted interventions for vulnerable groups such as women with disabilities, survivors of GBV, and young people. Through the UNPRPD, mobile OSCs were extended to women and girls with disabilities, demonstrating UNFPA’s dedication to meeting the needs of marginalized groups by providing comprehensive services in accessible and convenient settings. In addition, UNFPA’s partnerships with communities particularly through the training of Social and Behavioural Change Champions and Safe Space Peer Facilitators enhanced community participation in GBV prevention and response.

4.3.3.4 Challenges

The key challenges encountered were as follows:

Finding 64: UNFPA has fully funded OSC operations; however, a funding shortage for GBV initiatives in 2023-2024 severely constrained their functionality.¹⁹⁶ When the Spotlight Initiative ended, there were no adequate funds all due to a significant reduction of donor funds for GBV programming and the Government not allocating funds. This situation exposed the lack of diversified and sustainable financing mechanisms within the MWACSMED, creating significant operational gaps. The Spotlight Initiative funded Centre in Epworth in Harare City for example, has faced significant operational difficulties, including personnel shortages with only an administrator and no counsellor, delayed salary payments that affect staff morale, and the lack of essential equipment (e.g. printers, reliable internet, laptops), and dedicated play areas for minor survivors.¹⁹⁷ According to some stakeholders, dysfunction in some OSCs was largely due to poor inter-ministerial collaboration, particularly between the MoHCC and MWACSMED.¹⁹⁸

Finding 65: Efforts to include PWDs in GBV programming were constrained by limited funding, capacity gaps, and lack of adaptation to the needs of those with visual and hearing impairments.¹⁹⁹ While some OSCs had ramps and restrooms for physical accessibility, barriers persisted due to limited braille, sign language, and inclusive information and educational communication materials, alongside insufficient disability-specific expertise among service providers. Frequent rotation of trained officers sometimes compromised the quality of survivor support, as some incoming officers often lacked adequate training in handling such cases. In some other OSCs, heavy police presence created intimidating environments that might have prevented people from seeking assistance as they were concerned their cases would be reported to the police - and the consequences this might have (e.g. arresting the perpetrator/partner, stigma, safety concerns et cetera).²⁰⁰

4.3.3.5 Unintended effects

Finding 66: The rapid scale-up of GBV services at times led to service bottlenecks, especially where resource levels did not keep pace with demand, underscoring the importance of sustainable funding and strategic planning. Increased awareness and reporting have sometimes led to backlashes from community members or perpetrators, potentially placing survivors and frontline workers at risk. Increased awareness and reporting have sometimes led to backlashes from community members or perpetrators, potentially placing survivors and frontline workers at risk. Some interventions, such as the integration of police officers within OSCs, may inadvertently discourage survivors from seeking assistance,

¹⁹³ FGDs with multisectoral stakeholders in Matabeleland and Manicaland Provinces; document review.

¹⁹⁴ KIs with IPs.

¹⁹⁵ Quote from an IP.

¹⁹⁶ KIs with IPs.

¹⁹⁷ KIs with IPs.

¹⁹⁸ KIs with IPs.

¹⁹⁹ KIs with IPs at provincial and district levels.

²⁰⁰ Observation of OSCs; KIs with IPs.



as they may fear that their case would be reported to law enforcement, potentially resulting in consequences such as the arrest of the partner or perpetrator, heightened stigma, or safety risks. Staff burnout due to high workloads also affected service delivery sustainability, underscoring the need for ongoing capacity support and resource allocation.

4.3.4 Population and development

To what extent has UNFPA Zimbabwe strategies on SRHR, GBV, AYP and PD achieved the intended outcomes for the different target groups making sure that no one is left behind? In particular, (vi) increased use of population data in the development of evidence-based national development plans, policies and programmes?

Summary of findings

The UNFPA Zimbabwe strategy on PD has largely met its objectives across various target groups, promoting inclusivity and ensuring no one is left behind. It has notably enhanced the use of population data in formulating evidence-based national development plans, policies, and programmes. The contribution of the output to the outcome was deemed optimal since three indicators (75.0 per cent) out of four had been fully achieved (score of 100 per cent) and one indicator was most likely to be achieved. Under its 8th CP, UNFPA supported key data initiatives, including the 2022 PHC, the 2023/24 ZDHS, and preparations for the MICS. By 2024, 15 out of the targeted 26 in-depth analytical reports (58 per cent) had been completed using data from various surveys. UNFPA also strengthened the Civil Registration and Vital Statistics (CRVS) system, significantly reducing the data capture backlog, with some districts updating records through to 2025. An interactive data platform was launched, featuring indicators on transformative results, the SDGs, and NDS 1. The proportion of SDG indicators with current data increased from 65 per cent in 2020 to 85.5 per cent by 2025. Furthermore, a new National Development Plan incorporated recommendations from the DD Study. Upholding the “LNOB” principle, UNFPA and ZIMSTAT included the Washington Group disability questions in the 2022 Census and 2023/24 ZDHS, ensuring representation of PWDs.

For details of the evidence supporting findings in section 4.3, see the evaluation matrix: Assumption 5.4 in Annex 1.

4.3.4.1 Assessment of PD at outcome and output levels

Finding 67: The ToC underlying the PD component, as outlined in the CPD is generally based on a sound intervention logic. The PD strategic outcome had one output namely: Output 4: *Strengthened capacity of the national statistical system to produce, analyze and use disaggregated population data to inform policy decision-making and development programming, including in humanitarian situations.* The strategic outcome and the one output which were contributing to the attainment of the outcome were articulated well. The linkages between the activities for planned interventions for the output were clear as well as the linkage between the output and the outcome. The indicators for the output were sufficient to measure progress.

The indicator statements for the four output indicators, targets and achievement are shown in Annex 7.

Finding 68: The assessment of the four output indicators revealed that three of them (75.0 per cent) were achieved, and one indicator (25.0 per cent) was likely to be achieved as shown in Table 16.

Table 15: PD output indicators

Output	Total output indicators	Achieved $\geq 100\%$	Most likely to be achieved 70-99%	Likely to be achieved 25-69%	Unlikely to be achieved <25%	No data reported for achievement
PD Output 4	4	3		1		
Total	4	3		1		
Per cent		75.0%		25.0%		

Finding 69: Contribution to the outcome: The contribution of the output to the outcome was deemed optimal since three indicators (75.0 per cent) out of four had been achieved (score of 100 per cent) and one indicator was most likely to be achieved.²⁰¹

²⁰¹ Evaluation team analysis of UNFPA CO annual and quarterly reports (2022-2025).



4.3.4.2 Assessment of the results for PD component

Finding 70: UNFPA 8th CP carried out a 2022 PHC, a ZDHS 2023/24, and are planning for the implementation of the MICS. With financial and technical support from UNFPA, the 2022 PHC^{202, 203, 204} was successfully conducted and results were released to users and the public in a timely manner. Additional funding was received from UNECA. The UNPRPD, UNESCO, UNDP, UNFPA, ZIMSTAT and the Department of Disability Affairs collaboratively embedded the six Washington Group of Questions in the Population Housing Census to collect information on PWDs in compliance with the provisions of the UNPRPD. Additionally, UNFPA promoted and supported the use of new technologies in data collection, analysis and dissemination as the CAPI method of data collection was used for the first time in a census operation and this led to timeliness of data collection.

“We used CAPI for data collection: It is the best as it improves the data quality. It removes human errors on skip patterns or wrong reasons. Its faster,” KII with ZIMSTAT staff.

The census field mapping was completed on time, thereby facilitating the recruitment, training and subsequent deployment of about 50,000 field staff for the census enumeration by April 2022. Preliminary results, offering greater thematic detail and analytical depth than previous censuses, were released within three months as planned and are available on the ZIMSTAT website (<http://www.zimstat.co.zw>). The results were widely reported in mainstream and social media, both print and electronic, and were used by the Zimbabwe Electoral Commission in the Constitutional Delimitation of Electoral Boundaries for the 2023 Harmonized General Elections. The results, which were included as an Annex to the National Budget Statement 2023, were also used by MoFEDIP in crafting the 2023 National Budget.

Finding 71: Through the support from the GoZ and the HRF, UNFPA in collaboration with the Global Fund and USAID supported ZIMSTAT in the successful implementation and dissemination of the ZDHS 2023/2024^{205, 206} with the final report launched in June 2025. The ICF provided TA through the DHS Programme, a USAID-funded project offering support and TA in the implementation of population and health surveys worldwide. Ideally, a DHS should occur every five years to consistently track key health and population indicators. However, the last DHS was in 2015. The planned 2020 survey was delayed due to the COVID-19 pandemic, with further postponements caused by the 2022 PHC and the 2023 harmonized elections. The 2023-24 ZDHS provides essential data to support evidence-based policymaking and programme planning aimed at improving population health outcomes in Zimbabwe.²⁰⁷ In 2024, UNFPA, UN Women, UNICEF, UNDP, UNESCO, and the International Telecommunication Union (ITU), collaborated with the GoZ to enhance data systems for monitoring SDGs and promoting inclusive policies.²⁰⁸

Finding 72: The MICS²⁰⁹ was delayed due to the COVID-19 pandemic. The main funder of the MICS is UNICEF with technical support coming from UNFPA. At the time of the evaluation, training was undertaken on Paper Assisted Personal Interviewing (PAPI) with the CAPI expected to commence thereafter, and household listing was underway. Research assistants training was ongoing in September with data collection planned for October to December 2025.

Finding 73: Fifteen in-depth analysis reports out of a target of 26 (58 per cent) were produced from the census, ZDHS and other surveys by 2024. A total of 15 reports were produced by various UN agencies, with UNFPA generating thematic reports on youth, disability, and fertility using 2022 PHC data to support evidence-based policy decisions.^{210, 211, 212} UNICEF supported gender-specific analyses, such as the Women and Men Profile Reports, to promote evidence-based, gender-responsive policymaking. Together with UNFPA and ZIMSTAT, they also developed ten provincial, 90

²⁰² 2022 Annual Planning – Zimbabwe Finalized - 01 Apr. 2022.

²⁰³ 2022 Annual Report – Zimbabwe Finalized - 30 Jan. 2023.

²⁰⁴ KIIs with UNFPA CO staff, ZIMSTAT and MoFEDIP

²⁰⁵ 2023 Annual Planning - Zimbabwe Finalized - 13 Jul. 2023; UNFPA COARs 2023, 2024.

²⁰⁶ The HRF Joint Programme 2023 and 2024 Annual Reports.

²⁰⁷ Zimbabwe National Statistics Agency (ZIMSTAT) and ICF. Zimbabwe Demographic and Health Survey 2023– 24: Key Indicators Report. Harare, Zimbabwe, and Rockville, Maryland, USA: ZIMSTAT and ICF.

²⁰⁸ UN Zimbabwe. Annual Report 2024.

²⁰⁹ KIIs with UNFPA CO staff, ZIMSTAT, UNICEF.

²¹⁰ 2024 and 2025 Results and Resources Plan for Zimbabwe.

²¹¹ UNFPA Zimbabwe: 2022, 2023, and 2024 Annual Reports.

²¹² KIIs with UNFPA CO staff, ZIMSTAT, MOHCC, UNICEF.



district, and ward-level profiles using 51 SDG-aligned indicators to guide targeted resource allocation and reduce inequalities effectively. In 2022, further analyses were conducted using data from the Vital Medicines Availability and Health Survey (VMAHS) and the Health Management Information System (HMIS).^{213, 214} A key achievement was the analysis of selected maternal health indicators, which informed the HRF Concept Note and guided intervention prioritization and geographic targeting, including data on SGBV survivors receiving services within 72 hours.

Finding 74: UNFPA supported the CRVS system and managed to reduce the backlog in data capture from 2022 with some districts capturing data for 2025.²¹⁵ UNFPA contributed to the digital connectivity of ZIMSTAT and improved data capture to ensure that backlogs were cleared. The digitalized civil registration improved birth registration collecting births and deaths data at the Registrar’s Office since the beginning of 2025. Data was collected from files, captured via tablets, and uploaded to the ZIMSTAT server. Most districts in Manicaland and Mashonaland Central Provinces, for example, have updated births and deaths data from 2022 to 2025. The Vital Statistics Reports - Births and Mortality Reports - are expected to be developed during 2025.

“We are capturing data from 2022 and currently almost catching up with some districts now capturing data for 2025). We are still behind but by the end of year we will be on track,” said a KII ZIMSTAT staff.

Finding 75: UNFPA selected SDG indicators with up-to-date data increased from a baseline of 65 per cent in 2020 to 85.5 per cent in 2025 (195 indicators out of the 228 applicable to Zimbabwe) were uploaded.²¹⁶ This progress was largely driven by new data collected for the first time during the PHC, which provided information on 24 SDG indicators. In 2024, the ZDHS Key Indicator Report offered vital insights into population and health trends for SDG monitoring and maintaining an up-to-date monitoring database.²¹⁷ Additionally, the programme successfully collaborated with ICPD task forces to assess progress and identify critical PD concerns.²¹⁸ This collaboration resulted in a comprehensive progress report outlining key recommendations across various sectors to advance the ICPD agenda. The SDG/ICPD/transformative results data platform/dashboard was up and running with support from UNFPA (<https://sdg-zimstat.github.io/>).

Finding 76: An interactive data platform with indicators on transformative results, SDGs and NDS 1 was operational by the time of the evaluation. Data on all the relevant UNFPA-related SDG indicators, transformative results and UNSDCF indicators were updated using the 2022 census results and other data sources.²¹⁹ In 2024, a dedicated GitHub repository and platform for SDG support and reporting was successfully developed in collaboration with ZIMSTAT.²²⁰ This platform served as a crucial resource for developers and researchers, offering country-specific data and real-time tracking of Zimbabwe’s progress on the SDGs. At the time of this evaluation, UNFPA was working with ZIMSTAT to integrate Zimbabwe data portals into dashboards and ensure continuous platform updates.

Finding 77: A National Development Plan that integrated recommendations from the DD Study was available. UNFPA supported a study on harnessing the DD in 2017. The study identified four key pillars to attain the DD namely: Health and Well-being, Education and Skills Development, Employment and Entrepreneurship, Governance and Economic Reforms. Zimbabwe’s NDS 1, 2021–2025 addressed the idea of a DD, highlighting it as a key opportunity should the right policies be implemented. Key highlights in the NDS 1 relating to the DD are on human capital development, youth empowerment, women empowerment, and health pillars. The findings of the DD Study will continue to underpin the next NDS 2 2026-2030.

4.3.4.3 LNOB/reaching the furthest behind

Finding 78: UNFPA and ZIMSTAT practiced the principle of LNOB /reaching the furthest behind.^{221, 222} The incorporation of the Washington questions on disability in the 2022 PHC and the ZDHS 2023/24 ensured that PWDs

²¹³ 2022 Annual Planning - Zimbabwe Finalized - 01 Apr. 2022.

²¹⁴ 2022 Annual Report - Zimbabwe Finalized - 30 Jan. 2023.

²¹⁵ UN Zimbabwe. Annual Report 2024; 2025 Q1 ZIMSTAT Workplan; KIs with ZIMSTAT and UNFPA CO staff.

²¹⁶ 2022 Annual Report – Zimbabwe Finalized - 30 Jan. 2023.

²¹⁷ UNFPA Zimbabwe: 2024 Annual Report.

²¹⁸ UNFPA Zimbabwe: 2024 Annual Report.

²¹⁹ 2022 Annual Report – Zimbabwe Finalized - 30 Jan. 2023.

²²⁰ UNFPA Zimbabwe: 2024 Annual Report.

²²¹ Country Office Annual Reports (COARs) (2022, 2023, 2024).



were accounted for. Additionally, UNFPA ensured integration of data in the humanitarian-development nexus supporting data collection during humanitarian situations (e.g., COVID-19; cyclones; and floods) reaching vulnerable groups, PWDs, hard to reach areas, and the underserved, which provided evidence-based programming for those affected. During the cholera outbreak in 2024, UNFPA commissioned a Rapid Assessment on cholera on pregnant and lactating mothers, the results of which informed the response of UNFPA.

4.3.4.2 Challenges

Finding 79: A review of literature and information from various key informants identified some challenges listed herein. Data collected for the census and the ZDHS by enumerators through CAPI was transmitted straight to the national data server. This meant that Field Supervisors and Provincial Managers did not interface with the data to identify data errors and check for data quality before it was sent to the national server. However, when the issue was eventually raised during census data collection, ZIMSTAT introduced field check tables.

“Data goes straight to the server in Harare. We need a situation where we have the Survey Solution design where the provincial team leader can see the data and feedback to the team before it goes to Harare. This would need to be applied to all surveys including the census,” said a KII with ZIMSTAT staff.

Finding 80: Some key indicators lack data disaggregation at provincial and district level. There is a lack of disaggregation of data from ZDHS to district level e.g. maternal mortality which is only indicated at national level and not provincial nor district levels. Hence, the high reliance on extended analysis at district and provincial levels and the call to strengthen systems for the collection of administrative data. It is noteworthy that ZDHS samples were sufficient at provincial than district level and only the census covered the district level.

Finding 81: The Registrar General’s Office did not participate in the multi-sector mobile OSC interventions, missing an important opportunity to provide vital registration services. The reason for the exclusion was due to a limited budget.

Finding 82: Despite significant progress, financial constraints continue to be a major barrier to fully achieving UNFPA’s PD goals in Zimbabwe. Insufficient funding has consistently hindered the timely production and dissemination of data, limiting decision-makers’ ability to utilize critical information for evidence-based planning and policy formulation.²²³

Finding 83: Though disaggregation of data by disability has improved for the census and the ZDHS, there still exists a gap in the MoHCC tools which are not configured to capture such data. DHIS2 does not categorize PWDs either. This has limited information on disability inclusion, hence the need to customize data collection tools.

Finding 84: Key informants also lamented on the limited digitalization support from UNFPA to MoHCC noting that the system is still paper-based and does not capture all indicators. Interviews with staff at the hospitals visited during fieldwork revealed that some staff had not been trained yet on electronic health records. Further, M&E tools and M&E reporting frames were being reviewed at different times, causing problems in aligning data in both tools and the reporting frame (e.g. ANC and the Mother/Baby Pair registers).

4.3.4.4 Unintended effects

Finding 85: There were no unintended effects reported or identified from the implementation of PD activities.

4.4 Answer to evaluation question 6 (Efficiency)

EQ6: *To what extent has UNFPA Zimbabwe used resources at its disposal efficiently to achieve the planned results following laid down policies and procedures of UNFPA and the Government of Zimbabwe?*

Summary of findings

UNFPA Zimbabwe has largely utilized its available resources efficiently, achieving planned results in line with established policies and procedures of both UNFPA and the GoZ. UNFPA has strong financial and administrative systems ensuring timely implementation, accountability, and oversight. Fast-tracked processes support humanitarian

²²² KIIs with government staff, UNFPA CO staff, UN agencies, development partners and IPs.

²²³ UNFPA Zimbabwe: 2024 Annual Report.



response. Regular reviews of work plans and partner reports ensured quality and fund utilization. Routine audits aligned with good financial practices enhanced transparency and effectiveness, contributing to consistent and timely programme delivery. UNFPA's M&E framework effectively tracked IPs' alignment with the Results and Resources Matrix via the Quantum system. However, late fund disbursements and bureaucracy hindered timely implementation despite supportive financial management and reporting processes. The GoZ bureaucratic processes, particularly fund transfers via the Development Project Management System, caused delays in implementing and reporting SRHR, HIV/AIDS, and GBV prevention interventions under the CP. Efficiency was hindered by systemic bottlenecks, including delayed fund transfers that compressed activity timelines, financial issues in the MSM programme, and high staff attrition among nurses and midwives, caused service disruptions and repeated training. Frequent police unit transfers also affected GBV case management. Despite these challenges, UNFPA's skilled staff, TA, and capacity-building efforts enhanced overall efficiency. Addressing financial delays and workforce instability would further improve timely, cost-effective delivery. UNFPA has a functional CO organizational structure, which aligns mostly with the outcome area structure. In all the four outcome areas of the programme, implementing as well as strategic partners have referred to the high-quality professionalism of human resources within UNFPA CO and the high quality of the TA provided. UNFPA invested in capacity development of IPs at multiple levels. UNFPA provided technical support to ZIMSTAT, enhancing staff capacity in data management and analysis. Nevertheless, ZIMSTAT lacked systems to utilize administrative data from government ministries as the institution has no data sharing agreements with other government departments. A functional M&E system supports programme implementation through collaboration with partners, using the UNFPA CPD. UNFPA contributes to UNINFO, tracking outcome, intermediate, output, and sub-output level results. UNFPA adapted its reporting and Theories of Change to align with the 2021 strategic plan, integrating four thematic outputs with the three transformative results, enabling a more cohesive, cross-linked framework that supports an integrated, rather than siloed, programme approach.

For details of the evidence supporting findings in section 4.4, see the evaluation matrix: Assumptions 6.1-6.2 in Annex 1.

4.4.1 Modalities, planning, reporting and administrative arrangements

Finding 86: The planning, financial and administrative policies were generally adequate and followed to the book to ensure timely and effective implementation. There is a robust system for ensuring checks and balances, and to ensure that IPs are accountable for programmatic deliverables in a timely manner.²²⁴ These systems were considered effective in supporting timely implementation. In humanitarian contexts, fast-tracked processes (e.g., for mobile response services, dignity kits, and supplies) were in place. However, while IPs found UNFPA supportive with planning and financial management and the Quantum Plus system for accountability reporting, the overall experience with late fund disbursements indicated that some aspects of UNFPA's administrative and financial procedures hindered timely implementation of 8th CP interventions.²²⁵ Interviews with CO staff revealed that there were issues related to the Quantum Plus beyond their control and the UNFPA headquarter office provided as much technical support as it could to minimize operational disruptions during the implementation of CP interventions.²²⁶

Finding 87: The evaluation established that there is a strong and consistent system at UNFPA CO to review IP quarterly work plans, programme and financial reports and provide required feedback mainly on completeness, quality of reporting and utilization rates of the funds. In addition, UNFPA CO ensured that regular audits were carried out and made public in line with good financial management practices.²²⁷

Finding 88: The M&E function within UNFPA provided a commendable framework for tracking the alignment of IPs' work plans with the Results and Resources Matrix by the adoption of the Quantum system.

Finding 89: Delays due to GoZ bureaucratic processes affected timely implementation of CP interventions. For example, the MoFEDIP explained that fund transfer delays occurred because disbursements pass through the GoZ Development Project Management System, which caused delays in reporting for SRHR, HIV/AIDS, and GBV prevention projects. Other aspects of bureaucratic processes causing delays reported were as follows:²²⁸

²²⁴ Review of UNFPA CO financial management manual; KIs with CO staff.

²²⁵ KIs with staff of various IPs.

²²⁶ KIs with CO staff (senior management, programme and operations).

²²⁷ Review of IP plans and progress reports; KIs with stakeholders at national and provincial level; KIs with CO staff.

²²⁸ KIs with staff of ZIMSTAT provincial offices; staff of MoFEDIP.



- The MoFEDIP cited UNFPA communication on events being delayed especially where the UNFPA CO wanted the involvement of the Permanent Secretary and the clearance processes took a lot of time
- In the education sector, MoPSE highlighted that the ministry's new payment systems caused delays and that the compliance requirements for ministry accountants were burdensome.

Finding 90: However, efficiency was sometimes constrained by systemic bottlenecks. For AYP programming, while inputs were eventually received, delays in fund transfers meant activities were often compressed into the end of reporting periods. For example, a financial review of the MSM programme revealed expenditure challenges, including negative balances due to the incorporation of prior period costs.

4.4.2 Human resources and TA

Finding 91: The evaluation revealed that there is a functional CO organizational structure, which aligns mostly with the outcome area structure.²²⁹ Interviews with CO staff revealed an improved working environment since the 2023 staff restructuring. The UNFPA CO maintained adequate staffing for programme interventions, and effectively utilized UN Volunteers and JPOs to ensure at least two team members were consistently available, supporting successful implementation and results under the 8th CP.

Finding 92: In all the four outcome areas of the programme, implementing as well as strategic partners have referred to the high-quality professionalism of human resources within UNFPA CO and the high quality of the TA provided.²³⁰ UNFPA invested in capacity development of IPs at multiple levels:

- CSOs were supported with data and capacity to advocate for enabling policy and legal frameworks, and links were facilitated between Parliament and CSOs for youth-friendly budget consultations
- In GBV and HP, partners reported targeted capacity building, and training on UN reporting systems that enhanced reporting efficiency. The TA through in-country advisors and short-term specialists contributed to institutional strengthening of key IPs
- In PD, UNFPA played a central role in strengthening ZIMSTAT's institutional capacity. Over 75 census staff, including IT experts, were trained in STATA for data analysis. Data Quality Management Teams learned to analyze daily data and detect errors. Technical support helped ZIMSTAT implement the CAPI system, process census data, and conduct the Post Enumeration Survey.

Finding 93: Capacity development of ZIMSTAT staff on data collection and management improved efficiency.²³¹ UNFPA offered quality TA to build the capacity of ZIMSTAT to the level planned.

Finding 94: Efficiency faced challenges due to systemic bottlenecks, including high turnover of nurses and midwives (many emigrating) leading to service disruptions and repeated training needs. Frequent transfers within the police VFUs also hindered effective management of GBV cases at the reporting level. Overall, UNFPA's blend of skilled human resources, targeted TA, and institutional capacity strengthening was a significant driver of efficiency across all programme components.

4.4.3 Partnership strategy, joint programmes and implementation arrangements

Finding 95: UNFPA was proactive in partnering with other UN agencies on joint programmes (e.g., Together4SRH, EU Spotlight Initiative) to enhance effectiveness and efficiency. This coupled with Delivering-as-One provided a framework that enhanced coordination, consultation, joint planning and implementation among UN agencies.²³²

Finding 96: ZIMSTAT lacks systems to utilize administrative data from government ministries as the institution has no data sharing agreements with other government departments. This was a gap on the National Statistics System due to the limitations of the Census and Statistics Act which does not mandate ZIMSTAT to collect such administrative data.²³³

²²⁹ Review of the organizational structure document; Interviews with CO senior and junior staff.

²³⁰ KIIs with staff of various IPs.

²³¹ 2022 Annual Report – Zimbabwe Finalized - 30 January 2023.

²³² Document review of UNFPA COARs; KIIs with staff of UN agencies, UNFPA CO.

²³³ SADC Secretariat. 22 April 2025. Request for Expression of Interest (Individual Consultants Selection) to Review the Current Statistics Act of Zimbabwe and Develop a New Statistics Act in Line with Latest Developments.



²³⁴ Resultant to this was underutilization of administrative data, a critical source in the absence of survey and census data. By the time of the evaluation, the Census and Statistics Act was being reviewed under the guidance of the SADC Secretariat. The lack of memorandums of understanding within institutions made it difficult for data to be shared amongst institutions. Further, the lack of MOUs affected negatively the working relationship between UNFPA and the Department of Demography, Settlement and Development.²³⁵

4.4.4 Results-based management

Finding 97: The CO has a results and resources framework and there is a functional M&E system in place with a focus on monitoring programme implementation, in close cooperation with implementing and strategic partners, making use of the UNFPA CPD, which informed programme management and implementation.²³⁶ By the time of the evaluation, the M&E Unit had one specialist who was supported by another staff from the programme support unit (50 per cent), but a heavy work burden was reported. This resulted in work overload such that some strategic M&E activities were not done on time especially the provision of technical support to programmes and partners. The CO, however, distributed some of the work including monitoring visits to programmes thus reducing the workload on the M&E Unit. UNFPA provided inputs to the UNINFO system on UNSDCF monitoring, including a focus on outcome level results and intermediate level achievements that contribute to those results as well as output and sub-output level results. The UNFPA SIS quarterly and annual reporting, which transitioned into Quantum Plus in 2024 was in place and spot checks on programme implementation carried out. Currently, there is a costed M&E plan (2022-2026) with a total budget of US\$340,000. Document and interviews revealed that the plan was being implemented and the key evaluation activities (e.g., HDF end term evaluation, Spotlight Initiative evaluation, UNFPA/GoZ 8th CP (2022- 2026) evaluation, National Evaluation Capacity Development on evaluation and UNSDCF End Term Evaluation and Evaluation) took place or were on-going by the time of the CPE. Interviews with CO staff revealed that the M&E Specialist undertook the evaluation capacity building facilitated by the Independent Evaluation Office as well as the RBM-Quality programming capacity building facilitated by the Regional Office. In addition, he also undertook the online UNFPA RBM training. The capacity building initiatives enabled the M&E Specialist to provide quality TA to IPs and guidance to the CO staff.²³⁷ However, the 'internal capacity development activity on evaluation' in the M&E Plan was indicated for March 2022 as the start and end dates. It appears that there were no regular updates to the M&E Plan, which would make it a live document.

Finding 98: The UNFPA CP had mechanisms in place to track progress on activities being implemented.^{238, 239} These included a CP document with outputs, outcomes and impact indicators, an M&E Plan, and the development and dissemination of quarterly and annual reports.

Regarding whether the results achieved could have been achieved with fewer resources, document review²⁴⁰ and analysis of numerical data²⁴¹ revealed the following:

- (a) **Under SRHR output:** The utilization rate was 73 per cent (US\$20.25m of US\$27.73m spent) and yet three (75 per cent) out of the four output indicators were most likely to achieve the targets (refer to finding 28 and Table 11 on page 50). This implies that there was sub-optimal achievement of SRHR programme output targets though the resources were absorbed relatively well.
- (b) **Under AYP output:** The utilization rate was 51 per cent (US\$2.41m of US\$ 4.75m spent) and yet all (two) output indicators (100 per cent) were overachieved at over 100 per cent level (refer to finding 43 and Table 12 on page 54). This implies that AYP programme was cost-effective in delivering the results while using less than the allocated budget.
- (c) **Under GEWE output:** The utilization rate was 79 per cent (US\$6.77m of US\$ 5.38m spent) and yet two (50 per cent) out of the four output indicators were achieved (100 per cent level) and 25 per cent were most likely to achieve the target (refer to finding 54 and Table 13 on page 57). This implies that a significant proportion of the budget was spent to achieve only half of the output targets. The programme might be at a risk of cost overrun.

²³⁴ KIIs with UNFPA CO staff, ZIMSTAT.

²³⁵ KIIs with UNFPA CO staff, ZIMSTAT, Department of Demography, Settlement and Development.

²³⁶ Document review of the UNFPA results and resources framework and COARs; KIIs with CO staff.

²³⁷ KIIs with staff at CO; KIIs with IPs at national and provincial level.

²³⁸ United Nations Population Fund. 2021. Eighth Country programme document for Zimbabwe 2022-2026.

²³⁹ UNFPA Zimbabwe CO, 8th Country Programme 2022-2026 Monitoring and Evaluation Plan January 2022.

²⁴⁰ Document review of COARs 2022-2024 and January – March quarterly report 2025

²⁴¹ Analysis of UNFPA CO Cognos financial data.



- (d) Under PD output: The utilization rate was 79 per cent (US\$0.67m of 0.5m spent) and yet three output indicators (75 per cent) were achieved at 100 percent level (refer to finding 68 and Table 14 on page 61). Though the majority of PD programme output indicators were achieved, more resources than expected were used to achieve the output.

4.5 Answer to evaluation question 7 (Sustainability)

EQ7: *To what extent has UNFPA supported the establishment of local accountability and oversight systems to ensure sustainability and continuation of programmes that it is implementing?*

Summary of findings

UNFPA Zimbabwe has largely supported the creation of local accountability and oversight systems to promote sustainability and ensure the continued implementation of its programmes. There is broad ownership of UNFPA-supported interventions. Most stakeholders expressed confidence in independent planning and implementing programmes, citing strengthened skills and technical capacity gained through targeted capacity-building and training efforts provided during the course of UNFPA’s support. Government used the existing institutional structures at national and sub-national level to promote sustainability. Examples of the sustainable elements include existing policies, strategies, manuals and guidelines, which will continue to be used by stakeholders; trained personnel with specialist skills such as teachers trained in CSE will continue instruction independently, while peer educators at universities will sustain “safetalks” beyond donor support; surgeons and nurses trained in fistula repair; and economic empowerment through livelihood projects for GBV survivors. However, some interventions such as fistula repair and support to fistula survivors, which require substantial funding were deemed not sustainable without continued external financial support. The OSC model combines government support, donor funding, and civil society partnerships. However, uneven infrastructure, staffing, and coordination of OSCs often led to inconsistent service quality. This was largely attributed to inadequate funding from the Government and significant reduction of donor funding for GBV programming. Temporary closures of OSCs, like those in Epworth (Harare city) and Mpilo (Bulawayo Province), highlight the systemic vulnerabilities and gaps in care delivery. By the time of the evaluation, there was no evidence of documented sustainability plans between Government ministries and UNFPA to enhance government’s commitment to long-term sustainability. However, it was noted that there is on-going work related to OSCs to be completed by the end of 2025.

For details of the evidence supporting findings in section 4.5, see the evaluation matrix: Assumption 7.1 in Annex 1.

4.5.1 Ownership and sustainability of interventions

Finding 99: Political commitment for sustainability of interventions: Interviews at the national level and UNFPA CO revealed that there is strong national-level commitment to programme interventions across all outcome areas, with the design of programmes and initiatives aligned to government policies and strategies, including the NDS 1.²⁴² However, there was a lack of national-level policy support at provincial and district levels within the decentralized government system to ensure effective and sustained implementation on the ground.^{243, 244}

Finding 100: Technical capacity of government actors built: UNFPA aligned with national systems, strengthening partner capacities through training, resources, and pilots to sustain interventions and enhance the sustainability of CP results.²⁴⁵ However, the high staff turnover in many government ministries and agencies is still a challenge to be addressed.²⁴⁶

Finding 101: Financial support to government: UNFPA’s catalytic funding filled critical government budget gaps across key programme areas, supporting unfunded activities. However, heavy reliance on UNFPA raised concerns about financial sustainability and post-project continuity. The evaluation revealed that there are no documented sustainability plans between UNFPA and supported government ministries.²⁴⁷ However, under the SRHR component, UNFPA and the

²⁴² KIs with government ministries at national level (MoFEDIP, MoHCC, MoPSE etc); UNFPA CO staff.

²⁴³ KIs with government ministries at national level (MoFEDIP, MoHCC, MoPSE etc); UNFPA CO staff.

²⁴⁴ GoZ Devolution and Decentralization Policy 2020; <https://share.google/eJnYMXc7UFG5sSmi>

²⁴⁵ Review of UNFPA COARs (2022-2024); KIs with government ministries at national level; UNFPA CO staff.

²⁴⁶ Review of UNFPA COARs (2022-2024); KIs with government ministries at national and provincial levels; UNFPA CO staff.

²⁴⁷ KIs with officials at MoFEDIP, MoHCC, MWACSMED, MoPSE; and UNFPA CO.



GoZ established a matched funding arrangement for RH commodities, marking a key step toward strengthening domestic financing.²⁴⁸ Over three years, GoZ contributed US\$4.7 million, highlighting its commitment and capacity to mobilize government resources for essential RH commodities.

4.5.1.1 SRHR sustainability

Sustainable elements

Finding 102: Interviews with various stakeholders indicated the sustainable elements in the following areas:

- The policies and guidelines developed with UNFPA support will continue to be used in the medium- and long-term period
- Health staff trained will continue to use the skills learnt in initiatives such as eMPDNS and eMOTIVE
- RH commodity security: UNFPA has done a commendable job in advocating to GoZ on match funding of FP projects to promote the sustainability of FP programme
- The standard training midwifery curricula will continue to be used in the future as national curricula endorsed by MoHCC.

Non-sustainable elements

Finding 103: Generally, fistula surgical repair and treatment was deemed very expensive and not sustainable with external funding, but it has a social good. The intervention is not wholly sustainable without UNFPA funding support due to the high costs associated with it.^{249, 250}

4.5.1.2 AYP sustainability

Sustainable Elements

Finding 104: UNFPA Zimbabwe promoted sustainability of AYP programmes through institutional strengthening, human resource development, and youth empowerment. UNFPA supported national strategies like the Life Skills Empowerment Strategy (2018-2025) and developed tools and infrastructure, enabling sustained impact through capacity transfer to teachers and peer educators at universities beyond donor support.²⁵¹ Mentorship schemes for senior providers aim to offset attrition, and the MSM programme was handed over to the ZNAC in 2024.²⁵² UNFPA also strengthened youth-led groups, notably the YPNHW, which co-created the award-winning “Not In My Village” campaign. Youth desks were entrenched in government and delivered services to young people.²⁵³

Non-sustainable elements

Finding 105: Despite progress, sustainability is hindered by financial and policy gaps. Ministries and schools lack resources for infrastructure and CSE materials, especially for learners with disabilities. Stakeholders emphasized the need for ongoing UNFPA funding to support traditional leaders and address an emerging GBV issue of access to services, which is linked to gold mining.²⁵⁴ practices.²⁵⁵

4.5.1.3 GEWE sustainability

Sustainable elements

Finding 106: Donor funding tends to be short-term and project-based, limiting long-term service continuity especially for OSCs, Safe Spaces and humanitarian responses.^{256, 257} GBV funding has declined in recent years, worsened by the USAID funding cuts in early 2024 and the reduced traditional donor support. In response, UNFPA and partners collaborated with the government and donors like the World Bank on a GBV investment case, emphasizing prevention and response benefits to guide budgeting, attracting private sector support, and ensuring sustainable financing.

Non-sustainable elements

Finding 107: The government’s progress in integrating OSCs into national and subnational service delivery frameworks is commendable. Despite this progress, sustainability is challenged by reliance on donor funding. The OSC model

²⁴⁸ KIIs with officials at MoFEDIP, MoHCC and UNFPA CO.

²⁴⁹ KIIs at MoHCC and district hospitals.

²⁵⁰ UNFPA COARs (2022-2024).

²⁵¹ KIIs with staff of MoPSE and SAYWHAT; FGD of peer educators.

²⁵² KIIs with staff of MoHCC and UNFPA CO; Review of UNFPA CO Annual Report 2023 and 2024.

²⁵³ UNFPA CO Annual Reports 2022-2024; KII UNFPA and ZYC staff.

²⁵⁴ KIIs with staff of MWACSMED (Mashonaland Central); FGD of stakeholders (Shamva District).

²⁵⁵ KIIs with MoPSE staff.

²⁵⁶ KIIs with UNFPA staff and OSC staff.

²⁵⁷ Document review of IP reports.



combines various support sources, yet infrastructure, staffing, and coordination gaps lead to uneven services and temporary closures such as in Epworth and Mpilo.²⁵⁸ Limited fiscal space, weak infrastructure, and poor coordination threaten OSC sustainability post-donor support, risking service decline without strong, sustained government commitment.

4.5.1.4 PD sustainability

Sustainable elements

Finding 108: Technical and financial support from UNFPA to ZIMSTAT strengthened the government National Statistics System. Capacity development benefits are likely to continue as those trained staff should be able to train others for the sustainability of interventions.

Non-sustainable elements

Finding 109: The funding landscape has changed drastically. By the time of the evaluation, funding for the PD programme remained insufficient, restricting UNFPA Zimbabwe's ability to produce and disseminate vital population data. This limited decision-makers' access to timely information, hindering evidence-based planning, policy formulation, and strategic interventions.^{259, 260} Examples of activities not carried out or delayed due to lack of funding included the following: (i) Delayed dissemination of census reports; 2022 census had limited funding compared to 2012; (ii) limited in-depth analysis/fewer thematic reports from the census and major surveys; (iii) the engagement of a consultant to set up an SDG/ICPD/ transformative results data platform was delayed in 2022; and (iv) the dissemination of ZDHS findings occurred nationally but stopped at provincial level after ICF withdrew funding.

4.5.2 Strategic positioning of UNFPA in future CP development

Finding 110: UNFPA's niche is the provision of high-quality data on all the thematic components of the CP and being able to support other UN agencies on their data needs. The latter would be in line with one of the three key enablers for efficiency interventions defined by the UN Sustainable Development Group (UNSDG) Business Innovations Group (BIG) namely: Mutual Recognition, which allows one UN entity to obtain services from another UN entity if the latter can provide services more efficiently.²⁶¹ The other comparative advantages of UNFPA are: (a) Leadership in policy advocacy for FP and reproductive health commodity security right from the national to headquarter level; (b) leadership in the coordination of Data for Development and Innovation TWG. Given its comparative advantages, UNFPA is well-positioned to actively contribute to developing the post-2026 UNSDCF. National-level stakeholders emphasized UNFPA's pivotal role in shaping UNCT strategic decisions during the UNSDCF's design and implementation.²⁶² However, this requires UNFPA's pro-active and continuous engagement with all key stakeholders within the existing coordination fora.

4.6 Lessons learnt and best practices

4.6.1 Lessons learnt

The following lessons learned presented concern learning obtained in the context of the 8th CP implementation, but which can be considered useful beyond the context in which they were obtained.

Multi-sectoral strategic partnerships, coordination and collaboration are crucial for the success of interventions. Sustained alliances with government ministries and institutions, such as the MoHCC, MoFEDIP, MOWACSMED, MoPSE and ZIMSTAT, along with NGOs, CSOs, **UN Agencies**, community leaders, and humanitarian actors, enhanced synergy and the achievement of results (e.g. Safeguard Young People programme)

Continuous advocacy targeting key stakeholders in government, the private sector, and parliament is critical for leveraging domestic financing for long-term sustainability of CP interventions and data production. In the context of dwindling donor resources, financial constraints continue to challenge implementation of CP interventions especially data collection and dissemination. The advocacy for innovative funding mechanisms, such as public-private

²⁵⁸ KIIs with IPs.

²⁵⁹ UNFPA CO Annual Reports (COARs 2022, 2023, and 2024).

²⁶⁰ KIIs with UNFPA CO staff, ZIMSTAT, WHO, UN agencies, and development partners.

²⁶¹ <https://unsdg.un.org/2030-agenda/business-operations>.

²⁶² KIIs with staff of UN agencies; KIIs with staff of GoZ ministries and agencies.



partnerships and academic collaborations, are necessary to ensure long-term sustainability of interventions and data production. Domestic resources mobilisation was strengthened through partnerships with MoHCC.

The implementation of survivor-centered approaches improves access to comprehensive services for GBV survivors. These efforts included delivering the Minimum Essential Service Package via the implementation of both static and mobile OSCs, shuttle services for survivors, and strengthening the capacity of frontline workers in case management and inclusive service provision, especially for persons with disabilities. Furthermore, integrating services, such as incorporating livelihood activities into safe spaces, has demonstrated a positive impact on enhancing survivors' economic resilience, which in turn helps reduce the recurrence of GBV.

The implementation of robust M&E systems to track progress, analyze achievements and use findings for adaptive learning and reporting has proven to be essential for quality service provision. Continuous support, including quarterly monitoring visits and on-the-job mentorship from national and sub-national MoHCC and UNFPA teams is critical.

The limited implementation of social and behavioural change interventions has been shown to undermine the effectiveness of programmes aimed at reducing adolescent pregnancies or increasing the uptake of SRH services. Interventions like the "Not in My Village" campaign demonstrated the potential of these programmes to support positive behavioural change outcomes.

Innovations such as e-motive, e-partograph and midwifery e-learning take time to be established. The CO has learnt as it is implemented. Adaptive management is key for the successful implementation of these innovations.

The Delivering as One approach enhanced efficiency and results by fostering financial and technical synergies at national and program levels. Early joint programme design and planning strengthened coordination such as harmonized data activities which led to the development of the National Strategy for the Development of Statistics (NSDS) II.

4.6.2 Best practices

Domestic resource mobilization: UNFPA and partners' advocacy to the GoZ resulted in a matched funding arrangement for reproductive health commodities, marking a significant step toward improved domestic financing. The partnership strengthened national resource mobilization and RH procurement sustainability. Zimbabwe's commitment to domestic financing has received global recognition, and initiatives are underway to scale innovative domestic financing across other sectors. This is considered a good practice on advocacy such as the Cost Recovery Framework on Contraceptives

Strategic partnerships: Strategic engagement and the establishment of strong partnerships, including with the government has fostered trust and positioned UNFPA as a key partner on various thematic issues. UNFPA built strong partnerships with key government ministries, particularly the MoHCC, MOWACSMED, MoPSE, and MoFEDIP enabling joint policy development, technical support, and annual intervention planning. These collaborations were guided by continuous monitoring, feedback, and strong UNFPA leadership, resolving bottlenecks and reinforcing commitment to government priorities. This is considered a best practice for partnership. ZIFA, Zimbabwe Cricket, COSAFA, Community Health Equity Fund are good examples of strategic partnerships.

Integrated and joint programming: The effectiveness of the integrated approach to programming, where interventions address multiple transformative results simultaneously is a good practice. This integrated approach extends to joint programming within the UN Cooperation Framework, with significant involvement in joint initiatives. These include joint programming such as the Spotlight Initiative, Health Resilience Fund, UN Partnerships on the Rights of Persons With Disabilities.

Inclusivity: Innovations such as the Not in My Village campaign to engage community leaders in addressing SRH issues and a human rights-based approach through quality data development, and disability inclusion. These principles are mandatory and were integrated into the current programme through the joint UN initiatives on disability.



CHAPTER 5: CONCLUSIONS

The following conclusions are at strategic and programmatic levels and drawn directly from the findings presented in the previous chapter. The origin of the conclusion, evaluation criteria, and the corresponding recommendation to which the respective conclusion refers to are also provided.

5.1 Strategic level

Conclusion 1: The UNFPA 8th CP was highly relevant to Zimbabwe's national development priorities, sectoral needs, and aligned to government policy as well as UNFPA and the international development agenda. Nonetheless, alignment to government policies and strategies is an ongoing process as new policies are developed and/or old ones are reviewed.

Origin: EQ 1. Evaluation criteria: Relevance.

Associated findings: No. 1, 2 and 3.

Associated strategic recommendation: Nil.

Conclusion 2: UNFPA 8th CP addressed the needs of stakeholders and beneficiaries including vulnerable and marginalized populations considering the issue of disability, human rights and gender. The programme adapted to emerging issues like COVID-19, humanitarian needs, substance abuse, and teenage pregnancies. However, UNFPA recognized limited support for KPs amid LGBTQI+ restrictions and noted the need for stronger guidance to IPs on structured disability inclusion.

Origin: EQ1. Evaluation criteria: Relevance.

Associated findings: No. 4, 5, 6, 7, 8 and 9.

Associated strategic recommendation(s): Strategic level R 1.

Conclusion 3: The strategic relationships between UNFPA and with government ministries (such as MoPSE, MWACSMED, and MoHCC), UN agencies (including UNICEF, WHO, and UNESCO), CSOs (such as SAYWHAT, YPNHW, and PSZ), and other development partners facilitated co-created policies, joint planning, and programme implementation. However, some coordination gaps remain which constrain timely responsiveness to emerging issues.

Origin: EQ3. Evaluation criteria: Coherence.

Associated findings: No. 17.

Associated strategic recommendation(s): Strategic level R 2.

Conclusion 4: UNFPA and its partners' advocacy to the GoZ for a matched funding arrangement marked significant progress in strengthening domestic financing and sustainability for reproductive health (RH) commodities. However, the continued reliance on donor support for RH/FP commodity procurement limits the long-term sustainability of GoZ's funding efforts, underscoring the need for increased domestic investment.

Origin: EQ4. Evaluation criteria: Sustainability and coherence.

Associated findings: No. 33 and 101.

Associated strategic recommendation(s): Strategic level R 3.

Conclusion 5: UNFPA possesses a strong financial management and tracking system that supports programmatic and financial accountability. The introduction of the UNFPA global Quantum system in 2024 (a financial management system) was a move in the right direction. However, persistent delays between fund requisitions by IPs and UNFPA disbursements, coupled with IPs' limited absorptive capacity, hinder timely and high-quality implementation of interventions.

Origin: EQ6. Evaluation criteria: Efficiency.

Associated findings: No. 86, 87, 88, 89 and 90.

Associated strategic recommendation(s): Strategic level R 4.

Conclusion 6: UNFPA's investment in its human resources and TA is a major driver of programme success and efficiency. The well-staffed UNFPA CO delivered strong technical support, but systemic challenges like high attrition of IPs key personnel such as nurses, midwives and GBV case managers hindered impact and sustainability of services, requiring repeated training.



Origin: EQ6. Evaluation criteria: Efficiency.
Associated findings: No. 92, 93, 94, 95, 96, 97 and 98.
Associated strategic recommendation(s): Strategic level R 5.

5.2 Programmatic level

Conclusion 7: UNFPA's integrated approach at tertiary institutions combined mobile health services with CSE, addressing SRH, HIV, and GBV. Evidence-based targeting and youth participation ensured interventions were data-driven, relevant, and aligned with young people's needs and priorities. Limited economic empowerment integration, barriers to reaching LGBTQI+ populations, and inconsistent inclusion of youth with disabilities were key challenges.

Origin: EQ2. Evaluation criteria: Coherence.
Associated findings: No. 12 and 48.
Associated strategic recommendation(s): Programmatic level R 6.

Conclusion 8: (SRH) UNFPA support to MoHCC for health facilities to provide EmONC is critical in reducing maternal and newborn deaths. Though SBA improved, low-quality obstetric care in some facilities led to complications and deaths. Inadequate equipment and supplies limited full implementation of EmONC signal functions in some health facilities.

Origin: EQ5. Evaluation criteria: Effectiveness.
Associated findings: No. 36 and 37.
Associated prog. recommendation(s): Programmatic level R8.

Conclusion 9: (SRH). The current approach for addressing obstetric fistula through treatment camps has achieved results but it is not sustainable due to the substantial financial resources required. In addition, limited attention has been given to the re-integration of fistula survivors. Obstetric fistula treatment camps reduced the backlog, but few survivors were reintegrated, highlighting the need for support to restore their dignity in society.

Origin: EQ 5. Evaluation criterion: Effectiveness.
Associated findings: No. 38.
Associated prog. recommendation(s): Programmatic level R 8.

Conclusion 10: (AYP). UNFPA Zimbabwe's AYP strategies significantly empowered adolescents and young people by strengthening their voices, enhancing access to CSE and youth-friendly SRH services, and fostering policy engagement through institutionalized youth-led initiatives and government partnerships.

Origin: EQ5. Evaluation criteria: Effectiveness .
Associated findings: No. 46 and 47.
Associated prog. recommendation(s): Programmatic level R 9.

Conclusion 11: (AYP). UNFPA embraced technology to extend the reach of CSE among adolescents and young people. However, the operating landscape has a significant number of mobile applications offering inconsistent CSE which poses a risk for misinformation.

Origin: EQ5. Evaluation criteria: Effectiveness.
Associated findings: No. 10.
Associated prog. recommendation(s): Programmatic level R 9.

Conclusion 12: (GEWE). The 8th CP improved access to survivor-centred GBV care by establishing OSCs, mobile units, and safe spaces, overcoming geographic and social barriers. It ensured inclusivity by targeting vulnerable groups, including women and girls with disabilities, aligning with the "LNOB" principle. However, sustaining these services over time, particularly in under-resourced provinces, remains a significant challenge.

Origin: EQ5. Evaluation criteria: effectiveness.
Associated findings: No. 55, 58 and 59.
Associated prog. recommendation(s): Programmatic level R 10.

Conclusion 13: (GEWE). Economic empowerment and livelihood support interventions under the 8th CP significantly enhanced the resilience and autonomy of GBV survivors. Combining economic and social support strengthened survivor



agency and well-being, although sustaining these gains and ensuring equitable access across all communities remains a challenge.

Origin: EQ5. Evaluation criteria: effectiveness.
Associated findings: No. 56.
Associated prog. recommendation(s): Programmatic level R 11.

Conclusion 14: (GEWE). Under the 8th CP, UNFPA, in collaboration with the Council of Social Workers and academic institutions, supported the development of a GBV case management curriculum, marking a significant step toward institutionalizing GBV interventions. Once approved and implemented, this curriculum has the potential to build a skilled and consistent workforce, standardize GBV service delivery, and strengthen the evidence base for programming.

Origin: EQ5. Evaluation criteria: effectiveness.
Associated findings: No. 55.
Associated prog. recommendation(s): Programmatic level R 12.

Conclusion 15: (PD). UNFPA 8th CP strengthened the capacity of the NSS to produce, analyze and use disaggregated population data to inform policy decision-making and development programming, including in humanitarian situations. Capacity development is a continuous process and ZIMSTAT's strengthening will persist through future censuses, ZDHS, MICS, and other surveys. With the revised Census and Statistics Act empowering ZIMSTAT to coordinate administrative data collection, ongoing support is essential to enhance the national statistical system's capacity and ensure effective data management.

Origin: EQ1 and EQ5. Evaluation criteria: Relevance and effectiveness.
Associated findings: No. 7, 71, 72, 73, 74, 75 and 76.
Associated prog. recommendation(s): Programmatic level R 13.

Conclusion 16: (PD). Data disaggregation has improved over the years. UNFPA and ZIMSTAT increased efforts to provide disaggregated data. The disaggregation of census data by sex, age, disability (the Washington questions on disability incorporated in census), and geographic location right up to the lowest administrative level facilitates the realization of government's policy thrust of "leaving no one and no place behind". While data disaggregation by disability has improved in the census and ZDHS, significant gaps remain, particularly within MoHCC tools such as DHIS2, which are not yet configured to capture data on PWDs. This limits the availability of disability-related data. Key indicators like maternal mortality in ZDHS lack district-level disaggregation, limiting localized analysis, as sampling was adequate at provincial level, with only the census covering districts.

Origin: EQ5. Evaluation criteria: Effectiveness.
Associated findings: No. 74, 75, 82, 84, and 87.
Associated prog. recommendation(s): Programmatic level R14.

Conclusion 17: (PD). The promotion and support by UNFPA for the use of new technologies in data collection, analysis and dissemination was effective. Key digital innovations included: (i) CAPI for ZDHS and census; (ii) GBV IMS; (iii) eLMIS, supporting MoHCC's commodity and drug distribution; (iv) the WHO-supported Digital Adaptation System for collecting non-DHIS2 indicators; and (v) the 'Impilo' app, designed to work alongside the Impilo Platform.

However, the evaluation highlighted that the MoHCC system remains largely paper-based and does not capture all necessary indicators. The evaluation revealed that some hospital staff were yet to receive training on electronic health records. Additionally, misalignment between M&E tools and reporting frameworks, due to asynchronous review timelines, has caused data inconsistencies, particularly in areas such as ANC and the Mother/Baby Pair registers. While CAPI improved timeliness, census and ZDHS data were sent directly to the national server, preventing Field Supervisors and Provincial Managers from reviewing and ensuring data quality beforehand.

Origin: EQ1 and EQ5. Evaluation criteria: Relevance and Effectiveness.
Associated findings: No. 3, 7, 12, 15, 37, 61, 74, 75, 83 and 88.
Associated prog. recommendation(s): Programmatic level R 15.



CHAPTER 6: RECOMMENDATIONS

Based on the findings and conclusions above and the feedback from key stakeholders, the following recommendations were developed. These recommendations were refined through consultations with stakeholders, UNFPA Zimbabwe CO, and a validation round with the ERG, supported by the UNFPA ESARO and UNFPA headquarters. Following the UNFPA Evaluation Handbook (2024, page 83), the ET prioritized strategic and programmatic recommendations, specified their priority levels (high/medium/low), identified responsible parties, and outlined operational implications. The prioritization framework categorizes issues as: High (urgent, significant impact), Medium (notable, moderate urgency), and Low (minor impact, can be delayed with minimal consequences).

6.1 Strategic level

Recommendation 1: In close collaboration with relevant local and community actors, UNFPA should reinforce its strategy that focuses more on the most in-need and vulnerable populations.

Priority: High

Based on conclusion(s): 2

Target/responsibility: UNFPA CO (SRH, AY, Gender and PD units), MoHCC, MWACSMED, ZIMSTAT, MoFEDIP, and CSO IPs.

Operational implications:

The technical implications include the following:

- UNFPA should Identify emerging issues in each current programme component and bring them on board in the next CP
- Strengthen programming and partnerships to economically empower adolescents and young people to address poverty-related negative SRH outcomes like teenage pregnancy, STI/ HIV infections. Partnerships with ILO, UNDP, FAO etc then integrate AY/SRHR issues
- Carry out research on situation of youth: There is limited data about youth (e.g. the prevalence of substance abuse, economic empowerment) that are having a negative effect on adolescent SRHR and HIV outcomes
- UNFPA should support the scaling up of men's engagement activities to reinforce prevention efforts, particularly by addressing harmful social norms and promoting economic empowerment
- UNFPA to offer stronger guidance on structured disability inclusion and gender integration
- UNFPA to strengthen the delivery of interventions in hard-to-reach areas which are largely excluded from programmes.

The human resource implication is that the CO should have a cadre of staff who are dedicated to the continuous engagement of MoHCC, MWACSMED, ZIMSTAT, MoFEDIP, UN agencies, and CSO IPs.

Recommendation 2: UNFPA should strengthen and streamline strategic partnerships with government ministries, UN agencies, CSOs, academic institutions, and development partners to improve coordination, responsiveness, and collective impact of GEWE, SRHR, GBV, and AYP interventions. A more structured and adaptive partnership framework is needed to address coordination gaps and ensure timely responses to emerging issues.

Priority: High

Based on conclusion(s): 3

Target/responsibility: UNFPA CO (Senior management, programme units), Government line ministries (MoPSE, MOHCC, MWACSMED), UN agencies (UNICEF, WHO, UNESCO), CSO partners.

Operational implications:

The technical implications are as follows:

- Establish or strengthen high-level coordination bodies with clear mandates for joint planning, monitoring, and accountability
- Formalize partnership frameworks with CSOs, women-led and youth-led organisations to ensure inclusive participation and responsiveness to grassroots priorities
- Institutionalize regular policy dialogues and joint reviews with government and partners to adapt programmes to emerging issues.



The human resource implication is that the CO should have a cadre of staff (both senior management and programmatic levels) who are dedicated to the continuous engagement of government ministries, UN agencies, CSO partners and development partners.

Recommendation 3: UNFPA and partners should continue to advocate to the Government at the national level to make adequate annual budgetary allocations for SRH/FP and GBV services. The documented sustainability plans should show increasing annual government amounts matched with decreasing UNFPA/donor funds.

Priority: High

Based on conclusion(s): 4

Target/responsibility: UNFPA CO (Senior management; SRH unit), UNCT partners, MoFEDIP, MoHCC, MWACSMED.

Operational implications:

- The technical implication is that UNFPA CO should invest time and energy to sustain buy-in from the senior leadership of MoFEDIP and MoHCC on a comprehensive plan and advocate for increased government allocation to the SRH/FP services. A series of meetings among the relevant stakeholders (government, donors, development partners and UNFPA) will be needed to discuss the content and modalities of the plan
- The financial implication is that UNFPA CO should allocate some funds for these meetings
- The human resource implication is that senior management and SRH programme staff should give dedicated time to carry out the advocacy and lobbying work.

Recommendation 4: UNFPA should continue to strengthen the technical capacity of IPs particularly in financial reporting and accountability in order to improve timely reporting and fund absorption.

Priority: High

Based on conclusion(s): 5

Target/responsibility: UNFPA CO (Operations unit), IPs, GoZ MDAs.

Operational implications:

The technical implications are as follows:

- Streamline the mechanisms for the transfer of funds to IPs to ensure timely access to these funds, but at the same time facilitate oversight and accountability for IPs
- UNFPA should facilitate regular but focused training in financial management for IPs

The financial implication is the potential cost of hiring a consultant to conduct the training of IPs.

Recommendation 5: To mitigate high staff turnover in key sectors, UNFPA should integrate sustainable capacity-building and retention strategies into partnership agreements. This includes scaling up "train-the-trainer" programmes, investing in digital learning platforms, integration in and enhancement of GBV and SRHR related modules in pre-service curriculum for midwives, nurses, social workers, police, judiciary et cetera and promoting non-monetary incentives and professional development. Strengthening institutional capacity in the health, social, and legal sectors ensures knowledge continuity, enhances partner resilience, and maximizes the long-term impact of TA from UNFPA.

Priority: High

Based on conclusion(s): 6

Target/responsibility: UNFPA CO (SRH, AY, Gender and PD units), ESARO, IPs, GoZ.

Operational implications:

- The technical Implication is that UNFPA and its partners need to invest in and develop robust digital infrastructure. This includes creating and maintaining digital or e-learning platforms to host "train-the-trainer" materials, allowing new staff rapid, on-demand access to training. Platforms must be device-friendly and require expertise in content development, video production, and database management. UNFPA can utilize its IT and Communications department to reduce costs
- The financial implication is that the initial financial outlay for establishing the platform will be significant, as resources are needed to train partners. However, over time, reduced need for repeated trainings will lower costs, enabling UNFPA to achieve sustained impact and greater efficiency from its TA investments
- The human resource implication is the need to identify and develop a pool of internal trainers within partner institutions. These experts must also skillfully transfer knowledge, necessitating an initial investment to train them as effective trainers.



6.2 Programmatic level

Recommendation 6: UNFPA should enhance coordination mechanisms among IPs to promote "one-stop shop" models for young people that strengthen linkages with economic empowerment. Greater effort is needed to ensure LNOB is fully integrated in the UNFPA strategy and programmes. This will ensure AYP programmes are comprehensive and responsive to intersecting vulnerabilities.

Priority: Medium

Based on conclusion(s): 7

Target/responsibility: UNFPA CO (AY unit), IP, GoZ (MoPSE, MoHCC, MWACSMED).

Operational implications:

- The UNFPA should convene joint programme design and review forums with IPs to align services and avoid duplication
- Develop portfolio-wide guidance on how to integrate disability inclusion and economic empowerment into AYP, SRHR, and GBV interventions
- Expand monitoring frameworks to capture indicators of integration (e.g., number of multi-service delivery points, youth reached with combined services).

Recommendation 7: UNFPA should actively engage MoHCC to set operational standards in all health facilities carrying out EmONC in order to ensure high quality of obstetric care. In addition, UNFPA should continue to advocate to MoHCC to provide and maintain essential equipment and sundries for EmONC in the facilities.

Priority: High

Based on conclusion(s): 8

Target/responsibility: UNFPA CO (SRH unit), MoHCC, MoFEDIP

Operational implications:

The technical implication is that the CO should actively advocate for the following interventions:

- functionalizing district hospitals as CEmONC centres and secondary health facilities as BEmONC centres including the upgrading of some primary facilities to the secondary level
- deployment of appropriately skilled midwives, anaesthetists, medical doctors and laboratory staff
- advocating and supporting the recruitment as well as the retention of the above critical staff cadres
- establishment of blood transfusion services (space and equipment for storage) and infrastructural capacity (theatre rooms, equipment, lighting, running water and sanitation) in all secondary, tertiary and referral facilities.

The financial implication is that MoHCC should allocate appropriate funds for the effective running of maternity and labour wards, theatres in health facilities carrying out CEmONC and BEmONC.

Recommendation 8: UNFPA should advocate to MoHCC for fistula repair to be integrated into other routine health services and more attention should be given to the scaling up of the re-integration of fistula survivors in the general community.

Priority: Medium

Based on conclusion(s): 9

Target/responsibility: UNFPA CO (SRH unit), MoHCC, Subnational governments.

Operational implications:

The technical implications are as follows:

- The CO should engage MoHCC to ensure that treatment interventions are integrated and supported through routine health care in the health facilities.
- The intervention should be linked to efforts to prevent obstetric fistula, to raise community awareness on fistula and to generate demand through community mobilization.
- UNFPA should support MoHCC in the scale up of the re-integration of fistula survivors into their communities.

The human resource implication is that MoHCC should invest in the capacity building of frontline health staff to equip them with necessary skills. UNFPA CO should have dedicated staff to provide technical support to the MoHCC.

The financial implication is that GoZ should allocate sufficient funds to MoHCC and continue to subsidize the cost of fistula repair.



Recommendation 9: UNFPA and partners should support the development and national adoption of a unified, well-integrated “super SRH app” that consolidates all CSE information and digital platforms for young people. This centralized platform would enhance access, improve user experience, and reduce confusion caused by fragmented digital platforms, leveraging digitalization as an accelerator for impact.

Priority: Medium

Based on conclusion(s): 10 and 11

Target/responsibility: UNFPA CO (AY unit), MoHCC, PSZ, other IPs, Ministry of information, Communication and Technology, and technology partners.

Operational implications:

- The technical implications include assessing existing digital SRH platforms and developing detailed technical specifications for the “super CSE app” to ensure usability, data security, and seamless integration
- The financial implications include mobilizing significant resources for the design, development, thorough testing, nationwide promotion, ongoing maintenance, and future updates of the unified digital application
- The human resource implications include engaging IT specialists, SRHR experts, and youth in platform development, while building capacity of health workers and youth leaders to ensure effective implementation.

Recommendation 10: At the strategic level, UNFPA should continue to support Government ministries in integrating gender-responsive GBV and GEWE priorities into national policies and budgets. They should further enhance the GBV Coordination Forum at national, provincial and district level. At the programmatic level, UNFPA should advocate and provide TA to strengthen institutional capacity at service delivery points, including OSCs, mobile OSCs, and community-based mechanisms, to ensure accessible, comprehensive, and survivor-focused GBV prevention and response services.

Priority: Medium

Based on conclusion(s): 12

Target/responsibility: UNFPA CO (Gender Unit), MWCSAMED, MoHCC, CSO IPs.

Operational implications:

- Strengthen coordination mechanisms (e.g., joint planning forums, review platforms, and inter-ministerial taskforces) to harmonize efforts, foster peer learning, and align GBV and GEWE priorities cross-sectorally
- Government institutions should be supported to integrate GBV and GEWE services into sectoral operational plans and budgets, ensuring sustainability and reducing reliance on donor funding
- Develop and disseminate standardized protocols and referral systems to ensure disability-inclusive, survivor-centred, multi-sectoral services, supported by enhanced data-sharing among partners.

Recommendation 11: UNFPA should continue to support GBV survivors through programmes like livestock rearing, sewing, small-scale farming cooperatives, and other livelihood initiatives, combined with ongoing social and psychosocial support.

Priority: High

Based on conclusion (s): 13

Target/responsibility: UNFPA CO (Gender Unit), CSO IPs, MWACSMED.

Operational implications:

- UNFPA should scale up livelihood interventions in OSCs, safe spaces, and drought-affected communities and make sure these are sustainable
- UNFPA should also prioritise economic empowerment at scale within GBV programming, as financial stress is a major contributor to domestic conflicts; economically empowered survivors are less likely to experience violence
- UNFPA should monitor and evaluate the impact of livelihood interventions on GBV outcomes and resilience.

Recommendation 12: UNFPA should continue to formalize partnerships with academic institutions and CSOs to include GBV response into their curricula, research, and practice for long-term sustainability.

Priority: High

Based on conclusion(s): 14

Target/responsibility: UNFPA CO (Gender unit), MWACSMED, MoHCC, Partner CSOs, academic institutions.

Operational implications:

The technical implications include the following:

- UNFPA should continue to support universities and CSOs in forging long-term partnerships to integrate GBV and GEWE modules into curricula and scale evidence-based prevention with traditional and religious leaders



- UNFPA should work with its partners to strengthen applied and operational research on technology-facilitated GBV to build the evidence base and ensure findings inform national policy and programming
- UNFPA and partners should establish a standardized, nationally recognized framework for capacity-building that is integrated into training institutions and professional development pathways, complemented by refresher training, peer-learning platforms, and supervision mechanisms to sustain quality service delivery.

Recommendation 13: UNFPA should enhance efforts to adequately define the legal and institutional framework that empowers ZIMSTAT to systematically collect, harmonize, and integrate administrative data into official statistics in Zimbabwe.

Priority: High

Based on conclusion(s): 15

Target/responsibility: UNFPA CO (PD Unit), ZIMSTAT, MoFEDIP, and UN agencies.

Operational implications:

The technical implications include the following:

- UNFPA to provide technical capacity and financial support to ZIMSTAT to coordinate the collection of administrative data from government line ministries
- UNFPA should strengthen this mandate to enhance data availability while reducing the financial burden of large-scale surveys, contributing to greater budget efficiency and sustainability in national statistical operations
- Through the Coordination mechanism of the Data for Development and Innovation TWG, UNFPA should advocate for the Census and Statistical Act to formally recognize and operationalize existing coordination bodies by providing them with a clear legal mandate and operational framework within the National Statistical System
- Develop memoranda of understanding (MoU) with institutions and partners to facilitate communication and programme implementation for positive outcomes
- Strengthen collaboration with the Registrar General's Office to enhance birth and death registration by decentralizing services and integrating mobile OSC outreaches targeting vulnerable, hard-to-reach populations.

The human resource implication is that the CO should have a cadre of staff who are dedicated to the continuous engagement of ZIMSTAT, MoFEDIP, and UN agencies.

Recommendation 14: UNFPA is encouraged to further strengthen data disaggregation by sex, age, disability, and geographical area in all data collection processes to demonstrate inclusivity.

Priority: High

Based on conclusion(s): 16

Target/responsibility: UNFPA CO (PD unit), ZIMSTAT, MoHCC, MWACSMED and UN agencies.

Operational implications:

The technical implications are as follows:

- UNFPA to provide technical and financial support to MoHCC to review and update data tools which are not configured to capture data by disability. Categorization of PWDs in MoHCC data should be extended to DHIS2
- Ensure concurrent review of MoHCC M&E tools and M&E reporting frames to synchronize data in both the tools and the reporting frames (e.g. ANC and the Mother/Baby Pair registers were not reviewed concurrently)
- UNFPA to provide technical and financial support to MWACSMED and GBV IPs customize and standardize data collection tools to improve data disaggregation, currently lacking in GEWE
- Carry out disaggregation of survey data to provincial and district levels will improve information on indicators such as maternal mortality that is only indicated at national level
- Extended survey analyses should cover also provincial and district level profiles to cover the information gap.

The human resource implication is that the CO should have a cadre of staff who are dedicated to the continuous engagement of ZIMSTAT, MoHCC, MWACSMED and UN agencies.

Recommendation 15: UNFPA should scale up existing technical support to ZIMSTAT for expanding integrated data systems, enhancing interoperability, and broadening the reach and functionality of dashboards and mobile apps to increase accessibility and use of data, particularly census and SRHR-related indicators.

Priority: High

Based on conclusion(s): 17

Target/responsibility: UNFPA CO (PD unit), ZIMSTAT, MoHCC, MoFEDIP and UN agencies.

Operational implications:



- UNFPA to scale up innovation and digitalization for impact – digitalization as an accelerator across all UNFPA programme components in the next CP
- UNFPA to increase funding for strengthening Vital Statistics systems. Currently ZIMSTAT is receiving funding on vital statistics from Vital Strategies but it would be good to have UNFPA cover this aspect as well
- Invest in the ‘Survey Solution’ design where ZIMSTAT provincial team leaders and supervisors can check for data errors and feedback to the enumeration team before that data is transmitted to the main server in Harare
- Support MoHCC to accelerate migration from a paper-based system to a fully digitalized system.



ANNEXES



Annex 1: Evaluation matrix

Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
<p>RELEVANCE EQ1: To what extent has UNFPA positioned itself within the national development/policy space and adapted to changes that have taken place, and what strategies did it take to assist efforts on addressing the needs of vulnerable and marginalized populations taking into account the issue of disability, human rights and gender including emerging issues such as new diseases, drug abuses and challenges brought about by climate change?</p>			
Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
<p>Assumption 1.1: The UNFPA Zimbabwe positioned itself within the national development/policy space and adapted to changes that took place.</p>	<ul style="list-style-type: none"> ▫ Extent of alignment between the 8th CP priorities and priorities in the national development strategies and priorities. 1. The extent to which UNFPA supported interventions have appropriately taken into account the priorities of the GoZ and line ministries and institutions 2. Evidence that the CP adapted to national priorities and to the needs of beneficiaries. 	<ul style="list-style-type: none"> ▫ ICPD POA, SDG reports, UNFPA Strategic Plan 2022-2025, 8th CPD (2022-2026), UNSDCF (2022-2026); GoZ/UNFPA 7th CPE Report ▫ National policy/strategy documents ▫ Annual work plans (AWPs), Country Office Annual Reports (COARs) (2022, 2023, 2024), quarterly report (January-March 2025) ▫ Surveys (including ZDHS, MICS etc.), census data and other reports 	<ul style="list-style-type: none"> ▫ Document review ▫ Interviews with UNFPA CO staff, Implementation Partners, and 8th CP beneficiaries ▫ Interviews with UNCT staff ▫ Interviews with key GoZ officials in line Ministries and Departments - Ministry of Health and Child Care; Ministry of Primary and Secondary Education; Ministry of Women Affairs, Community and Small Enterprise Development; Ministry of Public Service Labour and Social Welfare (Dept. of Disability Affairs); Ministry of Local Government (Dept. of Civil Protection); Ministry of Finance, Economic Development and Investment Promotion; Ministry of Public Service Labour and Social Welfare (Dept. of Disability Affairs); National AIDS Council, Zimbabwe National Family Planning Council. ▫ Interviews with UN agencies and donors.



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
	<ul style="list-style-type: none"> ▫ Extent of alignment between CP outcomes and priorities set in national strategies and plans in the four thematic areas of the 8th CP. 	<ul style="list-style-type: none"> ▫ ICPD POA, SDG reports, UNFPA Strategic Plan 2022-2025, 8th CPD (2022-2026), UNSDCF (2022-2026); GoZ/UNFPA 7th CPE Report ▫ National policy/strategy documents ▫ AWP, COARs (2022, 2023, 2024), quarterly report (January-March 2025) 	<ul style="list-style-type: none"> ▫ Document review ▫ Interviews with UNFPA CO staff, Implementation Partners, and 8th CP beneficiaries ▫ Interviews with UNCT staff ▫ Interviews with key GoZ officials in line Ministries and Departments.
	<ul style="list-style-type: none"> ▫ Evidence that the programmatic interventions had flexibility to respond to changing needs. 	<ul style="list-style-type: none"> ▫ AWP, COARs (2022, 2023, 2024), quarterly report (January-March 2025) ▫ Special needs assessment reports 	<ul style="list-style-type: none"> ▫ Document review ▫ Interviews with UNFPA CO staff, Implementation Partners ▫ Interviews /focus groups with 8th CP beneficiaries ▫ Interviews with UNCT staff ▫ Interviews with key GoZ officials in line Ministries and Departments.
Data collected			Sources of information
<p>UNFPA provided technical support to MoHCC for the operationalization of the following policies, strategies and initiatives:</p> <p>UNFPA pro-actively positioned itself to bring value within the national development/policy space and adapted to changes that have taken place using the following ways among others:</p> <p><u>Building Relationships and Networks</u></p> <ul style="list-style-type: none"> • Collaborative advocacy: UNFPA partnered with other organizations (e.g., UN agencies within the UNCT coordination mechanism), civil society groups, or government agencies to amplify UNFPA messages and increase influence. • Stakeholder engagement: Fostered strong relationships with policymakers at national and provincial level, influencers, and other stakeholders to build trust and credibility. <p><u>Strategic Positioning and Visibility</u></p>			<p>Document review of strategic documents (8th CPD, UNSCDF 2022-2026); COARs</p> <p>KIIs with GoZ ministries and agencies</p> <p>KIIs with in-country UN agencies</p> <p>KIIs with development partners (donors)</p> <p>KIIs with UNFPA CO staff</p>



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
<ul style="list-style-type: none"> • Policy briefings and reports: UNFPA produced regular policy briefings and reports that provided timely and relevant analyses. Data briefs produced included the 2023-24 ZDHS HIV factsheet; the ZDHS factsheet-family planning; and Fertility factsheet. These were shared with MoHCC and other ministries. • High-profile events: UNFPA participated in high-profile in-country and global events to amplify its visibility (e.g., Government launch of the final 2024 ZDHS report; World Population Day on 11th July; International Women’s Day on 8th March; International Midwives Day on 5th May; International Day to End Obstetric Fistula on 23rd May; International Day for the Girl Child on 11th October; International Day for the Elimination of Violence against Women on 25th November; International AIDS Day on 1st December among others), conferences [International Conference on AIDS and STIs in Africa (ICASA) in December 2023 among others], or summits to showcase UNFPA’s expertise and influence. • Media engagement: UNFPA built relationships with media outlets and journalists to secure coverage and shape public discourse. <p><u>TA and Capacity Building</u></p> <ul style="list-style-type: none"> • TA: UNFPA provided TA to government agencies and other organizations (mentioned above), demonstrating UNFPA’s expertise and building trust. • Capacity building programmes: it also offered training and capacity building programmes for policymakers, civil society organizations, or other stakeholders. <p><u>Thought Leadership and Expertise</u></p> <ul style="list-style-type: none"> • Expertise sharing: It also offered expert advice, commentary on policy issues (e.g. through UNCT meetings, UNSDCF, TWGs), demonstrating UNFPA’s knowledge and authority. • Research and analysis: UNFPA facilitated the production of high-quality research, analysis, and policy briefs that provide valuable insights and recommendations. <p><u>Innovative Communication</u></p> <ul style="list-style-type: none"> • Data visualization: Utilized data visualization tools to present complex information in an engaging and accessible way (e.g., flyers, wall charts, tear-drop banners, key holders, head caps, t-shirts etc). <p>Through the above-mentioned ways, UNFPA became one of the agencies of choice for Government to provide technical support in the development and operationalization of various policies, strategies and guidelines under SRHR, AYP, GEWE and PD. The details of these documents are indicated under each of the thematic areas.</p>			
<p>Challenge:</p> <ul style="list-style-type: none"> • Competitive environment for policy space: There are numerous players who support the GoZ in the policy area and at times UNFPA finds itself 			<p>KIIs with UNFPA CO staff KIIs with key stakeholders at national level.</p>



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
working in a competitive environment. UNFPA's approach has been mutual respect, dialogue and collaboration with all actors involved.			
Data collected: SRHR			Sources of information:
<p>UPSTREAM LEVEL UNFPA Zimbabwe positioned itself within the national development/policy space through active and regular engagement with MoHCC. UNFPA in liaison with other UN agencies and partners provided technical support to the MoHCC in the development and the operationalization of the following policies, strategies and initiatives:</p> <ul style="list-style-type: none"> ● NHS 2021-2025: The strategy aims to improve the health and wellness of the population, ensuring universal access to health services. The strategy focuses on reproductive, maternal, neonatal, child, and adolescent health, as well as GBV and harmful traditional practices. ● Health Resilience Fund (HRF) 2022-2025: Launched in 2023, this fund is aligned with Zimbabwe's NDS1 and the NHS. It focuses on three health pillars namely: (a) Ending preventable maternal, newborn, child, and adolescent deaths; (b) Global health security; (c) Health systems strengthening. ● National Community Health Strategy (2021-2025) ● Investment Case for the NHS (2019-2020): This initiative calls for efficiencies in utilizing available health resources, ensuring better healthcare outcomes. ● SMART advocacy for increased domestic financing for FP ● Community Health Supply System for contraceptives ● Human Resources for Health (HRH) Strategy and Compact (2024-2026) ● National Family Planning Strategy 2022-2026 ● National Emergency Obstetric and Neonatal Care (EmONC) guidelines: UNFPA supported policy guideline reviews and innovations in EmONC. National EmONC guidelines (2024) were updated to standardize the provision of quality maternal health services in line with emerging innovations in obstetric care such as E-MOTIVE. ● Sayana Self Care Implementation Plan (March 2024) ● Comprehensive Abortion Care guidelines ● Minimum Initial Services Package (MISP) guidelines (November 2024) 			<ul style="list-style-type: none"> ● Document review of Annual Work Plans (AWPs) and Country Office Annual Reports (COARs) (2022 – 2025) ● KIIs with MoHCC Directorates. <p>KII with ZNFPC</p>



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
<ul style="list-style-type: none"> Revitalization of the e-MPDNS (2024). 			
<p>DOWNSTREAM LEVEL At the downstream level, the CP interventions under SRH were aligned to national priorities and adapted to the needs of beneficiaries in the following areas:</p> <ul style="list-style-type: none"> Support for the readiness (e.g. basic infrastructure, staff, equipment and supplies) of selected health facilities to offer SRH and CEmONC; cervical cancer prevention, youth friendly integrated SRH/HIV/GBV services Quality improvement and assurance for SRH (maternal health, ASRH and GBV) Maternal and perinatal death surveillance and response (MPDSR) Strengthening management of post-partum haemorrhage (PPH) Obstetric fistula repair and re-integration of fistula clients into their communities Capacity building of health workers in the following (a) integrated SRH/ASRH, HIV and GBV service provision; (b) job training for the implementation of innovations such as, rolling out e-learning, rolling out of Sayana press for self-care, eLMIS. 			<ul style="list-style-type: none"> Document review of Annual WPs and COARs (2022 – 2025) KIIs with MoHCC Directorates.
<ul style="list-style-type: none"> The current CP remains relevant, emphasizing its significant impact on FP in Zimbabwe across commodity supply, service provision, and SRH programmes. 			KII with ZNFPC
<ul style="list-style-type: none"> The UNFPA interventions under SRH are still very relevant to the priorities of GoZ. Maternal and newborn issues are still relevant. Maternal mortality is coming down, but it is still high and neonatal mortality is going up. 			KII with MoHCC.
<p>Data collected: Adolescents and young people</p>			<p>Sources of information:</p>
<ul style="list-style-type: none"> UNFPA support for AYP is developed with government support, leadership and participation. Support for CSE to the Ministry of Education has been led by MoPSE, with support for building youth participation through the Ministry of Youth. Support for youth Friendly Service Provision was aligned to YFHS guidelines including operationalization of the Ministry of Health's certification process for YHFS. Interventions targeting adolescents and youth were identified through a combination of national data analysis and collaboration with government partners, including studies and reports from government departments. This analysis gave life to the areas and locations of interventions for the CP, with geography targeting informed by national and sub-national data such as ZDHS, MICS 2019, desktop reviews and data from DHIS2. The programme was implemented within the framework of national policies guiding ASRH programming in the country with UNFPA actively supporting the development of strategies, policies, and guidelines, and building the capacity of Civil Society Organizations (CSOs) to enhance advocacy for 			Interviews with UNFPA, ZYC, MOHCC, MOPSE



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
<p>appropriate policy and legal frameworks.</p> <ul style="list-style-type: none"> UNFPA contributed to the development of the multi-sectoral framework for addressing adolescent pregnancies, which is led by the MoPSSLW. It has also contributed to the development of the 			
<ul style="list-style-type: none"> UNFPA led the UN youth group that supported the development of the youth empowerment strategy which has provided the operational and guiding framework for programmes. The ZYC confirms UNFPA support for reviewing the national youth policy (2020-2025) and building capacity for the parliamentary youth caucus and ministry youth desks. 			Interviews with UNFPA, ZYC, MOHCC, MOPSE, UNAIDS, UNESCO
<ul style="list-style-type: none"> The MoPSE was supported to develop the “fit for life” content and books for schools in 2019 and to train facilitators for these sessions. MoPSE also developed and reviewed the Life Skills Empowerment Strategy (2018-2025), which guides the implementation of guidance, counselling, and CSE Planning between MoPSE and UNFPA was collaborative, with annual work plans developed by MoPSE based on monitoring, learner and teacher feedback, ensuring alignment with national policies through regular meetings and joint signing of work plans⁸. PSZ’s self-care project for young people (24 years and below) was data-driven, utilizing ZDHS and MICS survey data on teenage pregnancy, fertility rates, early marriages, early sexual debut, child marriages, GBV, HIV, STIs, and Drug and Substance Abuse issues to conceptualize interventions. 			Interview with the MOPSE Review of Annual workplans and Global Fund reports 2022-2023
<ul style="list-style-type: none"> Young people exhibited a strong voice and contribution to intervention design as evidenced by the “Not In My Village” campaign, which was developed by the YPNHW. YPNHW, a powerful and informed partner, conducted national consultations with young people to understand their dreams, aspirations, challenges and viable solutions. The campaign was specifically co-created by UNFPA and YPNHW to address adolescent pregnancies and child marriages, issues informed by data on teenage pregnancies. 			Interviews with UNFPA, ZYC, MOHCC, MOPSE
<ul style="list-style-type: none"> There was evidence of programme flexibility emanating from the expansion of areas of interventions that expanded to 26 districts to include key hotspots including the entire Mashonaland Central and inclusion of Matabeleland North provinces. Evidence shows the alignment of the programme in being flexible to align with national outcomes with the work around the age of consent showcasing the adaptability of the programme to national interests. Through the UN Youth group UNFPA contributed to the development of the Multi-Sectoral Drug and Substance Abuse Plan (2024-2030). There were perceptions that UNFPA could have done more to support CSOs and possibly Parliament, with data on the implications of raising the age of consent to 18 years on access to SRH services and what mitigation measures could be employed to address the backlash for supporting adolescents under the age 18 years access SRH commodities and services . The implications have been evident with reported sensitivities around offering such services to adolescents from health managers to frontline staff as it is viewed as abating sexual abuse (rape). 			Interviews with UNFPA, UNESCO, IPs Review of Donor reports
<p>Data collected: GBV and HP</p>			<p>Sources of information:</p>



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
<ul style="list-style-type: none"> UNFPA Zimbabwe worked closely with the MWACSMED throughout the 8th CP. This collaboration was instrumental in identifying programme and policy gaps, particularly in GBV response, women’s economic empowerment, and social protection systems. Government endorsement was evident both at the design and implementation phases of the CP, reinforcing UNFPA’s role as a trusted partner aligned with national development priorities. This close engagement ensured that CP priorities were responsive to sectoral needs and grounded in national policy frameworks. The ministry worked closely with UNFPA in developing workplans. 			<p>KIIs with the CO, MWACSMED, FGDs with multi-sectoral stakeholders and beneficiaries</p>
<ul style="list-style-type: none"> UNFPA played a critical role in supporting government-led policy reviews, like the National Gender Policy (2023) review. This involvement ensured that updated policies were evidence-informed, rights-based, and aligned with international standards. UNFPA’s support extended to stakeholder consultations, policy drafting, and final validation processes, reinforcing its position as a key gender policy actor in Zimbabwe. The UNFPA was working in collaboration with the MWACSMED, other UN agencies, CSOs, NGOs and other government ministries. 			<p>KIIs with staff of MWACSMED, CO staff</p>
<ul style="list-style-type: none"> UNFPA played a catalytic role in the development and launch (2022) of the High-Level Political Compact on Ending GBV (2021-2030), providing technical and financial support to ensure high-level political commitment and accountability. This was in partnership with other UN agencies, EU, CSOs, NGOs, leaders (community and traditional) and the GoZ UNFPA also contributed significantly to the National Strategy for Preventing and Addressing GBV (2023-2030) through TA, stakeholder consultations, and alignment with the CPD. These contributions reflect UNFPA’s strong positioning within Zimbabwe’s national development and GBV response framework. The support extended to localization of these frameworks at subnational level demonstrates responsiveness to national priorities and sustainability. 			<p>Document review: National strategy document, COARs KIIs with the MWACSMED, CO staff, IPs</p>
<ul style="list-style-type: none"> Throughout the CP cycle, multisectoral stakeholders, at provincial and district levels, including health, justice, education, traditional leadership, and civil society, were regularly engaged to support GBV coordination and programme planning. These stakeholders were actively consulted during the CP design phase, ensuring that the programme addressed practical implementation realities and community-level needs. 			<p>KIIs with staff of MWACSMED, IPs, FGDs with GBV multi-sectoral stakeholders</p>
<ul style="list-style-type: none"> To ensure that the CP was locally relevant and socially inclusive, UNFPA invested in co-creation processes involving community members, religious leaders and traditional authorities. This participatory approach facilitated the design of culturally appropriate interventions and helped overcome resistance in conservative settings. Engagement with these influencers also strengthened social norm change efforts, particularly in addressing HP and promoting uptake of GBV and SRHR services. 			<p>FGDs with multi-sectoral stakeholders</p>
<ul style="list-style-type: none"> Beyond GBV policy reform, UNFPA consistently provided TA and strategic input in the formulation and revision of national strategies across its mandate, including SRH and population dynamics. This ongoing policy support reflects strategic coherence between UNFPA’s programme and Zimbabwe’s development frameworks, notably NDS1 (2021–2025). UNFPA’s contributions ensured that gender equality, human rights, and youth empowerment remained central to national planning and policy dialogue. 			<p>KIIs with MWACSMED, CO staff</p>



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
Data collected: Population and Development			Sources of information:
<p>The 8th CP recognizes the importance of data in shaping effective interventions. The PD component of the CPE8 is aligned to the Zimbabwe National Population Policy developed in 1998, which is used as the basis in the development and implementation of PD policies and strategies in the country.</p> <ul style="list-style-type: none"> • The goal of the NPP 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 PD 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 policy is outdated. In 2019, the GoZ made a commitment under the ICPD@25(Nairobi Summit) to update this policy. • KIs highlighted the need for the review of the National Population Policy, which is seen as no longer in-line with current issues. • The UNFPA AWP's indicate that the policy was supposed to be reviewed under the current programme. During the planning years of 2025. UNFPA has set aside funds to support the review process. • Challenge: Competing priorities in the Ministry of Finance and Economic Development and Investment have delayed the review of the National Population Policy, 			<p>Literature review: ICPD POA, GoZ/UNFPA 7th CPE Report National policy document; AWP's, COARs (2022, 2023, 2024. 2025),</p> <p>KIIs with ZIMSTAT; MoFEDIP; UNFPA CO</p>
<p>Census and Statistics Act [Chapter 10:29] Enacted by the Parliament of Zimbabwe on 20th July, 2007, the Act provides for the establishment of ZIMSTAT to replace the Central Statistical Office; to provide for the collection and processing of statistics; to repeal the Census and Statistics Act [Chapter 10:05]; and to provide for matters incidental to or connected with the foregoing. The functions of the Agency are to:</p> <ul style="list-style-type: none"> • conduct the national census or any other censuses and surveys in terms of sections 12 and 13; and • co-ordinate and supervise the National Statistical System (NSS); and • advise the Government on all matters related to statistics; and • develop and promote the use of statistical standards and appropriate methodologies in the NSS; and • collect, compile, analyze, interpret, publish and disseminate statistical information alone or in co-operation with other Government Ministries or institutions; and • develop and maintain a central business register in relation to establishments, containing such particulars as may be prescribed; and • develop and maintain a comprehensive national statistics database; and 			<p>Literature review: Census and Statistics Act [Chapter 10:29] on Friday 20th July 2007; SADC TOR Individual Consultancy to Review the Current Statistics Act of Zimbabwe and Develop a New Statistics Act in line with Latest Developments 22 April 2025.</p> <p>KII with ZIMSTAT; CO staff</p>



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
<ul style="list-style-type: none"> provide a focal point of contact with international agencies on statistical matters; and perform any other function that may be conferred on or imposed upon the Agency by this Act or any other enactment. <p>Challenges</p> <ul style="list-style-type: none"> The Act is outdated. The main problem is that the Act is essentially about the establishment of the Statistics office and the activities of the Statistics Office and does not cover the wider statistical system (National Statistical System). It does not provide for any coordination function for the Statistics office. Lack of mandate for ZIMSTAT to utilize administrative data from government ministries. There are no data sharing agreements. <p>Status</p> <ul style="list-style-type: none"> SADC Secretariat has called for an Individual Consultant to review and update the Act to reflect the current status of the Zimbabwe National Statistics Agency and the NSS. The framework will cater for national development priorities and be sufficiently robust to support the forthcoming National Strategy for Development of Statistics (NSDS) as well as current and future developments in statistics. The revised Act must be guided by regional, continental and international policy and legal instruments such as the SADC Protocol on Statistics, the African Charter on Statistics and UN Fundamental Principles of statistics. 			
<p>Aligned to Vision 2030.</p> <ul style="list-style-type: none"> Published in September 2018, Vision 2030 is the GoZ's overarching planning framework for the Second Republic, following the transition of November 2017. The goal of Vision 2030 is to achieve a prosperous upper middle-income economy by 2030. The UNFPA programme and development component is aligned mainly to 3 of the 5 pillars of Vision 2030. The governance Pillar which speaks to aspects of respect for human rights, devolution and decentralization of essential services including registration and issuance of birth certificates, death registration, passports. The Infrastructure Development Pillar embeds Information and Communication Technology (ICT) across all national development strategies as an enabling tool for development; The pillar covers the provision of housing as a human right. Social Development Pillar encompasses the principle of living no one behind recognizing that vulnerable groups, such as people living with 			<p>Literature review: National policy document. UNFPA Strategic Plan 2022-2025;</p> <p>KIIs with stakeholders at national level</p>



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
disabilities require special support to enable participation in policy formulation, decision making processes, and realization of their potential towards contributing to Zimbabwe’s development equitable access to resources.			
<p>Aligned to the NDS1 2021 - 2025) to drive sustainable development which leaves no one and no place behind.</p> <ul style="list-style-type: none"> • The first five-year NDS1 (2021-2025) underpins Vision 2030, targeting an annual GDP growth rate of above 5 per cent and the creation of at least 760,000 formal jobs over the five-year period. • The NDS1 is aimed at propelling the economy towards an upper middle-income economy by 2030, while at the same time addressing the global aspirations of SDGs. • The issue of data and statistics is covered under the Governance Pillar of NDS1. • Acknowledging that young people are a valuable resource for Zimbabwe if they can grow and flourish, NDS1 focuses on youth issues to ensure the country reaps its DD, outlining key strategies that include developing an enabling legal and policy framework and increasing the number of youth accessing empowerment opportunities in all sectors of the economy • With NDS1 coming to an end in December 2025, the GoZ has approved priorities for the second five-year blueprint, the NDS 2 2026-2030. • NDS1 was being reviewed during the time of the fieldwork for the CPE, a process aimed at developing NDS2. 			<p>Literature review: UNFPA Strategic Plan 2022-2025, 8th CPD (2022-2026), UNSDCF (2022-2026); GoZ/UNFPA 7th CPE Report National policy document</p> <p>KII with Min of Finance and Economic Development; ZIMSTAT, staff UNFPA CO;</p>
<p>The NHS 2021-2025 was developed taking into consideration the challenges that the country had gone through that include economic instability since 2008, the changeover from the First Republic, and the onset of the COVID-19 pandemic.</p> <ul style="list-style-type: none"> • These challenges had a negative bearing on the health sector highlighting the intricate interlinkages between health and social and economic determinants. • The adoption of 17 SDGs at the United Nations in 2015 paved the way for the historic adoption of the Political Declaration on Universal Health Coverage (UHC) in September 2019. • The SDGs provided the broad parameters by which Zimbabwe developed its health system with the objective of achieving UHC by 2030. 			<p>Literature review: National policy document; SDG reports.</p> <p>KII with Min of Finance and Economic Development; ZIMSTAT, staff UNFPA CO.</p>
<p>The national statistics system is coordinated by the Zimbabwe Statistical Agency (ZIMSTAT) through implementing activities in the Zimbabwe National Strategy for the Development of Statistics (NSDS III) 2021-2025 a framework aimed at improving the production and use of statistics to support national development planning and decision-making.</p> <ul style="list-style-type: none"> • It emphasizes collaboration among various stakeholders within the NSS and the use of both traditional and non-traditional data sources. • Promotes and ensures availability of quality and credible official statistics. • To improve capacities and systems across the NSS; and 			<p>Literature review. UNFPA Strategic Plan 2022-2025, National policy document UNCT Zimbabwe 2023 Annual Report</p> <p>KIIs with Min of Finance and Economic Development; ZIMSTAT, staff UNFPA CO;</p>



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
<ul style="list-style-type: none"> Enhance data user satisfaction. UNFPA supports the GoZ priorities in population data management through ZIMSTAT hence guided by the NSDS III 2021-2025. UNFPA and ZIMSTAT co-chair the Data for Development and Innovation TWG at the national level. Agreed workplans and interventions. 			
<p>A detailed review of literature and stakeholder consultative engagements were undertaken to identify the UNFPA areas of interventions in the 8th CP. The selection of geographical areas for programme implementation was based on the analysis of national data and sub-national evidence surveys such as the ZDHS, MICS 2019, and data from DHIS2 to ensure relevance of interventions to rights holders).</p> <ul style="list-style-type: none"> Extensive engagement with stakeholders – MoHCC, ZNFPC, ZNAC, ZIMSTAT and other stakeholders. The PD output is a critical enabler for the attainment of UNSDCF outcomes. It is aligned with the UNSDCF outcome on ensuring that by 2026, all people in Zimbabwe, especially the most vulnerable and marginalized, benefit from more accountable institutions and systems for rule of law, human rights and access to justice. 			<p>Literature review: UNFPA Strategic Plan 2022-2025, 8th CPD (2022-2026), UNSDCF (2022-2026); UNCT Zimbabwe Results Report 2022; ZDHS; MICS; DHIS2; census report.</p> <p>KIIs with government staff, UNFPA CO; IPs;</p>
<p>The identification and development of the CP8 thematic areas drew from the findings of the 7th CP Evaluation.</p>			<p>Literature review: GoZ/UNFPA 7th CPE Report; UNFPA Strategic Plan 2022-2025, 8th CPD (2022-2026), UNSDCF (2022-2026);</p> <p>KIIs with UNFPA CO</p>
<p>Assumption 1.2: The UNFPA Zimbabwe had strategies to assist efforts on addressing the needs of vulnerable and marginalized populations taking into account the issue of disability, human rights and gender.</p>	<p>▫ The extent to which 8th CP interventions in the thematic areas of programming were adapted to the needs and demands of the population, in particular, the vulnerable, marginalized on the issue of disability, human rights and gender.</p>	<p>▫ AWP, COARs (2022, 2023, 2024), quarterly report (January-March 2025)</p> <p>▫ UNFPA GBV related surveys</p> <p>▫ Other relevant studies related to GBV context, including those produced by the government, academia, the UN agencies, international human rights organizations</p> <p>▫ • Rights holders /beneficiaries.</p>	<p>▫ Document review</p> <p>▫ Interviews with UNFPA CO staff, Implementation Partners & other partners</p> <p>▫ Interviews with UN agencies</p> <p>▫ Interviews with NGOs, including local organizations</p> <p>▫ Interviews /focus groups with 8th CP beneficiaries</p> <p>▫ Observation.</p>



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
	<ul style="list-style-type: none"> □ The extent to which the targeted populations, including vulnerable and marginalized groups, such as PWD, were consulted in relation to project design and interventions throughout the 8th CP. 	<ul style="list-style-type: none"> ▫ AWP, COARs (2022, 2023, 2024), quarterly report (January-March 2025) ▫ Reports from the Disability Inclusion Project ▫ Special needs assessment reports ▫ IP reports 	<ul style="list-style-type: none"> ▫ Document review ▫ Interviews with UNFPA CO staff, Implementation Partners & other partners ▫ Interviews /focus groups with 8th CP beneficiaries.
Data collected: SRHR			Sources of information:
<ul style="list-style-type: none"> • There were different levels of consultations held at national and sub-national levels. Priority areas in the Manicaland Province were identified including maternal health, structural deficiencies, gender, AYP and the issue of data analysis. • There has been a continuous process of identifying gaps and in the review meetings all the provinces are represented. • For disability inclusion, the needs of people living with disabilities were taken care in terms of having user-friendly access (a) ramps at health facility buildings; (b) appropriate toilet facilities. 			<p>KII with Ag. PMD Manicaland</p> <p>KIIs with DMOs, hospital staff (Mpilo, UBH, Inyathil, Bindura hospitals)</p>
<ul style="list-style-type: none"> • NGOs which are current UNFPA partners were consulted during the development of the CP, building on a long-standing partnership between them and UNFPA. 			<p>KIIs with INGOs e.g. World Vision.</p>
<ul style="list-style-type: none"> • CP is still relevant as it focuses on the SRH as well as ASRH of girls and young women; early child marriages and teenage pregnancies; substance abuse. • Consultations with government counterparts were conducted at national and provincial levels. • ZNAC provided their priorities to UNFPA. When annual plans are being developed, ZNAC participates as well as participating in quarterly review meetings. 			<p>KII with ZNAC</p>
<ul style="list-style-type: none"> • Marginalized groups such as MSM were consulted on their needs through GALZ and SRC during the planning and implementation of services for MSM. 			<p>Document review of AWP; reports to Global Fund.</p>
Data collected: Adolescents and young people			Sources of information:
<ul style="list-style-type: none"> • Interventions were grounded in an understanding of gendered vulnerabilities and the exclusion of other vulnerable groups, such as MSM. UNFPA emphasized the significance of gender, human rights and social inclusion in developing interventions for youth, including young girls, young women selling sex, young men having sex with men, and PWD. There was a deliberate attempt to understand how men and boys, and women and 			<p>Review of Annual workplans and Global Fund reports 2022-2023</p> <p>Interviews with UNFPA, ZYC, MOHCC,</p>



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
<p>girls, are affected by gender component and which rights of young people were being infringed.</p> <ul style="list-style-type: none"> KPs were taken on board, for example through the global fund UNFPA was able to support service centres for MSM SRHR. The Implemented in collaboration with GALZ and SRC, aiming to reach and retain MSM within the HIV continuum of care, and provide psycho-social support and SRHR knowledge 			MOPSE
<ul style="list-style-type: none"> For disability, UNFPA was very deliberate in making CSE manuals disability-focused and disability inclusive. PSZ collected disability-specific data using the Washington Group questions to understand the proportion of young PWD accessing services (around 3 per cent). It was further noted by YPNHW that communities were becoming more acceptable of PWD, and hospitals now have ramps, demonstrating positive changes in social inclusion. Support to the tertiary institutions included PWD as peer educators. The ZYC ensured that in their junior Parliament that 10 per cent of young people must be with disability, and adopted the gender/women's quota, reflecting a commitment to inclusion. However, ZYC noted that UNFPA did not provide much direct guidance on integrating gender, human rights, and disability, as they rely on government policies for programming. 			<p>Interviews with UNFPA, ZYC, MOHCC, MOPSE, Young people from tertiary institutions</p> <p>Interviews with UNFPA, ZYC, MOHCC, MOPSE , PSZ, YPNHW</p>
<p>Data collected: GBV and HP</p>			<p>Sources of information:</p>
<ul style="list-style-type: none"> The UNPRPD programme (Feb. 2021 – Aug. 2025), a joint UN initiative (UNFPA, UNESCO, UNDP etc), includes Phase I—where UNFPA supported the strengthening of legal and policy frameworks—and Phase II, which pilots disability-friendly mobile OSCs serving primarily women and girls with disabilities. The pilot, implemented in Mt Darwin, Bindura, and Muzarabani, aimed to identify effective practices and lessons to inform future programming. 			<p>KIIs with IPs, CO staff, Document review</p>
<ul style="list-style-type: none"> In the OSCs visited, facilities such as wheelchair ramps and specialized restrooms, for example, at Mpilo OSC were available to accommodate individuals with physical disabilities. However, persons with visual and hearing impairments continued to face notable barriers in accessing services, largely due to the limited capacity of service providers to communicate using braille or sign language. These challenges were consistently raised by stakeholders during KIIs and FGDs. It is, however, important to acknowledge that while it may not be feasible for all service providers to be fluent in sign language or proficient in braille, what remains essential is their awareness of these limitations and their ability to coordinate with organisations of persons with disabilities (OPDs) or other specialised partners. Strengthening these referral and support linkages is a key step toward more inclusive and accessible service provision for persons with disabilities. 			<p>Observation at OSCs, FGDs with beneficiaries and GBV multisectoral stakeholders</p>
<ul style="list-style-type: none"> UNFPA made efforts to consult different stakeholders who represent different population groups at different stages of the CP, so that the 			



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
programme remained relevant to the targeted groups.			
Data collected: Population and Development			Sources of information:
<p>The PD component of the 8th CP aims to Strengthen the capacity of the national statistical system to produce, analyze and use disaggregated population data to inform policy decision-making and development programming, including in humanitarian situations.</p> <ul style="list-style-type: none"> UNFPA's support towards strengthening the availability and use of timely and disaggregated data seeks to inform national policies, support improved planning and targeting of programmes and enable evidence-based advocacy to advance the agenda of leaving no-one behind. Capacity development of staff from ZIMSTAT and MoHCC; national and regional trainings; ZIMSTAT staff capacitated on the SDG portal and GIS. It also ensures data disaggregation in all surveys by socio demographic indicators - sex; region; age; education and disability. 			<p>Literature review: UNFPA Strategic Plan 2022-2025, 8th CPD (2022-2026), UNSDCF (2022-2026); Monitoring and Evaluation Plan 2022; ZDHS; MICS; DHIS2; Census Report.</p> <p>KIIs with government staff, UNFPA CO; IPs;</p>
<p>Assumption 1.3: The UNFPA Zimbabwe had strategies to assist efforts on addressing the needs of vulnerable and marginalized populations taking into account emerging issues such as new diseases, drug abuses and challenges brought about by climate change.</p>	<p>▫ The extent of 8th CP interventions in the thematic areas of programming were adapted to the needs of vulnerable, marginalized populations regarding emerging issues such as new diseases, drug abuses and challenges brought about by climate change.</p> <ol style="list-style-type: none"> Evidence of capacity and flexibility in programming approaches to respond to emerging needs. Evidence of changes in programme design or interventions reflecting context and influencing factors i.e. change in population needs and Government priorities 	<p>▫ AWP, COARs (2022, 2023, 2024), quarterly report (January-March 2025)</p> <p>▫ UNFPA COVID-19 related assessments</p> <p>▫ Other relevant studies related to COVID-19 context, including those produced by the government, academia, and the UN agencies.</p> <p>▫ Special studies on vulnerability of population to climate change effects</p>	<p>▫ Document review</p> <p>▫ Interviews with UNFPA CO staff, Implementation Partners & other partners</p> <p>Interviews /focus groups with 8th CP beneficiaries.</p>
	<p>▫ Evidence of changes in programme design or interventions reflecting context and influencing factors such as new diseases, drug abuses and challenges brought about by climate change.</p>	<p>▫ AWP, COARs (2022, 2023, 2024), quarterly report (January-March 2025)</p> <p>▫ Reports on the COVID-19 response</p> <p>▫ IP reports</p> <p>▫ Key informants</p>	<p>▫ Document review</p> <p>▫ Interviews with UNFPA CO staff, Implementation Partners & other partners</p> <p>▫ Interviews /focus groups with 8th CP beneficiaries</p> <p>▫ Observation.</p>



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
		<ul style="list-style-type: none"> ▫ Rights holders/beneficiaries 	
<p>Data collected: SRHR</p>			<p>Sources of information:</p>
<p>Cholera response</p> <ul style="list-style-type: none"> • During 2024, UNFPA's assessment of Cholera in Pregnancy revealed lack of specific guidelines for the care of pregnant women. In response and using complimentary resources from the Emergency Response Fund (a UNFPA facility administered from the UNFPA HQ), 12 districts and 2 health facilities in Harare City were supported with 516 dignity kits and hygienic kits, 520 maternity kits, 150 cholera beds and 30 tents that were distributed to health facilities. Thirty (30) spaces for cholera management and safe birth of pregnant women with cholera were also set up. • In addition, 48 Provincial Health Executives were capacitated in a national trainer of trainers on the provision of MISP on SRH services during emergencies. 			<p>KIIs with CO staff Document review of COARs</p>
<p>COVID-19 response</p> <ul style="list-style-type: none"> • UNFPA supported the strengthening of EmONC in COVID-19 hotspots. All contributed to a number of national TWGs e.g. National COVID-19 Case Management TWG. • UNFPA provided support to the COVID-19 Case management and Infection Prevention and Control Pillars. Equipment was procured to support the isolation areas for pregnant women and infection prevention commodities were provided to maternity waiting homes and hospitals across the country. The financial support was from Health Development Fund and Governments of China and Japan 			<p>Document review of COARs KIIs with UNFPA CO staff</p>
<p>Data collected: Adolescents and young people</p>			<p>Sources of information:</p>
<ul style="list-style-type: none"> • SAYWHAT, an implementing partner in tertiary institutions, noted that during their implementation, emerging issues such as drug abuse, climate change, and mental health came up, which they aimed to integrate into their organizational work. They pushed for these issues to be prioritized by the government at the National Student Conference in 2024, after drug abuse was declared a national issue. • Drug and substance abuse is also recognized as a significant driver for negative SRHR outcomes for young people and recognized in the National Framework on the Prevention and Management of Adolescent Pregnancies and the Zimbabwe Adolescent Health and Well-Being Implementation Plan (ZAYHIP): 2025-2030 which UNFPA have been providing significant support. • UNFPA working with MoPSE developed an additional module on addressing CSE and climate change, SRHR and climate change; 			<p>Interviews SAYWHAT, Peer Educators/Counsellors in MSU and MTC</p> <p>Document review: Zimbabwe Adolescent Health and Well-Being Implementation Plan (ZAYHIP): 2025-2030; National Framework on the Prevention and Management of Adolescent Pregnancies</p>



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
<ul style="list-style-type: none"> The YPNHW identified drug and substance abuse as an emergency that should be addressed through programming, particularly targeting the arts. This has led to localized efforts, for example in Bindura the YPNHW staff have been holding an annual concert funding through local private sector on SRHR and drug and substance abuse. The emergence of teenage pregnancies as a significant issue especially post-COVID-19 resulted in the development of the “Not in my Village” campaign a data driven, youth designed, and community led campaign. Its success has inspired other sectors with the MoPSE for example exploring adopting it for schools through a “Not in my School Campaign” for teenage pregnancies, drug, alcohol and substance abuse. 			Interviews with YPNHW, UNFPA, MoPSE
Data collected: GBV and HP			Sources of information:
<ul style="list-style-type: none"> UNFPA and its partners implemented the Takeda and CERF (Central Emergency Response Fund) Project, across Chiredzi, Buhera, Chipinge, Gwanda, Umguza, and Beitbridge to address drought impacts by enhancing access to GBV services. Women’s resilience was bolstered through economic empowerment activities and the establishment of safe spaces, supported by UNFPA through the provision of start-up equipment such as peanut butter production materials, weaving supplies, and poultry farming inputs. 			KIIs with IPs, UN Agencies, Document review
<ul style="list-style-type: none"> UNFPA leads the GBV Sub-Cluster, co-chaired by MWACSMED, providing strategic coordination among stakeholders. The Sub-Cluster meets quarterly (or more frequently when needed), maintains updated 5Ws, facilitates knowledge sharing, and supports capacity building for both GBV and non-GBV actors through targeted training and technical support. UNFPA plays a key leadership and technical role in Zimbabwe’s humanitarian architecture, including co-leading the Protection Cluster (with UNICEF)). UNFPA ensures the integration of GBV risk mitigation across humanitarian sectors, strengthens GBV referral pathways, and coordinates the delivery of multi-sectoral services, such as mobile OSCs, safe spaces, psychosocial support, and dignity kits, especially in crisis-affected districts. 			KIIs with UN Agencies, Document review
<ul style="list-style-type: none"> The Bureau for Humanitarian Assistance Project 2022 (USAID and UNFPA) provided shuttle services to enhance access to GBV support, facilitating rapid response. This initiative improved access to emergency services such as post-exposure prophylaxis (PEP) and emergency contraception, addressing transport cost barriers. 			KIIs with IPs Document Review
<ul style="list-style-type: none"> UNFPA supported the MWACSMED in conducting 22 training workshops on GBV in Emergencies and Protection from Sexual Exploitation and Abuse (PSEA) covering 22 Districts around the country. These trainings targeted critical stakeholders which included representatives from the Government Ministries, Traditional and Religious Leaders and Civil Society Organizations (CSOs) in the respective Districts i.e.. GBV actors and non-GBV actors are responsible for responding to emergencies. 			Quarterly report review



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
Data collected: Population and Development			Sources of information:
UNFPA ensures integration of data in the humanitarian-development nexus <ul style="list-style-type: none"> Support for data collection during humanitarian situations – COVID-19; Cyclone; floods. Reach of vulnerable groups, PWD, hard to reach areas, the underserved to ensure data services reach these sections of the population. During the Cholera outbreak, UNFPA commissioned a Rapid Assessment on cholera on pregnant and lactating mothers (2024). Worked with government during cyclone Idai on data collection and analysis, providing evidence-based programming for those affected. 			Literature review: COARs (2022 – 2025) KII with government staff, UNFPA CO; IPs;
COHERENCE EQ2: To what extent have the different components of the 8th CP (SRHR, GBV, AYP) been integrated to ensure synergies in addressing SRHR issues, adolescents and youth, GBV and use of data for decision making?			
Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
Assumption 2.1: The different components of 8th CP (SRHR, GBV, AYP) were effectively integrated to ensure synergies in addressing SRHR issues, adolescents and youth, GBV and use of data for decision making.	Evidence of effective integration of thematic components (SRHR, GBV, AYP) to ensure synergies in addressing SRHR issues, adolescents and youth, GBV and use of data for decision making.	<ul style="list-style-type: none"> AWPs, COARs (2022, 2023, 2024), quarterly report (January-March 2025) Thematic plans and reports IP reports Key informants Rights holders/beneficiaries 	<ul style="list-style-type: none"> Document review Interviews with UNFPA CO staff, Implementation Partners & other partners Interviews /focus groups with 8th CP beneficiaries Observation.
Data collected: SRHR			Sources of information:
Data collected: Adolescents and young people			Sources of information:
<ul style="list-style-type: none"> UNFPA Zimbabwe made notable efforts to integrate the different components of its 8th CP including SRHR, GBV and AYP, to foster synergies and improve the use of data for decision-making. Evidence of integrated programming and policy alignment gave indication to the effect that there was a strong policy supporting CSE delivery in 			Interviews with UNFPA, ZYC, MOHCC, MOPSE, PSZ, YPNHW



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
<p>school that was underpinned by a vibrant school health policy.</p> <ul style="list-style-type: none"> It was further cemented by the Ministry of Youth Empowerment Development and Vocational training's youth empowerment mandate providing additional support in this area with CSE interconnected with other components such as life skills education and HIV/AIDS demonstrating a whole of programme approach. Similarly, the MoPSE actively developed and reviewed its Life Skills Empowerment Strategy (2018-2025), which provides a framework for implementing guidance, counselling, and CSE programmes. This strategy is set for another review from 2026 to 2030, indicating a long-term commitment to integrated education. In the development of CSE materials, MoPSE coordinated inputs from various ministries with UNFPA's support, ensuring a multi-sectoral approach. This collaboration extended to incorporating issues of gender and human rights into CSE materials and school quiz questions, with handbooks developed to assist teachers in delivering these topics effectively Youth participation is a key aspect of integration with UNFPA supporting CSOs like SAYWHAT and the YPNHW by providing data and establishing connections between Parliament and CSOs for youth-friendly budget consultations. These consultations included 125 young people from across the country, highlighting an effort to ensure young voices inform policy and budget decisions. The "not in my village" campaign, initiated based on data concerning teenage pregnancies, demonstrates how data directly informs targeted interventions that also address social norms. This campaign recognizes the critical role of traditional leaders in tackling social norms related to teenage pregnancies 			
<ul style="list-style-type: none"> The use of data on teenage pregnancies directly informed the creation of the "not in my village" campaign, showcasing a data-driven approach to programme design. Partners like PSZ actively used various national data sources, including ZDHS data, MICS survey data, and information on teenage pregnancy prevalence, fertility rates, early marriages, GBV, and HIV/STI prevalence, to conceptualize their interventions. This ensured that projects are designed to address identified challenges at the sub-national level. PSZ also reported improved commodity forecasting and reporting accuracy, with fewer discrepancies between facility and national DHIS2 data due to training and joint data supervisions supported by UNFPA. This indicates an effort to ensure data quality and its utility for supply chain management. There was further support to ZIMSTAT on statistical data generation and the MoHCC on impact models and estimates, further emphasizing data-driven decision-making. 			Interviews with UNFPA, ZYC, MOHCC, MOPSE
<ul style="list-style-type: none"> UNFPA's leadership has been credited with the success of the CPE through supporting team integration and driving results, effectively breaking down organizational silos to foster collaborative work. UNAIDS recognizes UNFPA as a core sponsor for HIV programmes, with roles allocated based on comparative advantages, particularly concerning young people, SRHR, condom programming, and KPs. UNFPA's initiation of the national sex work programme, which later involved the Global Fund and local IPs like GALZ, SRC, and CeSHHAR, is a key example of leveraging partnerships for comprehensive key population programming. GALZ, through its Mutare Drop-In Center, established an efficient referral pathway for MSM services by engaging strategic partners such as the ZNAC provincial office, MoHCC, CeSHHAR, and other key population organizations 			Interviews with UNFPA, UNAIDS, FCDO,



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
<ul style="list-style-type: none"> The collaboration extends to sensitizing religious leaders and PFLAG (Parents, Families, and Friends of Lesbians and Gays) on the MSM programme and training healthcare workers on KPs -friendly SRHR service provision. 			Interview with UNFPA
<p>Data collected: GBV and HP</p>			<p>Sources of information:</p>
<ul style="list-style-type: none"> UNFPA Zimbabwe employed integrated approaches to address SRHR, GBV, and AYP issues by leveraging multi-sectoral partnerships and community-based platforms. The OSCs were established and supported to provide comprehensive services ranging from clinical care and psychosocial support to legal assistance under one roof, particularly for GBV survivors. These centres serve as entry points for integrated GBV and SRHR services. 			<ul style="list-style-type: none"> KIIs with IPs, Gov't, and UN agencies FGD with beneficiaries in different districts and provinces Observations
<ul style="list-style-type: none"> UNFPA Zimbabwe plays a lead role in strengthening national data systems to support evidence-based decision-making. It chairs the UN Data for Development Group and coordinates closely with ZIMSTAT, positioning itself as the lead agency for information management within the UN Country Team. 			
<ul style="list-style-type: none"> A notable contribution is UNFPA's leadership in the development of the GBV IMS, which is designed to enhance data capturing and analysis of GBV cases. The GBV IMS is in collaboration with ZIMSTAT and will support harmonized and reliable data flows to inform GBV prevention and response programming. 			
<ul style="list-style-type: none"> To reach adolescents and youth, UNFPA collaborated with various organizations, including the Zimbabwe Cricket Association, which was engaged to disseminate GBV prevention messages through popular platforms, enhancing outreach and awareness among young people. 			
<p>Data collected: Population and Development</p>			<p>Sources of information:</p>
<p>In partnerships and collaboration, UNFPA leading in areas in line with their mandate</p> <ul style="list-style-type: none"> UNFPA collaborates with the ZIMSTAT which reports to the Ministry of Finance, Economic Development & Investment Promotion. The role of the ministry is to coordinate and oversee the interventions supported by various donors. UNFPA discusses with ZIMSTAT workplans and the implementation of projects. The ministry participates in thematic working groups MoFEDIP is responsible for the development of the NDS. Currently carrying out consultations with development partners on the development of NDS2 whose development is supported by UNFPA. 			<p>Literature review: COARs (2022 – 2025)</p> <p>KIIs with Ministry of Finance and Economic Development; ZIMSTAT; UNFPA CO staff;</p>



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
<ul style="list-style-type: none"> Tracking of the SDG Indicators on the SDG Platform is anchored on the NDS1 framework. In 2022 and 2023, UNFPA supported the GoZ to produce the ICPD@30; the Addis Ababa Report; Nairobi Commitment. Cordial working relationship. 			
<p>UNFPA collaborates with UN agencies, government and stakeholders in the management of GBV data from ZRP, NPA, MWACSMED, MoHCC, ZIMSTAT, Musasa project and other IPs.</p> <ul style="list-style-type: none"> UNFPA works in partnership with UN Women to strengthen gender and GBV data at institutional level. The GBV IMS establishment was delayed due to limited coordination of all relevant ministries involved and MWACSMED did not have an M&E Department for processing the GBV data (which is now in place). Under the new Spotlight Sustaining the Gains programme, which started 1 June 2025 UNFPA will support a pilot programme to implement GBVIMS in partnership with the MWACSMED and ZIMSTAT. 	<ul style="list-style-type: none"> Programming data - GBV IMS is a priority. Hence the need for a coordinated approach by relevant government ministries for its establishment. 		<p>Literature review: COARs (2022 – 2025)</p> <p>KIIs with UN Women; MWACSMED; ZIMSTAT; UNFPA CO staff; UNICEF;</p>
<p>UNFPA staff collaborate across thematic areas.</p> <ul style="list-style-type: none"> PD cuts across all thematic areas. Additionally, the P&D Unit works closely with the UNFPA M&E Unit. 			<p>Literature review: COARs (2022 – 2025)</p> <p>KIIs with UNFPA CO staff;</p>
<p>COHERENCE EQ3: To what extent has UNFPA worked with stakeholders and leveraged strategic partnerships at all levels (national, provincial and district) and development partners and ensure that no one is left behind?</p>			
Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
<p>Assumption 3.1: The UNFPA Zimbabwe effectively worked with stakeholders and leveraged strategic partnerships at all levels (national, provincial and district) and development partners and ensured that no one is left behind.</p> <p>NB: A strategic partnership is a collaborative</p>	<p><input type="checkbox"/> Evidence of UNFPA Zimbabwe playing a leading / participatory role to leverage strategic partnerships at all levels, including TWGs in the country.</p>	<ul style="list-style-type: none"> AWPs, COARs (2022, 2023, 2024) UNCT meeting reports UNSDCF pillar group reports Joint programme work plans and reports Key informants 	<ul style="list-style-type: none"> Document review Interviews with UNFPA CO staff, Implementation Partners & NGOs Interviews with key GoZ officials in line Ministries and Departments; Provincial and Districts officials



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
<p>agreement between two or more organizations to achieve mutually beneficial goals and objectives. Key characteristics include shared vision, complementary strengths, long-term commitment, risk and reward sharing, flexibility and adaptability.</p>		<ul style="list-style-type: none"> ▮ Rights holders/beneficiaries. 	<ul style="list-style-type: none"> ▮ Interviews with UNCT staff ▮ Observation.
	<input type="checkbox"/> Evidence of the collaborative efforts with local organizations in the targeted thematic interventions areas and degree of success.	<ul style="list-style-type: none"> ▮ AWP, COARs (2022, 2023, 2024) ▮ IP reports ▮ Key informants. 	<ul style="list-style-type: none"> ▮ Document review ▮ Interviews with UNFPA CO staff ▮ Interviews with local NGOs.
<p>Data collected: SRHR</p>			<p>Sources of information:</p>
<ul style="list-style-type: none"> ● UNFPA supported the MoHCC and ZNAC to implement programmes targeted at reducing maternal deaths, unmet need for FP and GBV at the national and provincial level. 			
<ul style="list-style-type: none"> ● The three UN agencies UNICEF, UNFPA and WHO are the first-tier IPs of the HRF. The UN Agencies and the Funding Partners' Technical Advisors and Programme managers met to facilitate technical discussions and ensure efficient and excellent collaboration in the implementation of the HRF. ● UNFPA collaborated well with the Higher Life Foundation (HLF), and GFF/WB in working together with the Family Health Directorate at MoHCC and responding to Maternal and Neonatal health problems in the country. ● UNFPA collaborated with WFP to support maternity waiting home with food for pregnant women at 38 districts 			
<ul style="list-style-type: none"> ● UNFPA collaborated with UNICEF to implement the Zimbabwe Health Development Fund Joint Programme (2016-2022) – Although this joint programme <u>was not under 8th CP per se</u>, it was extended by six months into 2022 due the COVID-19 pandemic. The programme thematic areas included <ul style="list-style-type: none"> • Thematic Area 1: Maternal, New-born and Child Health & Nutrition • Thematic Area 2: Sexual Reproductive Health and Rights (SRHR) • Thematic Area 3: Medicines, Vaccines and Commodities • Thematic Area 4: Human Resources for Health • Thematic Area 5: Health Financing • Thematic Area 6: Policy, Planning and M&E • Thematic Area 7: Technical Support and Innovation <p>UNFPA was an active member of the HDF Steering Committee (MoHCC, funding partners, UNICEF, UNFPA and WHO). The committee was responsible for oversight and decision making on all the issues which arose within the implementation of the HDF.</p>			<p>Document review (Zimbabwe Health Development Fund Joint Programme 2016-2022 Final Report)</p>



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
Data collected: Adolescents and young people		Sources of information:	
<ul style="list-style-type: none"> UNFPA Zimbabwe has demonstrated a strong commitment to working with a wide array of stakeholders and leveraging strategic partnerships across national, provincial, and district levels to ensure that its interventions reach and benefit all, particularly vulnerable and marginalized populations. UNFPA supported CSOs such as SAYWHAT and the YPNHW in enhancing their capacity to vocalize issues affecting young people and building bridges between Parliament and CSOs for youth-friendly budget consultation. Further collaboration with the MoPSE is visibly extensive, encompassing the development of CSE materials, national strategies for guidance and counselling, and coordination of inputs from other ministries. UNFPA's leadership within the CO is described as hands-on, driving results and breaking silos, which fosters collaborative work with IPs. UNFPA leadership was also credited for engagement with donors resulting in a better relationship between the agency and development partners which enhances joint collaborations. At the national level, UNFPA worked closely with various government ministries and departments, including the MoHCC, the Ministry of Youth, and the Department of Nursing Services. UNFPA participates in and contributes to United Nations (UN) joint teams and platforms, such as the UN joint team on youth and the ASRH forum meetings, demonstrating its commitment to broader UN efforts and inter-agency coordination. Under the banner of the UN youth group UNFPA was able to contribute to the process of reviewing the marriages act which abolished child marriages, supported the development of the national adolescent pregnancy prevention and response plan and the national adolescent and youth health and wellbeing strategy 2023 – 2026. UNFPA provided specific value addition in mobilizing youth to contribute during consultations of the marriages and sexual offenses Act and provision of data and support to youth CSOs to advocate for increasing the age of sex to 18 years as well as that of marriage. 		Interviews with UNFPA, MoPSE, MoHCC, SAYWHAT, FCDO	
<p>Strategic Partnerships for Service Delivery and Advocacy:</p> <ul style="list-style-type: none"> SAYWHAT implements the Reproductive Health and Advocacy Project in tertiary institutions, focusing on strengthening access to quality SRH and GBV information and services, and increasing uptake among students. They also support students and young people in participating in national consultative meetings and advocacy initiatives. UNFPA partnered with PSZ on health systems strengthening, specifically supporting public sector facilities. This included training service providers on FP, medical emergency management, infection prevention control, data quality, and commodity forecasting. PSZ also conducts competency assessments and identifies provincial and district mentors to ensure the sustainability of these improvements. PSZ's project design was explicitly data-driven, using national survey data (ZDHS, MICS) to identify needs related to teenage pregnancy, fertility, early marriage, GBV, and HIV/STIs, and collaborated with various sub-national departments and community-based organizations. UNFPA's collaboration with PSZ included joint data supervisions and spot checks, which have improved commodity forecasting and reporting accuracy. UNFPA is also recognized for its role in the HIV programme, particularly in KPs programming. It initiated the national sex work programme and worked with IPs like GALZ, SRC and CeSHHAR to reach KPs. UNFPA provides ongoing technical guidance to SRC and GALZ on financial and programmatic issues. GALZ has successfully created efficient referral pathways for MSM services by engaging a range of strategic 		Interviews with UNFPA, MoHCC, SAYWHAT, PSZ	



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
partners at the provincial level, including ZNAC, MoHCC, CeSHHAR, and City Health Department.			
<ul style="list-style-type: none"> UNFPA's programming is responsive to emerging issues such as drug abuse, climate change, and mental health, with a stated aim to integrate these into organizational work. For adolescents, the increase in the age of consent for sex to 18 years introduced complexities in accessing SRHR services, which UNFPA addressed by modifying the titles of self-care guidelines to ensure continued access. The "not in my village" campaign is specifically targeted to address teenage pregnancies, acknowledging the critical role of traditional leaders in influencing social norms around this issue. UNFPA ensured continuity of Psychosocial Support (PSS) services through helplines and access to education services, especially relevant during crises or disruptions. UNAIDS highlights UNFPA's comparative advantage in reproductive health services and its overall strength in demographic progression, noting its ability to compare statistical data. UNESCO views UNFPA as the lead agency for SRHR issues, complementing UNESCO's education-focused CSE by focusing on service provision and community awareness 			Interviews with UNFPA, MoPSE, MoHCC, UNAIDS, UNESCO
Data collected: GBV and HP			Sources of information:
<ul style="list-style-type: none"> UNFPA has taken a leading role in coordinating GBV efforts across government and development partners. It plays an active role in the GBV sub-sector and leads initiatives such as the development of the GBV Information Management System (GBV IMS), with ZIMSTAT and other government players. It also contributes to inter-agency GBV policy dialogue and coordination platforms. 			<ul style="list-style-type: none"> KIIs with IPs, CO staff, NGOs and UN Agencies Document review FGD with multisectoral stakeholders Observation
<ul style="list-style-type: none"> UNFPA collaborates with established local partners such as Musasa Project to deliver comprehensive GBV services, including shelter, psychosocial support, legal aid, and referral services. These services are integrated through OSCs across the country. Evidence shows increased accessibility and uptake of GBV services in targeted communities, particularly among women and adolescent girls. 			
<ul style="list-style-type: none"> Stakeholder meetings also revealed that UNFPA supports capacity strengthening for local civil society organization's (CSOs) involved in GBV prevention and response. This includes providing TA, training on survivor-centred approaches, and support for institutional development. Through this engagement, UNFPA helps to enhance the operational effectiveness of CSOs, enabling them to deliver more coordinated, accountable, and sustainable services, particularly in hard-to-reach and underserved communities. This investment in local actors also contributes to national ownership and long-term sustainability of GBV response systems. 			



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
<ul style="list-style-type: none"> UNFPA played a key role in raising awareness among survivors on the importance of timely reporting and accessing services to prevent further complications. Despite challenges, such as approximately 60 per cent of adolescents still presenting late, initiatives like the #72 Campaign, in collaboration with the Adult Rape Clinic and other partners, have contributed to improved access to emergency services following incidents of sexual assault. 			KIs with ARC
<p>Data collected: Population and Development</p>			<p>Sources of information:</p>
<p>ILO, UNDP, UNICEF, WFP, UNCHR supporting data collection and analysis activities through:</p> <ul style="list-style-type: none"> Support to demographic and health surveys Labour market information system development Census data analysis Social development survey Evidence collection and analysis for education sector Capacity building for statistical systems Livelihoods Assessment and Support Livelihood assessment Food security assessment 			<p>Literature review: UNCT. Zimbabwe 2023 Annual Report – Priorities for 2024; COARs (2022 – 2025)</p> <p>KII with ILO, UNDP, UNICEF, UNOPS, WFP, UNHCR; CO staff</p>
<p>Expand partnerships with International Financial Institutions (WB, AfDB), UNECA AUC, the Department of Demography, Human Settlements and Development (formerly Centre for Population Studies), universities and research and training institutions).</p> <ul style="list-style-type: none"> UNFPA recently worked with the World Bank on the GBV economic cost study and now currently working on the GBV investment case and financing mechanism. UNECA provided additional support for the 2022 PHC. <p>The relationship between the Department of Demography, Human Settlements and Development and UNFPA was describes as ‘strange’ as UNFPA has not worked with the institution but with individuals within the institution, to the extent that the Department is represented at the ERG by a student. There is no MOU between the Department and UNFPA. No student has been attached at UNFPA, no collaborations on international commemorations, and yet UNFPA is a key institution to the Department. However, in 2024, the Department received furniture (table and chairs) for their boardroom. An official communication received from UNFPA was on interviews for the CPE. Instead of perpetuating the status quo, the anomalies need to be corrected</p>			<p>Literature review: P&D ToC</p> <p>KII with the Department of Demography, Human Settlements and Development.</p>



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
<p>and establish institutional level engagement which works much better for sustainability. The Department indicated that they are collaborating better with the RCO than UNFPA.</p> <p><i>“We are not aware of any in-depth analysis. We have staff who can carry out further analysis of the census, ZDHS. Our staff are used by the regional office but not by the national office.”</i></p> <ul style="list-style-type: none"> UNFPA takes note of this concern. The relationship which was there over the years deteriorated and required a relook. UNFPA is also looking at expanding this and working with other universities on this aspect. 			
<p>COHERENCE EQ4: To what extent has UNFPA contributed to the functioning of various coordination mechanisms such as the UNCT, GBV Sub Cluster, Youth Networks, SRH TWG, M&E TWG, Data for development and Innovation TWG and other coordination mechanisms in the country?</p>			
<p>Assumption: 4.1 UNFPA Zimbabwe played a significant role in strengthening and supporting various coordination bodies within the country, including the UNCT, GBV Sub-Cluster, Youth Networks, SRH TWG, M&E TWG, Data for Development and Innovation TWG, and other related forums.</p>	<ul style="list-style-type: none"> Evidence of UNFPA actively participating in the UNCT and the GBV Sub-Cluster, Youth Networks Evidence of UNFPA playing a leading role in SRH, M&E, Data for Development and Innovation TWGs of the UNCT relevant to the UNFPA mandate Evidence of UNFPA actively contributing and taking initiative in UNCT meetings Evidence of UNFPA CO being part of joint programmes with other UN agencies in related thematic focus Evidence of UNFPA's comparative advantages and technical expertise of UNFPA in the 8th thematic areas of programming added value to the UNCT support for sustainable development. 	<ul style="list-style-type: none"> Minutes of UNCT working groups Programming documents regarding UNCT joint initiatives Monitoring/evaluation reports of joint programmes and projects Minutes and relevant documents on UN and National level coordination mechanisms for SRH, GBV and HIV integration UNSDCF progress reports on coordination mechanisms Minutes and reports of relevant coordination structures for thematic areas/issues. 	<ul style="list-style-type: none"> In-depth document review Interviews with UNFPA CO staff Interviews with UNFPA staff Interview with the UN Resident Coordinator Interviews with other UN agencies Interviews with GoZ officials in the line ministries.
<p>Data collected: SRHR</p>			<p>Sources of information:</p>
<ul style="list-style-type: none"> UNFPA is an active member of the Programme Management Team (PMT) and is an implementer of the UNSDCF Thematically UNFPA has been strong namely: 			<ul style="list-style-type: none"> KIs with UN agencies Document review of strategic



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
<ul style="list-style-type: none"> ○ The strength of UNFPA is its work on the empowerment of AYP through the Youth TWG. However, there is need to expand the mandate beyond ASRH to the economic empowerment of the youth. UNFPA is responsible for the Youth Scorecard. ● UNFPA's has provided support to integrate of human rights-based approaches and gender equality. UNFPA is under the UNCT development team <ul style="list-style-type: none"> ○ UNFPA is the coordinator of the prevention of sexual exploitation and abuse (PSEA) activities done by SRH Programme Analyst ○ UNFPA has been responsible for the GBV agenda. 			documents
<p>UNFPA's participation in joint programmes with other UN agencies</p> <ul style="list-style-type: none"> ● UNFPA is an active agency in several joint initiatives namely <ul style="list-style-type: none"> ○ Together4SRH (e.g. UNFPA, WHO, UNICEF), (Phase I: 2018 – 2023); Phase II 2024-2025). ○ Prevention of adolescent pregnancies (UNFPA, UNDP and UNICEF). ○ Promotion of South-to-South cooperation - UNFPA facilitated a South-to-South conference in Victoria Falls. The involvement of the Ministry of Foreign Affairs on South-to-South cooperation has been lukewarm as Ministry of Foreign Affairs thinks this is a bilateral matter. ○ UN agencies involved in South-to-South cooperation are UNFPA, UNDP, FAO, ILO, IFAD, UNESCO. ○ Spotlight Initiative (UNFPA, UNICEF, WHO, UN Women etc), Jan. 2019 – Sep. 2023. ○ UN Partnership on Rights of Persons with Disability (UNPRDP) Programme (UNFPA, UNESCO, UNDP etc)(Feb. 2021 –Aug. 2025), ● UNCT has a Health Cluster Group, which comprises of the UN agencies, government counterparts and it is chaired by WHO. UNFPA is a member focusing on RMNACHN in emergencies. UNFPA is very active in emergency programming. 			<ul style="list-style-type: none"> ● KIIs with UN agencies ● KIIs with Gov't ministries e.g. MoHCC ● Document review of UNSDCF (2022 - 2026)
<p>Data collected: Adolescents and young people</p>			<p>Sources of information:</p>
<p>There is strong evidence that UNFPA led to strengthening of the youth voices on SRHR. Support to YPNHW, SAYWHAT, Youth Parliament and the Zimbabwe Youth Parliament Caucus have all contributed to strengthening youth participation in SRHR policy and programmatic decisions.</p>			Interview SAYWHAT, UNFPA, ZYC, YPNHW (Shamva District)
<p>Participation and support to the ASRH Forum have enhanced the coordination of SRHR support for adolescents in the country</p>			Interview UNFPA, UNESCO,
<p>UNFPA was an integral part of the UN Youth Group. Complementarities with UNESCO in support to tertiary institutions demonstrated coordination</p>			Interviews with UNESCO, Peer Educators at Mutare State University



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
<p>Data collected: GBV and HP</p>		<p>Sources of information:</p>	
<ul style="list-style-type: none"> UNFPA’s recognized expertise in GBV programming, combined with its strong national partnerships (e.g., Musasa, MWACSMED, World Vision), positions it as a leader in this space. Its ability to link policy, service delivery, and community mobilization strengthens the collective UNCT GBV response. 		<p>KIIs with donors, IPs, UN Agencies</p>	
<ul style="list-style-type: none"> UNFPA plays a central role in the GBV Sub-Cluster, contributing technical expertise, supporting coordination efforts, and leading key initiatives to harmonize GBV prevention and response across sectors. UNFPA is also active in youth networks, ensuring GBV risks affecting young people are addressed within broader programming. <p>Quotes <i>“UNFPA’s strength is that they combine technical know-how with deep engagement at community level. That’s what makes their contribution to the UNCT so valuable,” remarked a donor representative.</i></p>		<p>KIIs with donors, IPs, UN Agencies</p>	
<ul style="list-style-type: none"> In addition to its role in the GBV Sub-Cluster, UNFPA has also supported the GBV Coordination Mechanism led by the MWACSMED. Since 2007, UNFPA has provided continuous support for GBV coordination at national, provincial, and district levels. Under the current 8th CP, UNFPA has continued to offer both technical and financial assistance to strengthen and sustain these coordination mechanisms. 		<p>KIIs with donors, IPs, UN Agencies</p>	
<p>Data collected: Population and Development</p>		<p>Sources of information:</p>	
<p>UNFPA Country Representative and ZIMSTAT Director co-chair the Data for Development and Innovation TWG.</p> <ul style="list-style-type: none"> UNFPA is the agency responsible for information management systems in the UN in the country. In 2024, the restructuring of the Data for Development and Innovation (DFDI) TWG into specialized clusters enhanced coordination, stakeholder engagement, and the integration of national work plans. The revival of the National Data for Development and Innovation TWG improved coordination within Zimbabwe’s NSS through Joint Work Plans across six clusters, aligning data-driven decisions with NDS1 and SDGs. UNFPA collaborates with UNICEF on the development of the MICS. Collaborated with USAID on the development of the ZDHS Collaborated with UNESCO and UNICEF, with UNICEF as the lead agency, on the Study on Adolescent Pregnancies in the Country December 2023). The Framework to guide implementation was being developed during the time of the CP8 evaluation. 		<p>Literature review: 2024 Results and Resources Plan for Zimbabwe; UNFPA Zimbabwe: 2024 Annual Report.</p> <p>KIIs with UN Women; UNICEF; MWACSMED; ZIMSTAT; UNFPA CO staff;</p>	



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
<ul style="list-style-type: none"> UNICEF is the fund administrator for the HRF (UNFPA/ZIMSTAT funded through the HRF). 			
<p>EFFECTIVENESS EQ5: To what extent has UNFPA Zimbabwe strategies on SRHR, GBV, AYP and PD achieved the intended outcomes for the different target groups making sure that no one is left behind? In particular: (i) increased access to and use of integrated SRH services?</p>			
Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
<p>Assumption 5.1: UNFPA Zimbabwe strategies on SRHR, GBV, AYP and PD successfully achieved the intended outcomes (i.e. ending unmet need for FP; ending preventable maternal deaths; and ending GBV and HP) for the different target groups making sure that no one is left behind and in particular the increased access to and use of integrated SRH services.</p>	<ul style="list-style-type: none"> Extent to which the improvements in integrated SRH services is/are a contribution from UNFPA interventions 	<ul style="list-style-type: none"> Relevant policy and strategy documents that were developed or revised (Reproductive health strategy; Reproductive normative tools, guidelines, strategies) Relevant national and district data sources for service and outcome indicators: ZDHS, MICS, DHIS and COARs Key informants. 	<ul style="list-style-type: none"> Document review Interviews with UNFPA CO staff, Implementation Partners & other partners Interviews with key GoZ officials in line Ministries and Departments; Provincial and Districts officials.
	<ul style="list-style-type: none"> Extent of strengthening the capacities at national and district levels, to improve quality integrated SRH services during the 8th CP 	<p>Strengthening the capacities</p> <ul style="list-style-type: none"> Reports on policy and planning level seminar / workshop Minutes of relevant policy and planning level meetings Training modules, that were revised Training modules that were produced Training reports UNFPA reports on capacity building initiatives and events Key informants. 	<ul style="list-style-type: none"> Document review Interviews with UNFPA CO staff, Implementation Partners & other partners Interviews with key GoZ officials in line Ministries and Departments; Provincial and Districts officials.



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
	<ul style="list-style-type: none"> ▫ Extent to which the SRH service delivery output / outcome indicators are improved. 	<ul style="list-style-type: none"> ▫ Service delivery improvement ▫ DHIS, MICS, health facilities' reports ▫ Client satisfaction survey reports ▫ Key informants. 	<ul style="list-style-type: none"> ▫ Document review ▫ Interviews with UNFPA CO staff, Implementation Partners & other partners
<p>Data collected: SRHR</p>			<p>Sources of information:</p>
<p>UPSTREAM LEVEL UNFPA's contribution to improvement in SRH services at the upstream level includes the following:</p> <ul style="list-style-type: none"> ● UNFPA has done a fantastic job and given the reduction of MMR from 364 to 212 per 100,000 live births one can assume that UNFPA has played a key role in the reduction of MMR as result of its work on maternal health. ● Due to the advocacy of UNFPA and partners to GoZ, UNFPA and GoZ established a matched funding arrangement for FP commodities, and this demonstrated significant strides in efforts to improve domestic financing for commodity procurement. <ul style="list-style-type: none"> ○ Through the support from the HRF, UNFPA facilitated the procurement of FP commodities with US\$2.6 million, whilst the GoZ and UNFPA contributed US\$1.5 million and US\$2.5 million respectively during 2023. ○ During 2024, the GoZ contributed US\$ 1.5 million and this unlocked US\$ 2 million from the UNFPA global supplies partnership. The HRF added US\$ 1.5 million, and the Global Financing Facility (GFF) contributed USS 1.4 million, complemented by PEPFAR support, ensuring sufficient FP supplies for 2024. Over three years, GoZ has contributed US\$ 4.7 million under this arrangement, demonstrating its ability to unlock government funding for commodities. ● UNFPA and UN partners facilitated the implementation of the Health Sector Coordination Framework. ● 			<ul style="list-style-type: none"> ● KIIs with CO staff; MoHCC officials ● Document review of COARs ● KIIs with RCO staff ● KIIs with CO staff; ● Document review of COARs
<p>DOWNSTREAM LEVEL UNFPA's contribution to improvement in SRH services at the downstream level includes the following:</p> <ul style="list-style-type: none"> ● The 2gether 4 SRHR is led by UNFPA and is a well-coordinated programme <ul style="list-style-type: none"> ○ Assisted MOH to adopt the Self Care Model ○ Partners awaiting guidelines to roll out the activity ○ UNFPA assisted MoHCC to introduce the Digital Adaptation System collecting all indicators that are not in the DHIS. ○ UNFPA is the lead agency at the regional level delivering as One UN. 			<ul style="list-style-type: none"> ● KIIs with CO staff; MoHCC officials ● LIIs with UN agencies ● Document review of COARs



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
<ul style="list-style-type: none"> UNFPA supported the roll-out of the e-LMIS to 1150 health facilities by the end of 2023. By the end of 2024, the government planned to have the e-LMIS rolled out to all facilities. The e-LMIS enabled real-time availability of logistics data. UNFPA has supported innovations to reduce haemorrhage in women. During 2024, two thousand one hundred (2100) Non-Pneumatic Anti-Shock Garments (NASG) were procured and distributed to district and provincial hospitals. The NASG is a low-cost first-aid device that limits persistent post-delivery bleeding by reducing blood flow to the uterus and stabilizes the patient during referral to a higher facility for appropriate treatment and care. UNFPA supported the procurement of fistula kits and 106 obstetric fistula repairs were conducted at mission and provincial hospitals during 2024. 			
<p>DOWNSTREAM LEVEL Regarding strengthening the capacities at national and district levels, to improve quality integrated SRH services, UNFPA supported the following:</p> <ul style="list-style-type: none"> <u>Midwifery training (Human resource for Health)</u>: UNFPA has been supporting MoHCC in midwifery training for a long time and has established e-learning systems at 22 schools of midwifery. This started off with 6 pilot schools - Chinhoyi, Mpilo, Sally Mugabe, St. Lukes, Karanda and Masvingo. After the revision of the <u>e-MPDNS</u>, the electric module of the forms was configured in the MoHCC DHIS2 and 76 participants underwent a TOT on using the e-MPDNS. <u>Comprehensive Abortion Care (CAC)</u>: To enhance healthcare workers' knowledge and skills, the UNFPA Supplies Partnership supported the training of 214 healthcare workers (doctors, nurses and midwives) in CAC during 2024, capacitating them in safe abortion care and post-abortion contraception. The health workers were from 68 facilities across 8 rural provinces. Support was also given for printing revised CAC guidelines <u>HRB approach to FP</u>: UNFPA and its partnership with the ZNFPC capacitated Provincial and District health executives on the HRB approach to FP as part of improving the provision of quality services. <u>Supply chain management and quality assurance</u>: Through UNFPA support, a total of 150 health facilities were capacitated in the eLMIS bringing to a total of 1400 (out of approximately 1800, ~77.8 per cent) health facilities across the country utilizing e-LMIS during 2024. 			<ul style="list-style-type: none"> KIIs with CO staff; MoHCC officials Document review of COARs
<p>EQ5: To what extent has UNFPA Zimbabwe strategies on SRHR, GBV, AYP and PD achieved the intended outcomes for the different target groups making sure that no one is left behind? In particular: (ii) empowerment of adolescents and youth to access SRH services and exercise their sexual and reproductive rights?</p>			
Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
Assumption 5.2: UNFPA Zimbabwe	Extent to which the improvements in ASRH services	Relevant policy and strategy documents	Document review



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
<p>ensured that comprehensive, gender-sensitive, high-quality ASRH services are in place and accessible with a focus on AYP to exercise their sexual and reproductive rights.</p>	<p>is/are a contribution from UNFPA interventions</p>	<p>that were developed or revised (Reproductive health strategy, Reproductive normative tools, guidelines, strategies)</p> <ul style="list-style-type: none"> ▫ Relevant national and district data sources for service and outcome indicators: ZDHS. MICS, DHIS and COARs ▫ Key informants. 	<ul style="list-style-type: none"> ▫ Interviews with UNFPA CO staff, Implementation Partners & other partners ▫ Interviews with key GoZ officials in line Ministries and Departments; Provincial and Districts officials
	<ul style="list-style-type: none"> ▫ Extent of strengthening the capacities at national and district levels, to improve the quality of ASRH services during the 8th CP 	<p>Strengthening the capacities</p> <ul style="list-style-type: none"> ▫ Reports of policy and planning level seminar / workshop ▫ Minutes of relevant policy and planning level meetings ▫ Training modules, that were revised ▫ Training modules that were produced ▫ Training reports ▫ UNFPA reports on capacity building initiatives and events ▫ Key informants. 	<ul style="list-style-type: none"> ▫ Document review ▫ Interviews with UNFPA CO staff, Implementation Partners & other partners ▫ Interviews with key GoZ officials in line Ministries and Departments; Provincial and Districts officials
	<ul style="list-style-type: none"> ▫ Extent to which the ASRH service delivery output / outcome indicators are improved. 	<ul style="list-style-type: none"> ▫ Service delivery improvement: Relevant national and district data sources for service and outcome indicators: ZDHS. MICS, DHIS and COARs ▫ Key informants. 	<ul style="list-style-type: none"> ▫ Document review ▫ Interviews with UNFPA CO staff, Implementation Partners & other partners.
<p>Data collected: Adolescents and young people</p>			<p>Sources of information:</p>
<ul style="list-style-type: none"> • UNFPA has extensively supported CSE in schools, including the development of interactive radio programmes (especially crucial during COVID-19 lockdowns) and the creation and distribution of "fit for life" books to schools. There was delivery of training to facilitators to effectively deliver CSE 			<p>Interviews with UNFPA. MOPSE, SAYWHAT, PSZ, MOHCC</p>



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
<p>sessions.</p> <ul style="list-style-type: none"> The Life Skills Empowerment Strategy (2018-2025), developed and regularly reviewed with UNFPA support, guides the implementation of guidance, counselling, and CSE, ensuring a structured approach to youth development. UNFPA has sponsored national school quiz competitions for six years, involving both primary and secondary sessions and including hearing-impaired students. UNFPA also covered the payments for ZBC TV screening of these programmes, broadening their reach. MoPSE with UNFPA's support, conducted practical assessments on guidance and counselling through supportive visits to model schools for CSE, involving joint monitoring to ensure quality and adherence 			<p>FGD with Manicaland State University</p>
<ul style="list-style-type: none"> SAYWHAT, IP, engaged in the Reproductive Health and Advocacy Project in tertiary institutions, focusing on strengthening access to quality SRH and GBV information and services, and increasing their uptake among students. SAYWHAT also supported students and young people outside of tertiary institutions to participate in consultative meetings and advocacy initiatives, such as the ASRH forum, ensuring youth voices contribute to decision-making and advocacy. It trained peer educators under the programme and they have gained critical life skills, including teamwork, responsibility, and accountability. They utilize social media engagement and digital resources like the "Smart learners app" to disseminate accurate SRH/HIV/GBV information, even maintaining engagement during school holidays. A key success of the programme includes peer educators successfully running a "Safer Campuses Campaign (2025)," which resulted in increased student participation in SRH meetings and positioned peer educators as trusted sources for SRHR/HIV/GBV information. Almost 90 per cent of primary health facilities have been certified Youth friendly enabling AYP to access services. This was enabled by training of health workers and support for the certification process which facilitated improvements at facilities to get certification. 			<p>Interviews with UNFPA. MOPSE, SAYWHAT, PSZ</p>
<ul style="list-style-type: none"> Direct support for mobile integrated SRHR/GBV/HIV services in tertiary institutions enhanced access for these services to young people in these environments. 			<p>Interviews with Peer Educators/Counsellors MSU, MTC, SAYWHAT</p>
<ul style="list-style-type: none"> KPs benefited from improved service provision through service centres established through the Global fund and partnerships with the CeSHHAR. 			<p>Interview with UNFPA Document review: annual reports</p>
<p>EQ5: To what extent has UNFPA Zimbabwe strategies on SRHR, GBV, AYP and PD achieved the intended outcomes for the different target groups making sure that no one is left behind? In particular: (iii) advancement of gender equality and the empowerment of all women and girls?</p>			
<p>Assumption 5.3: UNFPA Zimbabwe strategies on GBV, successfully achieved the intended outcome (i.e. ending GBV and HP) for the different target groups making sure that no one is left behind and</p>	<p>Degree of completion of GEWE-related outputs planned in the M&E Framework against indicators</p>	<ul style="list-style-type: none"> UNFPA strategic and annual reports (CP documents, output reports, midterm reviews) Relevant national and district data sources for service and outcome 	<ul style="list-style-type: none"> Document review (programme documents, M&E reports) Interviews with UNFPA CO staff, IPs and other partners



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
<p>in particular advancement of gender equality and the empowerment of all women and girls.</p>		<p>indicators: ZDHS, MICS, DHIS and COARs</p> <ul style="list-style-type: none"> ▫ UNFPA monitoring framework ▫ National GBV and gender equality policies and frameworks ▫ Administrative and health service data (police, health facilities, OSCs) ▫ Key informants ▫ Rights holders/beneficiaries 	<ul style="list-style-type: none"> ▫ Interviews with relevant government ministries and departments, provincial and district ▫ Observation.
	<ul style="list-style-type: none"> ▫ Evidence that completed GEWE outputs contributed to planned outcomes 	<ul style="list-style-type: none"> ▫ UNFPA M&E Framework and output completion records ▫ Reports from IPs and civil society organizations. ▫ Government reports from Ministries and departments ▫ Client satisfaction survey reports ▫ Administrative and service utilization data ▫ Key informants ▫ Rights holders/beneficiaries. 	<ul style="list-style-type: none"> ▫ Document Review (M&E reports; service utilization statistics) ▫ Interviews with UNFPA CO staff, IPs and other partners ▫ Interviews with beneficiaries (women and girls) ▫ Observation.
<p>Data collected: GBV and HP</p>			<p>Sources of information:</p>
<ul style="list-style-type: none"> ● UNFPA contributed to national gender equality and GBV policy frameworks, including the review of the National Gender Policy, High Level Political Compact, National GBV Strategy (2023-2030) and support to the Domestic Violence Act implementation and GBV Coordination at national, provincial and district level. 			<ul style="list-style-type: none"> ● KIIs with beneficiaries, multisectoral stakeholders ● Document review of AWP, COARs



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
<ul style="list-style-type: none"> Through its technical and financial support, UNFPA strengthened national commitments to GEWE under the ZUNSDCF and aligned the programming with regional and international instruments such as Southern Africa Development Cooperation (SADC) Protocol on Gender and SDG 5. The Spotlight Initiative significantly enhanced access to GBV-related services, particularly in peripheral and remote communities that had historically been left out of interventions. Unlike previous programmes that mainly focused on central or urban areas, Spotlight deliberately targeted hard-to-reach locations. Although full geographic coverage was not achieved, it remains the only programme, to date, that has successfully extended services to these communities. The initiative was described by stakeholders as a “breakthrough” for the Ministry, helping to decentralize GBV prevention and response activities. The Integrated SRHR-GBV service delivery models (e.g., static and mobile OSCs and health facility integration) were scaled up, contributing to enhanced uptake of services by women and adolescent girls, especially in humanitarian contexts. UNFPA and its partners (OCHA, MWACSMED, Musasa, UN agencies, CSOs) successfully increased access to survivor-centred GBV services, including clinical care, dignity kits, psychosocial support, legal aid, and safe shelter, particularly in emergency-affected districts. However, while these have been commended by many stakeholders, some have expressed that MOSCs are not always suitable due to privacy concerns. Furthermore, the placement of police officers inside clinics in some OSCs that were observed, may discourage survivors from accessing care if they are unwilling to report incidents. UNFPA supported community engagement efforts that challenged harmful gender norms and practices, such as early marriage and intimate partner violence. These included community dialogues, male engagement strategies, and life skills programmes. However, coverage remained limited, and barriers persisted in reaching persons living with disabilities. This was partly due to funding constraints, which limited the scale and reach of inclusive programming. In some cases, programmes were not fully designed or adapted to address the specific needs of persons with disabilities (PWDs), particularly girls, resulting in gaps in accessibility, communication, and service delivery. Additionally, the lack of disability-specific expertise among IPs and frontline service providers further constrained effective inclusion. Evidence from the UNFPA 2024 Annual Report shows that most GEWE-related output indicators were either achieved or exceeded, including the expansion of multisectoral GBV services (188,583 survivors reached), large-scale community engagement for gender norm transformation (over 1.9 million individuals reached), and institutional strengthening through curriculum reform in eight universities. While several capacity-building outputs such as in-service training for social workers and community awareness baselines were not yet achieved, these are scheduled for implementation in 2025 and supported by foundational work completed in 2024. Overall, the outputs delivered to-date demonstrate a strong contribution to GEWE outcomes, particularly in improving access to survivor-centred services, promoting positive gender norms, and laying the groundwork for sustainable system-wide change. 			<ul style="list-style-type: none"> KIIs with UNFPA CO staff, IPs and other partners FGDs with beneficiaries and multi-sectoral stakeholders



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
<p>Quote</p> <p><i>“Because we had support from UNFPA and other partners traditional leaders came with by-laws that led to the “Not in my Village campaign”. The by-laws were then adopted by the whole province, but they started in Shamva. We have done advocacy meetings with chiefs and different stakeholders talking about the challenges we had. This all comes from the effects of the multi-sectoral approach that has improved joint working,” narrated a KI stakeholder in Shamva District.</i></p>			
<p>In Shamva district,</p> <ul style="list-style-type: none"> UNFPA-supported partners, including AWET and FACT, conducted community dialogues, GBV awareness campaigns, and distributed hygiene kits to girls, increasing community knowledge and service uptake. Through UNFPA support, safe spaces and social behaviour change interventions were strengthened, contributing to improved GBV case identification and referral. UNFPA’s backing of advocacy events like the 16 Days of Activism enhanced awareness of GBV and related laws, helping increase reporting and community engagement. 			<p>KIIs with IP, MWACSMED</p>
<p>EQ5: To what extent has UNFPA Zimbabwe strategies on SRHR, GBV, AYP and PD achieved the intended outcomes for the different target groups making sure that no one is left behind? In particular: (iv) increased use of population data in the development of evidence-based national development plans, policies and programmes?</p>			
Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
<p>Assumption 5.4: UNFPA Zimbabwe strategies on PD achieved the intended outcomes for the different target groups making sure that no one is left behind in particular the increased use of population data in the development of evidence-based national development plans, policies and programmes.</p>	<ul style="list-style-type: none"> The extent to which outputs in CP8 are likely to have contributed to outcome results Evidence that data in planning and monitoring frameworks, at the national/ district level and at UNFPA office is disaggregated by different dimensions reflecting a variety of beneficiaries/ participants, including those furthest behind Evidence of data before it was improved along disaggregation lines Extent to which the LNOB approach was integrated into national data systems? Extent to which the evidence generated by UNFPA 	<ul style="list-style-type: none"> AWPs and COARs Relevant programme, project and institutional reports of stakeholders UNFPA CO staff GoZ line ministries, and IPs (ZIMSTAT) National/district data (ZDHS, MICS, DHIS, planning and monitoring units’ data) IP partner reports UNFPA Annual reports 2022- 2024) UNFPA monitoring framework 	<ul style="list-style-type: none"> Document review of Planning and Monitoring frameworks of relevant departments and organizations where UNFPA extended support for improvement in data. Interviews with ZIMSTAT; Ministry of Finance, Economic Development and Investment Promotion; academic institutions Interviews with relevant staff from M&E and planning units of the line departments and organizations



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
	<p>or other stakeholders was used in policies, programming etc.</p>	<ul style="list-style-type: none"> ▫ P&D Government departments ▫ Population Planning Departments ▫ M&E frameworks of departments/ organizations where data was improved. ▫ UNFPA CO staff ▫ Key informants. 	
<p>Data collected: Population and Development</p>			<p>Sources of information:</p>
<p>With financial and technical support from UNFPA, the 2022 PHC was successfully conducted and preliminary results released to users and the general public in a timely manner. Additional support was received from UNECA.</p> <ul style="list-style-type: none"> ● With support from the UNPRPD and UNESCO, UNDP UNFPA, ZIMSTAT and Department of Disability affairs collaboratively embedded the 6 Washington Group of Questions in the PHC to collect information on PWDs in compliance with the provisions of the UNPRPD. ● The Computer Assisted Personal Interviewing (CAPI) method of data collection was used for the first time in a census operation and was handy in the timeliness of data collection. ● Census field mapping was completed on time, with more than 40,000 Enumeration Areas (EAs) demarcated and mapped, thereby facilitating the recruitment, training and subsequent deployment of about 50,000 field staff for the census enumeration by April. ● Preliminary results, which were more detailed than in previous censuses in terms of themes covered and the depth of the analysis, were released within three months of the completion of data collection as planned and are accessible on the ZIMSTAT website (http://www.zimstat.co.zw). ● The results were widely reported in mainstream and social media, both print and electronic, and were used by the Zimbabwe Electoral Commission (ZEC) in the Constitutional Delimitation of Electoral Boundaries for the 2023 Harmonized General Elections. ● The results, which were included as an Annex to the National Budget Statement 2023, were also used by the Ministry of Finance and Economic Development and Investment in crafting the 2023 National Budget. ● A draft national report on the final census results was in place at the end of 2022. ● A Post Enumeration Survey (PES) was successfully conducted, which evaluated the quality of the census in terms of both coverage and content errors, and a report was produced. ● In 2023, UNFPA supported ZIMSTAT to print census reports for further dissemination in the provinces. 			<p>Literature review: 2022 Annual Report – Zimbabwe Finalized - 30 Jan. 2023; 2022 Annual Planning – Zimbabwe Finalized - 01 Apr. 2022; COAR; 2023 Annual Planning – Zimbabwe Finalized - 13 Jul. 2023; 2023 Annual Report – Zimbabwe Finalized - 19 Jan. 2024</p> <p>KIIs with ZIMSTAT; UNFPA CO.</p>



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
<ul style="list-style-type: none"> • Micro data shared (anonymized) for census. • Every survey is disseminated both physical and virtual dissemination. • There is a mobile App for census data. • Challenge: One problem in terms of monitoring. The data was coming straight from the enumerator to the data serve at national level. There is need for ZIMSTAT Provincial Managers and supervisors to have an interface with the data to check for quality before it is sent to the HQ to ensure there is pre-run of the tables to identify current data errors. When this issue was eventually raised during census data collection, ZIMSTAT introduced field check tables. <p><i>“We used CAPI for data collection: It is the best as it improves the data quality. Removes the human error on skip patterns or wrong reasons. Its faster,” said a KI respondent at provincial level.</i></p> <p><i>“Data goes straight to the server in Harare. We need a situation where we have the Survey Solution design where the provincial team leader can see the data feedback to the team before it goes to Harare. This would need to be applied to all surveys including census,” narrated a KI respondent at provincial level.</i></p>			
<p>UNFPA contributed to a successful implementation of the Zimbabwe Demographic and Health Survey 2023/2024 (ZDHS). In 2024, UN Women, UNICEF, UNFPA, UNDP, UNESCO, and ITU, collaborated with the GoZ to enhance data systems for monitoring SDGs and promoting inclusive policies.</p> <ul style="list-style-type: none"> • Ideally, a Demographic Health Survey (DHS) should take place in a country every 5 years, to enable regular monitoring of these key indicators. However, the last DHS in Zimbabwe took place in 2015. The subsequent DHS 2020 was delayed due to the COVID-19 pandemic. • Further delays were due to the conducting of the 2022 PHC and subsequent harmonized national elections in 2023. • Through the support from the GoZ and the Health Resilience Fund (HRF), UNFPA in collaboration with Global Fund and USAID supported ZIMSTAT to carry out the ZDHS in 2023/24. • Household listing was done, enumerators were trained and data collection commenced in 2023 and completed in Mid-May 2024. • ICF provided TA through The DHS Programme, a USAID-funded project offering support and TA in the implementation of population and health surveys in countries worldwide. Support for dissemination was received from UNFPA. • The information collected through the 2023–24 ZDHS will assist policymakers and programme managers in designing and evaluating programmes and strategies for improving the health of Zimbabwe’s population. • The survey also provides indicators for monitoring progress towards the 8th CP’s outcome and impact level indicators, national goals and global commitments such as the SDGs. 			<p>Literature review: 2023 Annual Planning – Zimbabwe Finalized - 13 Jul. 2023; 2023 Annual Report – Zimbabwe Finalized - 19 Jan. 2024; The HRF Joint Programme 2023 Annual Report; ZDHS 2023-24; HRF Annual Report Final Draft 2024; UN Zimbabwe. Annual Report 2024.</p> <p>KIIs with ZIMSTAT; UNFPA CO.</p>



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
<ul style="list-style-type: none"> The 2023/2024 ZDHS was fully launched in June 2025. Challenge: Lack of disaggregation to district level data e.g. maternal mortality which is indicated at national level and not provincial and district levels. There is reliance on extended analysis hence the need for administrative data. 			
<p>MICS</p> <ul style="list-style-type: none"> The MICS was delayed due to the COVID-19 pandemic. The main funder of the MICS is UNICEF with technical support from UNFPA. At the time of the fieldwork for the CPE, training was undertaken on Paper Assisted Personal Interviewing (PAPI) with the CAPI expected to commence thereafter. At the time of this CPE, MICS survey was currently underway with household listing taking place. Data collection is expected to take place in September 2025. 			<p>Literature review: 2023 Annual Planning – Zimbabwe Finalized - 13 Jul. 2023; 2023 Annual Report – Zimbabwe Finalized - 19 Jan. 2024; UN Zimbabwe. Annual Report 2024</p> <p>KIIs with ZIMSTAT; UNFPA CO;</p>
<p>15 in-depth analysis reports out of a target of 28 (58 per cent) were developed from census, ZDHS and other surveys produced by 2024:</p> <ul style="list-style-type: none"> A total of 15 reports were produced by various UN agencies, with UNFPA successfully generating thematic reports on youth, disability, and fertility, using data from the 2022 census, offering valuable insights to inform evidence-based policy decisions. Additionally, a comprehensive analysis of maternal mortality was conducted, resulting in a report that highlights key trends and priority areas for intervention. The analysis showed trends in Infant, Child, Under 5 and Maternal mortality. Although there is a downward trend in these rates, they are still high and more needs to be done to reduce them further. UNICEF supported gendered analyses like the Women and Men Profile Reports, strengthening evidence-based, gender-responsive policymaking. UNICEF further supported the production of provincial and districts profiles, Additionally, UNICEF, ZIMSTAT, and other partners supported the development of 10 provincial, 90 district, and ward-level profiles using 51 SDG-aligned indicators, enabling targeted resource allocation and addressing inequalities to ensure equitable development Several analyses were done in 2022 using the Vital Medicines Availability and Health Survey (VMAHS) and HMIS data. Notable was the analysis of selected maternal health indicators which informed the HRF Concept Note and later updated to inform prioritization and geographical coverage of proposed interventions. The analysis also included SGBV survivors who visited health facilities within 72 hours for services. Collaboration strengthens Data Ecosystem: Multi-stakeholder partnerships, including ZIMSTAT and the MoHCC, played a crucial role in producing key reports, such as the 2023/24 ZDHS Key Indicator Report, thereby improving access to reliable data for policymaking. Challenge: Despite significant progress, financial constraints continue to be a major barrier to fully achieving UNFPA's PD goals in Zimbabwe. Insufficient funding has consistently hindered the production and dissemination of data, limiting decision-makers' ability to utilize critical information for evidence-based planning and policy formulation. These financial limitations restrict access to timely and comprehensive 			<p>Literature review: 2022 Annual Report – Zimbabwe Finalized - 30 Jan. 2023; 2022 Annual Planning – Zimbabwe Finalized - 01 Apr. 2022; COAR; 2023 Annual Planning – Zimbabwe Finalized - 13 Jul. 2023; 2023 Annual Report – Zimbabwe Finalized - 19 Jan. 2024; 2024 Results and Resources Plan for Zimbabwe; UNFPA Zimbabwe: 2024 Annual Report; UN Zimbabwe. Annual Report 2024.</p> <p>KIIs with ZIMSTAT; UNFPA CO.</p>



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
<p>population data, thereby impacting strategic interventions.</p>			
<p>Support for Vital Statistics</p> <ul style="list-style-type: none"> ● Currently receiving funding on vital statistics from Vital Strategies and UNFPA has supported, specifically, data capture to ensure that backlogs are cleared. ● Vital Statistics Reports - Births and Mortality Reports - are to be developed in 2025 ● Contributions to digital connectivity - The digitalized civil registration improved birth registration. A new system was developed where ZIMSTAT now captures birth and deaths at district level for the production of the vital statistics reports that were being produced). In Manicaland Province, for example births and deaths data from 2023 to 2025 has been recorded. ● The other administrative data captured is from prisons (inmates, those discharged and disaggregated by sex). Data captured goes direct to the ZIMSTAT server. ● Migration data - exit cards for immigration/cross border data. This is uploaded directly to ZIMSTAT server. ● GBV data comes from Police but through the Police General HQ – more at national level. ● Higher and tertiary institutions: collecting data from nursing schools (enrolment by sex - 2025). For vocational and tertiary institutions (polytechnic, nursing, agriculture, teachers, colleges, vocational and universities) the data was coming late, or some institutions were not sending at all to the MoPSE. ● Mashonaland Central: collecting births and deaths data at the Registrar’s Office since the beginning of the year. Collect data from files, captured via tablets and uploaded to the server. <p>Quote <i>“We are capturing data from 2022 and currently almost catching up (Guruve and Mbire now capturing data for 2025). We are still behind but by the end of year we will be on track,”</i> narrated a KI respondent at provincial level.</p> <ul style="list-style-type: none"> ● Other administrative data collected include: <ul style="list-style-type: none"> ○ Price surveys for inflation rate calculation - mostly done in district capitals monthly. ○ A livestock and crop survey - listing done and not the actual data for the livestock and crop survey. ○ Quarterly employment statistics - questionnaires are sent to companies and collected at the end of the quarter. This data is usually 			<p>Literature review: UN Zimbabwe. Annual Report 2024; 2025 Q1 ZIMSTAT Workplan</p> <p>KIIs with ZIMSTAT; UNFPA CO;</p>



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
<p>complemented with a survey but only done for Q1 due to funding challenges.</p> <ul style="list-style-type: none"> ○ Industrial production is done on a yearly basis. An economic census covering all business units in the province was completed. ○ Prisons statistics on incarceration, and discharges etc (provincial level). Offences statistics are from head office. ○ GBV statistics are provided from the offences statistics. VFU submits statistics directly to Police headquarters. ● Challenge: The Registrar General’s office was not part of the mobile OSC, which was important to provide vital registration services. The reason for exclusion was budgeting issues. ● CP9: Funding for strengthening Vital Statistics systems. 			
<p>Proportion of (UNFPA-selected) SDG indicators with up-to-date data (not more than 5 years old).</p> <p>The percentage of UNFPA selected SDG indicators with up-to-date data increased from a baseline of 65 per cent at the beginning of the year to 85.5 per cent as of 2025. This was attributed to new data which was collected for the first time in the 2022 PHC, such as data on women who got into marriage or union before the age of 18 years and data on death registration. In total, the 2022 PHC provided data on 24 SDG indicators,</p> <ul style="list-style-type: none"> ● 195 indicators out of the 228 applicable to Zimbabwe were uploaded. ● The 2022 PHC provides data on 24 SDG indicators, NDS1-prioritised target populations and UN-supported interventions on nutrition and food security, education, reproductive health, adolescents and young persons, vaccination, and social protection. ● In 2024, the ZDHS Key Indicator Report was successfully produced and disseminated, providing critical insights into population and health trends essential for tracking SDG indicators and maintaining an up-to-date monitoring database. The findings revealed ongoing challenges, including high teenage pregnancy rates (23 per cent), an unmet need for FP (14.6 per cent), and gaps in maternal health services. Child mortality also remains a concern, with neonatal mortality at 37 per 1,000 live births. ● Additionally, the programme successfully collaborated with ICPD task forces to assess progress and identify critical PD concerns. This collaboration resulted in a comprehensive progress report outlining key recommendations across various sectors to advance the ICPD agenda. ● The SDG/ICPD/ transformative results data platform/dashboard is up and running with support from ZIMSTAT https://sdg-zimstat.github.io/ 			<p>Literature review: 2022 Annual Report – Zimbabwe Finalized - 30 Jan. 2023; 2022 Annual Planning – Zimbabwe Finalized - 01 Apr. 2022; COAR; 2024 Results and Resources Plan for Zimbabwe; UNFPA Zimbabwe: 2024 Annual Report.</p> <p>KIIs with ZIMSTAT; UNFPA CO.</p>
<p>Existence of an interactive data platform with indicators on transformative results, SDGs and NDS1.</p> <ul style="list-style-type: none"> ● While the data platform was not yet operational in 2022, data on all the relevant UNFPA-related SDG indicators, transformative results and UNSDCF indicators were updated using the 2022 census results and other data sources. 			<p>Literature review: 2022 Annual Report – Zimbabwe Finalized - 30 Jan. 2023; 2022 Annual Planning – Zimbabwe Finalized - 01 Apr. 2022; COAR; 2024 Results</p>



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
<ul style="list-style-type: none"> In 2024, a dedicated GitHub repository and platform for SDG support and reporting was successfully developed in collaboration with ZIMSTAT. This platform serves as a crucial resource for developers and researchers, offering country-specific data and real-time tracking of Zimbabwe’s progress on the SDGs. The time of this CPE, UNFPA was currently working with ZIMSTAT to support the dashboards to include the Zimbabwe data portals and to continuously update the platform. 			<p>and Resources Plan for Zimbabwe; UNFPA Zimbabwe: 2024 Annual Report.</p> <p>KIIs with ZIMSTAT; UNFPA CO.</p>
<p>Availability of a National Development Plan that integrates recommendations from the DD Study.</p> <ul style="list-style-type: none"> UNFPA supported a study on harnessing the DD in 2017. The study identified four key pillars to attain the DD namely: Health and Well-being, Education and Skills Development, Employment and Entrepreneurship, Governance and Economic Reforms Zimbabwe’s NDS1 (2021–2025) addresses the idea of a demographic dividend, highlighting it as a key opportunity should the right policies be implemented. key highlights in the NDS 1 relating to demographic dividend are on 1) human capital development, Youth empowerment, women empowerment and health pillar. The findings of the DD Study will continue to underpin the National Development Plan (NDS2 2026-2030). 			<p>Literature review: (chrome-extension://efaidnbmnribpcajpcglclefindmkaj/https://zimbabwe.unfpa.org/sites/default/files/pubpdf/Harnessing%20the%20Demographic%20Dividend%20Study%20Report.pdf)</p> <p>Theory of Change.</p> <p>KII with UNFPA CO</p>
<p>Increased efforts to provide disaggregated data.</p> <ul style="list-style-type: none"> The disaggregation of census data by sex, age, disability (the Washington questions on disability incorporated in census), and geographic location right up to the lowest administrative level facilitates the realization of government’s policy thrust of “leaving no one and no place behind”. The census results showed among other things a growing population growth rate, slightly rising fertility, increasing life expectancy at birth, increasing urbanization, declining mortality (including maternal mortality), and high unemployment among the youths, which informed policy and decision making on implementation of current programmes. The ZDHS data is disaggregated by age, sex, geographic location and disability (the Washington questions on disability incorporated in the survey). Positive information on social protection data – census, ZDHS and MICS. Gap in Disability disaggregation: MoHCC tools were not configured to capture data on PLWDs. The data collection forms do not ask for disability. DHISII does not have PLWDs either. This has limited information on disability inclusion. Need to customize data collection tools. MWACSMED indicated that there are still some gaps in disability disaggregated data: GBV data collected indicates sex (male or female) but not disaggregated by disability or age especially for the elderly. Data disaggregation/interpretation: Lack of disaggregation to district level data e.g. maternal mortality which is at national level and not provincial and district levels. Reliance on extended analysis hence the need for administrative data. 			<p>Literature review: 2022 Annual Report – Zimbabwe Finalized - 30 Jan. 2023; 2022 Annual Planning – Zimbabwe Finalized - 01 Apr. 2022; COAR; 2023 Annual Planning – Zimbabwe Finalized - 13 Jul. 2023; 2023 Annual Report – Zimbabwe Finalized - 19 Jan. 2024</p> <p>KIIs with ZIMSTAT; MOHCC; MWACSMED; UNFPA CO; UNICEF;</p>



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
<ul style="list-style-type: none"> Samples were sufficient at provincial than district level. Only the census covers the district level. 			
<p>Innovation and Digitalization</p> <ul style="list-style-type: none"> Post partum hemorrhage contributes 25 per cent of maternal mortality. UNFPA, in partnership with WHO introduced E-MOTIVE contextualized to Zimbabwe. UNFPA sourced funds for EmONC materials. UNFPA supported the review of EmONC National Guidelines to include E-MOTIVE, followed by the procurement of sundries to support the implementation of E-MOTIVE. E-MOTIVE training on how mothers and children can survive was done - measurement and management of clients. Accurately measure from pre-labour, labour to post-partum. It allows for quick response to challenges. Working well. Successful data capture. MoHCC eLMIS - Electronic records are supporting the commodities status – redistribution of drugs. WHO assisted MoHCC to introduce the Digital Adaptation System collecting all indicators that are not in DHIS. 'Impilo' to be used together with the Impilo Platform. Challenges: <ul style="list-style-type: none"> Limited digitalization support from UNFPA to MoHCC. The system in MoHCC is still paper-based and does not capture all indicators. Staff have not been trained yet on electronic health records (EHR) M&E tools and M&E reporting frame were being reviewed at different times, causing problems in aligning data in both tools and the reporting frame. For example, the ANC registers and the Mother/Baby Pair. It was noted that few partners have innovation and technology (digital adaptation). CP9: Innovation – digitalization as an accelerator in the next programme. Scaling up for impact. Digitalization across all programme components. E-MOTIVE (health digitalization) across all focus areas. There is need for digitalization support to MoHCC (e.g. for FP adaptation Kit; ANC digital adaptation Kit; Post-natal care digital adaptation Kit; and Self-Care digital adaptation Kit) Data collection and generation: There is a need for a system that is able to integrate various data sources in one data bank. Administrative 			<p>Literature review:</p> <p>KIIs with ZIMSTAT; MOHCC; WHO; UNFPA CO;</p>



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
data can cover in between surveys.			
EFFICIENCY EQ6: To what extent has UNFPA Zimbabwe used resources at its disposal efficiently to achieve the planned results following laid down policies and procedures of UNFPA and the GoZ?			
Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
<p>Assumption 6.1: The IPs received UNFPA financial and technical support as planned and in a timely manner, and UNFPA was able to mobilize appropriate resources in a timely manner to support the implementation of the 8th CP.</p>	<ul style="list-style-type: none"> ▫ Evidence that the planned resources were received to the foreseen level in AWP ▫ Evidence that the resources were received in a timely manner ▫ Evidence of adequacy of resources (financial, personnel etc.) to deliver the programme’s outputs /results ▫ Evidence of coordination and complementarity among the programme components of UNFPA and coherence among government ministries ▫ Evidence of progress towards the delivery of multi-year, predictable, core funding delivered to IPs ▫ Evidence of appropriateness of the IPs selected to deliver the results ▫ Evidence of timely transfer of funds ▫ Evidence of effective mechanisms to control waste and fraud ▫ Evidence that inefficiencies were identified and corrected in a timely manner ▫ Evidence that technology was introduced & that it improved efficiency pertaining to office activities and programme implementation. 	<ul style="list-style-type: none"> ▫ AWP ▫ COARs ▫ Relevant programme, administrative and financial management documents including: <ul style="list-style-type: none"> ▫ IP standard progress reports ▫ Financial reports from implementing partners, and UNFPA (Cognos reports) ▫ Audit reports for selected IPs, who received budgetary support ▫ Field monitoring visit reports ▫ Stakeholders at national level including: <ul style="list-style-type: none"> - UNFPA staff (including programme, finance/ administrative departments) - Representatives of IPs (Head offices) - Representatives of donors - Other UN agencies (e.g. UNCT, UNDP, UNICEF, UNAIDS, WHO, UN Women, FAO) ▫ Government ministries, departments and 	<ul style="list-style-type: none"> ▫ Documentary review: financial documents at the UNFPA CO ▫ Interviews with administrative and financial staff ▫ Documentary review: annual reports from partner ministries, and IPs, ▫ Audit reports and monitoring reports ▫ Interviews with IPs from government (ministry level/ secretariat level/ organizational staff) ▫ Interviews with implementing NGO partners who received budgetary support ▫ Interviews with UNFPA CO staff ▫ Interviews with beneficiaries of funding (including NGOs) ▫ Interviews with UNFPA administrative staff, government and NGOs, ▫ Interviews with donors on the coordination, complementarity of implementation, and leveraging of national resources.



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
		agencies	
Data collected: SRHR			Sources of information:
Challenges with fund transfers and direct payments from UNFPA: <ul style="list-style-type: none"> Several IPs have expressed challenges related to fund transfers from UNFPA, noting that the delays in fund disbursement after annual work plans were approved, especially in quarter one. This led to pressure to utilize funds by the year-end, sometimes impacting the quality of results. IPs also mentioned issues with the new Quantum system, which still presented challenges in its second year of use, leading to funds being carried over to the next year and delaying programme implementation. Direct payments from UNFPA to service providers and participants also caused complaints due to long delays in payments, prompting discussions for funds to be disbursed directly to the partner for implementation. 			KIs with IPs e.g., Gov't ministries, NGOs
IP human resources and capacity: <ul style="list-style-type: none"> Stakeholders reported that UNFPA regularly carries out due diligence exercises on IPs to check on their technical capacity and financial management systems. The IPs were selected based on their technical expertise and comparative advantage to deliver SHR interventions. 			KIs with IP staff, UNFPA CO staff
Data collected: Adolescents and young people			Sources of information:
<ul style="list-style-type: none"> Disbursements were consistently late, often experiencing 5-6 month delays due to the complex process of reporting, regional office clearance, and donor approval. The MoPSE also reported challenges with late payments for activities and per diems for participants, which undermined programme implementation and risked limiting government stakeholder participation and access to quality content. Similarly, the Global Fund reports frequently cited delays in fund disbursement as a major factor affecting the timely implementation of planned activities for the MSM programme throughout 2022 and 2023. Population Services Zimbabwe (PSZ) noted that these delays meant projects designed for 6 months sometimes had to be implemented in only 2 months, waiting long periods for approvals and disbursements. SAYWHAT also confirmed that late funding made planning difficult. UNFPA generally had sufficient staff capacity for the AYP interventions, utilizing UNVs and JPOs, with at least two people available at any given time. 			Interviews with UNFPA. MoPSE, SAYWHAT, PSZ
<ul style="list-style-type: none"> MoPSE felt that resources were inadequate to cover all provinces and learners, which could lead to accusations of favoritism if only a few areas were covered. SAYWHAT also noted that UNFPA's challenges in confirming funding availability made their own planning difficult. For the Global Fund's MSM programme, a lack of resources, particularly for transport, was identified as a factor limiting service uptake by MSM. However, the ZYC, as a government entity, reported leveraging its own contributions and other partnerships to supplement UNFPA funding. UNFPA's was observed by some stakeholders as being inflexible to quickly address emerging issues and allocated funds for specific activities. For instance, US\$ 4,000 for training of junior parliamentarians was sometimes cited as being too little to meet the need. 			Review of Annual Donor progress reports Interviews with UNFPA. MoPSE, SAYWHAT, PSZ, ZYC



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
<ul style="list-style-type: none"> UNFPA's leadership was credited for breaking 'silos' and fostering collaborative teamwork internally. However, PSZ noted a "silo approach" and duplication of services at the implementation level among partners, advocating better coordination by UNFPA to create "One-Stop Shop" service delivery points. PSZ indicated that UNFPA conducted due diligence and was satisfied with PSZ's capacity to deliver interventions. For KPs, UNFPA acted as a sub-recipient for the Global Fund, identifying local IPs such as GALZ, SRC, and CeSHHAR, demonstrating appropriate partner selection given the operating environment where LGBTQ+ organizations might face difficulties with direct government engagement. The pervasive delays in fund disbursements across various programmes, as detailed above, indicate a challenge in providing consistent multi-year, predictable core funding, as partners frequently experienced interruptions and uncertainty. In the MSM programme, a lack of alignment between Detailed Implementation Plan (DIP) activities and performance indicators was identified as an inefficiency factor. A "recovery plan" was subsequently submitted to the Global Fund, focusing on high-impact demand generation activities to improve service uptake for HIV testing and PrEP. This demonstrated efforts to identify and correct programmatic inefficiencies. MoPSE, however, highlighted UNFPA's inflexibility in responding quickly to emerging issues, which meant some urgent needs could not be addressed within the same programming year. 			Interviews with UNFPA CO. MoPSE, SAYWHAT, PSZ
<p>Data collected: GBV and HP</p>			<p>Sources of information:</p>
<ul style="list-style-type: none"> Most planned resources were delivered as per AWP, though some early-year delays were noted in fund disbursement. According to respondents, these delays were primarily attributed to challenges related to finalizing workplans and delays in financial and programmatic reporting by IPs, which in turn affected the timing of disbursements. Project implementation was occasionally hindered by delayed fund disbursement at the start of planning quarters, sometimes resulting in temporary suspension of activities. Through UNFPA support, some IP personnel have been trained on quantum reporting and capacitated in results-based management. UNFPA mobilized core and non-core resources, including multi-year funding (e.g. Takeda-funded "Women at the Centre"2024, Irish Aid HRF 2022-2025). However, since the beginning of 2025, the funding landscape has changed, there are funding cuts, and the current geopolitical climate have a severe impact on Gender and GBV programming in Zimbabwe. Coordination between UNFPA components and government ministries was strong, facilitated through the different TWGs. Stakeholders reported no major cases of financial mismanagement; and quality assurance mechanisms were in place. 			<ul style="list-style-type: none"> KIIs with IPs, MWACSMED, CO staff Document review: UNFPA annual reports
<ul style="list-style-type: none"> The IPs were selected based on their technical expertise, geographical reach, and alignment with programme objectives. Key partners such as Family Support Trust, Adult Rape Clinic, and Musasa were strategically chosen for their proven capacity to deliver GBV and SRHR interventions effectively. 			



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
<ul style="list-style-type: none"> Some stakeholders noted that following the cessation of funding from the Spotlight Initiative, there have been delays in salary payments and the supply of commodities, particularly in OSCs, which resulted in the temporary closure of some centres. However, a number of these centres have since reopened. Most stakeholders have suggested that there be an increase in the construction of static OSCs and shelters. An example is the government-run shelter in Tsholotsho a positive development that requires additional funding support to sustain its operations. 			<p>KIIs with MWACSMED, FST, IPs</p>
<p>Data collected: Population and Development</p>			<p>Sources of information:</p>
<ul style="list-style-type: none"> Tracking of activities being implemented. Use of CAPI in the census and ZDHS (efficient, timely, and improved data quality). Capacity Development of ZIMSTAT staff on the census processes improved efficiency. The funding landscape has changed. Funding for the PD programme was cited as generally low. Despite significant progress, financial constraints continue to be a major barrier to fully achieving UNFPA's PD goals in Zimbabwe. Insufficient funding has consistently hindered the production and dissemination of data, limiting decision-makers' ability to utilize critical information for evidence-based planning and policy formulation. These financial limitations have restricted access to timely and comprehensive population data, thereby impacting strategic interventions. Examples of activities not carried out or delayed due to lack of funding: <ul style="list-style-type: none"> Delayed dissemination of census reports. UNFPA funding declined in 2022. 2022 census had limited funding compared to 2012. The government funded the process. Limited in-depth analysis/fewer thematic reports from the census and major surveys. The engagement of a consultant to set up an SDG/ICPD/ transformative results data platform was delayed in 2022. The dissemination of the ZDHS findings was halted when money was recalled by ICF. Stakeholders reported that delays in government disbursements of funds affect timely implementation of activities. Disbursements go through the Development Project Management System for reporting on projects such as the SRHR projects; HIV/AIDS projects; and the Prevention of GBV/Violence against women. Stakeholders cited UNFPA communication or events being delayed when CO wants the involvement of the PS. The clearance process takes a lot of time due to the government bureaucracy. Delayed payment of DSA from UNFPA for the IPs. The issue of 20 per cent DSA being paid after the submission of the travel report - difficult 			<p>Literature review: 2022 Annual Report – Zimbabwe Finalized 30 Jan. 2023; 2023 Annual Report – Zimbabwe Finalized - 19 Jan. 2024; UNFPA ZIMBABWE: 2024 ANNUAL REPORT</p> <p>KII with ZIMSTAT; UNFPA CO; MoFEDIP;</p>



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
<p>system to pay applicants.</p> <ul style="list-style-type: none"> Delays in the transfer of funds for data collection (by enumerators). It was reported that data enumerators are typically only paid after completing data collection. This approach results in many enumerators having to fund their own transport and expenses upfront, which can compromise data quality. It was also reported that reimbursements often do not cover the actual costs incurred. Lack of systems for ZIMSTAT to utilize administrative data from ministries. Data is available but ZIMSTAT does not have the mandate on data sharing agreement– lack of data sharing agreements with other government departments. Limitation of the National Statistics System due to the limitations of the Census and Statistics Act. Results in underutilization of administrative data. Need to review the Census and Statistics Act. Review of the Act to be undertaken with the guidance of SADC. The lack of memorandums of understanding within institutions has made it difficult for data to be shared amongst institutions. The ZIMSTAT provincial offices are rarely involved in national-level decision-making processes, making it difficult for their operational challenges and context-specific needs to be acknowledged or addressed. Limited connectivity to the internet especially in the districts, and which affects real time checking. There is need for WiFi. Movement: At provincial level in terms of mobility, situation is okay but at the district level mobility is very restricted (it is important to have motorbikes for data collection). 			
<p>Assumption 6.2: UNFPA Zimbabwe followed the laid down policies and procedures (administrative, procurement and financial) of UNFPA and the GoZ, which led to the efficient achievement of programme outputs and outcomes.</p>	<ul style="list-style-type: none"> The planned inputs and resources were received by IPs as agreed upon with partners. Budget utilization rates per year Quality TA to build capacity was available to the level planned Evidence that TA increased capacity among IPs Evidence that efforts were made to identify inefficiencies in the 9th CP thematic area of programme and to correct them Evidence that qualified IPs with adequate capacity were selected for implementation of interventions in the 9th CP thematic areas of programming 	<ul style="list-style-type: none"> AWPs and COARs Relevant programme, administrative and financial management documents including: <ul style="list-style-type: none"> UNFPA financial management guidelines Financial reports from implementing partners, and UNFPA (Cognos reports) Field monitoring visit reports Stakeholders at national level including: 	<ul style="list-style-type: none"> Documentary review: financial documents at the UNFPA CO Interviews with administrative and financial staff Documentary review: annual reports from partner ministries, and IPs, Audit reports and monitoring reports Interviews with IPs from government (ministry level/ secretariat level/ organizational staff) Interviews with implementing NGO partners who received budgetary support



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
	<ul style="list-style-type: none"> ▫ The extent to which administrative, procurement and financial policies, rules and procedures were appropriate for timely and effective implementation, including in humanitarian settings. 	<ul style="list-style-type: none"> - UNFPA staff (including programme, finance/ administrative departments) - Representatives of IPs (Head offices) - Representatives of donors - Other UN agencies (e.g. UNCT, UNDP, UNICEF, UNAIDS, WHO, UN Women, FAO) ▫ Government ministries, departments and agencies 	<ul style="list-style-type: none"> ▫ Interviews with UNFPA CO staff ▫ Interviews with beneficiaries of funding (including NGOs) ▫ Interviews with UNFPA administrative staff, government and NGOs, ▫ Interviews with donors on the coordination, complementarity of implementation, and leveraging of national resources.
Data collected: SRHR			Sources of information:
<ul style="list-style-type: none"> ● Financial and administrative policies were generally adequate; The UNFPA resource management systems were followed to the book and were efficient to support timely implementation. 			KIIs with CO staff
<ul style="list-style-type: none"> ● The majority of stakeholders were of the view that the technical capacity of UNFPA staff was optimal and of a high standard. 			KIIs with IPs, MoHCC Directorates
<ul style="list-style-type: none"> ● UNFPA provided capacity building for health staff at all levels. However, the challenges are (a) the high turn-over of nurses and midwives going outside the country; (b) inadequate number at health facilities 			KIIs with IPs, MoHCC Directorates KIIs with frontline health staff at facilities
Data collected: Adolescents and young people			Sources of information:
<ul style="list-style-type: none"> ● While inputs were generally received by IPs, the timeliness was a consistent issue. Activities sometimes had to be "crammed" into shorter periods at the end of quarters due to late transfers of funds. ● The Global Fund Annual Report for 2022 showed a cumulative expenditure of 70.1 per cent of the approved budget for the MSM programme by the end of year 2. A Semester 6 financial analysis for UNFPA indicated that the expenditure incorporated some from Semester 5, leading to a negative balance and a need for a decision on disbursement or reversal of expenditure. 			KIIs with MoHCC, MoPSE, SAYWHAT, PSZ, ZYC Document review: annual reports
<p>There is substantial evidence of UNFPA providing TA and capacity building across various areas:</p> <ul style="list-style-type: none"> ● Supported the development of strategies, policies, and guidelines, and built the capacity of CSOs to enhance advocacy for appropriate policy and legal frameworks. 			



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
<ul style="list-style-type: none"> Strengthened the capacity of the YPNHW to vocalize issues affecting them. Supported CSOs with data and built bridges between Parliament and CSOs for youth-friendly budget consultations. Trained teachers on CSE, which empowered children and made them confident in reporting abuse. At the Bindura Hospital, UNFPA provided training for staff on FP, Long-Acting Reversible Contraceptives (LARCS), and the clinical management of SGBV survivors. They also supported capacity development for e-MOTIVE system. SAYWHAT reported that UNFPA strengthened health systems at the college level through capacity building of colleges and enhanced peer educators' capacities through training 			
<ul style="list-style-type: none"> MoPSE cited new payment systems causing delays and impacting participation. The "tiresome" and "very demanding" compliance requirements for the ministry's accountant were a significant burden. While PSZ found UNFPA supportive with financial management and the Quantum system for reporting, the overall experience with late disbursements and bureaucratic processes indicated that aspects of UNFPA's administrative and financial procedures hindered timely implementation of CP interventions. 			<p>KIIs with MoPSE</p> <p>KIIs with PSZ</p>
<p>Data collected: GBV and HP</p>			<p>Sources of information:</p>
<ul style="list-style-type: none"> Overall, UNFPA has had a good working relationship with its partners by timely disbursements of funds and capacity building. The partners are also trained on reporting using the UN system which makes reporting more efficient. 			<p>KIIs with IPs, CO staff</p>
<ul style="list-style-type: none"> Financial and administrative policies were generally adequate, including for fast-tracked processes in humanitarian contexts (e.g., mobile response services, dignity kits and supplies). 			<p>KIIs with IPs, OCHA</p>
<ul style="list-style-type: none"> TA was delivered through in-country advisors and short-term specialists, contributing to institutional strengthening of key IPs. 			<p>KIIs with IPs,</p>
<p>Data collected: Population and Development</p>			<p>Sources of information:</p>
<p>Capacity Development of ZIMSTAT</p> <ul style="list-style-type: none"> As part of data quality control and continued efforts in strengthening the capacity of ZIMSTAT, over seventy-five census staff (both subject matter persons and IT personnel), drawn from Data Quality Management Teams (DQMTs) established for the census, were trained on the use of STATA in analyzing census and household survey data. DQMTs were charged with the responsibility of downloading data from the central server on a daily basis and generating field check tables which were sent to provincial supervisors for analysis and detection of possible data errors and biases. 			<p>Literature review: 2022 Annual Report – Zimbabwe Finalized - 30 Jan. 2023; 2022 Annual Planning – Zimbabwe Finalized - 01 Apr. 2022; COAR;</p> <p>KIIs with ZIMSTAT; UNFPA CO.</p>



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
<ul style="list-style-type: none"> TA was provided to ZIMSTAT in the deployment of census CAPI Application and data processing system during enumeration as well as in the planning and execution of the Post Enumeration Survey (PES). 			
<p>SUSTAINABILITY EQ7: To what extent has UNFPA supported the establishment of local accountability and oversight systems to ensure sustainability and continuation of programmes that it is implementing?</p>			
<p>Assumption 7.1: UNFPA supported the establishment of effective local accountability and oversight systems to ensure sustainability and continuation of programmes that it was implementing.</p>	<ol style="list-style-type: none"> Evidence of UNFPA providing quality support for the establishment of local accountability and oversight systems to ensure sustainability and continuation of programmes Evidence for enhanced capacity of the Government and IPs at national and sub-national levels to implement interventions in the 8th CP thematic areas of programming without the technical support of UNFPA. Evidence of training of the beneficiaries to create demand for the 8th CP-supported services Evidence of government allocating resources to the 8th CP thematic activities e.g. government allocation of resources for RH commodities Evidence of localization and capacity building to undertake UNFPA-supported interventions Evidence of TA to the national and subnational level of governments 	<ul style="list-style-type: none"> IP AWP and reports UNFPA AWP and COARs <p>National level stakeholders:</p> <ul style="list-style-type: none"> UNFPA staff, Government, IP staff, and Heads of Directorates Relevant field level IPs Rights holders/beneficiaries. 	<ul style="list-style-type: none"> Documents review and analysis KIIs with IPs from government (ministry level/ secretariat level/ organizational staff) Interviews with implementing NGO partners who received budgetary support e.g Musasa, FACT, World Vision, Anti Rape Coalition, PSZ, SAYWHAT, Family Support Trust among others FGDs with community beneficiaries
<p>Data collected: SRHR</p>			<p>Sources of information:</p>
<ul style="list-style-type: none"> <u>Sustainable elements:</u> Stakeholders were of the view that among the sustainable elements are the following: <ul style="list-style-type: none"> The policies and guidelines developed with UNFPA support will continue to be used in the medium- and long-term period. 			<ul style="list-style-type: none"> KIIs with MoHCC Directorates KIIs with NGOs



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
<ul style="list-style-type: none"> ○ The health infrastructure (e.g., buildings, equipment) will continue to be used though Government at all levels need to commit adequate funds for maintenance. ○ Trained staff will continue to use the skills learnt from various capacity building initiatives. ○ UNFPA has worked mainly with existing government structures at all levels, which will allow health related interventions to continue. 			
<ul style="list-style-type: none"> ● <u>RH commodity security</u>: UNFPA has done a commendable job in advocating to GoZ on match funding of FP projects. This approach promotes the sustainability of FP programme. 			KIIs with MoHCC Directorates KIIs with CO staff
<ul style="list-style-type: none"> ● <u>E-learning system</u>: The government and the MoHCC need to commit to e-learning project in midwifery schools. The MoHCC needs government to come in and have some strategies to make sure the project is sustainable. There is commitment from Ministries of ICT and Finance to procure additional computers. The fact that students can access information from their phones they can continue to access from their phones. The health informatics – received funding to upgrade the systems for telemedicine... as long as UNFPA is there MoHCC is still happy. The ministry is hoping there will be sustainability in the programme. 			KIIs with MoHCC Directorates
<u>Concerns for sustainability</u> <ul style="list-style-type: none"> ● 			
Data collected: Adolescents and young people			Sources of information:
<ul style="list-style-type: none"> ● UNFPA has supported the development of various strategies, policies, and guidelines, which serve as foundational frameworks for programme continuation and accountability. There was strengthened institutional capacities through the development of guidelines, Standard Operating Procedures (SOPs), tools, and infrastructure development, all of which contribute to the continued provision of services. ● It was cited that teachers trained on CSE were now reportedly able to continue supporting CSE even after UNFPA's direct involvement concludes. ● Peer educators at Manicaland State University (MSU) gained critical life skills such as teamwork and accountability and were able to run campaigns²⁶. Continued "safe talks" by peer educators even without full SAYWHAT support also suggest sustained capacity. 			KIIs with UNFPA CO staff, ZYC, MOHCC, MOPSE, SAYWHAT FGDs with MSU Peer educators/counsellors
<ul style="list-style-type: none"> ● The chatbot line for CSE is now managed by the MoPSE, indicating successful transfer of operational capacity. ● UNFPA has strengthened the capacity of the YPNHW to enable them to advocate, design, implement, and monitor programmes. The "Not In My Village" campaign, which they co-created, is now being implemented and monitored by this youth network. The campaign also received a global innovation award for its engagement of traditional leaders to transform social norms. ● MoPSE has been capacitated on age-appropriate CSE in 26 districts. They developed handbooks for teachers to integrate gender and human 			KIIs with UNFPA, MoPSE FGD with Student Teachers



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
rights into CSE delivery.			
<ul style="list-style-type: none"> The capacity of the YPNHW was strengthened, enabling them to vocalize issues affecting young people. At Bindura Hospital, staff received training on FP, Long-Acting Reversible Contraceptives (LARCS), and clinical management of SGBV survivors. They now view the One-Stop Centre (OSC) as their responsibility, indicating increased ownership. 			Interviews with Bindura medical staff, Family Health, MoHCC
<p>Data collected: GBV and HP</p>			<p>Sources of information:</p>
<ul style="list-style-type: none"> Functional multisectoral GBV coordination structures were in place at both national and district levels, providing local accountability and enabling coordinated planning and implementation of GBV activities. UNFPA conducted a series of capacity-strengthening workshops for government, NGO, and CSO partners focused on GBV case management, reporting, and survivor-centred approaches. A GBV Case Management Curriculum was developed which will be an accredited course as part of the Social Work degree in 8 Universities. Community-level safe spaces were found to be operational, for example, in Bubi District, beneficiaries reported increased knowledge on GBV prevention and reporting as a result of Ministry-run safe spaces supported by UNFPA. It was reported that the OSCs are now managed by government institutions, with continued technical and financial support from UNFPA to ensure service quality and sustainability. Sustainability initiatives were also done at community level; an example being the community-based structures which were capacitated to identify and respond to GBV cases. Social and Behavioural Champions (SBCC) and Safe Space Peer Facilitators were trained on GBV, psychological first aid, referral pathways, and survivor-centered approaches. This was done through the Takeda and CERF project. Effective monitoring and support: In areas like Shamva and Bubi there is a shortage Ward Development Coordinators, which limits effective monitoring and support across all areas. Those coordinators who are in place face significant challenges due to a lack of essential resources such as transport, phones, and data. As a result, many are relying on their personal resources to carry out their duties. Addressing these resource gaps is crucial to strengthening local oversight and ensuring the sustainability of programme activities at the community level. Following the conclusion of UNFPA funding, the ARC successfully secured alternative funding from Oxfam and Higher life Foundation for the #72 campaign to continue. UNFPA supported livelihood and sustainability efforts for GBV survivors through initiatives such as chicken rearing, piggery, goat farming, and dishwashing liquid production. Survivors were provided with start-up kits to initiate income-generating activities, contributing to economic recovery 			<ul style="list-style-type: none"> Documents review and analysis KIIs with IPs from government Interviews with implementing NGO partners who received budgetary support e.g Musasa, Adult Rape Clinic, Family Support Trust FGDs with community beneficiaries, multisectoral stakeholders



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
<p>and long-term sustainability. Challenges included lack of proper infrastructure (e.g., secure fowl runs) and limited participation of persons with disabilities due to physical constraints. In some areas, survivors with disabilities relied on the support of relatives to sustain these initiatives.</p>			
<p>• It was reported that the OSCs are now managed by government institutions, with continued technical and financial support from UNFPA to ensure service quality and sustainability. The sustainability of OSCs in Zimbabwe is a critical concern as external funding under initiatives such as the Spotlight Initiative begins to phase out. While the GoZ has made commendable progress in integrating OSCs into national and subnational service delivery frameworks, significant challenges remain regarding long-term sustainability, standardization, and resource allocation.</p> <p>OSCs are currently supported through a hybrid model involving:</p> <ol style="list-style-type: none"> 1. Government contributions (in-kind resources, infrastructure, staff secondment from ministries such as Health, Social Welfare, and Justice) 2. UN agencies and donor funding (TA, operational costs, equipment, and capacity building) 3. Civil society partnerships, especially for community mobilization and referrals <p>Several OSCs operate from government health facilities or district hospitals, reflecting partial integration into the public service infrastructure. However, full operationalization still relies heavily on donor-funded staffing (e.g., counsellors, legal officers), utilities, and transport.</p> <p>Structure of OSCs and implications for service delivery: The structure and functionality of OSCs are not uniform across provinces and districts. Variability exists in:</p> <ul style="list-style-type: none"> • Physical infrastructure (some are standalone facilities, others embedded in hospitals or clinics) • Staffing and service availability (e.g., presence of legal aid officers, availability of 24-hour services) • Level of intersectoral coordination (stronger in some districts than others) <p>This inconsistency affects the quality, accessibility, and comprehensiveness of GBV service provision. Survivors in some areas may receive fully integrated support, while others face fragmented or delayed services, especially where coordination or staffing is weak.</p> <p>Sustainability prospects and risks post-donor support: The government’s commitment to mainstreaming OSCs into health and social services structures is a positive step. However, sustainability is challenged by: Limited fiscal space and competing national budget priorities</p> <ul style="list-style-type: none"> • Dependency on donor-funded posts, particularly psychosocial and legal services • Inconsistent provincial-level capacity to coordinate GBV response and maintain quality standards • Weak maintenance systems for OSC infrastructure and equipment once donor support ceases 			<ul style="list-style-type: none"> • KIIs with MWACSMED, OSC staff • Observation at OSCs



Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
<ul style="list-style-type: none"> Closure of some OSCs (e.g. Epworth OSCs was temporarily closed) If not adequately planned, the withdrawal of external funding could result in reduced functionality, staff attrition, and decreased survivor confidence in services. 			
<p>Data collected: Population and development</p>		<p>Sources of information:</p>	
<ul style="list-style-type: none"> Ownership is with GoZ through ministries and agencies. GoZ co-financing is a show of political commitment. Technical support strengthened the government system. Capacity building - sustainability of the National Statistics System. Capacity development benefits are likely to continue. Those trained should train others for sustainability of interventions. Sustainable Financing for Data Production: Financial constraints continue to challenge data collection and dissemination. Innovative funding mechanisms, such as Public-Private Partnerships (PPPs) and academic collaborations, are necessary to ensure long-term sustainability. 		<p>2024 Results and Resources Plan for Zimbabwe; UNFPA Zimbabwe: 2024 Annual Report.</p> <p>KIIs with ZIMSTAT; UNFPA CO.</p>	
<p>Overall concerns for sustainability (across sectors) <u>Power supply and communication infrastructure:</u> These two factors seem to be beyond that CO's and IPs' control. There were locations where power supply was inadequate (e.g. Schools of Midwifery in Mpilo, Bindura, Mutambara etc.) and remote places have inadequate connectivity (e.g. Tsholotsho) hence affecting the smooth implementation and sustainability of some activities.</p>		<p>KIIs with stakeholders at provincial and district level in Matabeleland North, Manicaland, and Mashonaland Central Provinces.</p>	



Annex 2: Bibliography

Programme documents
UNFPA CP Documents (2022-2026)
UNFPA Strategic Plan (2022-2026)
UNFPA Focus Districts
UNFPA M&E Documents
Annual Plans and Reports
Annual Work Plans 2022, 2023, 2024.
Donor annual reports
UNFPA Interventions
Table with a list of UNFPA interventions during the period under this evaluation (2022, 2023, 2024 and first half of 2025)
Reports, studies, analysis and other documents
Output 1: Sexual Reproductive health and rights
SRH ToC
National Health Information System reports
Zimbabwe /UNICEF Multiple Indicator Survey (MICS) 2019
Zimbabwe Demographic Health Survey (ZDHS) 2024: Key Indicator Report
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Yaya, S., Odusina, E.K. & Bishwajit, G. Prevalence of child marriage and its impact on fertility outcomes in 34 sub-Saharan African countries. BMC Int Health Hum Rights 19, 33 (2019). https://doi.org/10.1186/s12914-019-0219-1 .
Output 2: Adolescents and young people
SRH ToC
Government of Zimbabwe (2023) National Assessment on Adolescent Pregnancies in Zimbabwe.
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Output 3: Gender based-violence and harmful practices
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Communication

Multi-sectoral FP Advocacy and Communication Strategy

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Donor Agreements

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Preliminary interviews with key ZIMSTAT stakeholders

**Annex 3: List of stakeholders consulted /interviewed**

No.	Designation	Gender	Institution
1	Country Representative	F	UNFPA Head of Mission
2	Deputy Country Representative	M	UNFPA Country Office
3	International Operations Manager	M	UNFPA Operations
4	Technical Specialist	M	UNFPA SRHR Unit
5	Technical Specialist	F	UNFPA Gender and GBV Unit
6	Programme Specialist	M	UNFPA Adolescents and Youth
7	M&E Specialist	M	UNFPA M&E
8	Programme Specialist	M	UNFPA SRHR Unit
9	Programme Specialist	F	UNFPA Programme Coordination Unit
10	Strategic Information & Policy Specialist	M	UNFPA Population and Development
11	Communications Specialist	F	UNFPA Communications
12	IT Specialist	F	UNFPA Operations Unit
13	Programme Analyst	F	UNFPA SRHR Unit
14	Operations Analyst	M	UNFPA Operations Unit
15	Programme Analyst	F	UNFPA Adolescents and Youth Unit
16	Programme Analyst	F	UNFPA Gender and GBV Unit
17	Finance Associate	F	UNFPA Operations Unit
18	Finance Associate	M	UNFPA Operations Unit
19	Programme Associate	F	UNFPA Programme Support Unit
20	Procurement and Logistics Associate	M	UNFPA Operations Unit
21	Admin. Associate	F	UNFPA Operations Unit
22	Programme Officer	F	UNFPA Gender and GBV Unit
23	Communications Officer	F	UNFPA Communications Unit
24	Programme & Admin. Assistant	M	UNFPA Programme Support Unit
25	Programme Assistant	F	Programme Support Unit
26	Senior Transport Assistant	M	UNFPA Operations Unit



Country Programme Evaluation of GoZ /UNFPA 8th CP 2022-2026



27	Transport Assistant		M	UNFPA Operations Unit
28	Transport Assistant		M	UNFPA Operations Unit
29	Transport Assistant		M	UNFPA Operations Unit
30	Transport Assistant		M	UNFPA Operations Unit
31	Office Assistant	F		UNFPA Operations Unit
32	International Volunteer	F		UNFPA Gender and GBV Unit
33	International Volunteer	F		UNFPA Gender and GBV Unit
34	Social Development Adviser	F		FCDO
35	Social Protection Manager	F		UNICEF
36	Programme Manager		M	Irish Aid
37	Head of RCO		M	Resident Coordinator's Office
38	Health Specialist		M	UNICEF
39	Data Management, Results Monitoring and Reporting	F		Resident Coordinator's Office
40	Strategic Information Adviser		M	UNAIDS
41	Adviser		M	UNAIDS
42	Chief Education/Acting Representative	F		UNICEF
43	Child Protection Specialist	F		UNICEF
44	Nutrition Specialist	F		UNICEF
45	Deputy Country Representative	F		UN Women
46	Adolescents Specialist		M	UNICEF
47	Reporting, M&E Officer		M	UNOPS
48	Humanitarian Affairs Officer	F		OCHA
49	National Programme Officer	F		UNESCO
50	National Programme Officer	F		UNESCO
51	Medical Officer (RMNCAH)		M	WHO
52	Programme Management and Projects Specialist	F		UN Women
53	Programme Manager Global Fund		M	UNDP
54	Associate National Programme Officer	F		UNESCO
55	Senior Health Adviser	F		FCDO



Country Programme Evaluation of GoZ /UNFPA 8th CP 2022-2026



56	Programme Manager		M	Embassy of Japan
57	Health System Strengthening Specialist	F		WHO
58	Health and Lifeskills Lecturer - Project Focal Person	F		Mutare Teachers' College (Manicaland Province)
59	Shelter Administrator	F		Musasa
60	Director Demography and Social Statistics / ERG Member		M	ZIMSTAT
61	Chairperson		M	Department of Demography, Settlements and Development - University of Zimbabwe
62	Matron	F		Victoria Chitepo Provincial Hospital (Manicaland Province)
63	L&C Officer	F		DanchurchAid
64	National Youth Coordinator	F		Zimbabwe National AIDS Council
65	Registered Midwife In-charge Maternity Ward	F		Ministry of Health and Child Care (United Bulawayo Hospital)
66	Guidance and Counselling Schools Inspector (represented Provincial Education Director)	F		Ministry of Primary and Secondary Education (Mashonaland Central Province)
67	Zimbabwe Republic Police Crime Officer		M	Ministry of Home Affairs and Cultural Heritage
68	Senior Nurse		M	Manicaland State University of Applied Sciences
69	EHO		M	Ministry of Health and Child Care
70	EHO		M	Ministry of Health and Child Care
71	Programme Coordinator		M	ChildCare Ministries
72	Schools Inspector		M	Ministry of Primary and Secondary Education
73	District Development Coordinator		M	Ministry of Local Government, Public Works and National Housing
74	M&E Officer / ERG Member		M	Ministry of Health and Child Care (National)
75	Projects M&E Officer	F		Simukaupenye Integrated Youth Academy (SIYA)
76	Registrar		M	Civil Registry
77	Provincial Statistician		M	ZIMSTAT (Mashonaland Central Province)
78	District Development Officer		M	Ministry of Women Affairs, Community, Small and Medium Enterprises Development (MWACSMED)
79	Nurse In-charge		M	Ministry of Health and Child Care
80	Provincial Administrator	F		MWACSMED
81	Programme Officer	F		SAYWHAT



Country Programme Evaluation of GoZ /UNFPA 8th CP 2022-2026



82	Finance and Administration Officer		M	Ministry of Local Government, Public Works and National Housing
83	Chief Medical Officer		M	Mpilo Hospital (Bulawayo City)
84	Medical Superintendent		M	Ministry of Health and Child Care (Bindura Provincial Hospital (Mashonaland Central Province)
85	Provincial Maternal, Newborn Child Health Officer		M	Ministry of Health and Child Care (Manicaland Province)
86	District Medical Officer Chimanimani		M	Ministry of Health and Child Care (Manicaland Province)
87	Deputy Director Nursing Directorate	F		Ministry of Health and Child Care (National)
88	Government Medical Officer		M	Shamva District Hospital (Mashonaland Central Province)
89	Acting Medical Superintendent		M	Victoria Chitepo Hospital (Manicaland Province)
90	Acting Provincial Medical Director, Manicaland		M	Ministry of Health and Child Care (Manicaland Province)
91	Director Health Information System		M	Ministry of Health and Child Care (National)
92	Director Family Health Care	F		Ministry of Health and Child Care (National)
93	Acting District Medical Officer		M	Ministry of Health and Child Care (Tsholotsho Hospital, Matabeleland North Province)
94	Attachee	F		Bulawayo City Council
95	Deputy Director	F		Ministry of Finance, Economic Development and Investment Promotion (National)
96	District Facilitator		M	Young Peoples Network on Health and Wellbeing (YPNHW)
97	Sister-in-Charge Maternity	F		Kuwadzana Polyclinic, Harare
98	District Nursing Officer, Chimanimani		M	Ministry of Health and Child Care (Manicaland Province)
99	Chief Executive Officer		M	Zimbabwe National Family Planning Council
100	Officer	F		Office of the President and Cabinet
101	Provincial Development Officer		M	MWACSMED (Manicaland Province)
102	Tutor School of Nursing	F		Mutambara Mission Hospital (Manicaland Province)
103	Project Coordinator	F		Plan International
104	Provincial Development Officer	F		MWACSMED (Bulawayo Province)
105	Vice Principal for Administration and Finance		M	Mutare Teachers' College (Manicaland Province)
106	Acting Administrator	F		Bindura Provincial Hospital One Stop Centre (Mashonaland Central Province)
107	SRHR Technical Lead	F		Plan International



Country Programme Evaluation of GoZ /UNFPA 8th CP 2022-2026



108	Provincial Education Director		M	Ministry of Primary and Secondary Education
109	Administrative Officer		M	Ministry of Local Government, Public Works and National Housing
110	Director		M	SAYWHAT
111	Council Development Officer	F		Chimanimani Rural District Council (Manicaland Province)
112	Provincial Development Officer	F		MWACSMED (Mashonaland Central Province)
113	Monitoring & Evaluation Officer	F		Ministry of Public Service, Labour and Social Welfare
114	School Head		M	Danhiko Secondary School
115	Officer		M	Office of the President and Cabinet
116	Provincial Manager		M	ZIMSTAT (Manicaland Province)
117	District Development Officer		M	Ministry of Youth, Sports, Arts and Recreation
118	PPO		M	MYEDVT
119	Community Development Coordinator	F		MWACSMED
120	Sister-in-Charge	F		Kuwadzana Polyclinic, Harare
121	Programme Manager		M	Zimbabwe Youth Council
122	Processing Officer	f		Civil Registry
123	Permanent Secretary		M	Office of the President and Cabinet
124	Officer		M	Office of the President and Cabinet
125	National Team Captain	F		Zim Cricket
126	Deputy Director	F		MWACSMED (National)
127	Provincial Education Director		M	Provincial Office
128	Executive Officer		M	TRDC
129	Coordinator		M	Plan International
130	Administrative Officer	F		Ministry of Local Government, Public Works and National Housing
131	DIO	F		Ministry of Information
132	Intern	F		MWACSMED (Matabeleland North Province)
133	Monitoring and Evaluation Officer	F		ARC
134	Director Technical Services	F		Zimbabwe National Family Planning Council
135	Registered Nurse	F		Ministry of Health and Child Care (Inyathi Hospital, Matabeleland North Province)



Country Programme Evaluation of GoZ /UNFPA 8th CP 2022-2026



136	District Schools Inspector		M	Ministry of Primary and Secondary Education
137	Assistant Provincial Education Director		M	Ministry of Primary and Secondary Education
138	Director		M	Office of the President and Cabinet
139	Provincial Education Director		M	Ministry of Primary and Secondary Education
140	Director of Provincial Coordination		M	Office of the President and Cabinet
141	Administrator	F		Mutambara Mission Hospital (Manicaland Province)
142	Director Nursing Directorate	F		Ministry of Health and Child Care (National)
143	Coordinator Gender, GBV and Harmful Practices	F		MWACSMED (Manicaland Province)
144	Programmes Assistant		M	Zimbabwe National AIDS Council
145	Teacher		M	Danhiko Secondary School
146	District Nursing Officer		M	Ministry of Health and Child Care (Tsholotsho District, Matabeleland North Province)
147	Provincial Officer		M	ZIMSTAT (Matabeleland North Province)
148	Community Development Coordinator	F		MWACSMED
149	Registrar		M	Council of Social Workers
150	Counsellor	F		Bindura Provincial Hospital One Stop Centre (Mashonaland Central Province)
151	Nurse	F		Ministry of Health and Child Care
152	HIV/AIDS Focal Person		M	Ministry of Health and Child Care (Tsholotsho Hospital, Matabeleland North Province)
153	Investigations Officer	F		Zimbabwe Gender Commission
154	Sister In-charge Family Health Care	F		Ministry of Health and Child Care (Tsholotsho Hospital, Matabeleland North Province)
155	Human Resources Officer	F		MWACSMED
156	Project Manager	F		DanChurchAid
157	Student	F		Bindura Provincial Hospital One Stop Centre (Mashonaland Central Province)
158	Executive Assistant	F		Shamva District Hospital (Mashonaland Central Province)
159	Permanent Secretary		M	Office of the President and Cabinet
160	Sister In-charge maternity ward	F		Ministry of Health and Child Care (Tsholotsho Hospital, Matabeleland North Province)



Country Programme Evaluation of GoZ /UNFPA 8th CP 2022-2026



161	Constable	F		Zimbabwe Republic Police
162	Nurse	F		Bindura Provincial Hospital – Survivor Friendly Clinic (Mashonaland Central Province)
163	Senior Tutor	F		Mpilo School of Midwifery, Mpilo Hospital (Bulawayo City)
164	Community Care Worker	F		Lead Community Care Worker
165	Programme Manager	F		Emthonjeni Women's Forum
166	Programme Assistant	F		Zimbabwe National AIDS Council
167	Provincial Officer		M	Zimbabwe Republic Police
168	District AIDS Coordinator	F		Zimbabwe National AIDS Council
169	Lawyer, Legal Aid Directorate	F		Ministry of Justice and Legal Affairs
170	Principal Economist		M	Ministry of Finance, Economic Development and Investment Promotion (National)
171	Intern		M	Ministry of Local Government, Public Works and National Housing
172	Police Officer		M	Zimbabwe Republic Police
173	Magistrate		M	Judicial Service Commission
174	Provincial Manager		M	ZIMSTAT (Bulawayo Province)
175	Administrative Officer		M	Ministry of Primary and Secondary Education
176	Community Development Officer		M	MWACSMED
177	Economist		M	Ministry of Finance, Economic Development and Investment Promotion (National)
178	District Development Officer		M	MWACSMED (Tsholotsho District, Matabeleland North Province)
179	Matron	F		Ministry of Health and Child Care (Tsholotsho Hospital, Matabeleland North Province)
180	District Development Officer	F		MWACSMED
181	Student	F		Bindura Provincial Hospital One Stop Centre (Mashonaland Central Province)
182	Project Officer	F		Musasa
183	District Programme Officer	F		ZACH
184	Health Information Officer		M	Shamva District Hospital (Mashonaland Central Province)
185	District Head of Department		M	Command Livestock
186	Registered Nurse/Midwife in Charge YFS Centre	F		Ministry of Health and Child Care (United Bulawayo Hospital)
187	Sister-in-Charge Community	F		Kuwadzana Polyclinic, Harare



Country Programme Evaluation of GoZ /UNFPA 8th CP 2022-2026



188	Intern		M	Public Service Commission
189	District AIDS Coordinator		M	Zimbabwe National AIDS Council
190	Provincial Medical Director		M	Ministry of Health and Child Care
191	Sister In-charge Maternity Ward	F		Ministry of Health and Child Care (Inyathi Hospital, Matabeleland North Province)
192	District Development Officer	F		MWACSMED (Shamva District, Mashonaland Central Province)
193	Project Officer	F		Family Support Trust
194	HP Officer	F		ZIM-TECH
195	Acting Matron/Sister in Charge	F		Ministry of Health and Child Care (Inyathi Hospital. Matabeleland North Province)
196	Registered Nurse/Midwife in Charge Family Planning	F		Ministry of Health and Child Care (United Bulawayo Hospital)
197	Sister-in-Charge Maternity	F		Vitoria Chitepo Provincial Hospital (Manicaland Province)
198	Acting Matron	F		Mutambara Mission Hospital (Manicaland Province)
199	Community Nurse	F		Shamva District Hospital (Mashonaland Central Province)
200	Registered Nurse	F		Manicaland State University of Applied Sciences
201	Sister-in-Charge Family and Child Health Clinic	F		Victoria Chitepo Provincial Hospital (Manicaland Province)
202	Acting Administrator	F		Bindura Provincial Hospital One Stop Centre (Mashonaland Central Province)
203	Programme Officer		M	Population Services Zimbabwe
204	Registrar	F		Civil Registry
205	Director		M	FST
206	Officer	F		Office of the President and Cabinet
207	Department of Social Development Officer		M	Ministry of Public Service, Labour and Social Welfare
208	Project Officer	F		FACT
209	Principal Administration Officer	F		Ministry of Local Government, Public Works & National Housing
210	Registered Nurse		F	Mpilo Hospital (Bulawayo City)
211	YFS centre staff	F		Ministry of Health and Child Care (United Bulawayo Hospital)
212	Director		F	The Haven Trust
213	Pharmacist, Supply Chaim Management of Health Products	F		Ministry of Health and Child Care (National)
214	Deputy Director Economic Development -	F		Ministry of Finance, Economic Development



Country Programme Evaluation of GoZ /UNFPA 8th CP 2022-2026



	Population and Development Unit			and Investment Promotion (National)
215	DSD Officer		F	Department for Social Development
216	Officer Assistant	F		Department of Social Development
217	Police Officer	F		Victim Friendly Unit, Shamva District (Mashonaland Central Province)
218	Administration and Finance Officer	F		The Haven Trust
219	Beneficiary	F		Musasa
220	Peer Educator		M	Mutare Teachers College
221	Beneficiary	F		Musasa
222	Peer Educator	F		Manicaland State University of Applied Sciences (Manicaland province)
223	Beneficiary	F		Musasa
224	Beneficiary	F		Musasa
225	Beneficiary	F		Musasa
226	Peer Educator	F		Mutare Teachers College (Manicaland Province)
227	Peer Educator		M	Manicaland State University of Applied Sciences
228	Peer Educator		M	Manicaland State University of Applied Sciences
229	Peer Educator	F		Manicaland State University of Applied Sciences
230	Peer Educator	F		Mutare Teachers College (Manicaland Province)
231	Peer Educator		M	Mutare Teachers College (Manicaland Province)
232	Peer Educator		M	Manicaland State University of Applied Sciences
233	Beneficiary	F		Musasa
234	Student	F		Hillside Teachers College (Bulawayo)
235	Student	F		Hillside Teachers College (Bulawayo)
236	Peer Educator	F		Mutare Teachers College (Manicaland Province)
237	Young person with disability	F		Young People's Network for Health and Wellbeing (YPNHW)
238	Peer Educator	F		Manicaland State University of Applied Sciences
239	Student		M	Hillside Teachers College (Bulawayo)
240	Student	F		Hillside Teachers College (Bulawayo)
241	Peer Educator	F		Manicaland State University of Applied



Country Programme Evaluation of GoZ /UNFPA 8th CP 2022-2026



				Sciences
242	Student		M	Hillside Teachers College (Bulawayo)
243	Peer Educator		M	Manicaland State University of Applied Sciences
244	Beneficiary	F		Musasa
245	Beneficiary	F		Musasa
246	Youth in Governance		M	YPNHW
247	Youth in Sports	F		YPNHW
248	Beneficiary	F		Musasa
249	Peer Educator	F		Mutare Teachers College (Manicaland Province)
250	Young person with disability		M	YPNHW
251	Youth out of school		M	YPNHW
252	Student	F		Hillside Teachers College (Bulawayo)
253	Student		M	Hillside Teachers College
254	Student		M	Hillside Teachers College
255	Beneficiary	F		Musasa
256	Nurse	F		Hillside Teachers College
257	Beneficiary	F		Musasa
258	Student		M	Hillside Teachers College
259	Beneficiary	F		Musasa
260	Youth in schools	F		YPNHW
261	Peer Educator	F		Manicaland State University of Applied Sciences
262	FBO Sector	F		YPNHW
263	Peer Educator	F		Mutare Teachers College (Manicaland Province)
264	Youth in Arts		M	YPNHW
265	Peer Educator	F		Mutare Teachers College (Manicaland Province)
266	Peer Educator	F		Mutare Teachers College
267	Young person living with HIV/AIDS	F		YPNHW
268	Youth in tertiary institution	F		YPNHW



Annex 4: Data collection tools

Tool 1: UNFPA Programme Staff - Programme officers in-SRHR, Adolescents and Youth, Gender Equality and Women Empowerment, and Population Dynamics; and other Units

My name is.....(we) are evaluating the 8th CP between the GoZ 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 covering the period 2022 to date. I greatly appreciate your taking time to speak with me (us). Do you have any questions before we start?

Overall involvement in CP

What interventions is UNFPA supporting in your programme area?

Relevance

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?

To what extent were interventions informed by substantive gender, human rights and social exclusion analysis?

Which provinces and districts is your programme covering? How were the districts selected? Have the districts covered changed over time and why?

What policies and strategies are the interventions aligned to? How do the interventions advance the implementation of these policies and strategies?

Were any changes made to reflect the shift from UNFPA strategic plan 2018-2021 to 2022-2026? If so, what were these changes?

Were any changes made in your programme area to reflect the priorities of the country's National Development Strategy (NDS1) 2021-2025? If so, what are these changes?

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

What are the major achievements (outputs) of programme?

What factors facilitated the achievement of these results? (What worked well?)

What factors hindered the achievement of results? (What did not work well?)

How have the outputs been utilized?

Gender and human rights integration into the programme cycle

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 IPs have sufficient skills and knowledge in this area? Were they trained?



Country Programme Evaluation of GoZ /UNFPA 8th CP 2022-2026



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?

How well did these measures work? What did not work well?

To what extent were the CP interventions designed to transform gender relations and promote gender equality and with what outcomes?

What measures did UNFPA take to integrate disability in the CP? How well did these work? What did not work well?

What support would you require to integrate gender into your area of work?

What support would IPs require to integrate gender into their interventions?

Efficiency

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?

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 Annual Work Plan? Were the resources sufficient for IPs to complete activities? Were there activities not implemented due to lack of resources?

Did the IPs have adequate staff (human resources) to implement activities? Were there any activities not implemented due to inadequate staff?

Were there delays in implementation of activities? If yes, why and how did you solve the problem?

Were new activities added to the planned programme activities during implementation?

Are there occasions when the budget was not enough or you overspent?

Are there activities that were cancelled or postponed?

How did UNFPA financial and administrative regulations facilitate activity implementation? How did they hinder activity implementation?

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?

Was the programme approach, partner and stakeholder engagement appropriate for achievement of results?

How is the programme monitored? (monitoring tools in place and used by IPs). How often do they report on the programme? Is reporting timely?

Sustainability

How did UNFPA support the development of IPs' 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.)



Country Programme Evaluation of GoZ /UNFPA 8th CP 2022-2026



Did the CP create the institutional change conducive to systematically addressing gender equality?

To what extent are these capacities likely to sustain the results of the programme?

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?)

To what extent are programme results likely to be sustained beyond the programme period?

What measures are in place at the end of the programme cycle for various interventions to continue?

Have programmes been integrated in government institutional plans?

Humanitarian response: Coverage and Connectedness

What humanitarian emergencies took place during the life of the 8th CP?

How did the emergencies affect your specific programme?

What measures did UNFPA take to respond to humanitarian emergencies?

Which partners did UNFPA collaborate with in responding to humanitarian emergencies? What role did UNFPA play?

What humanitarian emergency activities were undertaken? What was the mode of delivery of the humanitarian assistance?

How were gender and human rights approaches integrated in humanitarian assistance?

How successful were these interventions? What were the major achievements?

How did the UNFPA humanitarian/disaster preparedness measures (SOPs and regulations) facilitate or hinder the response to humanitarian emergencies?

What were the weaknesses in the response to emergencies?

UNFPA Staff, UNCT and other UN Agencies on UNFPA role in coordination

What are the UNCT coordination structures and mechanisms in place for ZUNSDCF (2022 - 2026)?

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?

Any challenges? How could these be overcome?

To what extent has UNFPA proactively driven and supported the meaningful integration of gender equality and human rights-based approaches across interventions?

Is UNFPA CO participating in any joint programme? If so, which joint programme? What is UNFPA's role? What is the value addition of the joint programme to achievement of UNFPA results?

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 the achievement of UNFPA results?



UNFPA M&E Unit

What role do you play in the country programme as an M&E unit?

Did/does M&E unit play any role in identification of needs/priorities addressed by the CP identified? If so, what role?

Did/does M&E unit play any role in identifying provinces/districts covered by the CP selected? If so, what role?

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?

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?

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?

What support do you provide to programme staff in M&E?

What support do you provide to implementers in M&E?

What action have you taken to contribute to visibility of the CP achievements?

What challenges do you face? Do you have sufficient staff and financial resources?

What challenges do UNFPA programme staff and implementers face in M&E? How would these be addressed?

How relevant is the ToC for (*Probe for each Programme Component: Adolescents and Youth, Gender and Empowerment, Population and Development*)? What needs to be revised, if any (assumptions, risks, Output indicators, Outcome indicators, etc)?

UNFPA CO Communication Staff

1. What role do you play in the CP 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 CP 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?

UNFPA CO Finance and Operations Staff

What is the role of the finance and operations unit?

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?

How efficient is the mechanism for funds disbursement to IPs? Are there instances of delays and what causes such delays?

How efficient is 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 affect implementation?

What type of support do you provide to programmes and IPs to ensure timely funds disbursement and financial reporting?

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?

In your view, to what extent do financial and administrative procedures facilitate implementation of activities?

To what extent do the financial and administrative procedures hinder activity implementation?

What type of support would you require going forward?

Tool 2: UNFPA Country Management (Country Representative, Assistant Representative)

Relevance

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?

How were the province and districts covered by the CP selected? Have the districts covered changed over time and why?

What changes were made to align the CP to UNFPA strategic plan 2018-2021 and to the strategic plan 2022-2026?

What changes were made to align the CP to the National Development Strategy 1 (NDS1) 2021-2025?

To what extent were interventions informed by substantive gender analysis, human rights and disability?

What was done to adapt the CP to the New Way of Working (the business model)?

Effectiveness

What in your view are the major strategic achievements of the 8th CP?

What factors facilitated the attainment of these achievements?

What factors hindered the attainment of the achievements?

Efficiency



Country Programme Evaluation of GoZ /UNFPA 8th CP 2022-2026



How did the financial and administrative procedures of UNFPA facilitate implementation CP)?

How did the financial and administrative procedures of UNFPA hinder/affect implementation of the CP?

In your view, does UNFPA have adequate capacity to implement the CP?

In your view, do implementers have adequate capacity to implement the CP?

Sustainability

What measures were put in place to promote sustainability of achieved results?

What type of capacity building did UNFPA support? Is this capacity likely to contribute to sustainability of the CP results?

What was done to promote ownership of the interventions supported by the CP among national partners? How does this contribute to sustainability?

Coordination

What is the role of the UNFPA in the UNCT/ ZUNSDCF (2022 - 2026) coordination structures and mechanisms?

Is UNFPA CO participating in any joint programme? If so, which joint programme? What is UNFPAs role?

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?

What challenges is UNFPA facing in participating in the coordination structures?

Humanitarian response

What measures did UNFPA take to response to humanitarian emergencies?

How did the UNFPA humanitarian/disaster preparedness measures (SOPs and regulations) facilitate or hinder the response to humanitarian emergencies?

What were the challenges in the response to emergencies?

Tool 3: UNFPA Regional Office

What is your role?

What is the relationship with the Country Office?

What are your expectations of the Country Office?

To what extent the country office meets this expectations/ plays its role?

What support do you provide to the Country Office?

What in your view have been the achievements of the Country Office?

What can be improved?



Tool 4: CP Donors

What UNFPA programme interventions are you supporting?

What have been the major achievement? How has this assistance helped the country to achieve its objectives (policies and strategies)?

Are there any challenges in implementation of the interventions? if so, what are the challenges?

Efficiency: Does UNFPA meet its obligations as expected (timely submission of work plans, programme and financial reports etc?)

Going forward, what improvements would you recommend in terms of (i) programme areas (gaps not well addressed currently) and (ii) implementation approaches

Tool 5: Interview Guide for National stakeholder: Government, CSOs and NGOs

Introduction: What interventions were supported by UNFPA?

Relevance

How did you identify the needs/priorities addressed through UNFPA support?

Did these interventions address your needs and/or needs of your target populations?

Were the interventions discussed between yourselves and UNFPA?

How did you identify the districts covered through UNFPA support?

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?

What specific policies informed/guided CP interventions?

What specific national strategies guided the interventions?

To what extent were the interventions aligned with international gender and human rights instruments, national policies on gender, human rights, disability inclusion and the different needs of men and women?

How appropriate were the mode(s) of engagement with UNFPA? (Probe for)

Capacity building, advocacy, service delivery, technical assistance and knowledge management

What were the challenges with the mode(s) of engagement?

Effectiveness

Looking at implementation so far, to what extent has the CP reached intended beneficiaries?

What are the major achievements (outputs) of the interventions supported by UNFPA? To what extent were the set targets achieved?

What factors facilitated achievement of the targets/outputs? (what worked well?)

What are the factors that hindered achievement of the outputs? (what did not work well?)

How have the outputs been utilized?



Human rights and gender integration

How was gender equality, human rights and disability integrated in the CP? (Probe 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?

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

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 programmes effectively?

Efficiency

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?

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 planned activities during implementation? How is approval of work plan changes handled?

Are there occasions when the budget was not enough or you overspent?

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?

How did UNFPA financial and administrative regulations facilitate activity implementation? How did they hinder activity implementation?



Country Programme Evaluation of GoZ /UNFPA 8th CP 2022-2026



Was the programme approach, partner and stakeholder engagement appropriate for achievement of results?

Sustainability

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?

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?

Are you involved in UNFPA programme 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?)

Did the CP create the institutional change conducive to systematically addressing gender inequality?

Coverage and Connectedness

What humanitarian emergencies took place during the life of the 8th CP?

How did emergencies affect your specific project?

How did UNFPA support you to response to humanitarian emergencies?

What humanitarian emergency activities did you undertake? What was the mode of delivery of humanitarian assistance?

How were gender and human rights approaches integrated in humanitarian assistance?

How successful were these interventions? What were the major achievements?

What were the weaknesses in the response to emergencies?

Tool 6: Service providers at health facilities, OSCs and Shelters, Community Level implementers, Community led organizations, training institutions

How were/are you involved in implementation of FP/RMNCAH/SRH/GBV etc service delivery?

What type of services are you providing?

Who are you mainly targeting?

What approach are you using to provide the services?

What have been the major achievements or changes so far?

Have you been trained and/provided any equipment to delivery these services? Probe further

What other support has been provided to deliver the services?



Do these services meet the needs of targeted beneficiaries? If so how?

What other needs of beneficiaries are not met?

What challenges are you facing in delivering the services?

What challenges are beneficiaries facing in accessing services?

How would these challenges be solved?

Tool 7: Focus Group Discussion Guide with beneficiaries

Introduction:

- a. Introduce yourself and the purpose of the Interview: the objective of assessing experience and learning of the current programme cycle with the view of proposing recommendations for the next CP cycle.
- b. Ask participants for consent to participate in the discussions.
- b. Assure participants of the confidentiality of information exchange which will serve only for the purpose of analysis.
- c. Capture every participant's name
- d. Probe: Focus on vulnerability, gender, disability and human rights as appropriate

I/We would like to know the type of support you received from (UNFPA implementing partner)

Relevance

What are the national needs and priorities in Zimbabwe/in your community in terms of the development agenda with regards to CP component (SRH, HIV, A&Y, GEWE and PD)?

How important is the work supported by (UNFPA implementing partner) to these needs and priorities at the local, provincial and national levels?

Does the (UNFPA implementing partner)'s work address your needs in (SRH, HIV, A&Y, GEWE and PD)?

How has (UNFPA implementing partner) consulted you in the identification of your local needs in (SRH, HIV A&Y, GEWE and PD)?

How has (UNFPA IPs integrated support for the marginalized, gender and other human rights)?

Effectiveness

To what extent has (UNFPA Implementing Partner) support reached the intended beneficiaries? Probe for vulnerable groups in the locality (women, girls, persons with disability, hard to reach areas).

Can you give examples that show how different beneficiaries appreciate the benefits of the UNFPA interventions?

What are the specific indicators of success in your programme?

How are gender relations and human rights being influenced by the activities undertaken by the programme?

Are there ways to sustain the positive changes?

What do you think has worked best? What has not worked?

What factors contributed to the effectiveness or otherwise?

What else should be done to make the programmes more effective?

Sustainability

What are the benefits of the programme interventions to you?

To what extent are the benefits likely to go beyond the programme completion?

What measures are in place at the end of the programme cycle for the various activities to continue?



Country Programme Evaluation of GoZ /UNFPA 8th CP 2022-2026



Have programmes been integrated in institutional/government plans?

How does the UNFPA CO/ (Implementing partner) ensure ownership and durability of its programmes?

Tool 8: Observation during on-site visits

The observation during on-site visits supplements the data collected from FGDs, KIs, group interviews, surveys and review of documents. Observation during on-site visits should be adapted according to different settings and in relation to different thematic issues. The areas for observation in the table below are a guide - this is not an exhaustive list, and it should be tailored to context. As such, evaluators can include other aspects relevant to the CP.

Note: In reporting on-site assessments, it is important to keep note of which areas fall within the mandate of UNFPA and which do not, and which areas UNFPA has supported. It is relevant to highlight gaps even if they are outside the mandate of UNFPA, as these may affect the impact of UNFPA contributions. However, UNFPA cannot be held accountable for limitations that are beyond its remit. It may be useful to recommend that UNFPA advocates for strengthening particular aspects of a site, but recommendations to undertake support that is beyond the agency's mandate and capacity are not useful.

Evaluator **Date of visit**

Name/Type of Site

Location.....

External environment (brief description)
Ease of access (location, transport access, etc)
Opening hours (and appropriateness for given clientele)
Sufficiency of facilities: size, rooms, overcrowding, equipment (space for privacy as well as service provision, whether all equipment functioning, condition of the rooms etc.)
Range of services that can be accessed and are fully operational (i.e. supplement to documented services); indicate anything that is not operational



Availability of IEC/BCC materials, leaflets and posters etc. (e.g. variety, numbers, documents to take away etc, language, attractiveness, relevance, range, catering to which client groups)
Male and female condoms – available, sufficient for clients to take all they want, privately obtainable e.g. in toilets or only through provider; are numbers taken recorded per named client
Comprehensiveness of service provisions (adapt to specific type of service)
Interactions between staff and clients (friendly, relaxed, rushed?)
Guarantee of privacy for consultation/counseling/physical examination (note adequate doors/walls to prevent any overlooking or overhearing); any lapses in privacy observed
Queueing for services, streamlined flow of integrated service provision or multiple queueing required for different services/staff to client ratio
Youth and gender-friendliness (e.g. youth and gender-related materials, youth corner/youth-related activities, appropriate opening hours, staff trained to be youth and gender friendly, privacy and confidentiality for young people)
Disability inclusion: wheelchair accessible, availability of braille materials, staff who know sign language, other criteria
Other observations/comments



Annex 5: Stakeholder map

Table 1

Donor	Implementing agency							Other partners							Rights holders	Other
	Gov	Local NGO	Int. NGO	Women's rights org.	Other UN	Academia	Other	Gov	Local NGO	Int. NGO	Women's rights org.	Other UN	Academia	Other		
Strategic Plan 2022-2025 Outcomes																
SP Outcome 1 <i>By 2025, the reduction in the unmet need for family planning has accelerated</i>							SP Outcome 2 <i>By 2025, the reduction of preventable maternal deaths has accelerated</i>					SP Outcome 3 <i>By 2025, the reduction in GBV and harmful practices has accelerated</i>				
Output: Strengthened institutional capacity to deliver quality, integrated SRHR services and information, including for adolescents and vulnerable groups, at national, provincial, district and community levels, including in humanitarian situations																
Health Resilience Fund	MoHCC											UNICEF				
Health Dev't Fund UBRAF	ZNFPC											WHO				
CERF MNF												UNAIDS				
UNFPA Supplies Partnership												OCHA				
Output: Adolescents and young people, including vulnerable groups, are equipped with knowledge and skills to participate in decision making and make informed decisions on SRHR and their lives																



Country Programme Evaluation of GoZ /UNFPA 8th CP 2022-2026



Donor	Implementing agency							Other partners							Rights holders	Other
	Gov	Local NGO	Int. NGO	Women's rights org.	Other UN	Academia	Other	Gov	Local NGO	Int. NGO	Women's rights org.	Other UN	Academia	Other		
Health Resilience Fund	NAC	Plan Int.										UNESCO	Africa University			
Health Development Fund	MoPSE	PSZ										UNICEF	Mutare Teachers College			
Safeguard Young People	ZYC	SAYWHAT										UNAIDS				
2gether4SRHR												WHO	Manicaland State University of Science			
													Chinhoyi University			
													Great Zimbabwe University			
													Harare Institute of Technology			
													Reformed Church University			
													Midlands State University			
													Mkoba Teachers College			
													Mlezu Agricultural College			



Country Programme Evaluation of GoZ /UNFPA 8th CP 2022-2026



Donor	Implementing agency							Other partners							Rights holders	Other
	Gov	Local NGO	Int. NGO	Women's rights org.	Other UN	Academia	Other	Gov	Local NGO	Int. NGO	Women's rights org.	Other UN	Academia	Other		
													Lupane State University Hillside Teachers College JMN Polytechnic National University of Science and Technology Esigodini Agricultural College Gwanda State University Marondera University of Agricultural Science and Technology. Madziwa Teachers College Bindura University of Science Education			



Country Programme Evaluation of GoZ /UNFPA 8th CP 2022-2026



Donor	Implementing agency							Other partners							Rights holders	Other
	Gov	Local NGO	Int. NGO	Women's rights org.	Other UN	Academia	Other	Gov	Local NGO	Int. NGO	Women's rights org.	Other UN	Academia	Other		
													University of Zimbabwe			
Output: Strengthened national, provincial, district and community capacity to prevent and respond to GBV and harmful practice, including in humanitarian settings																
Takeda Health Resilience Fund	MoWA	Musasa	World Vision				Zim Cricket Association	Ministry of Public Service Labour and Social Welfare (Dept of Disability Affairs)	Family Support Trust			UN Women	ARUPE Jesuit University,	Zimbabwe Gender Commission	Women Girls	
CERF Spotlight	Ministry of Health and Child Care	ARC					Council of Social Workers					UNICEF	Africa University,	Leonard Cheshire Zimbabwe	Persons living with disabilities (PLWD)	
EU Irish AID							Judicial Services Commission					UNESCO UNOPS UNDP UNHCR OCHA WHO FAO	Bindura University,	Deaf women included		
Japan Sweden								Ministry of Local Government (Dept of Civil protection)				Great Zimbabwe University,				
SIDA UNPRPD MPTF												Midlands State University,				
World Bank												Reformed Church University				
												University of Zimbabwe				
												Zimbabwe Ezekiel Guti University.				



Country Programme Evaluation of GoZ /UNFPA 8th CP 2022-2026



Donor	Implementing agency							Other partners							Rights holders	Other	
	Gov	Local NGO	Int. NGO	Women's rights org.	Other UN	Academia	Other	Gov	Local NGO	Int. NGO	Women's rights org.	Other UN	Academia	Other			
Output: Strengthened capacity of the national statistical system to produce, analyse and use disaggregated population data to inform policy, decision-making and development programme, including in humanitarian situations																	
Health Resilience Fund	ZIMSTAT							Ministry of Finance Economic Development and Investment Promotion					UNICEF UN WOMEN UNRCO	UZ Centre for Population Studies			



Annex 6: List of site visits undertaken during field phase

S/N	Name of location	District /City	Province	Purpose of site visit
1.	District Development Office	Shamva	Mashonaland Central	KII with stakeholders; GBV multisectoral FGD and FGD with beneficiaries (young people)
2.	Shamva Hospital	Shamva	Mashonaland Central	KII with Staff
3.	Provincial ZIMSTAT Office	Bindura	Mashonaland Central	KII with staff
4.	Provincial Medical Office	Bindura	Mashonaland Central	KII with Provincial Medical Director
5.	Provincial Office - MWACSMED	Bindura	Mashonaland Central	KII with MWACSMED & Legal Aid staff
6.	Mutare Teachers' College	Mutare	Manicaland	KII with Project Focal Person
7.	Manicaland State University	Mutare	Manicaland	FGD with beneficiaries and KII with University nurse
8.	Victoria Chitepo Hospital	Chimanimani	Manicaland	KIIs with medical staff
9.	Chimanimani Rural District Council	Chimanimani	Manicaland	KII with Stakeholders
10.	Tsholotsho hospital	Tsholotsho	Matabeleland North	KIIs with medical staff
11.	Tsholotsho town	Tsholotsho	Matabeleland North	GBV multisectoral FGD
12.	Tsholotsho Town	Tsholotsho	Matabeleland North	KII with DSS
13.	Bubi town	Bubi	Matabeleland North	GBV multisectoral FGD
14.	Bubi town	Bubi	Matabeleland North	FGD with beneficiaries
15.	Inyathi Hospital	Bubi	Matabeleland North	KII with staff & observation
16.	Inyathi Shelter	Bubi	Matabeleland North	Observation & KII with Staff
17.	Provincial ZIMSTAT Office	Bulawayo city	Matabeleland North	KIIs with staff
18.	United Bulawayo Hospital	Bulawayo city	Bulawayo	KIIs with medical staff; observation of youth-friendly centre
19.	Hillside Teachers College	Bulawayo City	Bulawayo Metropolitan	FGD with beneficiaries (young people)
20.	Mpilo Hospital	Bulawayo city	Bulawayo	KIIs with medical staff
21.	Mpilo OSC	Bulawayo City	Bulawayo	Observation and KIIs with staff
22.	Mpilo School of Midwifery	Bulawayo city	Bulawayo	KIIs with tutors
23.	Mhlahlandlela	Bulawayo City	Bulawayo & Matabeleland	KIIs with Government stakeholders (PMD, OPC, PED, MWACSMED)
24.	Provincial ZIMSTAT Office	Bulawayo city	Bulawayo	KII with staff
25.	Epworth OSC	Harare city	Harare	Observation of OSC
26.	Zimbabwe National AIDS Council Office	Harare city	Harare	KII with IP staff
27.	University of Zimbabwe	Harare city	Harare	KII with Department of Demography
28.	MoHCC headquarter	Harare city	Harare	KIIs with stakeholders
29.	MoFEDIP headquarter	Harare city	Harare	KIIs with stakeholders
30.	MWACSMED headquarter	Harare City	Harare	KIIs with stakeholders
31.	Parienyatwa Hospital	Harare City	Harare	KII with IP staff
32.	Kuwadzana Polyclinic	Harare City	Harare	KII with staff
33.	Arundel Office Park (UN offices)	Harare City	Harare	KIIs with UN staff (RCO, UN Women, UNAIDS)
34.	Belgravia (UNICEF)	Harare City	Harare	KIIs with UNICEF Staff
35.	Highlands (WHO)	Harare City	Harare	KII with WHO Staff

Annex 7: The 8th CP performance by end of March 2025

Output indicator	Baseline and year	2024 Cumulative target	2024 Cumulative achievement	% Achievement	Source of data	Comments for non-achievement ²⁶³
SRH Output 1: Strengthened institutional capacity to deliver high-quality, integrated SRHR services and information, including for adolescents and vulnerable groups, at national, provincial, district and community levels, including in humanitarian situations.						
Proportion of health facilities with no stock-outs of modern methods of contraceptives in supported provinces.	96.5 % (2020)	97.5%	96.1%	99%	UNFPA CPD Indicator database 2022-2026; COARs	Overall performance is good. The target was not fully met due to a delayed Zimbabwe Assisted Pull System distribution/delivery run or few facilities (about 23 facilities out of 1700) not ordering in time. An eLMIS system is being rolled out to all the facilities to further enhance real time tracking and timely ordering of
Percentage of district hospitals with capacity and readiness to provide comprehensive emergency obstetric and newborn care services in supported provinces.	90% (2020)	92.7%	81.7%	88%	As above	An EmONC assessment was last done in 2023 (81,7% - VHMAS survey). A comprehensive national EmONC survey is penciled for Q4,2025. Factors for the lower EmONC coverage are related to shortages of equipment, drugs and health workers skills. Some equipment has been procured and distributed e.g. to support obstetric surgery in all 63 rural districts. A national roll-out of the EmONC training is being done to upskill health workers.

²⁶³ KIs with UNFPA CO staff (SRH, AY, Gender and PD Units).

Output indicator	Baseline and year	2024 Cumulative target	2024 Cumulative achievement	% Achievement	Source of data	Comments for non-achievement ²⁶³
Proportion of facilities providing adolescent and youth-friendly services that meet national standards in supported provinces.	78% (2020)	86%	80%	93%	As above	
Percentage of clients that received two or more SRHR, HIV and SGBV services in supported provinces.	24% (2020)	54%	No data	No data ²⁶⁴	As above	Service Delivery Point (SDP) survey was not done due to funding constraints.
AYP Output 2: Adolescents and young people, including vulnerable groups, are equipped with the knowledge and skills to participate in decision-making and make informed decisions on SRHR.						
Number of young people reached with life skills programmes that build their health, social and economic assets in schools, universities and communities in supported provinces.	2,563,084 (2020)	4,231,084	6,485,208	153%	UNFPA CPD Indicator database 2022-2026; COARs	
Number of key ministries and institutions that effectively engage youth networks in policy dialogue and programming.	12 (2020)	18	23	128%	As above	
GEWE Output 3: Strengthened national, provincial, district and community capacity to prevent and respond to gender-based violence and harmful practices, including in humanitarian settings.						
Proportion of SGBV survivors who report to health facilities within 72 hours in supported provinces.	26% (2020)	29%	28%	97%	UNFPA CPD Indicator database 2022-2026; COARs	Limited resources to conduct awareness raising sessions. Going forward, UNFPA is working with implementing partners in supported provinces to amplify the messaging, using an integrated approach, and create awareness on reporting within 72hrs.
Number of women, men, girls and boys reached with community programmes to promote gender-equitable norms, attitudes and behaviours,	1,475,700 (2020)	1,961,700	1,974,788	101%	As above	

²⁶⁴ By the time of the field phase of the evaluation, there was no data for the indicator as the Service Delivery Point (SDP) survey was not done due to funding constraints. According to interviews with CO staff, the CO plans to carry it out towards the end of 2025. Nevertheless, the lack of data at the time of evaluation meant that it was not possible to assess whether or not clients were receiving the expected SRHR, HIV and SGBV services.

Output indicator	Baseline and year	2024 Cumulative target	2024 Cumulative achievement	% Achievement	Source of data	Comments for non-achievement ²⁶³
including concerning women's and girls' sexuality and reproduction.						
Number of survivors of gender-based violence who have received at least one essential service (social services, health, police or justice).	95,517 (2020)	173,917	188,583	108%	As above	
Availability of a functional gender-based violence information management system.	No (2020)	Yes	No	0%	As above	Funding was not yet made available by donor. However, UNFPA supported an assessment of GBV data collection tools and existing systems and facilitated the development and validation of a National Harmonized Framework for the GBV IMS. Resources have been secured to set up the GBVIMS in 2026
PD Output 4: Strengthened capacity of the national statistical system to produce, analyze and use disaggregated population data to inform policy decision-making and development programming, including in humanitarian situations.						
Number of in-depth analysis reports produced from census, ZDHS and other surveys.	18	26	15	58%	UNFPA CPD Indicator database 2022-2026; COARs	Due to funding constraints, it was not possible to achieve the target.
Proportion of SDG indicators (UNFPA selected) with up-to-date data (not more than 5 years old).	65%	85%	85.5%	101%	As above	
Existence of an interactive data platform with indicators on transformative results, SDGs and NDS1.	No	Yes	Yes	100%	As above	
Availability of a National Development Plan that integrates recommendations from the Demographic Dividend Study	Yes	Yes	Yes	100%	As above	

Terms of Reference

United Nations Population Fund (UNFPA) Zimbabwe 8th Country Programme (2022 - 2026)

Country Programme Evaluation

January 2025

Contents

1. Introduction
2. Country Context
3. UNFPA Country Programme
4. Evaluation Purpose, Objectives and Scope
 - 4.1. Purpose
 - 4.2. Objectives
 - 4.3. Scope
5. Evaluation Criteria and Preliminary Evaluation Questions
 - 5.1. Evaluation Criteria
 - 5.2. Preliminary Evaluation Questions
6. Approach and Methodology
 - 6.1. Evaluation Approach
 - 6.2. Methodology
7. Evaluation Process
8. Expected Deliverables
9. Quality Assurance and Assessment
10. Indicative Timeframe and Work Plan
11. Management of the Evaluation
12. Composition of the Evaluation Team
 - 12.1. Roles and Responsibilities of the Evaluation Team
 - 12.2. Qualifications and Experience of the Evaluation Team
13. Budget and Payment Modalities
15. Annexes

Acronym

AIDS	Acquired Immunodeficiency Syndrome
CCA	Common country analysis
CO	Country office
CP	Country programme
CPD	Country programme document
CPE	Country programme evaluation
DSA	Daily subsistence allowance
EQA	Evaluation quality assessment
EQAA	Evaluation quality assurance and assessment
ERG	Evaluation reference group
ESA	East and Southern Africa
ESARO	East and Southern Africa Regional Office
GBV	Gender-based violence
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
ICT	Information and communication technologies
M&E	Monitoring and evaluation
MoFEDIP	Ministry of finance, economic development and investment promotion
SDGs	Sustainable Development Goals
SRHR	Sexual and reproductive health and rights
ToR	Terms of reference
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNEG	United Nations Evaluation Group
UNFPA	United Nations Population Fund
UNSDCF	United Nations Sustainable Development Cooperation Framework
YEE	Young and emerging evaluator
ZiG	Zimbabwe Gold
ZIMSTAT	Zimbabwe National Statistical Agency
ZNASP	Zimbabwe National HIV and AIDS Strategic Plan

1. Introduction

The United Nations Population Fund (UNFPA) is the lead United Nations agency on sexual and reproductive health and rights, supporting efforts to deliver a world where every pregnancy is wanted, every childbirth is safe and every young person's potential is fulfilled. The strategic goal of UNFPA is to “achieve universal access to sexual and reproductive health, realize reproductive rights, and accelerate progress on the implementation of the Programme of Action of the International Conference on Population and Development (ICPD). With this call to action, UNFPA contributes directly to the 2030 Agenda for Sustainable Development, in line with the Decade of Action to achieve the Sustainable Development Goals”.²⁶⁵

In pursuit of this goal, UNFPA works towards three transformative and people-centered results: (i) ending preventable maternal deaths; (ii) ending unmet need for family planning; and (iii) ending gender-based violence (GBV) and all harmful practices, including female genital mutilation and child, early and forced marriage. The UNFPA ESA region has a fourth transformative result to End sexual transmission of HIV. These three plus one transformative results contribute to the achievement of all the 17 Sustainable Development Goals (SDGs), but directly contribute to the following: (a) ensure healthy lives and promote well-being for all at ages (Goal 3); (b) achieve gender equality and empower all women and girls (Goal 5); (c) reduce inequality within and among countries (Goal 10); take urgent action to combat climate change and its impacts (Goal 13); promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels (Goal 16); and strengthen the means of implementation and revitalize the Global Partnership for Sustainable Development (Goal 17). In line with the vision of the 2030 Agenda for Sustainable Development, UNFPA seeks to ensure increasing focus on “leaving no one behind”, and emphasizing “reaching those furthest behind first”.

UNFPA has been operating in Zimbabwe since 1982. The support that the UNFPA Zimbabwe Country Office (CO) provides to the Government of Zimbabwe under the framework of the 8th Country Programme (CP) (2022 - 2026) builds on national development needs and priorities articulated in the:- (i) National Health Strategy (2021 - 2025), (ii) National Development Strategy 1 (2021 - 2025), (iii) United Nations Sustainable Cooperation Framework (UNSDCF, 2022 - 2026), (iv) National Strategy for the development of statistics 2 (2016 - 2020), (v) Zimbabwe National Gender Policy (2013 - 2017), (vi) Zimbabwe National HIV and AIDS Strategic Plan (2021 to 2026), (vii) National Youth Policy (2020 to 2025) and (viii) Common Country Analysis (CCA , 2021)

The 2024 UNFPA Evaluation Policy encourages CO to carry out CPEs every programme cycle, and as a minimum every two cycles.²⁶⁶ The Country Programme Evaluation (CPE) will provide an independent assessment of the performance of the UNFPA 8th country programme (2022 - 2026) in Zimbabwe , and

²⁶⁵ [UNFPA Strategic Plan 2022-2025](#)

²⁶⁶ [UNFPA Evaluation Policy](#) 2024, p. 22.

offer an analysis of various facilitating and constraining factors influencing programme delivery and the achievement of intended results. The CPE will also draw conclusions and provide a set of actionable recommendations for the next programme cycle.

The evaluation will be implemented in line with the [UNFPA Evaluation Handbook](#). The [Handbook](#) provides practical guidance for 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.²⁶⁷ It offers step-by-step guidance to prepare methodologically robust evaluations and sets out the roles and responsibilities of key stakeholders at all stages of the evaluation process. The [Handbook](#) includes links to a number of tools, resources and templates that provide practical guidance on specific activities and tasks that the evaluators and the CPE manager perform during the different evaluation phases. The evaluators, the CPE manager, Country Office staff and other engaged stakeholders are required to follow the full guidance of the [Handbook](#) throughout the evaluation process.

The main audience and primary intended users of the evaluation are: (i) The UNFPA Zimbabwe Country Office; (ii) the Government of Zimbabwe; (iii) implementing partners of the UNFPA Zimbabwe Country Office; (iv) rights-holders involved in UNFPA interventions and the organizations that represent them (in particular women, adolescents and youth); (v) the United Nations Country Team (UNCT); (vi) UNFPA East and Southern Africa Regional Office (ESARO); and (vii) donors. The evaluation results will also be of interest to a wider group of stakeholders, including: (i) UNFPA headquarters divisions, branches and offices; (ii) the UNFPA Executive Board; (iii) academia; and (iv) local civil society organizations and international NGOs. The evaluation results will be disseminated as appropriate, using traditional and digital channels of communication.

The evaluation will be managed by the CPE manager within the UNFPA Zimbabwe CO in close consultation with the Government of Zimbabwe, Ministry of Finance, Economic Development and Investment Promotion (MoFEDIP) that coordinates the country programme, 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 reference and the detailed guidance in the Handbook.

2. Country Context

Zimbabwe is a landlocked country with a land area of 390,757 square kilometers. According to the 2022 Zimbabwe Population and Housing Census, Zimbabwe had a population of 15,178,979 and is projected to increase to 21.2 million by 2042. An annual growth rate of 1.5% has been reported between 2012 and 2022. 48% of the population are male and 52 % are female giving a sex ratio of 92 males per 100

²⁶⁷ UNEG, Norms and Standards for Evaluation (2016). The document is available at <https://www.unevaluation.org/document/detail/1914>

females. 61.4% of the population live in the rural areas while 38.6% live in the urban areas. The population is relatively young with 54% of the population in the economical age group of 15 to 64, 32 % aged 10 to 24 years and 10 % aged 15 to 19 years.

Harare, the capital of Zimbabwe remains the most populous province with 16% of the total population residing in the city, followed by Manicaland (13.4 percent) and Mashonaland West (12.5 percent), while the least populous provinces are Bulawayo (4.4 percent), Matabeleland South (5 percent) and Matabeleland North (5.5 percent). The share of urban population has increased from 33 percent in 2012 to 38.6% in 2022.

Real GDP growth declined from 6.1% in 2022 to 5.0% in 2023.²⁶⁸ This is mainly due to drought and floods that affected agricultural output and to higher costs of fuel and food imports. Zimbabwe has a multi currency monetary system, with the Zimbabwe dollar known as the Zimbabwe Gold (ZiG) and the US dollar (\$) as dominant currencies. The nominal exchange rate depreciated by 89.8% in 2023, reaching ZWL6,104/\$1 by December 2023. To rebuild trust and confidence in the local currency, the Reserve Bank of Zimbabwe (RBZ) introduced a new currency on 5 April 2024, Zimbabwe gold (ZIG), which replaced the Zimbabwe dollar. The ZIG exchange rate is market determined and backed by the US dollar and mineral reserves. On its introduction, the exchange rate stood at ZiG13.55/\$1 but fell to ZiG25/\$1 in September 2024 and ZiG30/\$1 in November 2024. The Year-on Year monthly inflation rate declined from 41.9% in December 2022 to 29.4% in December 2023 and increased to 57.5% in April 2024. However, after the introduction of the new currency it decreased to 36.5% by the end of August 2024.

The fiscal deficit remained low, at 2.0% of GDP in 2023 from 2.1% in 2022, due to a combination of enhanced revenue mobilization and expenditure cuts. The current account surplus increased marginally from 1.0% of GDP in 2022 to 1.3% in 2023, reflecting increased export earnings. The financial sector remained strong in 2023, with a capital adequacy ratio of 33%, a ratio of nonperforming loans to gross loans of 1.5%, and a liquidity ratio of 60%, all above minimum regulatory requirements of 12%, 5%, and 30%, respectively. Poverty remains high, estimated at 38.7% in 2023. Unemployment stood at 21% in the third quarter of 2023.

Slower GDP growth of 2.0% is projected for 2024, mainly on account of below average agricultural output due to the El Niño weather phenomenon. Mining output is also expected to remain subdued because of lower international mineral prices. Inflation is projected to average 24.9% in 2024 as the exchange rate stabilizes. The downside risks are elevated due to drought caused by El Niño weather patterns that has affected the agriculture sector, while unstable international commodity prices pose further risks to the mining sector. A slowdown in global economic growth would be a major risk to the outlook. Zimbabwe has made notable progress on several key health indicators over the last decade. Maternal Mortality ratio declined from 651 per 100,000 live births in 2015 (ZDHS) to 462 per 100,000 live births in 2019 (MICS) and 362 per 100,000 live births in 2022 (2022, Census). While this decline is

²⁶⁸ African Development Bank.

commendable, it is still unacceptably high. Institutional maternal deaths increased from 107 per 100,000 in 2022 to 114 per 100,000 in 2024 against an SDG target of 73 per 100,000. This occurs within the context of high antenatal care (ANC) visits of 95% and skilled birth attendance of 86%. This disconnect is due to poor quality of service and a weak health delivery system characterized by underfunding, shortages of medicine and equipment and skills gap among other factors. The Ministry of Health and Child Care was allocated 11.2% of the national budget in 2023, 10.8% in 2024 and 10.2% in 2025. This is still short of the 15% target of the Abuja declaration. The 2022 population census estimates the crude Birth Rate (CBR) at 28.9 births per 1,000 population. The national total fertility rate (TFR) was 3.7. Rural areas had a higher TFR of 4.4 as compared to 3.0 in urban areas.

The average fertility rate among adolescents aged 15-19 years was 87 and was higher in the rural areas (114.4) compared to 49.7 in the urban areas. According to the National Assessment on Adolescent Pregnancy Report (2023), at least 21% of antenatal bookings between 2019 and 2022 were of adolescents aged 10 to 19 yrs. Adolescent pregnancy prevalence rate spiked from 9% in 2016 to 23.7% in 2023.

The median age at first live birth was 20 years. The median age at first live birth for women in urban areas was higher, at 21 years as compared to 19 years for women in rural areas

18.9 percent of women aged 20-24, were married or got into union before attaining the age of 18. The proportion was higher, at 27.4 percent in rural areas compared to 10.2 percent in urban areas. One percent of women aged 20-24 years were in union before age 15. The proportion was higher at 1.6 percent in rural areas compared to 0.5 percent in urban areas.

According to data from the National Health Information System, 691,791 new cases of sexually transmitted infections were reported between 2022 and October 2024. Of these, 409,065 were female while 282,726 were males. The HIV prevalence among adults aged 15 to 49 was estimated at 11% in 2023 while that in the age group 15 to 24 was estimated at 3%.

Zimbabwe carries a burden of cervical cancer with an age-standardised incidence rate of 62.3 per 100,000 women which is five times higher than the global average. Increasing coverage of cervical cancer screening and treatment, awareness raising and coordination of stakeholders working in the field is paramount to reducing the incidence rate.

In 2019, 4.6% of women aged 15 to 49 years reported having had sex before the age of 15 compared to 3.8% of men. In young people aged 15 to 24, 3.8% of women and 5.5% of men reported having sex before the age of 15 while 3.2% of adolescent women and 5.5% of adolescent men aged 15 to 19 also reported having sex before the age of 15. There are some marked differences between urban and rural women with 2.2 % of urban women compared to 6.1% in rural areas having had sex before age 15. In men, 2.5 % of those living in the urban areas compared to 4.6% had sex before the age of 15.

Total users of modern family planning among all women rose from 1.5 million in 2012 to 2.2 million in 2023. The percentage of married women with unmet need for modern methods of contraceptives declined from 14% in 2012 to 11% in 2023. The contraceptive prevalence rate among married women increased from 61% in 2012 to 67% in 2023.

According to ZDHS 2015, 39% of women and 33% of men agree that a husband is justified to beat his wife for any reason such as burning the food, argues with him, goes out without telling him, neglects the children and refuses sexual intercourse. 72 % of women reported that they participate in decisions about the woman's own health, major household purchases and visits to family or relatives.

ZDHS 2015 reported that 35 % of women aged 15 to 49 have experienced physical violence since the age of 15 while 15 experienced physical violence in the past 12 months. 14% of women aged 15-49 experienced sexual violence at least once in their lifetime while 8% experienced sexual violence in the past 12 months. 32 % of ever-married women have experienced spousal emotional violence in their lifetime while 24% experienced spousal emotional violence in the past 12 months. 6 % of women who have ever been pregnant experienced violence during one or more of their pregnancies. 35% of ever married women aged 15-49 have experienced physical or sexual violence from a spouse and of these 37% reported experiencing physical injuries. 39% of women who have ever experienced physical or sexual violence have sought help.

The national statistics system in Zimbabwe is coordinated by the Zimbabwe Statistical Agency (ZIMSTAT). This is done through implementing activities in the National Strategies for the Development of Statistics, the latest which runs from 2021 to 2025. The system is built around routine information systems which are at different stages of development and national household surveys such as demographic and health surveys, labour force surveys among others. However, challenges faced by the system include inadequate disaggregation of data, weak coordination and lack of funding.

Zimbabwe has been conducting the Population and Housing Census every ten years from 1982. The latest census was conducted in 2022.

Zimbabwe was not spared from the Covid-19 pandemic from 2020 to 2021 which affected the implementation of development and humanitarian projects thus impacting negatively on economic growth and health status of the population.

Zimbabwe has also been affected by cyclones such as cyclone IDAI that hit the country in 2019 and left a trail of destruction including shelter, lives and livelihood. Over 17,000 households were left homeless, 12 health facilities were damaged and 139 schools were affected resulting in disruption of learning for over 10,000 children. Though it happened before the 8th country programme, its impact was felt in the programme. This was followed by the El Nino induced drought in 2023 which affected agricultural production, leaving about 6 million people in need of food assistance 2.6 million people were water insecure and 1.8 learners affected. During El Nino drought, pregnant women and girls are considered high-risk for maternal complications that are compounded by poor quality of care, inadequate human resources and lack of essential medicine and supplies. Research also indicates that drought results in an

increase in gender based violence and sexual exploitation. The country was also hit by a cholera epidemic that started in 2023. By the end of 2024, over 19,000 suspected cholera cases and 370 confirmed deaths had been reported. .

3. UNFPA Country Programme

UNFPA has been working with the Government of Zimbabwe since 1982 towards enhancing sexual and reproductive health and reproductive rights (SRHR), advancing gender equality, realizing rights and choices for young people, and strengthening the generation and use of population data for development. UNFPA Zimbabwe is currently implementing the 8th country programme.

Development of the 8th CP was based on lessons learned from the previous 7th CP (2016 - 2020). Some of the key lessons learned include that improved geographical focus will increase impact of the program, interventions providing a continuum of services from demand generation to service provision results in more benefits to beneficiaries, bringing on board new players to work with Government partners will improve achievement of results in SRHR and GBV and implementing integrated programs will be more cost effective and have more impact.

The 8th country programme (2022 - 2026) is aligned with National Health Strategy (2021 - 2025), National Development Strategy 1 (2021 - 2025), United Nations Sustainable Cooperation Framework (UNSDCF, 2022 - 2026), National Strategy for the development of statistics 2 (2021 - 2025), Zimbabwe National Gender Policy (2013 - 2017), Zimbabwe National HIV and AIDS Strategic Plan (2021 to 2026). It was developed in consultation with the 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/vision** of the UNFPA Zimbabwe 8th country programme ([2022- 2026) is to improve the health and well-being of women, young people and vulnerable and marginalized groups in Zimbabwe by ensuring universal access to high-quality integrated SRHR information and services in an enabling environment. This will contribute to the achievement of the three plus one transformative results of UNFPA: zero unmet need for family planning; zero preventable maternal deaths; zero gender-based violence and in Southern Africa, zero sexual transmission of HIV. The country programme further aims to reduce the unmet need for family planning for married women aged 15-19 years (from 12.6 per cent to 10 per cent). The country programme contributes to the following national priorities, UNSDCF outcomes and UNFPA Strategic Plan 2022-2025 outcomes;

- **National priorities** (i) Improve the quality of life, (ii) improve life expectancy at birth from the current 61 years to 65 years (iii) Reduce morbidity and mortality due to communicable and non-communicable diseases (iv) Improved care and protection of vulnerable groups
- **UNSDCF Outcomes:** (i) All people in Zimbabwe, especially women and girls and those in the most vulnerable and marginalized communities, realize their rights and have access to equitable and high-quality social services and protection. (ii) All people in Zimbabwe, especially the most vulnerable and marginalized, benefit from more accountable institutions and systems for rule of law, human rights and access to justice
- **UNFPA Strategic Plan Outcomes.** (i) By 2025, the reduction in the unmet need for family planning has accelerated (ii) By 2025, the reduction of preventable maternal deaths has accelerated. (iii) By 2025, the reduction in gender based violence and harmful practices has accelerated.

The UNFPA Zimbabwe 8th country programme (2022- 2026) has four thematic areas of programming with four interconnected **outputs:** (i) Sexual Reproductive health and rights (ii) Adolescents and Young people (iii) Gender based-violence and harmful practices and (iv) Population and development. All outputs contribute to the achievement of the Strategic Plan 2022-2025 outcomes, UNSDCF outcomes and national priorities; they have a multidimensional, ‘many-to-many’ relationship with these outcomes.

Output 1: Sexual Reproductive health and rights

Strengthened institutional capacity to deliver high-quality, integrated SRHR services and information, including for adolescents and vulnerable groups, at national, provincial, district and community levels, including in humanitarian situations.

This has been delivered through the following broad interventions:-

1. Support readiness (basic infrastructure; staff; equipment; supplies) of selected health facilities to offer comprehensive emergency obstetric and neonatal care, cervical cancer prevention and youth-friendly integrated SRH, HIV and GBV services ;
2. Provide technical assistance to improve high-quality SRHR service delivery, including the use of maternal and perinatal death surveillance and response as a quality-improvement tool;
3. Build capacity of the Government to effectively forecast, procure, distribute and track the delivery of SRH commodities, to reduce stock-outs of contraceptives and other essential SRH medicines and supplies;
4. Ensure continuity of SRHR services during emergencies and humanitarian situations through the distribution of life-saving reproductive health kits, menstrual hygiene kits and mainstreaming the minimum initial services package within the health delivery system;

5. Strengthen the capacities of career training schools (midwifery, medical) to improve competency-based training and support health management and inservice clinical skills for delivering high- quality integrated SRHR services, including for adolescents and young people
6. Advocacy to invigorate and better integrate comprehensive condom programming, including for key populations;
7. Develop strategic partnerships and cooperation with the Government, the private sector, the United Nations and academia to drive innovation (including e-learning), strengthen health management information systems, encourage operational research, documentation and dissemination of information and best practices to enhance service delivery, including for humanitarian response;
8. Strengthen advocacy with the Government to increase domestic funding for family planning and SRH, and expand human resources for health management, including bringing innovation to the issue of staff retention, to facilitate the provision of high-quality integrated SRH services; and
9. Support the Ministry of Health and Child Care and other ministries to operationalize the National Health Strategy and other strategic plans on strengthening reproductive, maternal, newborn, child and adolescent health

Output 2:Adolescents and Young people

Adolescents and young people, including vulnerable groups, are equipped with the knowledge and skills to participate in decision-making and make informed decisions on SRHR.

This has been delivered through:-

1. Support advocacy and development of inclusive policies, legislation and accountability mechanisms for the promotion and protection of the rights of young people, including menstrual health management for all adolescents, key populations and young people with disabilities;
2. Strengthen the capacities of educational and community institutions, faith-based organizations and youth networks to design and implement innovative integrated approaches to deliver high-quality comprehensive sexuality education and tailored social and behavior change communication interventions for in-school, tertiary and out-of-school youth;
3. Support access to comprehensive sexuality education, SRHR, GBV and HIV information and services by young people and strengthen their agency to make informed decisions;
4. Provide technical support for innovations to facilitate access to information and services on menstrual health and hygiene for adolescents and young girls, including continued support for developing eco-friendly and reusable sanitary pads;

5. Support national and subnational platforms that facilitate the generation, dissemination and sharing of strategic information on best practices around adolescents and young people to inform programmes and policies;
6. Develop strategic partnerships and strengthen cooperation with the Government, the private sector, the United Nations and academia to improve innovation and operational research and explore emerging issues in adolescent SRHR to economically empower adolescents and young people.

Output 3: Gender based-violence and harmful practices

Strengthened national, provincial, district and community to prevent and respond to gender-based violence and harmful practices, including in humanitarian settings.

This has been delivered through:-

1. Advocacy for the development and implementation of gender responsive legislation, policy guidelines and strategies, and improved funding for reducing GBV;
2. Improve knowledge of women and girls on life skills, gender-equitable norms, attitudes and behaviors, including sexuality and reproduction, self-confidence and self esteem, and their capacity to adequately access GBV services;
3. Enhance the capacity of national and subnational partners on GBV in emergencies preparedness;
4. Support male engagement interventions on positive masculinities for the active involvement of men and boys to prevent and address gender-based violence;
5. Strengthen the capacities of communities to ensure gender equality and increase the agency of women and girls;
6. Strengthen the integrated essential services package on GBV within the health, judicial and other sectors, including 'one-stop centers', community shelters and safe spaces;
7. Scale-up mobile and remote GBV essential service provision models in remote and hard-to-reach areas; and
8. Scale-up partnership and coordination and cooperation with the Government, United Nations agencies and other key stakeholders for joint programming and improved coordination to address gender-based violence and early marriage.

Output 4: Population and development

Strengthened capacity of the national statistical system to produce, analyse and use disaggregated population data to inform policy decision-making and development programming, including in humanitarian situations.

This has been delivered through:-

Advocate and support the use of new technologies and sustainable funding for the national statistical system;

Generate knowledge around the demographic dividend based on the latest population data;

Strengthen sector information management systems (health, education, GBV) and their inter-linkages;

Build capacity on data analysis and utilization for producers and users of data at national and subnational levels;

Strengthen partnerships with international financial institutions and research bodies on the coordination of national statistics, partnerships in data generation and use during humanitarian response and in research; and

Coordinate and collaborate with other United Nations agencies, especially for data generation and analysis in humanitarian settings ,including vulnerability analyses.

The UNFPA Zimbabwe CO also engages in activities of the UNCT, with the objective to ensure inter-agency coordination and the efficient and effective delivery of tangible results in support of the national development agenda and the SDGs. Beyond the UNCT, UNFPA Zimbabwe participates in the Humanitarian Country Team (HCT) to ensure that inter-agency humanitarian action is well-coordinated, timely, principled and effective, to alleviate human suffering and protect the lives, livelihoods and dignity of people affected by humanitarian crises.

The central tenet of the CPE is the country programme **theory of change** and the analysis of its logic and internal coherence. The theory of change describes how and why the set of activities planned under the country programme are expected to contribute to a sequence of results that culminates in the strategic goal of UNFPA. It is presented in Annex A. The theory of change will be an essential building block of the evaluation methodology. The country programme theory of change explains how the activities undertaken contribute to a chain of results that lead to the intended or observed outcomes. At the design phase, the evaluators will perform an in-depth analysis of the country programme theory of change and its intervention logic. This will help them refine the evaluation questions (see preliminary questions in section 5.2), identify key indicators for the evaluation, plan data collection (and identify potential gaps in available data), and provide a structure for data collection, analysis and reporting. The evaluators' review of the theory of change (its validity and comprehensiveness) is also crucial with a view to informing the preparation of the next country programme's theory of change.

The UNFPA Zimbabwe 8th country programme (2022- 2026) is based on the following results framework presented below:

Zimbabwe /UNFPA 8th Country Programme (2022 - 2026) Results Framework

<p>CPD Goal/vision: to improve the health and well-being of women, young people and vulnerable and marginalized groups in Zimbabwe by ensuring universal access to high-quality integrated SRHR information and services in an enabling environment.</p>	
<p>National Priority (s): (i) Improve the quality of life, (ii) improve life expectancy at birth from the current 61 years to 65 years (iii) Reduce morbidity and mortality due to communicable and non-communicable diseases</p>	<p>National Priority (s): (i) Improved care and protection of vulnerable groups</p>
<p>UNSDCF Outcome (s):(i) All people in Zimbabwe, especially women and girls and those in the most vulnerable and marginalized communities, realize their rights and have access to equitable and high-quality social services and protection.</p>	<p>UNSDCF Outcome (s): (i) All people in Zimbabwe, especially the most vulnerable and marginalized, benefit from more accountable institutions and systems for rule of law, human rights and access to justice</p>
<p>Related UNFPA Strategic Plan Outcome(s): 1: By 2025, the reduction in the unmet need for family planning has accelerated; 2: By 2025, the reduction of preventable maternal deaths has accelerated;</p>	<p>Related UNFPA Strategic Plan Outcome(s): By 2025, the reduction in gender-based violence and harmful practices has accelerated</p>
<p>UNFPA Zimbabwe 8th Country Programme Output:</p> <p>Strengthened institutional capacity to deliver high-quality, integrated SRHR services and information, including for adolescents and vulnerable groups, at national, provincial, district and community levels, including in humanitarian situations.</p>	<p>UNFPA Zimbabwe 8]th Country Programme Output:</p> <p>Adolescents and young people, including vulnerable groups, are equipped with the knowledge and skills to participate in decision-making and make informed decisions on SRHR.</p>
<p>UNFPA Zimbabwe 8th Country Programme Intervention Areas:</p> <ol style="list-style-type: none"> 1. Support readiness (basic infrastructure; staff; equipment; supplies) of selected health facilities to offer comprehensive emergency obstetric and neonatal care, cervical cancer prevention and youth-friendly integrated SRH, 	<p>UNFPA Zimbabwe 8th Country Programme Intervention Areas:</p> <ol style="list-style-type: none"> 1. Support advocacy and development of inclusive policies ,legislation and accountability mechanisms for the promotion and protection of the rights of young people, including menstrual health management for all adolescents,

<p>HIV and GBV services ;</p> <ol style="list-style-type: none"> 2. Provide technical assistance to improve high-quality SRHR service delivery, including the use of maternal and perinatal death surveillance and response as a quality-improvement tool; 3. Build capacity of the Government to effectively forecast, procure, distribute and track the delivery of SRH commodities, to reduce stock-outs of contraceptives and other essential SRH medicines and supplies; 4. Ensure continuity of SRHR services during emergencies and humanitarian situations through the distribution of life-saving reproductive health kits, menstrual hygiene kits and mainstreaming the minimum initial services package within the health delivery system; 5. Strengthen the capacities of career training schools (midwifery, medical) to improve competency-based training and support health management and inservice clinical skills for delivering high- quality integrated SRHR services, including for adolescents and young people 6. Advocacy to invigorate and better integrate comprehensive condom programming, including for key populations; 7. Develop strategic partnerships and cooperation with the Government, the private sector, the United Nations and academia to drive innovation (including e-learning), strengthen health management information systems, encourage operational research, documentation and dissemination of information and best practices to enhance service delivery, including for humanitarian response; 8. Strengthen advocacy with the Government to increase domestic funding for family planning and SRH, and expand human resources for health management, including bringing innovation to the issue of staff retention, to facilitate the provision of high-quality integrated SRH services; and 9. Support the Ministry of Health and Child Care and other ministries to operationalize the National Health Strategy and other strategic plans on strengthening reproductive, maternal, newborn, child and adolescent health 	<p>key populations and young people with disabilities;</p> <ol style="list-style-type: none"> 2. Strengthen the capacities of educational and community institutions, faith-based organizations and youth networks to design and implement innovative integrated approaches to deliver high-quality comprehensive sexuality education and tailored social and behaviour change communication interventions for in-school, tertiary and out-of-school youth; 3. Support access to comprehensive sexuality education, SRHR, GBV and HIV information and services by young people and strengthen their agency to make informed decisions; 4. Provide technical support for innovations to facilitate access to information and services on menstrual health and hygiene for adolescents and young girls, including continued support for developing eco-friendly and reusable sanitary pads; 5. Support national and subnational platforms that facilitate the generation, dissemination and sharing of strategic information on best practices around adolescents and young people to inform programmes and policies; 6. Develop strategic partnerships and strengthen cooperation with the Government, the private sector, the United Nations and academia to improve innovation and operational research and explore emerging issues in adolescent SRHR to economically empower adolescents and young people.
<p>UNFPA Zimbabwe 8th Country Programme Output:</p> <p>Strengthened national, provincial, district and community to prevent and respond to gender-based violence and harmful practices, including in humanitarian settings.</p>	<p>UNFPA Zimbabwe 8th Country Programme Output:</p> <p>Strengthened capacity of the national statistical system to produce, analyse and use disaggregated population data to inform policy decision-making and development</p>

	programming, including in humanitarian situations.
<p>UNFPA Zimbabwe 8th Country Programme Intervention Areas:</p> <ol style="list-style-type: none"> 1. Advocacy for the development and implementation of gender responsive legislation, policy guidelines and strategies, and improved funding for reducing GBV; 2. Improve knowledge of women and girls on life skills, gender-equitable norms, attitudes and behaviours, including sexuality and reproduction, self-confidence and self esteem, and their capacity to adequately access GBV services; 3. Enhance the capacity of national and subnational partners on GBV in emergencies preparedness; 4. Support male engagement interventions on positive masculinities for the active involvement of men and boys to prevent and address gender-based violence; 5. Strengthen the capacities of communities to ensure gender equality and increase the agency of women and girls; 6. Strengthen the integrated essential services package on GBV within the health, judicial and other sectors, including ‘one-stop centres’, community shelters and safe spaces; 7. Scale-up mobile and remote GBV essential service provision models in remote and hard-to-reach areas; and 8. Scale-up partnership and coordination and cooperation with the Government, United Nations agencies and other key stakeholders for joint programming and improved coordination to address gender-based violence and early marriage. 	<p>UNFPA Zimbabwe 8th Country Programme Intervention Areas:</p> <ol style="list-style-type: none"> 1. Advocate and support the use of new technologies and sustainable funding for the national statistical system; 2. Generate knowledge around the demographic dividend based on the latest population data; 3. Strengthen sector information management systems (health, education, GBV) and their inter-linkages; 4. Build capacity on data analysis and utilization for producers and users of data at national and subnational levels; 5. Strengthen partnerships with international financial institutions and research bodies on the coordination of national statistics, partnerships in data generation and use during humanitarian response and in research; and 6. Coordinate and collaborate with other United Nations agencies, especially for data generation and analysis in humanitarian settings ,including vulnerability analyses.

4. Evaluation Purpose, Objectives and Scope

4.1. Purpose

The CPE will serve the following four main purposes, as outlined in the 2024 UNFPA Evaluation Policy: (i) oversight and demonstrate accountability to stakeholders on performance in achieving development results and on invested resources; (ii) support evidence-based decision-making to inform development, humanitarian response and peace-responsive programming; and (iii) aggregating and sharing good practices and credible evaluative evidence to support organizational learning on how to achieve the best results; and (iv) empower community, national and regional stakeholders.

4.2. Objectives

The **objectives** of this CPE are:

- i. To provide the UNFPA Zimbabwe CO, national stakeholders and rights-holders, the UNFPA ESARO, UNFPA Headquarters as well as a wider audience with an independent assessment of the UNFPA Zimbabwe 8th Country Programme (2022- 2026).
- ii. To broaden the evidence base to inform the design of the next programme cycle.

The **specific objectives** of this CPE are:

- i. To provide an independent assessment of the relevance, coherence, efficiency, sustainability, and effectiveness of UNFPA support, clearly articulating the achievements versus targets of the CP.
- ii. To provide an assessment of the geographic and demographic coverage of UNFPA humanitarian assistance and the ability of UNFPA to connect immediate, life-saving support with long-term development objectives.
- iii. To provide an assessment of the role played by the UNFPA Zimbabwe CO 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 conclusions from past and current cooperation and provide a set of clear, forward-looking and actionable recommendations for the next programme cycle.

4.3. Scope

Geographic Scope

The evaluation will cover sampled districts from the following provinces, Manicaland, Mashonaland Central, Mashonaland East, Midlands and Matabeleland North where UNFPA implemented interventions.

Thematic Scope

The evaluation will cover the following thematic areas of the 8th CP:

1. Sexual and reproductive health and rights
2. Adolescent and Young People
3. Gender Based Violence and harmful practices
4. Population and development

In addition, the evaluation will cover cross-cutting issues, such as [human rights; gender equality; disability inclusion, etc.], and transversal functions, such as coordination; monitoring and evaluation (M&E); innovation; resource mobilization and strategic partnerships.

Temporal Scope

The evaluation will cover interventions planned and/or implemented within the time period of the current CP: 2022 - April 2024.

5. Evaluation Criteria and Preliminary Evaluation Questions

5.1. Evaluation Criteria

In accordance with the methodology for CPEs outlined in section 6 (below) and in the [UNFPA Evaluation Handbook](#), the evaluation will examine the following five OECD/DAC evaluation criteria: relevance, coherence, effectiveness, efficiency and sustainability.²⁶⁹

Criterion	Definition
Relevance	The extent to which the intervention objectives and design respond to rights-holders, country, and partner/institution needs, policies, and priorities, and continue to do so if circumstances change.
Coherence	The compatibility of the intervention with other interventions in the country, sector or institution. The search for coherence applies to other interventions under different thematic areas of the UNFPA mandate which the CO implements (e.g. linkages between SRHR and GBV programming) and to UNFPA projects and projects implemented by other UN agencies, INGOs and development partners in the country.
Effectiveness	The extent to which the intervention achieved, or is expected to achieve, its objectives and results, including any differential results across groups.
Efficiency	The extent to which the intervention delivers, or is likely to deliver, results in an economic and timely way. Could the same results have been achieved with fewer financial or technical resources, for instance?

²⁶⁹ The full set of OECD/DAC evaluation criteria, their definitions and principles of use are available at: <https://www.oecd.org/dac/evaluation/revised-evaluation-criteria-dec-2019.pdf>. Note that OECD/DAC criteria impact, but this is beyond the scope of the CPE.

Sustainability	The extent to which the net rights-holders of the intervention continue, or are likely to continue (even if, or when, the intervention ends).
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5.2. Preliminary Evaluation Questions

The evaluation of the country programme will provide answers to the evaluation questions (related to the above-mentioned criteria). Reflecting on the country programme theory of change, the country office has generated a set of preliminary evaluation questions that focus the CPE on the most relevant and meaningful aspects of the country programme. At the design phase (see [Handbook](#), Chapter 2), the evaluators are expected to further refine the evaluation questions (in consultation with the CPE manager at the UNFPA Zimbabwe CO and the ERG). In particular, they will ensure that each evaluation question is accompanied by a number of “assumptions for verification”. Thus, for each evaluation question, and based upon their understanding of the theory of change (the different pathways in the results chain and the theory’s internal logic), the evaluators are expected to formulate assumptions that, in fact, constitute the hypotheses they will be testing through data collection and analysis in order to formulate their responses to the evaluation questions. As they document the assumptions, the evaluators will be able to explain why and the extent to which the interventions did (or did not) lead towards the expected outcomes, identify what are the critical elements to success, and pinpoint other external factors that have influenced the programme and contributed to change.

Relevance

1. To what extent has UNFPA positioned itself within the national development/policy space and adapted to changes that have taken place, and what strategies did it take to assist efforts on addressing the needs of vulnerable and marginalized populations taking into account the issue of disability, human rights and gender including emerging issues such as new diseases, drug abuses and challenges brought about by climate change?

Coherence

2. To what extent have the different components of 8th Country programme (SRHR, GBV, AYP) been integrated to ensure synergies in addressing SRHR issues, adolescents and youth, gender based violence and use of data for decision making?
3. To what extent has UNFPA worked with stakeholders and leveraged strategic partnerships at all levels (national, provincial and district) and development partners and ensure that no one is left behind?
4. To what extent has UNFPA contributed to the functioning of various coordination mechanisms such as the UNCT, GBV Sub Cluster, Youth Networks, SRH technical working group (TWG), M&E TWG, Data for Development and Innovation TWG and other coordination mechanisms in the country?

Effectiveness

5. To what extent has UNFPA Zimbabwe strategies on SRHR, GBV, adolescents and young people and population and development achieved the intended outcomes for the different target groups making sure that no one is

left behind? In particular: (i) increased access to 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?

Efficiency

6. To what extent has UNFPA Zimbabwe used resources at its disposal efficiently to achieve the planned results following laid down policies and procedures of UNFPA and the Government of Zimbabwe?

Sustainability

7. To what extent has UNFPA supported establishment of local accountability and oversight systems to ensure sustainability and continuation of programmes that it is implementing?

The final evaluation questions and the evaluation matrix will be presented in the design report.

6. Approach and Methodology

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 Zimbabwe CO are expected to contribute to a series of results (outputs and outcomes) that contribute to the overall goal of UNFPA. The theory of change also identifies the causal links between the results, as well as critical assumptions 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. It focuses on the analysis of causal links between changes at different levels of the results chain that the theory of change describes, by exploring how the assumptions behind these causal links and contextual factors affect 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 8th country programme (2022-2026) (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, coherent, effective, efficient and sustainable has the support provided by the UNFPA Zimbabwe CO been during the period of the 8th country programme. Where applicable, the humanitarian context needs to be considered in analyzing the theory of change.

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 8th country programme (2022- 2026) 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 level. The UNFPA Zimbabwe CO has developed an initial stakeholder map (see Annex B) to identify stakeholders who have been involved in the preparation and implementation of the country programme, and those partners who do not work directly with UNFPA, yet play a key role in a relevant outcome or thematic area in the national context. These stakeholders include Government representatives, civil society organizations, implementing partners, the private sector, academia, other United Nations organizations, donors and most importantly rights-holders (notably women, adolescents and youth)]. They can provide information and data that the evaluators should use to assess the contribution of UNFPA support to changes in each thematic area of the country programme. Particular attention will be paid to ensuring the participation of women, adolescents and young people, especially those from vulnerable and marginalized groups (e.g., young people and women with disabilities, etc.).

The CPE manager in the UNFPA Zimbabwe CO has established an ERG comprised of key stakeholders of the country programme, including Ministry of Finance, Economic Development and Investment promotion, Ministry of Health and Child Care, Ministry of Primary and Secondary Education, ZIMSTAT, Ministry of Women’s Affairs, Community and Small Enterprise Development, National AIDS Council, Zimbabwe National Family Planning Council, Zimbabwe Youth Council, Musasa, Young people’s network, UZ Centre for Population Studies, UNRCO, UNICEF, UNAIDS and UNWOMEN. 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 during field visits, where appropriate. The qualitative data will be complemented with quantitative data to minimize bias and strengthen the validity of findings. 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. The use of innovative and context-adapted evaluation tools (including ICT) is encouraged.

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 human rights and principles throughout the evaluation process, including through participation and consultation of key stakeholders (rights holders and duty bearers); and (iii) provides credible information about the benefits for duty bearers and rights-holders (women, 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](#). This 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 essential that, once contracted by the UNFPA Zimbabwe CO, the evaluators acquire a solid knowledge of the [UNFPA methodological framework](#), which includes, in particular, the [Evaluation Handbook](#) and the evaluation quality assurance and assessment principles.

The CPE will be conducted in accordance with the UNEG *Norms and Standards for Evaluation*,²⁷⁰ *Ethical Guidelines for Evaluation*,²⁷¹ *Code of Conduct for Evaluation in the UN System*²⁷², and *Guidance on Integrating Human Rights and Gender Equality in Evaluations*.²⁷³ When contracted by the UNFPA Zimbabwe CO, the evaluators will be requested to sign the UNEG *Code of Conduct*²⁷⁴ 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 critical review of the country programme

²⁷⁰ Document available at: <http://www.unevaluation.org/document/detail/1914>.

²⁷¹ Document available at: <http://www.unevaluation.org/document/detail/102>.

²⁷² Document available at: <http://www.unevaluation.org/document/detail/100>.

²⁷³ Document available at: <http://www.unevaluation.org/document/detail/980>.

²⁷⁴ UNEG Code of conduct: <http://www.unevaluation.org/document/detail/100>.

theory of change; (ii) an evaluation matrix ; (iii) a strategy and tools for collecting and analyzing data; and (iv) a detailed evaluation work plan and fieldwork agenda.

The evaluation matrix

The evaluation matrix is the backbone of the methodological design of the evaluation. It contains the core elements of the evaluation. It outlines (i) *what will be evaluated*: evaluation questions with assumptions for verification; and (ii) *how it will be evaluated*: data collection methods and tools and sources of information for each evaluation question and associated assumptions. The evaluation matrix plays a crucial role before, during and after data collection. The design and use of the evaluation matrix is described in Chapter 2, section 2.2.2.2 of the [Handbook](#).

- In the design phase, the evaluators should use the evaluation matrix to develop a detailed agenda for data collection and analysis and to prepare the structure of interviews, group discussions and site visits. At the design phase, the evaluation team must enter, in the matrix, the data and information resulting from their desk (documentary review) in a clear and orderly manner.
- During the field phase, the evaluation matrix serves as a working document to ensure that the data and information are systematically collected (for each evaluation question) and are presented in an organized manner. Throughout the field phase, the evaluators must enter, in the matrix, all data and information collected. The CPE manager will ensure that the matrix is placed in a Google drive and will check the evaluation matrix on a daily basis to ensure that data and information is properly compiled. S/he will alert the evaluation team in the event of gaps that require additional data collection or if the data/information entered in the matrix is insufficiently clear/precise.
- In the reporting phase, the evaluators should use the data and information presented in the evaluation matrix to build their analysis (or findings) for each evaluation question. The fully completed matrix is an indispensable annex to the report and the CPE manager will verify that sufficient evidence has been collected to answer all evaluation questions in a credible manner. The matrix will enable users of the report to access the supporting evidence for the evaluation results. Confidentiality of respondents must be assured in how their feedback is presented in the evaluation matrix.

Finalization of the evaluation questions and related assumptions

Based on the preliminary questions presented in the present terms of reference (section 5.2) and the theory of change underlying the country programme (see Annex A), the evaluators are required to refine the evaluation questions. In their final form, the questions should reflect the evaluation criteria (section 5.1) and clearly define the key areas of inquiry of the CPE. The final evaluation questions will structure the evaluation matrix and shall be presented in the design report.

The evaluation questions must be complemented by a set of assumptions for verification that capture key aspects of how and why change is expected to occur, based on the theory of change of the country programme. This will allow the evaluators to assess whether the conditions for the achievement of outputs and the contribution of UNFPA to higher-level results, in particular at outcome level, are met. The data collection for each of the evaluation questions (and related assumptions for verification) 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 an initial stakeholder map to identify the range of stakeholders that are directly or indirectly involved in the implementation, or affected by the implementation of the CP (see Annex B).

Building on the initial stakeholder map and based on information gathered through document review and discussions with CO staff, the evaluators will develop the final stakeholder map. From this final stakeholder map, the evaluation team will select a sample of stakeholders at national and sub-national level 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](#), section 2.3). In the design report, the evaluators should also make explicit which 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 necessary information to access the selected locations, including logistical requirements and security risks, if applicable. The sample of sites selected for visits should reflect the variety of interventions supported by UNFPA, both in terms of thematic focus and context.

The final sample of stakeholders and sites will be determined in consultation with the CPE 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 2.2.3.1.

Primary data will be collected through interviews with a wide range of key informants at national and sub-national levels (e.g., government officials, representatives of implementing partners, civil society organizations, other United Nations organizations, donors, and other stakeholders), as well as focus and group discussions (e.g., with service providers and rights-holders, notably women, adolescents and youth) and direct observation during visits to selected sites. Secondary data will be collected through extensive document review, notably, but not limited to the resources assembled by the CO in a Document repository. The evaluation team will ensure that data collected is disaggregated by sex, age, location and other relevant dimensions, such as disability status, to the extent possible.

The evaluation team is expected to dedicate a total of two weeks for data collection in the field. The data collection tools that the evaluation team will develop (e.g, interview guides for each stakeholder categories, themes for and composition of focus groups, survey questionnaires, checklists for on-site observation) shall be presented in the design report.

Data analysis

The evaluators must enter the qualitative and quantitative data in the evaluation matrix for each evaluation question and related assumption for verification. Once the evaluation matrix is completed, the evaluators should identify common themes and patterns that will help them formulate evidence-based answers to the evaluation questions. The evaluators shall also identify aspects that should be further explored and for which complementary data should be collected, to fully answer all the evaluation questions and thus cover the whole scope of the evaluation (see [Handbook](#), Chapter 4).

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 and information as highlighted in the Handbook (chapter 3). Data validation is a continuous process throughout the different evaluation phases, and the proposed validation mechanisms will be presented in the design report. In particular, there must be systematic triangulation of data sources and data collection methods, internal evaluation team meetings to corroborate and analyze data, and regular exchanges with the CPE manager. During a debriefing meeting with the CO and the ERG, at the end of the field phase, the evaluation team will present the emerging findings.

Use of Artificial Intelligence (AI) in CPEs

AI technologies cannot be used in the management and conduct of the CPE unless a prior written agreement is obtained from the CPE manager. Upon this prior agreement, the consultant is obligated to disclose the utilization of AI tools in evaluation and commits to upholding ethical standards and accuracy in the application of AI tools.

- **Prior approval for utilization of AI tools:** The use of AI tools must be explicitly agreed upon and approved in writing by the CPE manager
- **Declaration of the utilization of AI tools:** If the use of AI tools in evaluation is agreed upon with the CPE manager, the evaluator must be transparent and declare the use of AI tools in evaluation work and other work-related tasks, specifying the nature of AI usage. The AI tools utilized in work-related tasks must include only those tools that are vetted by EO
- **Verification of accuracy:** The evaluator commits to diligently checking the accuracy of AI-generated results and assumes full responsibility for its reliability and validity
- **Ethical and responsible use:** The evaluator is obligated to uphold ethical principles in the use of AI in work-related tasks, as well as relevant regulations that govern the use of AI in the UN system. This includes the [Digital and Technology Network Guidance on the Use of Generative AI Tools in the UN System](#), [Principles for the Ethical Use of Artificial Intelligence in the United Nations System](#), and [UNFPA Information Security Policy](#). The consultant commits to employing AI tools that adhere to principles of non-discrimination, fairness, transparency, and accountability. The consultant will adopt an approach that aligns with the principle of ‘leaving no one behind’, ensuring that AI tool usage avoids exclusion or disadvantage to any group.

7. Evaluation Process

The CPE process is broken down into five different phases that include different stages and lead to different deliverables: preparation phase; design phase; field phase; reporting phase; and phase of dissemination and facilitation of use. The CPE manager and the evaluation team leader must undertake quality assurance of each deliverable at each phase and step of the process, with a view to ensuring the production of a credible, useful and timely evaluation.

7.1. Preparation Phase (*Handbook, Chapter 1*)

The CPE manager at the UNFPA Zimbabwe CO leads the preparation phase of the CPE. This includes:

- CPE launch and orientation meeting for CO staff
- Recruitment of a young and emerging evaluator (YEE) [optional]
- Evaluation questions workshop
- Establishing the evaluation reference group
- Drafting the terms of reference
- Assembling and maintaining background information
- Mapping the CPE stakeholders
- Recruiting the evaluation team. If the YEE was not recruited at the beginning of the preparation phase, the YEE can be hired during the recruitment of the entire evaluation team.

The full tasks of the preparation phase and responsible entities are detailed in Chapter 1 of the Handbook.

7.2. Design Phase (*Handbook, Chapter 2*)

The design phase sets the overall framework for the CPE. This phase includes:

- Induction meeting(s) between CPE manager and evaluation team
- Orientation meeting with CO Representative and relevant UNFPA staff with evaluation team
- Desk review by the evaluation team and preliminary interviews, mainly with CO staff
- Developing the evaluation approach i.e., critical analysis of the theory of change using contribution analysis, refining the preliminary evaluation questions and developing the assumptions for verification, developing the evaluation matrix, methods for data collection, and sampling method
- Stakeholder sampling and site selection
- Developing the field work agenda
- Developing the initial communications plan
- Drafting the design report version 1
- Quality assurance of design report version 1

- ERG meeting to present the design report
- Drafting the design report version 2
- Quality assurance of design report version 2

The **design report** presents a robust, practical and feasible evaluation approach, detailed methodology and work plan. The evaluation team will develop the design report in consultation with the CPE manager and the ERG; it will be submitted to the regional M&E adviser in UNFPA ESARO for review.

The detailed activities of the design phase with guidance on how they should be undertaken are provided in the Handbook, Chapter 2.

7.3. Field Phase (*Handbook, Chapter 3*)

The evaluation team will collect the data and information required to answer the evaluation questions in the field phase. Towards the end of the field phase, the evaluation team will conduct a preliminary analysis of the data to identify emerging findings that will be presented to the CO and the ERG. The field phase should allow the evaluators sufficient time to collect valid and reliable data to cover the thematic scope of the CPE. A period of two weeks for data collection is planned for this evaluation. However, the CPE manager will determine the optimal duration of data collection, in consultation with the evaluation team during the design phase.

The field phase includes:

- Preparing all logistical and practical arrangements for data collection
- Launching the field phase
- Collecting primary data at national and sub-national level
- Supplementing with secondary data
- Collecting photographic material
- Filling in the evaluation matrix
- Conducting a data analysis workshop
- Debriefing meeting and consolidation of the feedback

At the end of the field phase, the evaluation team will hold a **debriefing meeting with the CO and the ERG** to present the initial analysis and emerging findings from the data collection in a PowerPoint presentation. The debriefing meeting presents an invaluable opportunity for the evaluation team to expand, qualify and verify information as well as to obtain feedback and correct misperceptions or misinterpretations.

The detailed activities of the field phase with guidance on how they should be undertaken are provided in the Handbook, Chapter 3.

7.4. Reporting Phase (*Handbook, Chapter 4*)

One of the most important tasks in drafting the CPE report is to organize it into three interrelated, yet distinct, components: findings, conclusions, and recommendations. Together they represent the core of the CPE report. The reporting phase includes:

- Brainstorming on feedback received during the debriefing meeting
- Additional data collection (if required)
- Consolidating the evaluation matrix
- Drafting the findings and conclusions
- Identifying tentative recommendations using the recommendations worksheet
- Drafting CPE report version 1 (incl. quality assurance by team leader)
- Quality assurance of CPE report version 1 and recommendations worksheet by the CPE manager and RO M&E Adviser
- ERG meeting on CPE report version 1
- Recommendations workshop with ERG to finalize recommendations
- Drafting CPE report version 2 (incl. quality assurance by team leader)
- Quality assurance of CPE report version 2 by the CPE manager and RO M&E Adviser
- Final CPE report with compulsory set of annexes (incl completed evaluation matrix)

The [Handbook](#), Chapter 4, provides comprehensive details of the process that must be followed throughout the reporting phase, including details of all quality assurance steps and requirements for a good quality report.. 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. Each conclusion shall make reference to the evaluation question(s) upon which it is based, while each recommendation shall indicate the conclusion(s) from which it logically stems.

The evaluation report is considered final once it is formally approved by the CPE manager in the UNFPA Zimbabwe CO.

At the end of the reporting phase, the CPE manager and the regional M&E Adviser will jointly prepare an internal EQA of the final evaluation report. The Independent Evaluation Office will subsequently conduct the final EQA of the report, which will be made publicly available.

7.5. Dissemination and Facilitation of Use Phase *(Handbook, Chapter 5)*

This phase focuses on strategically communicating the CPE results to targeted audiences and facilitating the use of the CPE to inform decision-making and learning for programme and policy improvement. It serves as a bridge between generating evaluation results, and the practical steps needed to ensure CPE leads to meaningful programme adaptation. While this phase is specifically about dissemination and facilitating the use of the evaluation results, its foundation rests upon the preceding phases. This phase is largely the responsibility of the CPE manager, CO communications officer and other CO staff. However, key responsibilities of the evaluation team in this phase include:

- Taking photographs during primary data collection and during the evaluation process
- Adhering to the [editorial guidelines of the United Nations](#) and the [UNFPA Evaluation Office](#) to ensure high editorial standards
- Contribute to the CPE communications plan

The detailed guidance on the dissemination and facilitation of use phase is provided in the [Handbook](#), Chapter 5.

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. In addition to presenting the evaluation matrix, the design report also provides information on the country situation and the UN and UNFPA response. The Handbook section 2.4 provides the required structure of the design report and guidance on how to draft it.
- **PowerPoint presentation of the design report.** The PowerPoint 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 CPE 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 the ERG.** The presentation provides an overview of key emerging findings of the evaluation at the end of the field phase. It will serve as the basis for the exchange of views between the evaluation team, UNFPA Zimbabwe CO staff (incl. senior management) and the members of the ERG who will thus have the opportunity to provide complementary information and/or rectify the inaccurate interpretation of data and information collected.
- **Version 1 evaluation report.** The version 1 evaluation report will present the findings and conclusions, based on the evidence that data collection yielded. It will undergo review by the CPE manager, the CO, the ERG and the regional M&E adviser, and the evaluation team will undertake revisions accordingly.
- **Recommendations worksheet.** The process of co-creating the CPE recommendations begins with a set of tentative recommendations proposed by the evaluation team (see [Handbook](#), section 4.3).

- **Final evaluation report.** The final evaluation report (*maximum 80 pages, excluding opening pages and annexes*) will present the findings and conclusions, as well as a set of practical and actionable recommendations to inform the next programme cycle. The Handbook (section 4.5) provides the structure and guidance on developing the report. The set of annexes must be complete and must include the evaluation matrix containing all supporting evidence (data and information and their source).
- **PowerPoint presentation of the evaluation results.** The presentation will provide a clear overview of the key findings, conclusions and recommendations to be used for the dissemination of the final evaluation report.

Based on these deliverables, the CPE manager, in collaboration with the communication officer in the UNFPA Zimbabwe CO will develop an:

- **Evaluation brief.** The evaluation brief will consist of a short and concise document that provides an overview of the key evaluation results in an easily understandable and visually appealing manner, to promote their use among decision-makers and other stakeholders. The structure, content and layout of the evaluation brief should be similar to the briefs that the UNFPA Independent Evaluation Office produces for centralized evaluations.

All the deliverables will be developed in English.

9. Quality Assurance and Assessment

The UNFPA Evaluation Quality Assurance and Assessment (EQAA) system aims to ensure the production of good quality evaluations through two processes: quality assurance and quality assessment. Quality assurance occurs throughout the evaluation process and involves a proactive approach which aims to prevent the production of an evaluation report that would not comply with the ToR. Quality assessment takes place following the completion of the evaluation process and is limited to the final evaluation report with a view to assessing compliance with specific criteria.

The EQAA of this CPE will be undertaken in accordance with the IEO [guidance and tools](#). An essential component of the EQAA system is the EQA grid, which sets the criteria against which the versions 1 and 2 of the CPE report are assessed to ensure clarity of reporting, methodological robustness, rigor of the analysis, credibility of findings, impartiality of conclusions and usefulness of recommendations.

The evaluation team leader plays an instrumental quality assurance role. S/he must ensure that all members of the evaluation team provide high-quality contributions (both form and substance) and, in particular, that the versions 1 and 2 of the CPE report comply with the quality assessment criteria outlined in the EQA grid²⁷⁵ before submission to the CPE manager for review. The evaluation quality assessment checklist below outlines the main quality criteria that the version 1 and version 2 of the evaluation report must meet.

²⁷⁵ The evaluators are also invited to look at good quality CPE reports that can be found in the UNFPA evaluation database, which is available at: <https://www.unfpa.org/evaluation/database>. 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.

- **Executive summary:** Provide an overview of the evaluation. It is written as a stand-alone section and includes the following key elements of the evaluation: overview of the context and country programme; evaluation purpose, objectives and intended users; scope and evaluation methodology; summary of most significant findings; main conclusions; and key recommendations. The executive summary can inform decision-making.
- **Background:** The evaluation (i.e. interventions under the country programme) and context of the evaluation are clearly described. The key stakeholders are clearly identified and presented.
- **Purpose, Objectives and Scope:** The purpose of the country programme evaluation is clearly described. The objectives and scope of the evaluation are clear and realistic. The evaluation questions are appropriate for meeting the objectives and purpose of the evaluation.
- **Design and Methodology:** The analysis of the country programme theory of change, results chain or logical framework should be well-articulated. The report should provide the rationale for the methodological approach and the appropriateness of the methods and tools selected, as well as sampling with a clear description of ethical issues and considerations. Constraints and limitations are explicit (incl. limitations applying to interpretations and extrapolations in the analysis; robustness of data sources, etc).
- **Findings:** They are evidence-based and systematically address all of the evaluation's questions. Findings are built upon multiple and credible data sources and result from a rigorous data analysis.
- **Conclusions:** They are based on credible findings and convey the evaluators' unbiased judgment. Conclusions are well substantiated and derived from findings and add deeper insight beyond the findings themselves.
- **Recommendations:** They are clearly formulated and logically derived from the conclusions. They are prioritized based on their importance, urgency, and potential impact.
- **Structure and presentation:** The report is clear, user-friendly, comprehensive, logically structured and drafted in accordance with the outline presented in the [Handbook](#), section 4.5.
- **Evaluation Principles/cross-cutting issues:** Cross cutting issues, in particular, human rights-based approach, gender equality, disability inclusion, LNOB are integrated in the core elements of the evaluation (evaluation design, methodology, findings, conclusions and recommendations).

Using the EQA grid, the EQAA process for this CPE will be multi-layered and will involve: (i) the evaluation team leader (and each evaluation team member); (ii) the CPE manager in the UNFPA Zimbabwe CO, (iii) the regional M&E adviser in UNFPA ESARO, and (iv) the UNFPA Independent Evaluation Office, whose roles and responsibilities are outlined in section 11.

10. Indicative Timeframe and Work Plan

The table below indicates the main activities that will be undertaken throughout the evaluation process, as well as their estimated duration for the submission of corresponding deliverables. The involvement of the evaluation team starts

with the design phase and ends after the reporting phase. The Handbook contains full details on all the CPE activities and must be used by the evaluators throughout the evaluation process.

Tentative timelines for main tasks and deliverables in the design, field and reporting phases of the CPE²⁷⁶

Main tasks	Responsible entity	Deliverables	Estimated Duration
Design phase			
Induction meeting with the evaluation team	CPE Manager and evaluation team		Approximately 9 weeks
Orientation meeting with CO staff	CO Representative, CPE Manager, CO staff and RO M&E Adviser		
Desk review and preliminary interviews, mainly with CO staff	Evaluation team		
Developing the evaluation approach	Evaluation team		
Stakeholder sampling and site selection	Evaluation team, CPE Manager	Stakeholder map	
Developing the field work agenda	Evaluation team, CPE Manager	Field work agenda	
Developing the initial communications plan	CPE Manager and CO communications officer	<i>Communication plan (see Evaluation Handbook, Chapter 5)</i>	
Drafting the design report version 1	Evaluation team	Design report- version 1	
Quality assurance of design report version 1	CPE Manager and RO M&E Adviser		
ERG meeting to present the design report	Evaluation team, CPE manager	PowerPoint presentation on design report version 1	
Drafting the design report version 2	Evaluation team	Design report - version 2	
Quality assurance of design report version 2	CPE Manager and RO M&E Adviser		
Final design report	Evaluation Team	Final design report (see Evaluation Handbook , section 2.4.4)	
Field phase			
Preparing all logistical and practical arrangements for data collection	CPE Manager		4 to 5 weeks
Collecting primary data at national and sub-national level	Evaluation team		
Supplementing with secondary data	Evaluation team		
Collecting photographic material	Evaluation team	Photos (see Evaluation Handbook , Section 3.2.5)	
Filling in the evaluation matrix	Evaluation team	Evaluation matrix	

²⁷⁶ For full information on all tasks and responsible entities, see the relevant chapters of the [Handbook](#)

Conducting a data analysis workshop	Evaluation team		
Debriefing meeting with CO and ERG	Evaluation team and CPE manager	PowerPoint presentation	
Reporting phase			
Consolidating the evaluation matrix	Evaluation team	Evaluation matrix	Approximately 12 weeks
Drafting CPE report version 1	Evaluation team	Evaluation report - version 1	
Quality assurance of CPE report version 1	CPE Manager and RO M&E Adviser		
ERG meeting on CPE report version 1	Evaluation team and CPE Manager	PowerPoint presentation	
Recommendations workshop	Evaluation team, CPE manager, ERG members	Recommendations worksheet	
Drafting CPE version 2	Evaluation team	Evaluation report - version 2	
Quality assurance of CPE report version 2	CPE Manager and RO M&E Adviser		
Final CPE report	Evaluation team	Final CPE report (<i>see Evaluation Handbook, section 4.5</i>) with powerpoint presentation and audit trail	

Nota Bene: Column "Deliverables": In italics: The deliverables are the responsibility of the CO/CPE Manager; in bold: The deliverables are the responsibility of the evaluation team.

11. Management of the Evaluation

The **CPE manager** in the UNFPA Zimbabwe CO, in close consultation with the Ministry of Finance, Economic development and investment promotion that coordinates the country programme will be responsible for the management of the evaluation and supervision of the evaluation team in line with the [UNFPA Evaluation Handbook](#). The CPE manager will oversee the entire process of the evaluation, from the preparation to the dissemination and facilitation of use of the evaluation results. It is the prime responsibility of the CPE manager to ensure the quality, independence and impartiality of the evaluation in line with UNFPA IEO methodological framework, as well as the UNEG norms and standards and ethical guidelines for evaluation. The tasks assigned to the CPE manager, for each phase of the CPE, are detailed in the [Handbook](#).

At all stages of the evaluation process, the CPE manager will require support from staff of the UNFPA Zimbabwe CO. In particular, the **country office staff** contribute to the identification of the evaluation questions and the preparation of the ToR (and annexes). They contribute to the compilation of background information and documentation related to the country programme. They make time to meet with the evaluation team at the design phase and during data collection. They also provide support to the CPE manager in making logistical arrangements for site visits and setting up interviews and group discussions with stakeholders at national and sub-national level. Finally, they provide inputs to the management response and contribute to the dissemination of evaluation results.

The progress of the evaluation will be closely followed 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, implementing partners, as well as other relevant key stakeholders, including organizations representing vulnerable and marginalized groups (see [Handbook](#), section 1.4). The ERG serves as a body to ensure the relevance, quality and credibility of the evaluation. It provides input on key milestones in the evaluation process, facilitates the evaluation team's access to sources of information and key informants and undertakes quality assurance of the evaluation deliverables from a technical perspective. The ERG has the following key responsibilities:

- Support the CPE manager in the development of the ToR, including the selection of preliminary evaluation questions
- Provide feedback and comments on the design report
- Act as the interface between the evaluators and key stakeholders of the evaluation, and facilitate access to key informants and documentation
- Provide comments and substantive feedback from a technical perspective on the version 1 evaluation report
- Participate in meetings with the evaluation team
- Contribute to the dissemination of the evaluation results and learning and knowledge sharing, based on the final evaluation report, including follow-up on the management response

In compliance with UNFPA evaluation policy (2024), the **regional M&E adviser** in ESARO will provide guidance and backstopping support to the CPE manager at all stages of the evaluation process. In particular, the regional M&E plays a crucial role in the quality assurance of the CPE deliverables. This includes quality assurance and approval of the ToR, pre-qualification of consultants, quality assurance and assessment of the design and evaluation reports. S/he also assists with dissemination and use of the evaluation results. The role and responsibilities of the regional M&E adviser at all phases of the CPE are indicated in the Handbook.

The UNFPA **Independent Evaluation Office (IEO)** commissions an independent quality assessment of the final evaluation report. The IEO also publishes the final evaluation report, independent quality assessment (EQA) and management response in the [UNFPA 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 with overall responsibility for carrying out the evaluation exercise, and (ii) team members who will provide technical expertise in thematic areas relevant to the UNFPA mandate (SRHR; adolescents and youth; gender equality and women's empowerment; and population dynamics).

As part of the efforts of UNFPA to strengthen national evaluation capacities, the evaluation team will also include a young and emerging evaluator who will provide support to the evaluation team throughout the evaluation process.

In addition to her/his primary responsibility for the design of the evaluation methodology and the coordination of the evaluation team throughout the CPE process, the team leader will perform the role of technical expert for one of the thematic areas of the 8th UNFPA CP in Zimbabwe.

The evaluation team leader will be recruited internationally (incl. in the region or sub-region), while the evaluation team members will be recruited locally to ensure adequate knowledge of the country context including the young and emerging evaluator. Finally, the evaluation team should have the requisite level of knowledge to conduct human rights- and gender-responsive evaluations and all evaluators should be able to work in a multidisciplinary team and 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. S/he will be responsible for the production and timely submission of all expected deliverables in line with the ToR. S/he will lead and coordinate the work of the evaluation team and ensure the quality of all evaluation deliverables at all stages of the process. The CPE manager will provide methodological guidance to the evaluation team in developing the design report, in particular, but not limited to, defining the evaluation approach, methodology and work plan, as well as the agenda for the field phase. S/he will lead the drafting and presentation of the design report and the draft and final evaluation report, and play a leading role in meetings with the ERG and the CO. The team leader will also be responsible for communication with the CPE manager. Beyond her/his responsibilities as team leader, the evaluation team leader will serve as technical expert for one of the thematic areas of the country programme described below.

Evaluation team member: SRHR expert

The SRHR expert will provide expertise on integrated sexual and reproductive health services, HIV and other sexually transmitted infections, maternal health, obstetric fistula and family planning. S/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 evaluation deliverables in her/his thematic area of expertise. S/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 CPE manager, UNFPA Zimbabwe CO staff and the

ERG. S/he will undertake a document review and conduct interviews and group discussions with stakeholders, as agreed with the evaluation team leader. Depending on experience, the SRHR expert may be asked to work in other thematic areas.

Evaluation team member: Adolescents and youth expert

The adolescents 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, youth economic empowerment and adolescent girls and youth leadership and participation. S/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 evaluation deliverables in her/his thematic area of expertise. S/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 CPE manager, UNFPA Zimbabwe CO staff and the ERG. S/he will undertake a document review and conduct interviews and group discussions with stakeholders, as agreed with the evaluation team leader. Depending on experience, the AY expert may be asked to work in other thematic areas.

Evaluation team member: Gender equality and women's empowerment expert

The gender equality and women's empowerment 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 GBV and harmful practices, such as early, prevention of gender based violence and provision of services and forced marriage. S/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 evaluation deliverables in her/his thematic area of expertise. S/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 CPE manager, UNFPA Zimbabwe CO staff and the ERG. S/he will undertake a document review and conduct interviews and group discussions with stakeholders, as agreed with the evaluation team leader. Depending on experience, the gender expert may be asked to work in other thematic areas.

Evaluation team member: Population dynamics expert

The population dynamics expert will provide expertise on population and development issues, such as census, ageing, migration, the demographic dividend, and national statistical systems. S/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 evaluation deliverables in her/his thematic area of expertise. S/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 CPE manager, UNFPA Zimbabwe CO staff and the ERG. S/he will undertake a document review and conduct interviews and group discussions with stakeholders, as agreed with the evaluation team leader. Depending on experience, the P&D expert may be asked to work in other thematic areas.

Evaluation team member: Young and emerging evaluator. The young and emerging evaluator (YEE) will contribute to all phases of the CPE. S/he will support the evaluation team leader and members in developing the evaluation methodology, reviewing and refining the theory of change, finalizing the evaluation questions, and developing the evaluation matrix, data collection methods and tools, as well as indicators. The young and emerging evaluator will participate in data collection (site visits, interviews, group discussions and document review) and support data analysis, as agreed with the evaluation team leader and the CPE manager. The YEE will also support the dissemination and facilitation of use of the evaluation results. Finally, S/he will provide administrative support throughout the evaluation process and participate in meetings with the CPE manager, UNFPA Zimbabwe CO staff and the ERG.

The modalities for the participation of the evaluation team members and young emerging evaluator in the evaluation process, their responsibilities during data collection and analysis, as well as the nature of their respective contributions to the drafting of the design report and the version 1 and version 2 evaluation report will be agreed with the evaluation team leader. These tasks will be performed under her/his supervision.

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 and/or humanitarian assistance].

- 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 the country programme covered by the evaluation (see expert profiles below).

- In-depth knowledge of theory-based evaluation approaches and ability to apply both qualitative and quantitative data collection methods and to uphold high quality standards for evaluation as defined by UNFPA and UNEG.

- Good knowledge of humanitarian strategies, policies, frameworks and international humanitarian law and humanitarian principles, as well as the international humanitarian architecture and coordination mechanisms].

- Ability to ensure ethics and integrity of the evaluation process, including confidentiality and the principle of do no harm.

- Ability to consistently integrate human rights and gender perspectives in all phases of the evaluation process.

- Excellent management and leadership skills to coordinate the work of the evaluation team, and strong ability to share technical evaluation skills and knowledge.

- Ability to supervise a young and emerging evaluator, create an enabling environment for her/his meaningful participation in the work of the evaluation team, and provide guidance and support required to develop her/his capacity.

Experience working with a multidisciplinary team of experts.

Excellent ability to analyze and synthesize large volumes of data and information from diverse sources.

Excellent interpersonal and communication skills (written and spoken).

Work experience in/good knowledge of the region and the national development context of Zimbabwe

Fluent in written and spoken English

SRHR expert

The competencies, skills and experience of the SRHR expert 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 and/or humanitarian assistance].

Substantive knowledge of SRHR, including HIV and other sexually transmitted infections, maternal health, and family planning. Knowledge and experience in evaluation of other thematic areas will be an advantage.

Good knowledge of humanitarian strategies, policies, frameworks and international humanitarian law and humanitarian principles, as well as the international humanitarian architecture and coordination mechanisms is an added advantage.

Ability to ensure ethics and integrity of the evaluation process, including confidentiality and the principle of do no harm.

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 qualitative and quantitative data collection methods.

Excellent analytical and problem-solving skills.

Experience working with a multidisciplinary team of experts.

Excellent interpersonal and communication skills (written and spoken).

Work experience in/good knowledge of the national development context of Zimbabwe

Familiarity with UNFPA or other United Nations organizations' mandates and activities will be an advantage.

Fluent in written and spoken English

Adolescents and youth expert

The competencies, skills and experience of the adolescents and youth expert 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 and/or humanitarian assistance].

Substantive knowledge of adolescent and youth issues, in particular SRHR of adolescents and youth. Knowledge and experience in evaluation of other thematic areas will be an advantage.

Good knowledge of humanitarian strategies, policies, frameworks and international humanitarian law and humanitarian principles, as well as the international humanitarian architecture and coordination mechanisms is an added advantage.

Ability to ensure ethics and integrity of the evaluation process, including confidentiality and the principle of do no harm.

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 qualitative and quantitative data collection methods.

Excellent analytical and problem-solving skills.

Experience working with a multidisciplinary team of experts.

Excellent interpersonal and communication skills (written and spoken).

Work experience in/good knowledge of the national development context of Zimbabwe

Familiarity with UNFPA or other United Nations organizations' mandates and activities will be an advantage.

Fluent in written and spoken English

Gender equality and women's empowerment expert

The competencies, skills and experience of the gender equality and women's empowerment 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 and/or humanitarian assistance.

Substantive knowledge on gender equality and the empowerment of women and girls, GBV and other harmful practices, such as female genital mutilation, early, child and forced marriage, and issues surrounding masculinity, gender relationships and sexuality. Knowledge and experience in evaluation of other thematic areas will be an advantage.

Good knowledge of humanitarian strategies, policies, frameworks and international humanitarian law and humanitarian principles, as well as the international humanitarian architecture and coordination mechanisms is an added advantage.

Ability to ensure ethics and integrity of the evaluation process, including confidentiality and the principle of do no harm.

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 qualitative and quantitative data collection methods.

Excellent analytical and problem-solving skills.

Experience working with a multidisciplinary team of experts.

Excellent interpersonal and communication skills (written and spoken).

Work experience in/good knowledge of the national development context of Zimbabwe

Familiarity with UNFPA or other United Nations organizations' mandates and activities will be an advantage.

Fluent in written and spoken English

Population dynamics expert

The competencies, skills and experience of the population dynamics 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 and/or humanitarian assistance.

Substantive knowledge on the generation, analysis, dissemination and use of housing census and population data for development, population dynamics, migration and national statistics systems. Knowledge and experience in evaluation of other thematic areas will be an advantage.

Good knowledge of humanitarian strategies, policies, frameworks and international humanitarian law and humanitarian principles, as well as the international humanitarian architecture and coordination mechanisms is an added advantage.

Ability to ensure ethics and integrity of the evaluation process, including confidentiality and the principle of do no harm.

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 qualitative and quantitative data collection methods.

Excellent analytical and problem-solving skills.

Experience working with a multidisciplinary team of experts.

Excellent interpersonal and communication skills (written and spoken).

Work experience in/good knowledge of the national development context of Zimbabwe

Familiarity with UNFPA or other United Nations organizations' mandates and activities will be an advantage.

Fluent in written and spoken English

Young and emerging evaluator

The young and emerging evaluator must be under 35 years of age and her/his competencies, skills and experience should include:

- Bachelor's degree in development studies, population studies, economics, monitoring and evaluation, social sciences, public health, or any other relevant discipline;
- Certificate in evaluation or equivalent qualification;
- Less than 5 years of work experience in monitoring and evaluation, research or social studies in the field of international development;
- Excellent analytical and problem-solving skills;
- Demonstrated ability to work in a team;
- Strong organizational skills, communication skills and writing skills;
- Good command of information and communication technology and data visualization tools;
- Good knowledge of the mandate and activities of UNFPA or other United Nations organizations will be an advantage;
- Keen interest to progress professionally and become a competent evaluator;
- Fluent in written and spoken [select one of the three languages of UNFPA: English, French or Spanish, and add other local languages as relevant].

13. Budget and Payment Modalities

The evaluators including the young and emerging evaluator 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 submission of a draft final evaluation report of satisfactory quality	40%
Upon approval of the final evaluation report and the PowerPoint presentation of the	40%

evaluation results	
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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	Thematic experts	Young and emerging evaluator ²⁷⁷
Preparatory phase	0	0	10
Design phase	13	10	40
Field phase	20	20	20
Reporting phase	15	9	30
Dissemination and facilitation of use phase	2	1	0
TOTAL (days)	50	40	100

Please note the numbers of days in the table are indicative. The final distribution of the volume of work and corresponding number of days for each consultant will be proposed by the evaluation team in the design report and will be subject to the approval of the CPE manager.

14. Bibliography and Resources

The following documents will be made available to the evaluation team upon recruitment:

UNFPA documents

1. UNFPA Strategic Plan (2018-2021) (incl. annexes)
<https://www.unfpa.org/strategic-plan-2018-2021>
2. UNFPA Strategic Plan (2022-2025) (incl. annexes)
<https://www.unfpa.org/unfpa-strategic-plan-2022-2025-dpfa20218>
3. [UNFPA Evaluation Policy \(2024\)](#)
4. [UNFPA Evaluation Handbook](#)

²⁷⁷ Note that the YEE will be employed on a full time basis for 8 months at an estimated 20 days per month.

5. The following are relevant centralized evaluations conducted by the UNFPA Independent Evaluation Office and are found in [this folder](#).
- a. Are we getting there? A synthesis of UN system evaluations of SDG 5 (2024)*
 - b. Baseline and evaluability assessment on generation, provision and utilization of data in humanitarian assistance (2022)*
 - c. Evaluation of the UNFPA support to the HIV response (2016-2019) (2020)*
 - d. Evaluation of UNFPA support to population dynamics and data (2023)*
 - e. Formative evaluation of the organizational resilience of UNFPA in light of its response to the COVID-19 pandemic (2024)*
 - f. Formative evaluation of UNFPA approach to South-South and triangular cooperation (2020)*
 - g. Formative evaluation of UNFPA support to adolescents and youth 2023 (2023)*
 - h. Formative evaluation of the UNFPA engagement in the reform of the United Nations development system (2022)*
 - i. Inter-Agency Humanitarian Evaluation of the COVID-19 Humanitarian Response (2022)*
 - j. Joint Assessment of Adaptations to the UNFPA-UNICEF Global Programme to End Child Marriage in light of COVID-19 (2021)*
 - k. Joint evaluation of the UN Joint Programme on AIDS on preventing and responding to violence against women and girls (2021)*
 - l. Joint evaluation of the UN Joint Programme on AIDS's work on efficient and sustainable financing (2022)*
 - m. Joint Evaluation of phase II (2020–2023) of the UNFPAUNICEF Global Programme to End Child Marriage (2023)*
 - n. Mid-term evaluation of the Maternal and Newborn Health Thematic Fund Phase III 2018-2022 (2022)*
 - o. Mid-Term Evaluation of the UNFPA Supplies Programme (2013-2020) (2018)*
 - p. UNFPA Regional Programme Evaluation East and Southern Africa Regional Office 2018–2021 (2021)*
 - q. What works to amplify the rights and voices of youth Meta-synthesis of lessons learned from youth evaluations (2015-2020) to support the implementation of the United Nations Youth Strategy (2021)*
 - r. What works to amplify the rights and voices of youth in peace and resilience building (2022)*

The evaluation reports are available at: <https://www.unfpa.org/evaluation>

Zimbabwe national strategies, policies and action plans

The following are relevant national strategies and policies for the 8th Country programme. They can be obtained in this [folder](#).

- a. Education Sector Strategic Plan (2021 -2025)
- b. National Development Strategy 1 (2021 - 2025)
- c. National Health Strategy (2021 - 2025)
- d. National Youth Policy (2020 - 2025)
- e. Transitional Stabilization Programme (October 2018 - December 2020)
- f. Zimbabwe National AIDS Strategy (2021 - 2025)
- g. Zimbabwe National Strategy to prevent and address gender based violence (2023 - 2030)
- h. ZUNSDCF (2022 - 2026)

UNFPA Zimbabwe CO programming documents. These can be accessed in this [folder](#).

6. Government of Zimbabwe/UNFPA 8th Country Programme Document (2022 - 2026)
7. Zimbabwe UN Common Country Analysis (2021)
8. Zimbabwe UN Common Country Analysis (2024)
9. Joint programme documents
 - a. Health Development Fund (2016 - 2022)
 - b. Health Resilient Fund (2021 - 2025)
 - c. Zimbabwe Spotlight Programme (2018 - 2023)
10. Mid-term reviews of interventions/programmes in different thematic areas of the CP
11. CO resource mobilization strategy

UNFPA Zimbabwe CO M&E documents. These are available in this [folder](#)

12. Government of Zimbabwe/UNFPA 8th Country Programme M&E Plan (2022 - 2026)

- 13. 2022, 2023 and 2024 CO annual results plans and reports (SIS/MyResults and QuantumPlus)
- 14. 2022, 2023 and 2024 CO quarterly monitoring reports (SIS/MyResults and Quantum Plus)
- 15. Previous evaluation of the Government of Zimbabwe/UNFPA 7th Country Programme (2016 - 2021), available at: <https://web2.unfpa.org/public/about/oversight/evaluations/>

Other documents

- 16. Implementing partner annual work plans and quarterly progress reports
- 17. Implementing partner assessments
- 18. Audit reports and spot check reports
- 19. Meeting agendas and minutes of joint United Nations working groups
- 20. Donor reports of projects of the UNFPA Zimbabwe CO
- 21. HRP- Humanitarian Response Plan and related reports <https://response.reliefweb.int/> [optional: for CPE with a humanitarian component]
- 22. RRP- Refugee Response Plan and related reports <https://www.unhcr.org/refugee-response-plans> [optional: for CPE with a humanitarian component]
- 23. Evaluations conducted by other UN agencies
- 24. IAHE- Inter-Agency Humanitarian evaluations <https://interagencystandingcommittee.org/inter-agency-humanitarian-evaluations>

15. Annexes

A	Theory of change
B	Stakeholder map (will be provided to the contracted consultants)
C	Excel sheet on analysis of UNFPA interventions (will be provided to the contracted consultants)
D	Tentative evaluation work plan

Annex A : Theory of change

The theories of change for the different thematic areas can be accessed in this [folder](#).

Annex D: Tentative time frame and workplan

Evaluation Phases and Tasks	March 2025				April 2025:				May 2025:				June 2025				July 2025]:				August 2025				September 2025				October 2025			
	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
Design phase																																
Induction meeting with the evaluation team																																
Orientation meeting with CO staff																																
Desk review and preliminary interviews, mainly with CO staff																																
Develop evaluation approach and methodology																																
Conduct first round of interviews																																
Field work preparations																																
Developing the initial communications plan																																
Drafting the design report version 1																																
Quality assurance of design report version 1																																
ERG meeting to present the design report																																
Drafting the design report version 2																																
Quality assurance of design report version 2																																
Submission of final design report to CPEmanager																																
Update of communication plan (based on final stakeholder map and evaluation work plan presented in the approved design report)																																
Fieldwork phase																																
Inception meeting																																

Evaluation Phases and Tasks	March 2025				April 2025:				May 2025:				June 2025				July 2025]:				August 2025				September 2025				October 2025			
	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
for data collection with CO staff																																
Preparations of field phase completed																																
Individual meetings of evaluators with relevant programme officers at CO																																
Data collection (document review, site visits, interviews, group discussions, etc.)																																
Conducting a data analysis workshop																																
Debriefing meeting with CO staff and ERG																																
Update of communication plan (as required)																																
Field phase follow up completed																																
Reporting phase																																
Additional data collection completed																																
Consolidated evaluation matrix produced																																
Drafting of the evaluation report findings completed																																
Drafting of conclusions completed																																
Tentative recommendations drafted																																
Preparation of CPE report version 1 and recommendations worksheet																																
Quality assurance of CPE report version 1 and recommendations worksheet																																
ERG meeting on CPE report version 1																																
Recommendation																																

